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

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 07/06/22 to 07/08/22.	{D 000}		
{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: FOLLOW UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to ensure health care and referrals were followed up on for 3 of 5 sampled residents (#1, #2, #3 and #4) who had orders for a referral to a pain specialist, a daily laxative medication, continuous oxygen with no portable containers (#2 and #4), as needed oxygen with no portable oxygen container (#3), and a resident complaining of sleep apnea and using an oxygen concentrator without notifying the physician (#1). The findings are: 1. Review of Resident #4's current FL2 dated 10/22/21 revealed diagnoses included dementia, chronic obstructive pulmonary disease (COPD), fibromyalgia, pseudoseizures, anxiety, major depressive disorder, and type 2 diabetes. a. Review of Resident #4's physician's order dated 12/10/22 revealed an order which noted	{D 273}		

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{D 273}	Continued From page 1 "please refer pt (patient) out to pain clinic if has not done so - 3rd request." Review of Resident #4's physician's order dated 02/18/22 revealed an order to refer Resident #4 to the pain clinic for a diagnosis of uncontrolled pain syndrome. Interview with the Resident Care Coordinator (RCC) on 07/06/22 at 12:00pm revealed: -She was responsible for reviewing new orders from the primary care provider (PCP) and forwarding any appointment or referral orders to the Scheduler. -She had been aware of the referral order and forwarded it on to the Scheduler. -Resident #4 had not had any appointments scheduled with the pain clinic, she thought it was due to COVID-19 outbreaks. -She did not know where the pain clinic referral for Resident #4 had been sent to. Interview with the Scheduler on 07/06/22 at 2:00pm revealed: -She was responsible for scheduling all appointments and new referral orders. -Resident #4 had not yet been to the pain clinic because either the pain clinic was not accepting patients due to COVID-19 outbreaks, or the facility was not sending residents to appointments due to COVID-19. -She had attempted to schedule Resident #4 to be seen at the pain clinic, but could not remember which pain clinic she had contacted and sent the referral to. Interview with Resident #4 on 07/06/22 at 3:10pm revealed: -She had not had any appointments with the pain clinic.	{D 273}		

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-She wanted to go to the pain clinic because she had chronic pain in her knees, hips, ankle and neck.
-Her pain levels varied but her knee pain was always a 10 out of 10 on the pain scale.
-She thought that she would be more active around the facility if her pain was better controlled.
-She did not have any pain medication ordered for her, so she did not ask the medication aide (MA) for as-needed (PRN) pain medication.

Interview with a MA on 07/07/22 at 12:08pm revealed Resident #4 had not complained of pain or asked her for pain medication.

Interview with a second MA on 07/07/22 at 3:30pm revealed:
-Resident #4 sometimes complained of discomfort but always reported that it resolved after she had something to eat.
-Resident #4 never requested PRN pain medication.

Interview with a third MA on 07/07/22 at 3:44pm revealed:
-Resident #4 sometimes complained of discomfort but related it to being hungry and had never mentioned pain in her knees, hips, ankle or neck.
-Resident #4 had never requested PRN pain medication from her.

Interview with Resident #4's PCP on 07/08/22 at 11:45am revealed:
-She had written several referral orders for Resident #4 to see the pain clinic due to chronic pain in her hips and lower back.
-She referred Resident #4 to the pain clinic because she did not want to manage her pain

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{D 273}	Continued From page 3 due to Resident #4's medical history. -She had not been made aware until that morning that Resident #4 had not been to the pain clinic. -She expected the staff to ensure the referral appointments were scheduled, or to notify her if a resident was unable to be scheduled so that she could make an alternate plan of care. Attempted interview with the Administrator on 07/08/22 at 12:00pm was unsuccessful. b. Review of Resident #4's physician's order dated 11/05/22 revealed there was an order for Miralax (a laxative used to treat constipation) 17 grams once daily mixed with 6 ounces (oz) of fluid, hold for diarrhea. Review of Resident #4's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17 grams in 6oz of fluid daily scheduled at 8:00am. -There was documentation that Resident #4 refused Miralax 16 times from 06/01/22 through 06/30/22. Review of the facility's medication administration policy revealed: -There was a Refusal of Medication Form to be completed for the primary care provider (PCP) after a resident refused a medication three consecutive times. -The form had a space to document the dates of the medication refusals and the reason why the medication was refused. -There was a space on the form to document when the PCP was contacted, and what the PCP's instructions were in response to the medication refusals. -There was a space for the PCP to sign the	{D 273}		

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bottom of the form.

Review of Resident #4's resident record on 07/07/22 revealed there were no Refusal of Medication Forms for Miralax refusals.

Interview with a medication aide (MA) on 07/07/22 at 8:00am revealed:
-She had documented all 16 Miralax refusals for Resident #4.
-Resident #4 had three consecutive days of refusing Miralax on 06/05/22 through 06/07/22 but she had not completed a Refusal of Medication Form.
-She thought she had notified Resident #4's PCP in person regarding her Miralax refusals.

Interview with Resident #4 on 07/07/22 at 9:50am revealed:
-She thought she only refused her Miralax around once per month.
-She took her Miralax with her morning medications, but did not always drink all of it.
-She denied having issues with diarrhea or constipation.
-She did not think that she needed to take Miralax daily and would prefer the order to be changed to as-needed (PRN), but she had not yet made that request to staff or the PCP.

Interview with the Resident Care Coordinator (RCC) on 07/07/22 at 10:20am revealed:
-The MAs were supposed to notify the PCP and RCC after three consecutive medication refusals so that the PCP could either discontinue the order, change it to PRN, or acknowledge the refusals.
-Either the RCC or the MA would notify the PCP about medication refusals, usually by filling out the Refused Medication Form and putting it in the

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PCP's folder for when she was at the facility on Fridays.
-She was not aware that Resident #4 had been refusing Miralax.
-She was responsible for completing audits of the eMAR, but she had been doing audits on an as-needed basis and did not have a schedule for which eMARs to audit.
-She could not remember when she had last audited Resident #4's eMAR.

Interview with Resident #4's PCP on 07/08/22 at 11:45am revealed:
-She could not remember if she had been notified of Resident #4's Miralax refusals or not, but thought that if she had been aware, she would have changed the order to PRN.
-She expected to be notified if a resident refused the same medication three times in a week.
-She was at the facility every Friday which was when staff should notify her about medication refusals unless there was an urgent concern, or it was a high-risk medication.

Attempted interview with the Administrator on 07/08/22 at 12:00pm was unsuccessful.

c. Review of Resident #4's physician order dated 10/22/21 revealed an order for 3 liters (L) of continuous oxygen per minute.

Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for continuous oxygen 3L/minute to be documented three times per day from 7:00am to 2:59pm, from 3:00pm to 10:59pm, and from 11:00pm to 6:59am.
-There was documentation that continuous oxygen was administered at 3L/minute on all

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{D 273}	Continued From page 6 three shifts from 05/01/22 through 05/31/22. Review of Resident #4's June 2022 eMAR revealed: -There was an entry for continuous oxygen 3L/minute to be documented three times per day from 7:00am to 2:59pm, from 3:00pm to 10:59pm, and from 11:00pm to 6:59am. -There was documentation that continuous oxygen was administered at 3L/minute on all three shifts from 06/01/22 through 06/30/22. Review of Resident #4's July 2022 eMAR revealed: -There was an entry for continuous oxygen 3L/minute to be documented three times per day from 7:00am to 2:59pm, from 3:00pm to 10:59pm, and from 11:00pm to 6:59am. -There was documentation that continuous oxygen was administered at 3L/minute on all three shifts from 07/01/22 through 07/06/22. Observation of Resident #4 on 07/06/22 at 2:36pm revealed she was sitting in the dining room participating in an activity and not wearing oxygen. Observation of Resident #4 on 07/08/22 at 11:30am revealed: -Resident #4 walked inside the building from being outside on the smoking patio for approximately 15 minutes and went to the medication cart. -She picked up the pulse oximeter that was on top of the medication cart and checked her oxygen saturation level, which showed as 94%. -She did not have oxygen on or a portable oxygen tank with her in the hallway. Interview with a medication aide (MA) on	{D 273}		

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07/06/22 at 2:30pm revealed:
-Residents who had an oxygen concentrator in their rooms did not have portable oxygen tanks too.
-Resident #4 did not wear her oxygen all the time.
-She thought Resident #4's oxygen order was just to be worn at nighttime.

