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BROCKFORD INN	**56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630**

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D 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an annual survey, follow up survey, and complaint investigation on August 29-31, 2017 with an exit conference via telephone on September 1, 2017.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure table service included a non-disposable place setting consisting of at least a knife, fork, spoon, dinnerware and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. The findings are: Interview with the Administrator on 8/29/17 at 9:30am revealed the current census was 64. Observations in the Special Care Unit (SCU) dining room on 8/29/17 at 12:00pm to 12:57pm	D 287		

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revealed:
-There were 26 residents seated in the dining area.
-The meal served to residents included a grilled chicken patty, fried squash, sweet potato, roll, pears, water, and beverage of choice.
-Water was served to each resident in a disposable cup.
-The place setting for all residents did not include a knife.

Observations in the Assisted Living dining room on 8/29/17 at 12:20pm to 1:05pm revealed:
-There were 27 residents seated in the dining area.
-The meal served to residents included a grilled chicken patty, fried squash, sweet potato, roll, pears, water, and beverage of choice.
-The place setting for all residents did not include a knife.
-There were 9 residents who where observed to be pulling the chicken patty apart with their fingers.
-Staff did not offer assistance.
-There were 13 residents who did not eat the chicken patty.
-One resident was observed to have eaten all of the food on her plate except the chicken patty.
-When the same resident asked staff for assistance with cutting up the chicken patty, the resident was provided a new bowl of chicken cut into small pieces of which the resident ate 100%.

1. Interview with a resident on 8/29/17 at 12:50pm revealed:
-The resident was not able to eat the chicken without it being cut into smaller pieces.
-The resident did not have enough teeth to be able to bite the chicken.

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Interview with the Dietary Manager on 8/29/17 at 2:30pm revealed:
-A place setting consisted of a fork and spoon rolled in a paper napkin.
-She had never given out knives for the residents.
-A "specialty" spoon was provided for residents who received puree consistency foods.
-If a resident asked for a knife, "we would give it to them."
-"We don't usually put them out."
-"The [nurse aides] go around and cut up meat for the residents."
-"In the Special Care Unit, everyone gets a fork and spoon."
-"I didn't know we were supposed to put out knives for everyone."
-She had knives in the kitchen and would have provided to residents if asked.

Observation of the supply of knives on hand in the kitchen on 8/29/17 at 2:50pm revealed there were 68 total case knives.

Interview with the Administrator on 8/29/17 at 4:35pm revealed:
-She had been the Administrator since 2015.
-She told staff to give the residents knives, "just make sure they come back."
-"If we give out 30 knives, get 30 back."
-Staff cut up residents' meat if needed, or pull the meat off the bone.
-The residents not getting knives was not a safety issue, 'they just weren't coming back, residents were keeping them in their rooms."

Observations in the SCU dining room during breakfast on 8/30/17 at 8:15am revealed the place setting for all residents included a fork, spoon, knife, and a paper napkin.

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Observations in the SCU dining room during lunch on 8/30/17 at 11:54am revealed the place setting for all residents included a fork, spoon, knife, and a paper napkin.

Observations in the Assisted Living dining room during lunch on 8/30/17 at 12:36pm revealed the place setting for all residents included a fork, spoon, knife, and a paper napkin.

Interview with a resident on 8/30/17 at 10:52am revealed:
-She had lived in the facility since 2016.
-"I cut my food up with my fork."
-"I've never used a case knife to cut my meat up."
-They put case knives out for "everybody" at supper on 8/29/17.
-"That's the first time they've ever done that, put knives out with a fork."

Interview with the Administrator on 8/30/17 at 2:51pm revealed:
-"We have knives available."
-The facility staff had "never" wrapped a knife in with the fork and spoon in the napkin.
-"We always cut up the residents meat."

2. Observations in the SCU dining room during breakfast on 8/30/17 at 8:15am revealed all residents received their beverages in disposable cups.

Observations in the SCU dining room during lunch on 8/30/17 at 11:54am revealed all beverages served to residents except coffee were served in disposable cups.

Observations in the Assisted Living dining room during lunch on 8/30/17 at 12:36pm revealed all beverages served to resident were served in

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non-disposable cups.

Observation of the supply of non-disposable cups on hand in the facility kitchen on 8/30/17 at 2:30pm revealed:
-There were forty one 16oz. cups on hand for resident use.
-There were sixty eight 8oz. cups on hand for resident use.

