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 |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

RECEIVED OCT 28 2015 ADULT CARE LICENSURE SECTION RALEIGH

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 86 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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<br><br>The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted a follow-up survey and complaint investigation on September 22, 23, and 24, 2015. The Caldwell County DSS initiated the complaint investigation on September 10, 2015. | {D 000} | Management Team consisting of Administrator and AIC are conducting meetings for each shift two times monthly. Supervisors meetings, dietary and housekeeping and maintenance meetings held monthly. Also family meetings to open lines of communication to ensure all area of non-compliance areas corrected. Daily assignment sheets for individual staff will allow for better reporting of issues with residents to assure timely action with any concern.<br><br>Daily and weekly assessments by AIC, special care coordinator and Supervisors to report any changes with residents | 10-23-15 |
| D 176 | 10A NCAC 13F .0601 (a) Management Of Facilities<br><br>10A NCAC 13F .0601Management Of Facilities<br><br>(a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, personal care and supervision, medication administration, Health Care Personnel Registry, and resident | D 176 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyn McKeal — TITLE: administrator — (X6) DATE: 10-26-15



10-26-15

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 176 | Continued From page 1<br>rights.<br><br>The findings are:<br><br>Interview with the Administrator-In-Charge on 9/22/15 at 3:15pm revealed the Administrator was present in the facility monthly for staff meetings, and daily at shift change.<br><br>The Administrator was not on-site at the facility during the survey.<br><br>Areas of non-compliance identified during the survey were:<br><br>A. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 8 sampled residents (#5) received supervision in accordance with resident's needs concerning confusion associated with urinary tract infection. [Refer to D270 NCAC 13F .0901(b) Personal Care and Supervision. (Type A2 Violation.)]<br><br>B. Based on observations, record reviews, and interviews, the facility failed to assure medications (Imdur, Sinemet CR, and Acetaminophen) were administered as ordered by a licensed prescribing practitioner to 1 of 4 residents (#9) observed during a morning medication pass. [Refer to D358 NCAC 13F .1004(a) Medication Administration.]<br><br>C. Based on observations, record reviews, and interviews, the facility failed to assure medications (Imdur, Sinemet CR, and Acetaminophen) were administered as ordered by a licensed prescribing practitioner to 1 of 4 residents (#9) observed during a morning medication pass. [Refer to D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B | D 176 | associated with behavioral changes, medication changes and fall risk.<br>All residents with new antibiotic orders or behavioral changes will be monitored for seven-teen days from 30 minute to 2 hours based on physician's direction. 102315<br><br>Contacted Royal Apothecary pharmacy, pharmacist and have made changes to all medication labeling and MAR's to include the wording "Do Not Crush" where applicable. AIC will review MAR's and med containers to assure accuracy. Organy training with med-tech's monthly 102315 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 176 | Continued From page 2<br>Violation.)]<br><br>A plan of protection was requested from the facility on 10/9/15.<br><br>THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2015. | D 176 | And unannounced reviews.<br><br>Management team conducted 10-23-15 in-service training for all staff on 9-25-15 concerning reporting to Healthcare Personnel Registry (HCPR) Facility updated policy on HCPR and will continue training monthly with all staff. Next meeting will be Nov 20th 2015. | |