Interview with Resident #4 on 07/06/22 at 3:10pm revealed:
-She wore her oxygen at 3L/minute as often as she needed it.
-She did not wear oxygen when she was outside of her room because she did not have a working portable oxygen tank.
-She did have a portable oxygen tank in her room that she had from before moving into the facility one year prior, but it did not work because she lost the charging cord for it.
-She thought she had asked one of the facility staff to order her a new charging cord from the medical equipment company, but she could not remember when, or who she had asked.
-Staff were aware that she did not have a portable oxygen tank to use when she was outside of her room, but nobody had ever offered to get her one.
-She did not get short of breath when she was out of her room without her oxygen.

Telephone interview with Resident #4's medical equipment company on 07/07/22 at 2:20pm revealed:
-They had not received any communication from the facility to request a new charging cord for Resident #4.
-They had received an order from the facility in April 2022 for other oxygen supplies for Resident #4 and prior to that was in April 2021.

Interview with a MA on 07/07/22 at 2:35am

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revealed:
-She had been documenting Resident #4's continuous oxygen as administered on the eMAR because Resident #4 wore it constantly except when she was out of her room.
-When Resident #4 was out of her room most of the time she was outside smoking and could not wear it then, so she did not think to get her a portable oxygen tank.
-If Resident #4 needed a portable oxygen tank she would need a separate order for that.
-Resident #4 had never asked her to order a charging cord for her portable tank and she had not been made aware that Resident #4 had a portable tank in her room.

Interview with a second MA on 07/07/22 at 2:40pm revealed:
-She knew that Resident #4 had her own portable oxygen tank in her room but not that she needed a new charging cord for it to work.
-She had never seen Resident #4 wear oxygen when she was outside of her bedroom.
-Resident #4 had never complained of being short of breath.
-She documented Resident #4's oxygen as administered continuously on the eMAR because Resident #4 had the option to wear it continuously in her room, and if she did not have her oxygen on it was her right to refuse it.

Interview with a third MA on 07/07/22 at 3:30pm revealed:
-She knew Resident #4 did not have a working portable oxygen tank.
-To get a portable oxygen tank through the facility she would need a new order for it.
-Resident #4 had asked her to order a new charging cord for her portable oxygen tank but it was a holiday weekend and she worked evening

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shift when companies were not typically open.
-She did not know if anyone on day shift had ordered a new charging cord for Resident #4's portable tank.
-She had not remembered to forward the request for a new charging cord on to the Resident Care Coordinator (RCC) who would be responsible for ordering it.

Interview with the RCC on 07/07/22 at 3:40pm revealed:
-Resident #4 had never asked her to order a new charging cord for her portable oxygen tank.
-It was her responsibility to follow up with the PCP if residents did not have the supplied needed to follow orders as written so that additional follow-up could be done if needed.

Interview with a fourth MA on 07/07/22 at 3:45pm revealed:
-Resident #4 did not wear her oxygen continuously by choice because she only came out of her room to smoke or eat.
-Resident #4 had never requested a portable oxygen tank from her or requested she call and order her a new charging cord for her portable oxygen tank.
-Resident #4 never complained of being short of breath.
-She occasionally checked Resident #4's oxygen saturation level if Resident #4 was agitated about something and it was never below 95%.

Interview with Resident #4's primary care provider (PCP) on 07/08/22 at 11:45am revealed:
-She had just learned that morning that Resident #4 did not have a portable oxygen tank, was not wearing her oxygen continuously, and that she needed a new charging cord ordered for the portable tank she already had in her room.

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-She expected the facility's staff to provide a portable oxygen tank to any resident with an order for continuous oxygen.
-She expected either the MA or the RCC to contact her if an order was needed for a portable oxygen tank.
-She expected to be notified if Resident #4 was not wearing her oxygen continuously so that she could address the reason why and potentially change the order to as-needed rather than continuous.

Attempted interview with the Administrator on 07/08/22 at 12:00pm was unsuccessful.

2. Review of Resident #3's current FL-2 dated 07/25/21 revealed:
-Diagnoses that included dementia, diabetes mellitus, atrial fibrillation, hypertension, coronary artery disease and hyperlipidemia.
-There was an order for 2 liters of oxygen as needed (PRN) for shortness of breath or wheezing.

Review of a signed physician's order dated 06/24/2022 revealed an order for a home health agent to provide portable oxygen tanks.

Interview with Resident #3 on 07/06/22 at 9:23am revealed:
-He used an oxygen concentrator but did not have portable oxygen tanks.
-Three or four physical therapists called a medical equipment company in attempts to get portable oxygen tanks for Resident #3.
-The medical equipment company told Resident #3 on 07/01/22 that the portable oxygen tanks would be delivered on 07/05/22.
-It had been at least two weeks since he had portable oxygen tanks.

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{D 273}	Continued From page 11 -He used oxygen at night and PRN. -He went to eat meals in the dining room and was sometimes short of breath after he returned to his room. Second interview with Resident #3 on 07/07/22 at 9:45am revealed: -A medication aide (MA) and one additional facility staff had called the medical equipment company on 07/06/22 about the oxygen tanks. -The medical equipment company called Resident #3 and said the oxygen tanks would be delivered on 07/07/22. -He had been without portable oxygen for about three weeks. Interview with the Resident Care Coordinator (RCC) on 07/07/22 at 10:08am revealed: -She followed up with the home health agency and they said that Resident #3's oxygen tanks should be delivered to the facility on 07/07/22. -Resident #3 was supposed to have portable oxygen tanks when he went to the hospital on 06/19/22. -Resident #3 told the RCC that he needed more oxygen tanks during the week of 06/19/22. -She told the home health agency that Resident #3 needed portable oxygen tanks during the week of 06/19/22. Observation of Resident #3 in the dining room on 07/07/22 at 12:15pm revealed Resident #3 was eating lunch without wearing any oxygen. Telephone interview with a representative of Resident #3's medical equipment company on 07/07/22 at 3:45pm revealed: -There were voided orders for portable oxygen tanks on 07/05/22. -There were no prior orders for portable oxygen	{D 273}		

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tanks prior to 07/05/22 since 2020.
-No facility staff contacted the company or made an order for the portable oxygen tanks until 07/05/22.

Observation on 07/07/22 at 2:43pm revealed that the portable oxygen tanks were delivered to Resident #3's room.

Telephone interview with a representative from a home health agency on 07/07/22 at 2:56pm revealed that the home health agency did not handle portable oxygen tanks.

Interview with a personal care aide (PCA) on 07/08/22 at 11:08am revealed that she overheard Resident #3 ask a MA about getting portable oxygen tanks about two weeks ago.

Interview with Resident #3's primary care provider (PCP) on 07/08/22 at 12:30pm revealed:
-She expected facility staff to inform her that portable oxygen tanks were not available for Resident #3.
-Oxygen tanks were delivered for Resident #3 on 07/07/22.

Telephone interview with a medication aide (MA) on 07/08/22 at 1:40pm revealed that Resident #3 told her that the oxygen tanks were ordered, but was not sure why they had not gotten to the facility yet.