Interview with the Dietary Manager on 8/30/17 at 2:36pm revealed:
-"We don't usually use Styrofoam" for resident place settings.
-"With the Special Care Unit, we just wash what they send back and then send it back to be used back there."
-"Styrofoam is normally not used unless there's an issue with the water or problems with the dishwasher."
-"I don't know why disposable cups were used."

Observation of the the supply of non-disposable cups on hand in the SCU on 8/30/17 at 2:38pm revealed:
-There were six used 8oz. cups sitting on a shelf of the beverage/snack cart in the SCU dining room.
-There were six clean 16oz. cups stored in a cabinet on the left side of the sink.
-There were four clean 8oz. cups stored in a cabinet on the left side of the sink.
-There was one clean 4 oz. cup stored in a cabinet on the left side of the sink.

Interview with the Administrator on 8/30/17 at 2:51pm revealed:
-"Some of our cups have gotten cracked and thrown away. So we ordered 15 dozen and they will be here no later than this Friday (9/1/17)."

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-The staff had "served in Styrofoam rather than the residents not have their water."
-"This new order will provide two place settings worth" of non-disposable beverage cups for the Assisted Living and SCU dining rooms.
-The order for non-disposable cups was placed on 8/30/17.

D 292 — 10A NCAC 13F .0904(c)(3) Nutrition And Food Service — D 292

10A NCAC 13F .0904 Nutrition and Food Service
(c) Menus In Adult Care Home:
(3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure substitutions made in the menu were of equal nutritional value and documented to indicate the foods actually served to residents.

The findings are:

Interview with the Administrator on 8/29/17 at 9:30am revealed the current census was 64.

A. Review of the Regular Diet Weekly Spring/Summer 2017 Week 4 Menu for the lunch meal on 8/29/17 revealed the following items were to be served:
-1 grilled chicken breast
-1/2 of a whole baked sweet potato
-1/2 cup of summer squash
-1/2 cup of blushing pears

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-1 each white/wheat roll
-1 each margarine spread

Observation in the Special Care Unit (SCU) dining room lunch meal on 8/29/17 at 12:16pm revealed:
-There were 26 residents being served.
-The residents were served 1 grilled chicken patty, 3 pieces of fried squash, 1/4 of a baked sweet potato, 1 white roll, 1/2 cup of pears, fruit flavored beverage, and water.

Observation in the Assisted Living dining room lunch meal on 8/29/17 at 12:20pm revealed the residents were served 1 grilled chicken patty, 3 pieces of fried squash , 1/4 of a baked sweet potato, 1 white roll, 1/2 cup of pears, and water.

Observation in the facility food storage area on 8/30/17 at 8:22am revealed there were 18 large sweet potatoes on hand.

Review of the facility substitution list revealed there was no vegetable substituted for the remaining serving of sweet potato for lunch on 8/29/17.

Interview with the Dietary Manager on 8/29/17 at 2:30pm revealed:
-"I cut [the sweet potatoes] in half and quartered them, because they were so big."
-"I thought I might run out."

Refer to the interview with the Business Office Manager (BOM) on 8/30/17 at 10:00am.

B. Review of the Weekly Spring/Summer 2017 Week 4 Menu for the breakfast meal on 8/30/17 revealed the following items were to be served:
-1/2 cup of stewed prunes

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-1 serving of cereal
-1/4 cup of eggs
-1 serving of breakfast meat
-1 slice of toasted bread
-1 each jelly
-8 oz. of 2% milk
-6 oz. of vitamin C fortified juice

Observation in the SCU dining room breakfast meal on 8/30/17 at 7:45am revealed:
-Residents on a regular diet were served 1/2 cup of scrambled eggs, 1 slice of toast, 1 each jelly, and choice of cereal.
-The residents were not served a breakfast meat.
-Regular diet residents were not served stewed prunes or a substitute for the stewed prunes.
-Puree diet residents were served applesauce as a substitute for the stewed prunes.

Observation in the Assisted Living dining room on 8/30/17 at 8:15am revealed:
-Residents on a regular diet were served 1/2 cup of scrambled eggs, 1 slice of toast, 1 each jelly, and choice of cereal.
-The residents were not served a breakfast meat.
-Regular diet residents were not served stewed prunes or a substitute for the stewed prunes.
-Puree diet residents were served applesauce as a substitute for the stewed prunes.

