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 01/10/2019

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 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an Annual survey on January 9-10, 2019.	D 000		
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 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Resident #2 and #5) related to not administering hydrochlorothiazide and tylenol. The findings are: 1. Review of Resident #5's current FL2 dated 11/29/18 revealed diagnoses included hypertension, diabetes, and hyperlipidemia.	D 358		

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D 358	Continued From page 1 Review of Resident #5's physician's order dated 01/03/19 revealed a physician's order for hydrochlorothiazide 12.5mg take 1 tablet daily (used to treat high blood pressure). Review of Resident #5's January 2019 Medication Administration Record (MAR) revealed: -There was a hand written entry for hydrochlorothiazide 12.5mg take 1 tablet daily scheduled to be administered at 6:00am. -Hydrochlorothiazide was documented as administered from 01/04/19 to 01/10/19. -There was a hand written entry to check Resident #5's blood pressure every 6 hours for 72 hours starting 01/04/19. -Resident #5's blood pressure range was documented as 118-136/68-78 from 01/04/19 to 01/06/19. Observation of Resident #5's medication on hand on 01/10/19 at 10:30am revealed no hydrochlorothiazide was available to administer. Interview with Resident #5 on 01/09/19 at 10:13am revealed: -He had moved into the facility on 12/11/18. -His blood pressure medication he was taking when he moved to the facility was recently discontinued. -He did not know which medication the facility contracted provider had prescribed him to treat his high blood pressure. -He did not know if he was receiving the new blood pressure medication. Review of the facility's Medication Administration Policy revealed: -If a medication was needed after 5:00pm then	D 358		

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the backup pharmacy should be called to dispense the medication.
-Unless a medication was an emergency, new medication orders were scheduled to start after the next routine pharmacy delivery.

Interview with a third shift medication aide (MA) on 01/10/19 at 3:00pm revealed:
-She administered Resident #5's morning medications during the 6:00am medpass.
-She had only worked one shift since Resident #5 was prescribed hydrochlorothiazide.
-She had borrowed the hydrochlorothiazide from another resident to administer to Resident #5.
-She did not document on the MAR the medication was borrowed from another resident.
-She was aware there was special documentation required on the MAR for borrowed medications.
-Another MA had told her she could borrow the medication to administer to Resident #5.
-The Resident Care Coordinator (RCC) was aware Resident #5 did not have hydrochlorothiazide available for administration and the medication was borrowed from another resident.

Review of the facility's Borrowing Medication Policy revealed medications were to be borrowed only in extreme emergencies and the pharmacy should be notified.

Telephone interview with the Business Manager from the facility's contracted pharmacy on 01/10/19 at 12:59pm revealed:
-The pharmacy received the order for hydrochlorothiazide for Resident #5 in afternoon on 01/03/19.
-The pharmacy did not dispense the hydrochlorothiazide to Resident #5 because his insurance had expired.

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-The pharmacy notified the facility by fax for permission to fill the medication order and charge the price to Resident #5.
-The pharmacy technician who processed the order had called and notified the facility.
-The facility was responsible for contacting the pharmacy to determine why the hydrochlorothiazide was not delivered to the facility.
-The pharmacy had not been notified of any medications that had been borrowed from other residents at the facility.

Interview with a MA on 01/10/19 at 2:53pm revealed:
-She had recently changed positions from the RCC to a MA.
-She was responsible for training the new RCC.
-She only worked on the weekends.
-She gave the pharmacy verbal permission to dispense the hydrochlorothiazide to Resident #5.
-She did not follow up to make sure the pharmacy had dispensed the medication to Resident #5 because she had not administered medications to Resident #5 since the medication was prescribed.
-She had told a MA to borrow the medication to administer to Resident #5 on 01/03/19.
-The third shift MA should have informed the RCC the medication was not available to administer to Resident #5.

Interview with the RCC on 01/10/19 at 10:55am revealed:
-She was being trained as the RCC and worked previously as an MA.
-She knew the pharmacy was having trouble processing claims to Resident #5's insurance.
-She was told the previous RCC had instructed the pharmacy to dispense the hydrochlorothiazide to Resident #5.

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-She did not know the hydrochlorothiazide was never delivered to the pharmacy for Resident #5.
-She did not know if the hydrochlorothiazide was borrowed from another resident.
-The MAs were responsible for notifying her if any medications were not available to administer to the residents.
-She was responsible for processing new orders.
-She was responsible for faxing new orders to the pharmacy and making the changes on the MARs.
-The third shift MAs were responsible for filing new orders in the resident's record.
-No one was responsible for making sure new medications were delivered from the pharmacy.

Observation of Resident #5's blood pressure measurement on 01/10/19 at 1:45pm revealed a blood pressure reading of 140/90.