| (D 270) | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO A TYPE A1 VIOLATION<br><br>Based on these findings, the previous Type A1 Violation was abated, noncompliance continues.<br><br>TYPE A2 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to assure 1 of 8 sampled residents (#5) received supervision in accordance with resident's needs concerning confusion associated with urinary tract infection.<br><br>The findings are:<br><br>Review of Resident #5's current FL2, dated | (D 270) | In addition to plan of protection dated 10-9-15, any resident with antibiotic orders, increased confusion or behavioral changes will be monitored from 30 minutes to 2 hours based physician's direction. | 10-23-15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 3<br><br>6/1/15 revealed:<br>-Diagnoses of atrial fibrillation, muscle weakness, aftercare following joint replacement, history of TIA (transient ischemic attack), hypertrophy prostate, hypothyroidism, osteoarthritis and HTN (hypertension).<br>-Resident was semi-ambulatory.<br>-Resident #5's functional limitations included sight.<br>-Resident's special care factors included PT (physical therapy) and OT (occupational therapy).<br><br>Review of Resident #5's facility Admission Face Sheet dated 6/2/15 revealed:<br>-Medical diagnoses of blindness of both eyes-impairment level not further specified, abnormal involuntary movements, unspecified acquired hypothyroidism, and osteoarthritis.<br><br>Review of Resident #5's Care Plan dated 7/2/15 revealed:<br>-Resident was a fall risk.<br>-Resident required a tab alarm.<br>-Resident required the use of a wheelchair.<br>-Resident was sometimes disoriented.<br>-Resident was forgetful and needed reminders.<br>-Resident required assistance with all activities of daily living (eating- limited assistance; toileting-extensive assistance; ambulation/locomotion-limited assistance; bathing-extensive assistance; dressing-extensive assistance; grooming/personal hygiene-extensive assistance; transferring-limited assistance).<br><br>Review of Resident #5's Licensed Health Professional Support Form, dated 7/2/15 revealed:<br>-Diagnoses included dementia, falls.<br>-Physical therapy and occupational therapy were ordered. | (D 270) | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 4<br>-Resident required ambulation with a walker and 1 person stand by.<br>-Resident required one person assist to transfer.<br>-Resident required the use of a tab-alert at all times.<br><br>Review of Resident #5's Family Nurse Practitioner Note, dated 8/24/15 revealed:<br>-Resident was seen for dysuria and increased confusion.<br>-Resident was oriented x2 and slow of thought.<br>-Resident was to be monitored to see if he was developing dementia.<br>-Documentation included: "not sure if his intermittent confusion has to do with dementia or if he has a urinary tract infection (UTI)."<br><br>Review of Resident #5's Family Nurse Practitioner Note, dated 7/15/15 revealed:<br>-Resident was seen "for follow up for urinalysis that was obtained on 7/10/15 for increased behaviors by staff."<br>- "Poor vision and does not distinguish objects well."<br><br>Review of Resident #5's hospital laboratory services report, dated 7/10/15 revealed:<br>-Urinalysis positive for nitrate, (indicating a urinary tract infection.)<br>- "Macrobid was ordered on 6/29/15 for 7 days, and was completed" and signed by the Family Nurse Practitioner.<br><br>Review of Resident #5's physician orders revealed:<br>- On 6/2/15 continued use of a wheelchair, physical therapy and occupational therapy evaluation and treatment, use of tab-alert at all times to prevent falls.<br>-On 8/24/15 obtained a urinalysis and C&S | (D 270) | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 5<br>(culture and sensitivity) for dysuria, due to increased confusion and resident talking to self.<br>-On 7/10/15 obtained a urinalysis and C&S, due to urine having strong odor and increased confusion.<br>-On 9/1/15 obtained a urinalysis and C&S.<br>-On 9/9/15 discontinued Macrobid and begin Doxycycline for UTI, due to increased behaviors, talking to self, seeing unusual things, sitting on front porch and rolling to road, recent UTI.<br><br>Per record review, Macrobid was ordered as a result of the urinalysis on 9/1/15.<br><br>Review of Resident #5's September 2015 Medication Administration Record revealed:<br>-On 9/4/15, administration began for Macrobid 100mg, 1 tablet twice a day and continued until 9/9/15.<br>-On 9/9/15 Macrobid was discontinued.<br>-on 9/9/15 administration began for Doxycycline 100mg, 1 tablet twice a day for 10 days.<br><br>Review of Resident #5's Nurses Notes revealed:<br>-On 6/24/15 home health obtained a urinalysis.<br>-On 9/2/15 home health obtained a urinalysis.<br>-On 9/9/15 resident was at the road in his wheelchair, redirected back to the facility by staff, and placed on 10 minute checks.<br><br>Review of Resident #5's facility Incident Report dated 9/9/15 at 8:15am revealed:<br>-Resident was sitting on the front porch and rolled down the ramp to the road.<br>-Resident stated he was going to sit on the porch across the street.<br>-Resident was redirected back to the facility.<br>-Resident was put on 10 minute checks.<br>-Resident was not allowed to sit on the front porch. | (D 270) | | |