Review of the facility substitution list revealed there was no substitute documented for the breakfast meat and stewed prunes for breakfast on 8/30/17.

Interview with Cook #2 on 8/30/17 at 8:20am revealed:
-"We had the cereal, eggs, toast, milk, and juice" to serve for breakfast today.
-"We were told if we have eggs that's the protein

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and we don't have to serve the meat."
-"Today's menu from the office called for eggs, cereal, and toast."

Interview with the Dietary Manager on 8/30/17 at 8:37am revealed:
-"If they get a [breakfast] meat they don't get eggs."
-"It's been this way for the 4 years I've been here."

Interview with Cook #1 on 8/30/17 at 8:55am revealed:
-"When we serve eggs, we don't serve the [breakfast] meat."
-"When [breakfast] meat is served we don't serve eggs."
-The business office personnel had instructed Cook #1 to not serve meat with eggs.

Review of a printed menu from the office for breakfast on Wednesday August 30, which was posted in the Assisted Living dining room, revealed the items listed on the menu were eggs, toast, and cereal.

Observation in the facility refrigerator on 8/29/17 at 10:20am revealed there were fourteen 32 oz. size cartons (which provided 20 servings per carton) plus one additional case of pasteurized eggs.

Observation in the facility food storage area on 8/30/17 at 8:22am revealed:
-There were two 6lb. boxes of sausage links.
-There was one box of bacon which contained 150 servings (2 slices per serving).
-There were seven 46 oz. bottles of prune juice on hand, however there were no prunes on hand.

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Interview with the BOM on 8/30/17 at 10:00am revealed:
-The 6lb. boxes of sausage links had 60 links in a box.
-A serving is "based on what the menu calls for."

Interview with Cook #2 on 8/30/17 at 8:25am and 8:45am revealed:
-"This is what we have until the truck comes Tuesday."
-"Sometimes they will do chicken and biscuits."
-"There's chicken in here too" to use for a breakfast meat.
-An appropriate substitution for the stewed prunes on the regular menu would have been "another fruit, apples, peaches, pineapple, oranges are here to serve instead."
-She did not serve a substitute for the prunes, because she had been instructed to serve the menu which came from the front office.
-"I just follow the menu the office gives us."
-"Most of the time we have everything" that is called for on the menu to serve.

Interview with the Dietary Manager on 8/30/17 at 8:57am revealed "I put down prunes on my last order, but when it came in it was prune juice."

Interview with two additional residents on 8/30/17 revealed:
-"I would prefer both eggs and meat."
-"Sometimes I do get hungry between meals, but if I do I go to the machine and get me a snack."
-"On the mornings we have pancakes and waffles, I would like to have a meat with the sweet things. Don't care to have eggs with it. It's good when you do, but money and cost. I'm a reasonable person. I'm not going to demand the kings banquet everyday."

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Review of an email available for reference by kitchen staff dated 11/21/11 from a Registered Dietitian revealed:
-"I have talked with [kitchen staff name] and he requested to know what he could do as a substitute for eggs."
-"He did not want to give eggs every morning."
-"I told him that most places the residents did not like it when I put eggs on the menu only 3 to 4 times a week-they wanted it everyday."
-"If he did want to take eggs off the menu on some days, he would need to increase the protein at lunch and dinner to 3 oz."

Refer to the interview with the Business Office Manager on 8/30/17 at 10:00am.

____

Interview with the Business Office Manager (BOM) on 8/30/17 at 10:00am revealed:
-The Dietary Manager gave her a list of items that were needed each week on Monday.
-She was responsible for entering the order with the facility food distributor.
-"We order by Monday lunchtime."
-The food order "arrives on Tuesday's before lunchtime."
-"If something's overlooked they can drop ship it."

D 358 | D 358

10A NCAC 13F .1004(a) Medication Administration

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

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(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 5 residents (#11) observed during a medication pass, and 1 of 3 sampled residents (#2) with orders for insulin administration and dosing parameters. (Novolog insulin and Vitamin B12.)

The findings are:

A. Review of Resident #2's current FL2 dated 7/10/17 revealed:
-Diagnoses included traumatic brain injury, dementia, seizure disorder, and uncontrolled diabetes.
-A medication order for Novolog, 8 units given subcutaneously (SQ) three times a day, hold for blood sugar reading less than 150. (Novolog is a quick acting insulin used to lower blood sugar readings around meal times.)
-An order for fingerstick blood sugars (FSBS) three times a day.