Review of Resident #5's primary care provider's (PCP) visit summary dated 09/04/18 revealed:
-Resident #5 was diagnosed with high blood pressure.
-High blood pressure could cause congestive heart failure, stroke, kidney disease, and blindness.

Telephone interview with the facility's contracted provider on 01/10/19 at 12:20pm revealed there were long term risks associated with not treating high blood pressure.

Interview with the Administrator on 01/10/19 at 10:47am revealed:
-She did not know the hydrochlorothiazide was not available to administer to Resident #5.
-The RCC or the facility's Management Consultant was responsible for performing random record audits monthly.
-The RCC was responsible for processing new

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medication orders.
-The RCC should follow up with the pharmacy if a medication was not delivered by the pharmacy to the facility when ordered.
2. Review of Resident #2's current FL2 dated 11/21/18 revealed diagnoses included diabetes, bipolar, mild retardation and history of heart disease.

Review of Resident #2's physician's order dated 09/27/18 revealed a physician's order for Tylenol arthritis strength (used for pain control) 650mg take 2 tablets two times daily.

Review of Resident #2's September 2018 MAR revealed:
-A handwritten entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 8:00pm.
-There were documentation Tylenol 650mg was administered 09/28/18 through 09/30/18.

Review of Resident #2's October 2018 MAR revealed:
-A handwritten entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 8:00pm.
-There were documentation Tylenol 650mg was administered 10/01/18 through 10/31/18.

Review of Resident #2's November 2018 MAR revealed:
-A computer generated entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 6:00pm.
-The order had been crossed out and "No order" hand-written on the MAR.
-There was no documentation Tylenol 650mg had been administered the month of November 2018.

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Review of Resident #2's December 2018 MAR revealed:
-A computer generated entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 6:00pm.
-There was documentation Tylenol 650mg had been administered two times daily at 6:00am and 6:00pm the month of December 2018.

Review of Resident #2's January 2019 MAR revealed:
-A computer generated entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 6:00pm.
-There was documentation on 01/01/19- 01/09/19 Tylenol 650mg had been administered two times daily at 6:00am and 6:00pm the month of January 2019.

Interview with Resident #2 on 01/10/19 at 11:45am revealed:
-He could not elaborate on which medications he was taking.
-He did know he had Tylenol ordered for his shoulder pain.
-He had to ask the staff for the Tylenol when he was in pain.
-He could not recall how many pills he took every day, but relied on the staff to administer his medications.

Interview with a pharmacy technician from the facility's contracted pharmacy on 01/10/19 at 11:50am revealed:
-There was a physician's order for Resident # 2's Tylenol arthritis strength 650 mg dated 09/28/18.
-There were 100 tablets of Tylenol 650mg dispensed to Resident #2 on 09/28/18 and on 12/31/18 with the directions take 1 tablet two times daily.

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D 358	Continued From page 7 -Based on the refill history for Tylenol 650mg, Resident #2 was out of medication after 11/16/18. -The facility staff was responsible for requesting medication refills. Observation of Resident #2's medications on hand on 01/10/19 at 10:17am revealed there was a bottle of Tylenol 650mg (dispensed dated 12/31/18) with a total of 96 tablets available to be administered. Interview with a second shift MA on 01/10/19 at 3:04pm revealed: -She worked second and third shift and had administered Resident #2's medications. -Third shift was responsible for administering Resident #2' medications at 6:00am and second administered medications at 6:00pm. -She knew Resident #2 had an order for Tylenol 650mg two times daily. -She had administered the Tylenol on the last day she worked 4 days ago. -She had administered the Tylenol 650mg to Resident #2 using the new bottle dated 12/31/18. -The MAs were responsible for entering new physician orders into the MAR. -The MAs were responsible for faxing medication orders to the pharmacy for refills and new orders. -She was not sure who had documented "No order" on the November 2018 MAR. -She could not recall administering the Tylenol to Resident #2 in November 2018. Interview with the RCC on 01/10/19 at 12:09pm revealed: -She knew Resident #2 had an order for Tylenol 650mg for pain control. -She did not know the Tylenol was not documented as administered in November 2018. -The MAs are responsible for administering	D 358		