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 |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 6<br>-Nurse Practitioner evaluated Resident #5 and changed the antibiotic to Doxycycline.<br><br>Interview with Resident #5 on 9/10/15 at 10:00am revealed:<br>-He was in his wheelchair, on the front porch by himself, and decided to go across the street.<br>-The wheels of the wheelchair were in the road.<br>-Someone came to him from behind and wheeled him back to the facility.<br><br>Interview with Resident #5's family member on 9/10/15 at 10:00am revealed:<br>-Facility staff informed the family on 9/9/15 that the resident went to the road.<br>-The resident was suffering from a UTI, and "was talking out of his head."<br><br>Confidential staff interview revealed:<br>-Staff person was not at the facility when Resident #5 wheeled himself off of the porch.<br>-Staff person heard that the resident was in the road and a car almost hit resident.<br>-Resident revealed that he does not see well and thought he saw his friends sitting on the porch across the street.<br>- Staff were trying to keep the incident "hush, hush," no elaboration noted.<br><br>Interview with a facility resident on 9/10/15 at 12:39am and 9/9/23/15 at 12:25pm, revealed:<br>-Resident was sitting on the front porch with Resident #5.<br>-Resident #5 "went all the way across the road in his wheelchair."<br>-This resident informed the Special Care Unit Care Coordinator (SCC) Resident #5 went across the road.<br>-SCC went after resident. | (D 270) | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 7<br>Interview with SCC on 9/10/15 at 1:05pm revealed:<br>-SCC completed the Incident Report concerning Resident #5 crossing the road.<br>-Resident #5 wheeled himself onto the road.<br>-A man and lady in a silver car stopped and appeared to be upset, stating to the SCC, "Can't you watch them (residents) any better than that?"<br>-SCC and another staff person brought resident back to facility.<br>-Resident was placed on 10 minute checks.<br>-Resident #5 was not allowed to go on the porch alone.<br><br>Review of the facility's security camera video on 9/10/15 at 1:15pm revealed:<br>-On 9/9/15 at 8:14am, Resident #5 and another resident were sitting on the front porch together, looking straight ahead, (across the road.)<br>- On 9/9/15 at 8:17am, resident walked to the other side of the porch, and Resident #5 wheeled himself down the concrete ramp from the front porch.<br>-The video did not display activity beyond the ramp.<br><br>Interview with Resident #5's family member on 9/23/15 at 8:30am revealed:<br>-Family member was informed of the incident on the morning of 9/9/15.<br>-Family member was informed that resident went toward the highway and a car stopped for him.<br>-Resident #5 stated that he wanted to sit on the porch of the house across the street.<br><br>Observation of the state maintained secondary road in front of the facility revealed:<br>- The posted speed limit on the road was 35 miles per hour.<br>- The edge of the road was approximately 60 feet | (D 270) | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 66 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 8<br>from the end of the ramp attached to the front porch of the facility.<br>- The house across the street from the facility was approximately 180 feet from the front of the porch.<br><br>Interview with Resident #5 on 9/23/15 at 9:44am revealed:<br>-Resident #5 was in his wheelchair on the front porch, and "rolled across the street to sit on the front porch," (of the house across the street from the facility.)<br>-Resident #5 was going back across the road (headed back to the facility) and a car stopped.<br>-Someone grabbed Resident #5's wheelchair and stated "Let's get out of the way."<br>-Resident #5 did not know who helped him back to the facility.<br><br>Interview with Resident #5's family member on 9/23/15 at 9:44am revealed:<br>-Staff informed family member that Resident #5 "never made it across the road, his wheelchair hit the curb and it kicked the wheelchair all the way around."<br>-Resident #5 had a kidney infection and "his brain went hay-wire."<br><br>Interview with SCC on 9/23/15 at 12:38pm revealed:<br>-SCC was in the main dining room on the morning of 9/9/15.<br>- Someone said Resident #5 was "off the porch."<br>-SCC "grabbed" another staff person and they brought Resident #5 back to the facility.<br>-The incident occurred during hours of heavy school traffic (an elementary school was next door to the facility).<br>-Cars in both lanes of the road had stopped.<br>-The police officer that directed traffic at the | (D 270) | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R-C 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROCKFORD INN | 66 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

| (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 270) | Continued From page 9<br>school had already left.<br>-Resident #5 told the SCC that he was going to the porch across the street.<br>-Resident #5 was suffering from a UTI at the time of this incident.<br>-SCC did not believe Resident #5 was legally blind.<br><br>Attempts to contact the Nurse Practitioner on 9/24/15 at 3:19pm were unsuccessful.<br><br>---<br><br>On 9/10/15 and 9/22/15 the facility provided the following plan of protection:<br>- Any resident with a diagnosis of blindness will be directed to the back patio.<br>- Immediate intervention, Resident #5's power of attorney requested resident not be allowed on front porch without them present.<br>- To ensure resident's safety, any resident with a diagnosis of blindness will be directed to the back patio. If resident still wants to sit on front patio, a staff member will sit with them.<br>- Staff will make rounds every 15 minutes to the front patio to ensure the safety of all residents on the front patio.<br><br>THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2015. | (D 270) | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments | D 358 | Contacted Royal Apothecary pharmacist on 9.25.15 requesting label changes to include Do Not crush on medication on the | 10.23.15 |