Review of a prior medication order dated 4/5/17 for Resident #2 revealed an order for Novolog 8 units three times a day before meals, hold for blood sugar less than 150.

Review of Resident #2's FSBS and insulin administration record for June 2017 revealed:
-An entry for Novolog insulin, inject 8 units SQ 3 times a day, with scheduled administration times of 7am, 11am, and 4pm.

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-An entry for FSBS scheduled for 7am, 11am, and 4pm.
-Resident #2's FSBS ranged from 99 to 265.
-Twenty-two FSBS readings were less than 150.
-Twelve doses of Novolog were documented as held either by initialing and circling the Medication Aide's (MA) initials or documenting on the back of the Medication Administration Record (MAR), "insulin held due to blood sugar reading less than 150."
-Ten doses of Novolog were documented as given that should had been held.

Review of Resident #2's FSBS and insulin administration record for July 2017 revealed:
-An entry for Novolog insulin, inject 8 units SQ 3 times a day, with scheduled administration times of 7am, 11am, and 4pm.
-An entry for FSBS scheduled for 7am, 11am, and 4pm.
-Resident #2's FSBS ranged from 114-235.
-Twenty-three FSBS readings were less than 150.
-Seven doses of Novolog were documented as held either by initialing and circling the MA's initials or documenting on the back of the MAR, "insulin held due to blood sugar reading less than 150."
-Sixteen doses of Novolog were documented as given that should had been held.

Review of Resident #2's FSBS and insulin administration record for August 2017 revealed:
-An entry for Novolog insulin, inject 8 units SQ 3 times a day, with scheduled administration times of 7am, 11am, and 4pm.
-An entry for FSBS scheduled for 7am, 11am, and 4pm.
-Resident #2's FSBS ranged from 114-224.
-Thirteen FSBS readings were less than 150.
-Five doses of Novolog were documented as held

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	HAL014014	A. BUILDING: ______ B. WING ______	R-C **09/01/2017**

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 358	Continued From page 13 either by initialing and circling the MA's initials or documenting on the back of the MAR, "insulin held due to blood sugar reading less than 150." -Eight doses of Novolog were documented as given that should had been held. Interview with a MA on 8/30/17 at 3:34pm revealed: -If Resident #2's insulin was held, "we would initial and circle the initials" to designate the dose held. -"The MAs are also supposed to document on the back of the MAR any medications held." Interview with the Resident Care Coordinator (RCC) on 8/30/17 at 4:25pm revealed: -"If the initials are not circled on the MAR, then the medication was given." -The MA should document on the back of the MAR also if a medication was held. Interview with a second MA on 8/31/17 at 8:55am revealed if Resident #2's insulin was held, it would be initialed and circled on the front of the MAR, and documented on the back of the MAR as not given. Interview with Resident #2 on 8/31/17 at 2:20pm revealed: -He was aware he took insulin, but was not sure of the dose. -He believed he received his insulin as ordered by his physician. -The MAs sometimes hold the insulin but he was not sure why. Interview with the facility Administrator on 8/31/17 at 3:25pm revealed she was not sure why the MAs were not holding the insulin for Resident #2 based on the parameters.	D 358		

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Review of Resident #2's record revealed:
-The prescribing practitioner wrote an order on the afternoon of 8/31/17 to "remove the hold" on Resident #2's Novolog 8 units if blood sugar under 150.
-Follow-up with the prescribing practitioner on 9/6/17.

Attempted interviews with the prescribing practitioner on 8/31/17 at 1:55pm and 8/31/17 at 2:15pm were unsuccessful.

Refer to review of the facility's medication administration policy.

B. Review of Resident #11's current FL2 dated 6/5/17 revealed diagnoses included Alzheimer's dementia, diabetes, and hypothyroidism.

Review of Resident #11's medication orders revealed an order dated 8/17/17 for Vitamin B12 1000mcg, 1 daily (used to treat pernicious anemia).

Observation of the morning medication pass on 8/30/17 at 9:22am revealed:
-Resident #11 received 12 oral medications and 1 patch applied to the skin.
-The resident did not receive Vitamin B12.