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D 358	Continued From page 8 medications as ordered by the physician. -The MAs were responsible for notifying her if any medications were not available to administer to the residents. -She was responsible for making sure the MAs had entered all new medication orders into the MAR correctly. Interview with Resident #2's physician on 01/10/19 at 12:25pm revealed: -He ordered the Tylenol 650mg for Resident #2 on 09/28/18 for shoulder pain due to arthritis. -He did not know Resident #2 was not administered Tylenol 650mg in November 2018. -The consequences of Resident #2 not receiving the Tylenol as ordered could cause extra pain, but was not significant to Resident #2's care or treatment. Interview with the Administrator on 01/10/19 at 12:35pm revealed: -Residents should be receiving medications based on physician's orders. -She was not sure why Resident #2 had not received Tylenol 650mg in November 2018. -She was not sure why a staff person had hand written "no order" on the November 2018 MAR. -The RCC and SCUC were responsible for completing cart audits on Monday and Wednesday to check for medication refills and outdated medications. -The MAs, RCC, or SCUC were responsible for clarifying and correcting any discrepancies. -The MAs were responsible for medication administration to the residents.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 9 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure Medication Administration Records (MARs) were accurate for 2 of 5 sampled residents (Resident #2 and #5). The findings are: 1. Review of Resident #2's current FL2 dated 11/21/18 revealed diagnoses included diabetes, bipolar, mild retardation and history of heart disease.	D 367		

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D 367	Continued From page 10 Review of Resident #2's physician's visit dated 09/28/18 revealed a physician's order for Tylenol arthritis strength (used for pain control) 650mg take 2 tablets two times daily. Review of Resident #2's September 2018 MAR revealed Tylenol 650mg was documented as administered on 09/28/18 through 09/30/18 two times daily at 6:00am and 8:00pm. Review of Resident #2's October 2018 MAR revealed Tylenol 650mg was documented as administered on 10/01/18 through 10/31/18 two times daily at 6:00am and 8:00pm. Review of Resident #2's November 2018 MAR on 01/09/18 at 11:45am revealed: -A computer generated entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 6:00pm. -The order had been crossed out and "No order" hand-written on the MAR. -There was no documentation Tylenol 650mg had been administered the month of November 2018. Another review of Resident #2's November 2018 MAR on 01/10/18 at 8:45am revealed: -A computer generated entry for Tylenol arthritis ER 650mg 1 tablet two times daily scheduled at 6:00am and 6:00pm. -The order had been crossed out and "No order" hand-written on the MAR, beside the No Order was "error see next page" which was not present on review of the MAR on 01/09/19. -There was documentation on the "see next page" Tylenol 650mg had been administered the month of November 2018. -The documentation of the MAs signature on the "next page" were not corresponding with the MA	D 367		

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who had administered medications to Resident #2 on the first page.
-On 09/07/18 a MA "CI" had administered all medications at 6:00am to Resident #2.
-On the "next page" the MA "A" had initialed she had given the Tylenol 650mg at 6:00am.

Review of Resident #2's December 2018 MAR and January 2019 revealed Tylenol 650mg was documented as administered on 01/01/19 through 01/09/19 two times daily at 6:00am and 6:00pm.

Interview with Resident #2 on 01/10/19 at 11:45am revealed:
-He could not elaborate on which medications he was taking.
-He did know he had Tylenol ordered for his shoulder pain.
-He had to ask the staff for the Tylenol when he was in pain.

Interview with a pharmacy technician from the facility's contracted pharmacy on 01/10/19 at 11:50am revealed:
-The physician's order for Resident # 2's Tylenol arthritis strength 650 mg was written on 09/28/18.
-There were 100 tablets of Tylenol 650mg dispensed to Resident #2 on 09/28/18 and on 12/31/18 with the directions take 1 tablet two times daily.
-Based on the refill history for Tylenol 650mg, Resident #2 was out of medication after 11/16/18.
-The facility staff was responsible for requesting medication refills.

Interview with a second shift MA on 01/10/19 at 3:04pm revealed:
-The facility only staffed one MA per shift to administer medications to the residents.

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-She worked second and third shift and had administered Resident #2's medications.
-Third shift was responsible for administering Resident #2' medications at 6:00am and second administered medications at 6:00pm.
-She knew Resident #2 had an order for Tylenol 650mg two times daily.
-She was not sure who had documented "No order" on the November 2018 MAR.
-She was not sure who had documented on 01/09/19 "error see next page" on the November 2018 MAR.
-She could not recall administering Tylenol 650mg to Resident #2 in November 2018.
-She had not ordered any Tylenol 650mg for Resident #2.
-She would leave a note or ask the RCC to order if a resident was low on medications.
-She never informed the RCC at any time Resident #2 was out of Tylenol 650mg.

Interview with the Resident Care Coordinator (RCC) on 01/10/18 at 11:00am revealed:
-The facility staffed one MA per shift to administer medications to the residents.
-She was unsure why a staff person documented on Resident #2's November 2018 MAR "No order" for the Tylenol 650mg.
-She did not know where the "nest page" MAR came from, "Maybe it was filed and a MA found it."
-She was not sure why the MA initials administering the Tylenol 650mg on 11/07/18 did not match to the MA administering all the 6:00am medications to Resident #2 on 11/07/18.
-She knew Resident #2 had an order for Tylenol 650mg dated 09/28/18.
-She was unsure why the pharmacy only filled the Tylenol 650mg on 09/28/18 dispensing 100 tablets and not filled again until 12/31/18

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dispensing another 100 tablets for Resident #2.
-"[Resident #2] should had been out of Tylenol in 50 days of the first refill."