Telephone interview with the RCC on 07/08/22 at 3:38pm revealed she was responsible for referral and follow-up on the portable oxygen tanks for Resident #3.

The Administrator was unavailable for interview on 07/08/22 at 3:45pm.

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

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{D 273}	Continued From page 13 3. Review of Resident #2's current FL2 dated 06/01/22 revealed diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, asthma, dependence on supplemental oxygen, type II diabetes with diabetic neuropathy, and insulin dependency. Review of Resident #2's hospice notes revealed: -Resident #2 had disabling shortness of breath at rest and endorse chest pain with deep inspiration. -The resident's oxygen saturation had been 84-88% on room air. Observation of Resident #2 on 07/06/22 from 8:50am to 4:40pm revealed the resident was observed greater than five times wheeling himself throughout the facility going to meals, activities and throughout the facility without oxygen. Observation of Resident #2 on 07/07/22 from 9:30am to 4:35pm revealed: -The resident was observed at 9:30am in the dining room without oxygen. -The resident was observed at 10:43am in the common hallway without oxygen. -The resident was observed at 11:12am in the hallway without oxygen. -The resident was observed at 12:20pm in the dining consuming his meal without oxygen. -The resident was observed at 2:30pm participating in an activity for greater than one hour without oxygen. -At 3:30pm the resident's oxygen saturation was 90%. -The resident was observed at 4:35pm in the hallway without oxygen. -The resident eyes were glossy, and was not observed to be experiencing shortness of breath or to be struggling for breaths.	{D 273}		

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Observation of Resident #2 on 07/08/22 from 8:10am to 4:43pm revealed the resident was observed up to ten times wheeling himself throughout the facility going to meals, activities and throughout the facility without oxygen.

Interview with Resident #2 on 07/06/22 at 3:00pm revealed:
-He was supposed to wear his oxygen continuously.
-He did not have any portable tanks to use when he was not in his room.
-The facility did not give him any portable oxygen tanks to use.
-He moved back into the facility the first week of June 2022 and had not had any portable oxygen tanks to use.
-He was sometimes short of breath because he had atrial fibrillation.
-He mostly felt like his head was in a fog.
-He had not said anything to anyone about not having a portable oxygen tank.

Interview with a medication aide (MA) on 07/07/22 at 10:30am revealed:
-When a resident returned to the facility from the hospital or rehabilitation, she gave the paperwork to the Resident Care Coordinator (RCC).
-The RCC was supposed to check the paperwork to ensure the resident had everything needed.

Interview with the Resident Care Coordinator (RCC) on 07/07/22 at 12:00pm revealed:
-She thought hospice was going to order Resident #2's oxygen tanks.
-When a resident went on hospice they usually were responsible for the oxygen.
-Resident #2 returned back to the facility on 06/06/22.
-The resident did not have portable oxygen tanks.

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{D 273}	Continued From page 15 -She had not checked with hospice to find out when they were going to deliver portable oxygen tanks for Resident #2. Interview with the RCC on 07/08/22 at 1:30pm revealed: -She was responsible for making Resident #2 portable oxygen tanks. -She was responsible for making sure hospice or someone was aware the resident needed portable oxygen tanks. Telephone interview with the oxygen company on 07/07/22 at 2:56pm revealed: -The oxygen concentrator currently being used by Resident #2 did not belong to the resident. -The oxygen company had no orders for oxygen for Resident #2. Telephone interview with Resident #2's hospice nurse on 07/07/22 at 3:25pm revealed: -The hospice agency was not responsible for Resident #2's oxygen supply. -There was clause in the contact that some facilities provided oxygen supplies to the resident as part of the contract. -In the hospice notes it noted the facility was supposed to provide Resident #2's oxygen equipment. -If the facility was unable to provide the oxygen equipment they should have let hospice know, and they would have obtained an order for the oxygen. Interview with Resident #2's Primary Care Provider (PCP) on 07/08/22 at 11:41am revealed: -Resident #2 recently returned to the facility. -The resident had a lot of cardiac health problems and should be on oxygen continuously. -She expected the resident to have portable	{D 273}		

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{D 273}	Continued From page 16	{D 273}		

oxygen tanks to use when out of his room.
-She was in the facility every Friday and no one at the facility told her the resident did not have portable oxygen tanks.
-Sometimes facility staff did not share information about the residents with her.
-She expected to be notified if a resident needed something he was not getting.

Attempted interview with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.

4. Review of Resident #1's current FL2 dated 10/22/21 revealed there were no diagnoses listed on the current FL2.

Review of Resident #1's physician's order sheet dated 04/22/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation.
-There was no order for oxygen and no documentation of sleep apnea.

Observation of Resident #1's room during the tour of the facility on 07/06/22 at 8:48am revealed:
-There was a pale light blue oxygen concentrator in the resident's room.
-The back of the concentrator was had by three pieces of clear plastic tape.
-There were no sounds coming from the concentrator as it was in the off position.
-There was hose with a nasal cannula attached coming from the front of the machine.
-The nasal cannula was lying on the floor.
-The machine was dirty and needed to be cleaned.

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Interview with Resident #1 on 07/06/22 at 8:49am revealed:
-The oxygen concentrator was his machine.
-He had sleep apnea and used the machine at night.
-Lately, he did not used the machine every night because it was not working properly.
-The machine was dirty and needed to be cleaned.
-Because the machine was dirty, it caused him to wake up feeling congested.
-He also sometimes had shortness of breath and difficulty thinking.
-He had asked several medication aides (MAs) about getting another machine or getting the one he had cleaned.
-No one at the facility had helped him.
-He had also asked the Resident Care Coordinator (RCC) about helping with his machine.

Interview with the RCC on 07/07/22 at 11:48am revealed:
-She was not aware Resident #1 did not have an order for oxygen.
-She did not recall the resident telling her that his oxygen concentrator needed to be repaired.
-If a resident was given an oxygen concentrator there should be an order, if not the staff needed to let the Primary Care Provider (PCP) know what going on with the resident.

Interview with the MA on 07/06/22 at 10:39am revealed:
-When Resident #1 was admitted to the facility, his family informed that he always used oxygen for comfort measures.
-The facility gave him an oxygen concentrator.
-She did not obtain an order for the oxygen and she did not let the PCP know.

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{D 273}	Continued From page 18 -She was aware the oxygen concentrator was not working properly but there was no current order for oxygen. Telephone interview with Resident #1's mental health provider on 07/07/22 at 2:23pm revealed: -To her knowledge Resident #1 did not have a diagnoses of sleep apnea. -When she visited the resident, she observed the oxygen container, but the resident had never complained of shortness of breath. -The issue was not something she would address, but the Primary Care Provider (PCP) would need to address. Interview with Resident #1's PCP on 07/08/22 at 11:34am revealed: -The facility staff did not let her know the resident requested oxygen. -The facility staff should have requested an order for oxygen. -She continually reinforced to facility staff that they should let her know what was going on with a resident. -Today (07/08/22), she was made aware that Resident #1 continually requested oxygen for sleep apnea. -She also referred Resident #1 for a sleep study on 07/08/22. -She expected to be notified if a resident complained they needed oxygen and there was no order. Attempted interview with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.	{D 273}		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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10A NCAC 13F .0904 Nutrition and Food Service
(e) Therapeutic Diets in Adult Care Homes:
(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure nutritional supplements were served as ordered for 1 of 5 sampled residents (#5) who had an order for nutritional shakes.

The findings are:

Review of Resident #5's current FL2 dated 07/16/21 revealed diagnoses included dementia, delusional disorder, major depressive disorder, physical disability, and adult failure to thrive.