Review of Resident #11's MAR for August 2017 revealed no entry for Vitamin B12.

Interview with the MA on 8/30/17 at 10:07am revealed:
-She did not give Resident #11 her B12 this morning because it was not on the MAR.
-The Resident Care Coordinator (RCC) was responsible for entering new orders onto the

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MAR.
-She had never administered Vitamin B12 to Resident #11.

Interview with the RCC on 8/30/17 at 10:25am revealed:
-She was the one responsible for entering medications onto the MAR.
-She had "just missed" entering Resident #11's Vitamin B12 onto the MAR.
-Upon being made aware of the missed doses of Vitamin B12, the RCC contacted the Nurse Practitioner about the missed doses.

Observation of Resident #11's medications on hand at 10:15am on 8/30/17 revealed:
-Resident #11 had a bottle of Vitamin B12 tablets 1000mcg in the medication cart with a dispense date of 8/17/17.
-The directions on the label were to take 1 tablet by mouth daily.
-The original bottle contained 100 tablets, but it had been opened, and only 96 tablets remained.

Review of Resident #11's medication orders dated 8/31/17 revealed:
-An order from Resident #11's prescribing practitioner to discontinue the Vitamin B12 1000mcg.
-An order to recheck the resident B12 level.

Review of Resident #11's entire record revealed no labs.

Based on observation and record review, it was determined that Resident #11 was not interviewable.

Attempted interviews with the prescribing practitioner on 8/31/17 at 1:55pm and 8/31/17 at

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D 358	Continued From page 16 2:15pm were unsuccessful. Refer to review of the facility's medication administration policy. ______________________________ Review of the facility's medication administration policy revealed, "medications are to be administered only by the Med-Tech according to the physician's order and any reactions documented."	D 358		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate	D 400		

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D 400	Continued From page 17	D 400		

prescribing practitioner; and
(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and
(C) documenting the results of the medication review in the resident's record.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 sampled insulin dependent residents (#2) received medication monitoring that addressed inaccurate insulin administration based on dosing parameters.

The findings are:

Review of Resident #2's current FL2 dated 7/10/17 revealed:
-Diagnoses included traumatic brain injury, dementia, seizure disorder, and uncontrolled diabetes.
-A medication order for Novolog, 8 units given subcutaneously (SQ) three times a day, hold for blood sugar reading less than 150. (Novolog is a quick acting insulin used to lower blood sugar readings around meal times.)
-An order for fingerstick blood sugars (FSBS) three time a day.

Review of a prior medication order dated 4/5/17 for Resident #2 revealed an order for Novolog 8 units three times a day before meals, hold for blood sugar less than 150.

Review of Resident #2's FSBS and insulin

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administration record for June 2017 revealed:
-An entry for Novolog insulin, inject 8 units SQ 3 times a day, with scheduled administration times of 7am, 11am, and 4pm.
-An entry for FSBS scheduled for 7am, 11am, and 4pm.
-Resident #2's FSBS ranged from 99 to 265.
-Twenty-two FSBS readings were less than 150.
-Twelve doses of Novolog were documented as held either by initialing and circling the Medication Aide's (MA) initials or documenting on the back of the MAR,"insulin held due to blood sugar reading less than 150."

Interview with a MA on 8/30/17 at 3:34pm revealed:
-If Resident #2's insulin were held, "we would initial and circle the initials" to designate the dose held.
-"The MAs are also supposed to document on the back of the MAR any medications held."

Interview with the Resident Care Coordinator (RCC) on 8/30/17 at 4:25pm revealed:
-"If the initials are not circled on the MAR, then the medication was given."
-The MA should document on the back of the MAR also if a medication was held.

Interview with a second MA on 8/31/17 at 8:55am revealed if Resident #2's insulin was held, it would be initialed and circled on the front of the MAR, and documented on the back of the MAR as not given.

Review of Resident #2's medication reviews dated 3/30/17 and 6/29/17 revealed no recommendations.

Interview on 8/31/17 at 2:45pm with one of the

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D 400	Continued From page 19 two pharmacists who provide consulting services to the facility revealed: -During the medication reviews, the consultant pharmacist checked on the nursing notes, progress notes, labs, MARs, and blood sugar levels. -They try to look at the blood sugars and insulin administration, but "it's hard to match them up because they aren't kept with the regular MARs."	D 400		