Interview with the Administrator on 01/10/18 at 11:10am revealed:
-The facility staffed one MA per shift to administer medications to the residents.
-She knew Resident #2 had an order for Tylenol 650mg dated 09/28/18.
-She did not know a staff person documented on Resident #2's November 2018 MAR "No order" for the Tylenol 650mg.
-She did not know why on 01/10/18 the MAR had handwritten documentation "error see next page" which was not present on 01/09/19.
-She was not sure why the MA initials administering the Tylenol 650 on 11/07/18 at 6:00am did not match to the MA administering Resident #2's medications on 11/07/18 at 6:00am.
-She relied on the MAs to document accurately on the MAR.
-She was unsure why the pharmacy filled the Tylenol 650mg on 09/28/18 dispensing 100 tablets and not filled again until 12/31/18 dispensing another 100 tablets for Resident #2.
-The RCC was responsible for reviewing MAR for accuracy and "holes".
-The RCC completed cart audits two times weekly on Monday and Wednesday.
-She would conduct cart audits with the RCC "every so often" for compliance.

Observation of Resident #2's medications on hand on 01/10/19 at 10:17am revealed there was a bottle of Tylenol 650mg (dispensed dated 12/31/18) with a total of 96 tablets available to be administered.

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 01/10/2019

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 367	Continued From page 14 2. Review of Resident #5's current FL2 dated 11/29/18 revealed diagnoses included hypertension, diabetes, and hyperlipidemia. Review of Resident #5's physician's order dated 01/01/19 revealed a physician's order for hydrochlorothiazide 12.5mg take 1 tablet daily (used to treat high blood pressure). Review of Resident #5's January 2019 Medication Administration Record (MAR) revealed: -There was a hand written entry for hydrochlorothiazide 12.5mg take 1 tablet daily scheduled to be administered at 6:00am. -Hydrochlorothiazide was documented as administered from 01/04/19 to 01/10/19. Telephone interview with the Business Manager from the facility's contracted pharmacy on 01/10/19 at 12:59pm revealed: -The pharmacy was responsible for printing the MARs for the facility. -The facility was responsible for checking the MARs for accuracy and sending corrections to the pharmacy. -The pharmacy received the order for hydrochlorothiazide for Resident #5 on 01/03/19. -The pharmacy did not dispense the hydrochlorothiazide to Resident #5 because his insurance had expired. -The pharmacy notified the facility by fax for permission to fill the order and charge the price to Resident #5. -The pharmacy technician who processed the order had called and notified the facility. -The pharmacy never dispensed hydrochlorothiazide to Resident #5. Interview with a third shift medication aide (MA)	D 367		

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 01/10/2019

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 367	Continued From page 15 on 01/10/19 at 3:00pm revealed: -She administered Resident #5's morning medications during the 6:00am med pass. -She had borrowed the hydrochlorothiazide from another resident to administer to Resident #5. -She did not document on the MAR the medication was borrowed from another resident. -She was aware special documentation was required on the MAR for borrowed medications. Interview with a MA on 01/10/19 at 2:53pm revealed: -She had recently changed positions from the Resident Care Coordinator (RCC) to a MA. -She was responsible for training the new RCC. -She only worked on the weekends. -She gave the pharmacy verbal permission to dispense the hydrochlorothiazide to Resident #5. -She did not follow up to make sure the pharmacy had dispensed the medication to Resident #5 because she had not administered medications to Resident #5 since the medication was prescribed. -She had told a MA to borrow the medication to administer to Resident #5 on 01/03/19. -The third shift MA should have informed the RCC the medication was not available to administer to Resident #5. Interview with the RCC on 01/10/19 at 10:55am revealed: -She was being trained as the RCC. -She was told the previous RCC had instructed the pharmacy to dispense the hydrochlorothiazide to Resident #5. -She did not know the hydrochlorothiazide was never delivered from the pharmacy for Resident #5. -The MAs were responsible for notifying her if any medications were not available to administer to the residents.	D 367		

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 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 16 -The MAs were responsible for notifying her if any medications were borrowed from other residents. -She was responsible for faxing new orders to the pharmacy and making the changes on the MARs. Interview with the Administrator on 01/10/19 at 10:47am revealed: -She did not know the hydrochlorothiazide was not available to administer to Resident #5. -The RCC or the facility's Management Consultant were responsible for performing random record audits monthly. -The random monthly record audits included comparing new orders with the MARs. -The RCC was responsible for processing new medication orders. -The RCC was responsible for comparing previous MARs with the new MARs monthly.	D 367		