Review of Resident #5's physician's order dated 03/23/22 revealed:
-There was an order for a nutritional shake (a shake drink used to add calories and protein to the diet).
-There was no specification for how many nutritional shakes Resident #5 should have per day.

Observation of Resident #5 on 07/07/22 at 11:00am and 12:15pm, and on 07/08/22 at 8:15am and 9:15am revealed he did not have any nutritional shakes served to him at mealtimes.

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Review of Resident #5's May, June and July 2022 electronic medication administration records (eMAR) revealed there was no entry to document administration of nutritional shakes.

Interview with a medication aide (MA) on 07/07/22 at 12:03pm revealed:
-Resident #5 had not received a nutritional shake since his previous order for them was discontinued last fall of 2021.
-Resident #5 had been refusing to take the nutritional shakes because he thought all medicine was poison, so that was why his previous order had been discontinued.

Interview with the Resident Care Coordinator (RCC) on 07/07/22 at 12:30pm revealed:
-Resident #5 received nutritional shakes three times per day.
-Nutritional shakes were supposed to be on the eMAR for the MAs to document on, but she had forgotten to put the entry back into the eMAR when they were reordered in March 2022.
-She thought that all the MAs knew Resident #5 had nutritional shakes ordered and provided them to him even if they were not documenting it anywhere.

Interview with a dietary aide on 07/07/22 at 12:50pm revealed:
-He had a supply of nutritional shakes in the kitchen and the MAs told him how many they needed, and he gave them that amount each day.
-He did not know which specific residents had nutritional shakes ordered for them.

Interview with a second MA on 07/07/22 at 3:30pm revealed she did not serve Resident #5 nutritional shakes because it was not listed on the eMAR as an order.

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Interview with a third MA on 07/07/22 at 3:45pm revealed:
-Resident #5 did not receive nutritional shakes during her shift.
-If nutritional shakes were due for a resident it would be listed on the eMAR.

Interview with Resident #5's primary care provider (PCP) on 07/08/22 at 11:45am revealed:
-She had ordered the nutritional shakes for Resident #5 due to concerns about malnutrition due to his poor oral intake and need for supplementation.
-She was not aware that Resident #5 had not been receiving nutritional shakes as ordered.
-She expected orders to be followed as written or for staff to contact her if any clarification was needed or if Resident #5 was refusing the shakes.

Based on observation, record review and attempted interview, it was determined Resident #5 was not interviewable.

Attempted interview with the Administrator on 07/08/22 at 12:00pm was unsuccessful.

D 338 — 10A NCAC 13F .0909 Resident Rights — D 338

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

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

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Based on record reviews, observations and interviews the facility failed to ensure 3 of 6 sampled residents (#2, #5 and #6) were free from verbal abuse and provided as needed (PRN) medications as requested from a medication aide (Staff A) who was rude to the residents and yelled at them.

The findings are:

1. Review of Resident #2's current FL2 dated 06/01/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, asthma, dependence on supplemental oxygen, type II diabetes with diabetic neuropathy, and insulin dependency.
-The resident was ordered oxygen at 2 liters continuously.

Review of Resident #2's physician's orders revealed an order dated 06/29/22 for morphine (used to treat pain) 5mg every two hours as needed for pain or shortness of breath.

Review of Resident #2's Care Plan dated 06/10/22 revealed:
-The resident required limited assistance with eating, toileting, ambulation and transferring.
-The resident required extensive assistance with bathing and dressing.
-The resident was totally dependent upon facility staff for dressing.
-The resident was receiving hospice services.

Interview with Resident #2 on 07/07/22 at 3:49pm revealed:
-Today (07/07/22), he asked Staff A for his morphine because his legs and feet were hurting.
-Staff A refused to give him the medication and

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stated "you take the medication like it's candy."
-Staff A told him that he only had 1 syringe of morphine left and he should wait.
-Staff A was rude and she cursed and yelled loudly at him when he asked for his pain medication.
-When Staff A decided to give him his pain medication, she complained as she walked from the office to the medication cart.
-Once at the medication cart Staff A slammed whatever she had in her hand hard on the cart creating a very loud bang.
-He was afraid sometimes to ask ask Staff A for his pain medication.
-When he decided to ask Staff A for his pain medication he was in a lot of pain and the pain was unbearable.
-Staff A sometimes refused to give him his pain medication like she did today.

Observation of Staff A on 07/07/22 at 4:08pm revealed:
-Staff A was sitting in the medication room.
-When asked to check Resident #2's morphine the MA sighed with a loud voice, rolled her eyes and eventually got up out of the chair that she was sitting in and walked to the medication cart.
-Staff A did not say anything as she tossed the morphine on the top of the medication cart.

Observation of Resident #2's medications on 07/07/22 at 4:10pm revealed there were three syringes of morphine available.

Interview with Resident #2 on 07/08/22 at 9:10am revealed:
-Last night when Staff A was administering his insulin he asked again for his morphine because the pain was getting unbearable.
-Staff A sighed loudly, grumbled and cursed.

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-Staff A had a vial of insulin in her hand and slammed it hard on the medication cart making a very loud sound.
-Staff A took the morphine from the medication cart and "jabbed" the needle into his leg.
-It hurt like "hell."
-There were no bruises but his leg was still sore.
-He did not tell anyone because everyone knew how Staff A treated residents and she got away with it.

Interview with Resident #2's hospice nurse on 07/07/22 at 3:41pm revealed:
-Resident #2 was receiving end of life care.
-The resident had an order for morphine 5mg every two hours as needed for pain.
-The medication should be administered to the resident as long as it was within the correct time frames.
-If there were concerns, and morphine was needed, the hospice nurse should be contacted.
-Because the resident was almost out of syringes was not a reason to withhold the medication.
-Resident #2 was a diabetic with ulcers on his legs and feet.
-There was discussion the resident needed his toes amputated and comfort care was decided; therefore, Resident #2 may be in a lot of pain.

Attempted telephone interview with Staff A on 07/08/22 at 1:43pm was unsuccessful.

Attempted interview with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.

Refer to interview with a third resident on 07/08/22 at 2:40pm.

Refer to interview with a fourth resident on

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07/08/22 at 2:48pm.

Refer to interview with a second shift medication aide/personal care aide (MA/PCA) on 07/08/22 at 3:20pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 07/08/22 at 3:43pm.

2. Review of Resident #5's current FL2 dated 05/12/21 revealed:
-Diagnoses included diabetes mellitus, dementia, hypothyroidism, chronic obstructive pulmonary disease (COPD), asthma, conjunctivitis, gastroesophageal reflux disease (GERD) and portal vein thrombosis (PVT).
-There was an order for norco (used to treat pain) 5-325mg 2 tablets three times daily.

Review of Resident #5's care plan dated 12/17/21 revealed:
-The resident required supervision with eating, ambulation and transferring.
-The resident required limited assistance with toileting, bathing, dressing and grooming.
-The resident was currently receiving hospice services.

Interview with Resident #5 on 07/07/22 at 3:59pm revealed:
-Staff A often refused to give her pain medication norco (used to treat pain).
-Staff A told her that she could not get the pain medication because she had a morphine patch on.
-Sometimes she was "doubled over" with the pain in her back because Staff A refused to give her pain medication.
-Staff A was mean, rude and she yelled at residents for no reason.

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-There was no reason to treat residents like they were not human beings and had no feelings.
-She tried not to let it bother her, but it did bother her sometimes that someone could be so mean.
-She had told another MA about how Staff A treated her and sometimes refused to give her medications, but nothing had been done about Staff A.

Attempted telephone interview with Staff A on 07/08/22 at 1:43pm was unsuccessful.

Attempted interview with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.

Refer to interview with a third resident on 07/08/22 at 2:40pm.

Refer to interview with a fourth resident on 07/08/22 at 2:48pm.

Refer to interview with a second shift medication aide/personal care aide (MA/PCA) on 07/08/22 at 3:20pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 07/08/22 at 3:43pm.

3. Review of Resident #6's current FL2 dated 05/22/22 revealed diagnoses included insomnia, cerebrovascular accident, hypertension and behavioral disorder.

Review of Resident #6's Care Plan dated 02/02/22 revealed the resident required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.

Interview with Resident #6 on 07/08/22 at 2:43pm

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revealed:
-Staff A was rude and mean to him.
-Staff A did not curse directly at him, but when she was upset she cursed loudly so everyone could hear her.
-Sometimes when he asked Staff A for his as needed pain medication, and she refused to give the medication.
-Staff A would say she was busy, come back later and she was sitting in the medication room doing nothing.
-When he came back to get his medications Staff A grunted and sighed loudly like she was frustrated and angry.
-When Staff A got to the medication cart, she slammed whatever she had in her hand hard on the medication cart making a loud bang.
-When Staff A gave his medications she "slammed" his medications hard on the on the medication cart causing a loud noise.
-Once when in the dining room Staff A was yelling and cursing so he said "if you do not like your job then quit", Staff A yelled at him and told him to "shut-up."
-Every time Staff A worked; she was mean like that.
-Staff A treated residents with no respect, and he was afraid of Staff A.
-Sometimes he did not ask for his medications because he did not know the mood Staff A was going to be in.
-He hated that he had to go to Staff A for his medications.
-When Staff A worked most of the management staff were gone for the day.
-He told another MA, but nothing had been done about Staff A.

Interview with a resident on 07/08/22 at 2:30pm revealed:

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-He noticed Staff A was rude and yelled at other residents.
-Staff A was "hateful" towards some residents.
-Recently, (a few days ago), he observed Staff A yelling at Resident #6 in the dining room.
-Staff A yelled and told Resident #6 to "shut-up" because the resident said "if she did not like her job then she should get another job."
-Staff A was not rude to him because he talked back to her and she did not refuse to give him his medications.

Interview with a second resident on 07/08/22 at 3:01pm revealed:
-Staff A was sometimes rude and mean to other residents.
-Staff A was not mean to her, but she did not get her medications from Staff A.
-She had observed Staff A being "snappy" with Resident #6 for no reason.

Attempted telephone interview with Staff A on 07/08/22 at 1:43pm was unsuccessful.

Attempted interview with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.

Refer to interview with a third resident on 07/08/22 at 2:40pm.

Refer to interview with a fourth resident on 07/08/22 at 2:48pm.

Refer to interview with a second shift medication aide/personal care aide (MA/PCA) on 07/08/22 at 3:20pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 07/08/22 at 3:43pm.

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____
Interview with a third resident on 07/08/22 at 2:40pm revealed:
-She thought Staff A was mean and had no patience with the residents.
-Staff A did not curse at her but used curse words around her and other residents and she did not like that.
-She remembered Staff A getting angry with another resident and saying things like "all of this just for a [expletive] cigarette?"

Interview with a fourth resident on 07/08/22 at 2:48pm revealed:
-Staff A was very mean and talked rude to the residents.
-She felt if Staff A was upset, she should still respect the residents.
-She thought management was aware how Staff A treated the residents but continued to allow Staff A to be rude and verbally abusive to the residents.

Interview with a second shift medication aide/personal care aide (MA/PCA) on 07/08/22 at 3:20pm revealed:
-Residents had complained to her about Staff A being rude, yelling and calling them names.
-She had even observed Staff A being rude to residents and yelling at the residents.
-She had not observed Staff A refusing to give residents PRN medications but residents had told her that Staff A refused to give them PRN medications.
-She had not told the Administrator but the Resident Care Coordinator (RCC) was aware of how Staff A treated the residents.

Telephone interview with the RCC on 07/08/22 at 3:43pm revealed:

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-No one had made her aware Staff A was rude to the residents.
-To her knowledge the Administrator was not aware of how Staff A treated the residents because he would have said something to her about Staff A.
-When Staff A was hired, she received Residents Rights training from her and the Business Office Manager.
-She had not reported Staff A to the Health Care Personnel Registry because no one made her aware of how Staff A treated the residents.

Interview with the Activity Director on 07/08/22 at 4:11pm revealed:
-During a resident council meeting on 03/11/22, the residents brought up that staff were rude and mean to them.
-She was unable to recall if Staff A's name was specifically mentioned.
-The Administrator talked with staff about respecting others.

____
The facility failed to ensure residents were free from verbal abuse, treated with respect and dignity, resulting in residents being denied PRN pain medications when requested, yelled at or were cursed at by Staff A. The facility's failure resulted in residents experiencing increased pain and fear of Staff A, which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

____
The facility provided a plan of protection in accordance with G.S. 131D-34 on July 8, 2022 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 22, 2022

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{D 358}	10A NCAC 13F .1004(a) Medication Administration	{D 358}		

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2 and #3) including a resident with errors administering insulin and an as needed (PRN) insulin order not being restarted (#3), and errors administering the correct units of insulin and not administering diuretic medication (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 07/25/21 revealed diagnoses that included dementia, diabetes mellitus, atrial fibrillation, hypertension, coronary artery disease and hyperlipidemia.

a. Review of Resident #3's current FL-2 dated 07/25/21 revealed that there was an order for Novolin 100 units/ml inject 12 units subcutaneously three times a day (TID) with

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{D 358}	Continued From page 32 meals, hold if blood sugar less than 100 or not eating. Review of a signed physician's order dated 05/13/22 revealed an order for Novolin R Flexpen 100 unit/ml: inject 28 units subcutaneously TID, hold if blood sugar less than 100 or not eating. Review of Resident #3's May 2022 electronic medication administration record (eMAR) from 05/22/22 to 05/31/22 revealed: -There was an entry for Novolin R Flexpen 100 unit/ml: inject 28 units subcutaneously TID, hold if blood sugar less than 100 or not eating with administration times of 7:00am, 12:00pm, and 5:00pm. -There was a second entry for Novolin R Flexpen 100 unit/ml: inject 15 units subcutaneously TID, hold if blood sugar less than 100 or not eating with administration times of 6:30am, 11:30am, 4:30pm, and 8:00pm. -There was documentation that 28 units of insulin was administered as ordered from 05/22/22 to 05/31/22. -There was documentation that 15 units of insulin was administered at 4:30pm on 05/23/22 and 05/24/22 and at 8:00pm on 05/23/22, 05/24/22, 05/26/22, and 05/31/22. -There was documentation that both the 28 units of insulin and 15 units of insulin were administered to Resident #3 within 30 minutes of one another on three occasions from 05/22/22 to 05/31/22. -Resident #3's blood sugar values were 451, 459, and 478 when both doses of insulin were documented as administered. -Resident #3's blood sugar ranged from 89 to 571 from 05/22/22 to 05/31/22. Review of Resident #3's signed physician's order	{D 358}		

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{D 358}	Continued From page 33	{D 358}		

sheet dated 06/08/22 revealed that there was an order for Novolog 100 units/ml flexpen: inject 5 units subcutaneously four times daily as needed (PRN) for blood sugar greater than 450, recheck in 1 hour and if blood sugar not lower, notify provider.

Review of Resident #3's signed physician's order dated 06/10/22 revealed that there was an order for Novolin R flexpen inject 28 units subcutaneously with breakfast and lunch time; and 25 units subcutaneously at dinner time, hold if blood sugar is less than 100 and/or patient is not eating.

Review of Resident #3's signed physician's order dated 06/17/22 revealed that there was an order for Novolin R flexpen inject 15 units subcutaneously three times a day, hold if blood sugar is less than 100 and/or patient is not eating.

Review of Resident #3's June 2022 eMAR revealed:
-There was an entry from 06/01/22 to 06/10/22 for Novolin R Flexpen 100 unit/ml: inject 28 units subcutaneously TID, hold if blood sugar less than 100 or not eating with administration times of 7:00am, 12:00pm, and 5:00pm.
-There was a second entry from 06/01/22 to 06/20/22 for Novolin R Flexpen 100 unit/ml: inject 15 units subcutaneously TID, hold if blood sugar less than 100 or not eating with administration times of 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation that 15 units of insulin was administered at 6:30am on 06/02/22.
-There was documentation that 28 units of insulin was administered at 7:00am on 06/02/22.
-Resident #3's blood sugar was documented as 139 at 6:30am on 06/02/22.
-There was an entry from 06/11/22 to 06/19/22 for

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Novolin R Flexpen 100 unit/ml: inject 28 units subcutaneously twice daily (breakfast and lunch), hold if blood sugar less than 100 or not eating with administration times of 7:00am and 12:00pm.
-There was an entry from 06/11/22 to 06/19/22 for Novolin R Flexpen 100 unit/ml: inject 25 units subcutaneously with dinner, hold if blood sugar less than 100 or not eating with an administration time of 5:00pm.
-The 5:00pm dose of insulin was marked as "held per MD orders" on 06/13/22, 06/14/22, 06/15/22, and 06/18/22.
-Resident #3's blood sugar ranged from 116-371 at 5:00pm on 06/13/22, 06/14/22, 06/15/22, and 06/18/22.
-Resident #3's blood sugar ranged from 59 to 481 from 06/01/22 to 06/30/22.

Review of Resident #3's signed physician's order dated 07/01/22 revealed:
-There was an order for Novolin R flexpen inject 3 units subcutaneously three times a day with meals, hold if blood sugar is less than 100 and/or patient is not eating.
-There was an order for "continue on Novolog PRN order as is."

Review of Resident #3's July 2022 eMAR revealed:
-There was an entry for Novolin R flexpen 100 unit/ml: inject 3 units three times a day with meals, hold if blood sugar less than 100 or patient is not eating.
-There was a discontinued order entry with a stop date of 06/20/22 for Novolin R Flexpen 100 unit/ml: inject 28 units subcutaneously twice daily (breakfast and lunch), hold if blood sugar less than 100 or not eating with administration times of 7:00am and 12:00pm.

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-There was not an entry for Novolog 100 units/ml flexpen: inject 5 units subcutaneously four times daily as needed (PRN) for blood sugar greater than 450, recheck in 1 hour and if blood sugar not lower, notify provider.
-A medication aide (MA) documented administration of the discontinued order of 28 units of insulin at 7:00am on 07/04/22.
-Resident #3's blood sugar values were 481 on 07/04/22 at 8:00pm and 464 on 07/05/22 at 8:00pm.

Observation of Resident #3's medications on hand on 07/07/22 at 12:15pm revealed:
-There was one Novolin R flexpen available for administration.
-There were no other vials of insulin for Resident #3.

Interview with Resident #3 on 07/07/22 at 9:45am revealed:
-He was in the hospital for a few days in June 2022 related to shortness of breath.
-His basal insulin order was currently 10 units twice a day.
-There was never a time when facility staff had administered two different doses of short-acting insulin to him in a short time period.
-If he received 15 units and 28 units of insulin within 30 minutes of one another as indicated on his eMAR, he was not aware of it.
-His current medication order for Novolin was 3 units three times a day.
-If his blood sugar ranged from 100-120, he refused his insulin.

Telephone interview with a medication aide (MA) on 07/08/22 at 1:40pm revealed:
-There was sometimes an issue on the eMAR when she tried to document the number of units

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of insulin administered to Resident #3.
-She thought that the Resident Care Coordinator (RCC) was responsible for new orders on the eMAR.
-She thought that the RCC was aware that there was an issue on the eMAR when she tried to document the number of units of insulin administered to Resident #3.
-The pharmacy put new orders on the eMAR and the RCC approved the orders.
-Discontinued orders needed to be approved to be removed from the eMAR.
-MAs were able to approve discontinued orders on the eMAR.
-Resident #3 refused insulin if his blood sugar was below a certain number.
-Resident #3 refused insulin from 06/13/22 to 06/18/22 and it was documented on the eMAR.
-She administered 28 units of insulin to Resident #3 on 05/23/22 and 05/24/22 as ordered.
-She did not administer 15 units of insulin to Resident #3 on 05/23/22 and 05/24/22.
-She thought that the issues with insulin documentation was the reason for both orders being documented as administered to Resident #3 on 05/23/22 and 05/24/22.

Interview with a second MA on 07/08/22 at 2:20pm revealed:
-She was not sure why there were old medication orders that were still on the eMAR for Resident #3.
-She had documented "pending discontinue (d/c) order" on the eMAR for most of the old insulin orders.
-She clicked the wrong order in the eMAR system on 07/04/22 and documented administration of the discontinued order of 28 units.
-Resident #3 received 3 units of insulin on 07/04/22.

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-MAs were able to approve new orders before they were on the eMAR.
-The RCC was responsible to ensure that there were no old or discontinued orders on the eMAR.
-Resident #3 refused insulin on several occasions in June 2022.
-She was not aware that the PRN order for 5 extra units of insulin for a finger-stick blood sugar (FSBS) greater than 450 was not on the eMAR.

Interview with Resident #3's PCP on 07/08/22 at 12:18pm revealed:
-She was not aware that there were multiple orders of Novolin on the eMAR in May and June 2022.
-She expected the facility to administer the 28 units of Novolin that was ordered from 05/22/22 to 06/10/22.
-She was concerned about hypoglycemia for Resident #3 related to multiple orders of insulin that were documented as administered on the eMAR.
-She expected the PRN order for 5 extra units of insulin for a FSBS greater than 450 to be on the eMAR and administered if Resident #3's FSBS was greater than 450.
-She was concerned about potential hypoglycemia for Resident #3 because the discontinued order of 28 units of insulin was documented as administered instead of the ordered 3 units on 07/04/22.
-No facility staff informed her that there were multiple insulin orders on the eMAR or clarified which orders to administer.
-Resident #3 refused his insulin if his FSBS was below a certain number.
-If Resident #3 refused his insulin she expected the facility to document refusals so that she could review his eMARs when she visited the facility weekly.

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Interview with the RCC on 07/08/22 11:15am revealed:
-She was not aware that there were multiple orders of short-acting insulin on the eMAR for Resident #3.
-MAs were responsible to clarify different medication orders with the PCP.
-The pharmacy normally entered new orders and removed discontinued orders from the eMAR.
-MAs were expected to compare physician orders for Resident #3 to the eMAR.
-If there was a difference in the physician orders and the orders on the eMAR, MAs should let the RCC know so that she could complete an order clarification.
-There was an issue with verifying units of insulin in the eMAR system and she had reported it to the pharmacy.
-She thought that some of the MAs were not aware of which insulin order they documented as administered.
-There were old Novolin orders that were discontinued on 06/20/22 that were still displayed on the eMAR.
-The RCC normally approved or rejected discontinued orders so that they would no longer be on the eMAR.
-Some of the old insulin orders were locked, and she was unable to remove them from the eMAR.
-She was not sure how a MA documented administration of 28 units of insulin to Resident #3 on 07/04/22 when the order was discontinued.
-She was not aware that the PRN order for 5 extra units of insulin for a FSBS greater than 450 was not restarted as ordered on 07/01/22.
-MAs were responsible to administer the correct amount of medication.
-Both the RCC and MAs were responsible to ensure that the correct orders were on the eMAR

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{D 358}	Continued From page 39 and to clarify physician orders. Attempted interviews with The Administrator on 07/06/22, 07/07/22, 07/08/22 from 8:00am to 4:45pm were unsuccessful. b. Review of Resident #3's current FL-2 dated 07/25/21 revealed that there was an order for Basaglar 100 units/ml inject 50 units subcutaneously twice a day (BID). Review of Resident #3's signed physician's order dated 06/24/22 revealed that there was an order to decrease Basaglar kwikpen U-100 insulin to inject 10 units subcutaneously twice a day. Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check finger stick blood sugar (FSBS) three times daily and at bedtime. -There was an entry for Basaglar (a long-acting insulin) 100 unit/ml kwikpen inject 50 units subcutaneously twice daily. -There were no hold parameters on the Basaglar order. -There were 12 of 37 opportunities where Basaglar was documented as "held per MD orders," "physically unable to take" due to low FSBS or "resident refused" on the eMAR. -Resident #3's blood sugar ranged from 59 to 396 from 06/01/22 to 06/19/22. -Resident #3 was in the hospital from 06/19/22 to 06/24/22. Observation of Resident #3's medications on hand on 07/07/22 at 12:15pm revealed one Basaglar kwikpen was available for administration.	{D 358}		

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Interview with Resident #3 on 07/07/22 at 9:46am revealed:
-He was administered 50 units of the Basaglar insulin before he went to the hospital per his primary care provider's (PCP) orders.
-His basal insulin order was currently 10 units twice a day.
-If his blood sugar ranged from 100-120, he refused his insulin.

Telephone interview with a medication aide (MA) on 07/08/22 at 1:41pm revealed Resident #3 refused insulin if his blood sugar was below a certain number.

Interview with a second MA on 07/08/22 at 2:21pm revealed she offered Resident #3 his Basaglar kwikpen several times in June 2022 and he refused.

Interview with Resident #3's PCP on 07/08/22 at 12:19pm revealed:
-She expected the MAs to administer the Basaglar kwikpen to Resident #3.
-She was aware that Resident #3 refused his insulin if his blood sugar was below a certain number.
-If Resident #3 refused his insulin she expected the facility to document refusals so that she could review his eMARs when she visited the facility weekly.

Interview with the Resident Care Coordinator (RCC) on 07/08/22 11:16am revealed:
-MAs were responsible to administer the correct amount of medication.
-There was an issue with verifying units of insulin in the eMAR system.
-She thought that the MAs accidentally clicked "held per MD orders" on the eMAR for the basal

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insulin.

Attempted interviews with The Administrator on 07/06/22, 07/07/22, 07/08/22 from 8:00am to 4:45pm were unsuccessful.

2. Review of Resident #2's current FL2 dated 06/01/22 revealed diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, asthma, dependence on supplemental oxygen, type II diabetes with diabetic neuropathy, and insulin dependency.

a. Review of Resident #2's current FL2 dated 06/01/22 revealed an order for humalog insulin (fast acting insulin used to lower blood sugar) provided subcutaneously before meals with parameters for sliding scale: 201-250= 2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; greater 500 call the physician.

Review of Resident #2's physician's order sheet dated 06/10/22 revealed:
-There was an order for fingerstick blood sugars (FSBS) three times daily.
-There was an order for humalog 12 units three times daily before meals; hold for blood sugars less than 100.
-There was an order for humalog 3 units four times daily for blood sugars greater than 450; recheck within one hour if not lower call the physician.

Review of Resident #2's May 2022 electronic medication administration record (eMAR) from 05/01/22 through 05/03/22 revealed:
-There was an entry for FSBS three times daily scheduled at 6:00am, 12:00pm and 5:00pm.
-There was documentation Resident #2's FSBS

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was checked 9 times from 05/01/22 through 05/03/22.
-There was documentation Resident #2's FSBS was within range for humalog 7 out of 9 opportunities.
-There was documentation humalog was not administered on 05/02/22 at 5:00pm and the FSBS was 141.
-The medication aide (MA) circled her initials and documented on the eMAR "withheld per DR/RN orders."
-There was documentation Resident #2 was out of the facility in the hospital and then in rehabilitation from 05/04/22 through 06/06/22.
-Resident #2's FSBS ranged between 91 and 221 from 05/01/22 through 05/03/22.

Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS three times daily scheduled at 6:00am, 12:00pm and 5:00pm.
-There was documentation Resident #2's FSBS was checked 73 times from 06/06/22 through 06/30/22.
-There was documentation Resident #2's FSBS was in range for humalog 69 out of 73 opportunities.
-There was documentation humalog was not administered by staff circling their initials and documenting "withheld per DR/RN orders."
-There was documentation Resident #2's humalog was not administered 19 times by the MA circling initials and documenting "withheld per DR/RN orders" when the resident's FSBS was greater than 100 and required insulin with examples as follows:
-On 06/06/22 at 5:00pm, FSBS was 265, no insulin administered.
-On 06/08/22 at 5:00pm, FSBS was 149, no

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{D 358}	Continued From page 43 insulin administered. -On 06/13/22 at 5:00pm, FSBS was 125, no insulin administered. -On 06/14/22 at 5:00pm, FSBS was 118, no insulin administered. -On 06/15/22 at 5:00pm, FSBS was 112, no insulin administered. -On 06/16/22 at 5:00pm, FSBS was 175, no insulin administered. -On 06/18/22 at 5:00pm, FSBS was 121, no insulin administered. -On 06/19/22 at 5:00pm, FSBS was 122, no insulin administered. -On 06/20/22 at 5:00pm, FSBS was 131, no insulin administered. -On 06/22/22 at 5:00pm, FSBS was 166, no insulin administered. -On 06/23/21 at 5:00pm, FSBS was 136, no insulin administered. -On 06/27/22 at 5:00pm, FSBS was 123, no insulin administered. -On 06/28/22 at 5:00pm, FSBS was 129, no insulin administered. -On 06/30/22 at 5:00pm, FSBS was 112, no insulin administered. -Resident #2's FSBS ranged between 87 and 265 from 06/06/22 through 06/30/22. Review of Resident #2's July 2022 eMAR from 07/01/22 through 07/07/22 revealed: -There was an entry for FSBS three times daily scheduled at 6:00am, 12:00pm and 5:00pm. -There was documentation Resident #2's FSBS was checked 14 times from 07/01/22 through 07/06/22. -There was documentation Resident #2's FSBS was within range for insulin 10 of the 14 opportunities. -There was documentation Resident #2 was not administered humalog as ordered 2 times when	{D 358}		

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the resident's FSBS was greater than 100 as follows:
-On 07/02/22 at 5:00pm, FSBS was 138, no insulin was administered. Staff circled initials and documented "withheld per DR/RN orders."
-On 07/04/22 at 5:00pm, FSBS was 172, no insulin was administered. Staff circled initials and documented "withheld per DR/RN orders."
-Resident #2's FSBS ranged between 73 and 243 from 07/01/22 through 07/06/22.

Observation of Resident #2's medications on hand on 07/08/22 at 10:33am revealed humalog was available for administration.

Interview with Resident #2 on 07/08/22 at 9:10am revealed:
-He was a diabetic and was ordered insulin, he thought he was ordered humalog and lantus, but was not sure.
-The MA checked his FSBS four times daily.
-The MA did not tell him what his FSBS was.
-Insulin was administered, but the MA did not tell him the units of insulin administered.
-If insulin was not administered, he guessed it was because his blood sugar was low and did not require insulin.

Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 1:30pm revealed:
-She completed eMAR and cart audits every two weeks.
-She had been busy lately and had not completed audits since 05/27/22.
-She was aware there was problem with the eMAR system not accepting units of insulin administered.
-She had discussed the issue with the pharmacy, maybe twice but the pharmacy had done nothing to correct the issue.

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-She told the MAs to document the units of insulin administered in the progress notes to show the medication was administered.
-She searched the progress notes for Resident #2 and was unable to find where the MA documented that she administered the resident's insulin.
-The expectation was that the MAs read the eMAR and administered the medications according to the orders.

Interview with a MA on 07/07/22 at 10:30am revealed:
-She and another MA did cart audits daily.
-Her audits consisted of going through the control drug book and checking the medications on hand.
-She did not look at the units of insulin administered because any errors would be after the fact and MAs would not be able to go back to correct the errors.
-She was aware that when entering the units of insulin for some residents the eMAR system did not accept certain numbers due to a problem with the system.
-The MA was supposed to manually enter the units in the progress notes to show the insulin was administered.
-She had never had a problem entering the units of insulin administered for Resident #2 on the eMAR.

Telephone interview with the second shift MA on 07/08/22 at 1:43pm revealed:
-Sometimes the eMAR system kicked out the units of insulin entered.
-There was a way to do a nurse's note to show she administered the resident's insulin.
-She was unable to explain why she did not document in the nurse notes that she

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administered Resident #2's insulin 17 of the 19 times the resident's insulin was documented as not administered.

Interview with Resident #2's Primary Care Provider (PCP) on at 11:41am revealed:
-Resident #2 had venous stasis with ulcers on his legs and feet.
-The resident was diabetic and medications should be administered as ordered.

Attempted interview with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.

b. Review of Resident #2's physician's order sheet dated 06/10/22 revealed:
-There was an order for daily weights in the morning.
-There was an order for bumetanide 2mg as needed daily (used to treat edema/fluid in the body) for weight gain of 3 pounds within 24 hours or 5 pounds within one week.
-There was an order for metolazone 2.5mg twice daily (used to reduce excess water in the body) to be given with bumetanide 2mg for a weight gain of 3 pounds within 24 hours or 5 pounds within one week.

Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for daily weights scheduled at 8:00am.
-There was an entry for evening weights with the notation "validate if twice daily as needed medication needed to be given on second shift" scheduled at 4:00pm.
-On 06/12/22, Resident #2's documented weight was 260 pounds.

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-On 06/13/22, Resident #2's documented weight was 268 pounds.
-There was no documentation bumetanide 2mg and/or metolazone 2.5mg was administered as ordered.
-On 06/29/22, Resident #2's documented weight was 211 pounds.
-On 06/30/22, Resident #2's documented weight was 272.4 pounds.
-There was no documentation bumetanide 2mg and/or metolazone 2.5mg was administered as ordered.

Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for evening weights scheduled at 4:00pm with the notation "validate if twice daily as needed medication needed to be given on second shift."
-There was documentation Resident #2 weighed 267 pounds from 06/07/22 through 06/11/22.
-There was documentation Resident #2 weighed 262 pounds from 06/12/22 through 06/16/22.
-There was documentation Resident #2 weighed 272 pounds from 06/17/22 through 06/30/22.
-Based on the documented weights Resident #2 had weight gain and required the administration of bumetanide 2mg and metolazone 2.5mg was administered as ordered as follows:
-On 06/25/22 at 8:00am, the weight was 211 at 4:00pm the weight was 272.
-On 06/26/22 at 8:00am, the weight was 211 at 4:00pm the weight was 272.
-On 06/27/22 at 8:00am, the weight was 211 at 4:00pm the weight was 272.
-On 06/28/22 at 8:00am, the weight was 211 at 4:00pm the weight was 272.
-On 06/29/22 at 8:00am, the weight was 211 at 4:00pm the weight was 272.

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-There was no documentation metolazone 2.5mg was administered as ordered.

Observation of Resident #2's medications on hand on 07/08/22 at 10:33am revealed:
-Bumetanide 2mg was available for administration.
-Metolazone 2.5mg was available for administration.

Interview with Resident #2 on 07/08/22 at 9:10am revealed:
-He was supposed to be weighed daily because of his heart condition.
-He was not weighed by the MA this morning.
-He was not sure where the MA got the weight that she told the surveyor.
-Sometimes staff weighed him in the morning but not every day.
-Facility staff never weighed him in the evening, instead of weighing him they asked him how much he weighed.
-When he told staff the weight, he was not sure if the weight was accurate because he did not weigh himself.
-No medication was administered based on his weight.

Interview with the medication aide (MA) on 07/08/22 at 8:35am revealed:
-She had weighed Resident #2 this morning.
-The resident's weight was 258 pounds.
-She did not administer the resident any medications based on the weight.

Observation of Resident #2 on 07/08/22 at 11:25am revealed:
-Resident #2 was sitting in his wheelchair and wheeled himself to the hallway scale.
-Staff assisted him to standing up and stepping

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on the scale.
-The weight reading was 264.2 pounds.
-The residents legs were wrapped and edema could not be identified.

Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 1:30pm revealed:
-If there was an order for weights, then Resident #2 should have been weighed twice daily according to the order and the weights documented on the eMAR.
-The MA should not ask the resident how much he weighed but they should weigh the residents.
-If the resident refused to be weighed it should be documented on the eMAR and followed-up with the resident's doctor.
-She was not aware Resident #2 was not being weighed twice daily as ordered.
-She was not aware Resident #2's medications were not administered when the resident weighed 3 pounds more within 24 hours or 5 pounds within one week.

Telephone interview the second shift MA on 07/08/22 at 1:43pm revealed:
-She did not weigh Resident #2 in the evening because there was no order to weigh the resident.
-She copied the 8:00am weight for the 4:00pm weight.
-When asked why the 8:00am and 4:00pm weights did not correspond with each other the MA became extremely loud, yelled and cursed and hung up.

Interview with Resident #2's PCP on 07/08/22 at 11:41am revealed:
-Resident #2 had venous stasis with ulcers on his legs and toes.
-The resident had toes amputated on both his

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right and left foot.
-The resident had cardiac health problems and weight gain could be detrimental for the resident.
-The resident had been in the hospital several times this year already for a variety of health complications, all medications should be administered as ordered.
-The order for Resident #2's bumetanide 2mg as needed for weight gain 3 pounds within 24 hours or 5 pounds within one week was initiated by the resident's cardiologist.
-She signed the eMAR with the medication listed for the medication to continue to be administered.
-If the facility staff were not sure how to implement the order, they should have let her know.

Attempted interview on 07/08/22 at 11:41am with Resident #2's cardiologist was unsuccessful.

Attempted interviews with the Administrator on 07/06/22, 07/07/22, and 07/08/22 from 8:00am to 4:45pm were unsuccessful.

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The facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents including a resident who was at risk for hypoglycemia by receiving the incorrect number of units of insulin, and at risk for hyperglycemia by not receiving an as needed insulin (#3); and a resident who was at risk for edema and exacerbation of a heart condition from not receiving as needed fluid retention medication, and at risk for hyperglycemia by not receiving the correct number of units of insulin (#2). This failure was detrimental to the health, safety, and welfare of the residents which constitutes an Unabated Type B Violation.

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The facility provided a plan of protection in

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 07/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 51 accordance with G.S. 131D-34 on July 8, 2022 for this violation.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2 and #3) for record review including a resident with errors administering insulin and an as needed (PRN) insulin order not being restarted (#3), and errors administering the correct units of insulin and not administering diuretic medication (#2). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
D914	Continued From page 52 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure all residents were free from verbal abuse and neglect related to residents' rights. The findings are: Based on record reviews, observations and interviews the facility failed to ensure 3 of 6 sampled residents (#2, #5 and #6) were free from verbal abuse and provided as needed (PRN) medications as requested from a medication aide (Staff A) who was rude to the residents and yelled at them. [Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		