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 _____	02/13/2020

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 and complaint investigation on February 11, 2020 through February 13, 2020. The complaint investigation was initiated by the Caldwell County Department of Social Services on February 7, 2020.	D 000	RECEIVED MAR 16 2020 ADULT CARE LICENSURE SECTION RALEIGH	
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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 3 of 3 sampled residents (#5, #6, and #8) who did not receive dialysis treatments due to the facility being quarantined during an outbreak of illness, resulting in two of the residents being hospitalized (#5 and #6). The findings are: 1. Review of Resident #6's current FL-2 dated 03/04/19 revealed diagnoses included end-stage renal disease with hemodialysis, impaired	D 273	Facility revised transportation policy and reporting on 3.9.2020. Inservice held on 2.12.2020 and 2.13.2020 on proper personal care and reporting to supervision of any changes of a resident. Also notify physician immediately of any changes and documenting. Inservice held 2.14.2020 and to 2.21.2020	3.11.2020

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Daniel Coffey TITLE administrator (X6) DATE 3.11.202

Reviewed and Accepted JG 3/19/20

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D 273	Continued From page 1 intellectual disability, dementia, hypertension, and coronary artery disease. Review of Resident #6's Resident Register revealed: -Resident #6 was admitted on 04/20/16. -Resident #6 had a Health Care Power of Attorney (HCPOA). Review of Resident #6's hospital record dated 02/03/20 through 02/08/20 revealed: -Resident #6 presented to the emergency room (ER) on 02/03/20 with a critical potassium level of 7.1 (normal range is 3.6 to 5.2), a critical blood urea nitrogen level of 191 (normal range is 7-20), and a creatinine level of 18.2 (normal range is 0.6-1.2), (Potassium, blood urea nitrogen, and creatinine levels in the blood are used to monitor kidney function in patients with renal failure) after he missed dialysis treatments for 7 days. -He was "emergently dialyzed". -Resident #6 was confused and unable to answer questions. -The ER physician was informed by the HCPOA upon admission that Resident #6 refused dialysis treatment on 01/28/20 and was scheduled for dialysis on 01/30/20 and 02/01/20 but due to the facility where he resided being on quarantine, Resident #6 was not taken back for dialysis. -Resident #6 had a second hemodialysis treatment on 02/04/20. -Resident #6 received a third dialysis treatment on 02/06/20 and his heart converted into an abnormal heart rhythm called atrial fibrillation with a rapid ventricular rate (a rapid or fluttering heartbeat). -A physician's note from the Nephrologist dated 02/07/20 at 2:39pm documented that family had visited Resident #6 on 02/03/20 and took him to the hospital and by them doing that "literally	D 273	to review and reeducate on personal care and supervision and notify physician and documenting. Inservice will be held with supervisors/med-tech every 2 weeks by admin. and monthly with personal care aides to continue to educate on personal care and supervision, reporting, notify MD and documenting. Also during inservices administrator will review with staff the resident rights. On 3-9-2020 inservice held on new transportation policy, appointments will be scheduled 7 days a weeks with transportation provided by Brockford Inn specialized vechiles. If a resident refuses the admin, medical director/physician, scheduled medical facility and resident's family/guardian	3-11-2020

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D 273	Continued From page 2 saved his life". -On 02/08/20 Resident #6 was scheduled for dialysis treatment but wanted to stop hemodialysis; HCPOA was consulted and in agreement, and Resident #6 was referred to Hospice. Review of the facility Nurses Notes in Resident #6's record revealed: -Resident #6 woke up sick on 01/28/20 and refused to go to dialysis and family was notified. - On 02/03/20 Resident #6 had refused dialysis for his last 3 sessions and the facility was anticipating sending him to the ER. -There was no documentation that Resident #6 refused dialysis treatment on 01/30/20 and 02/01/20 or that his Primary Care Physician, the dialysis center, or HCPOA were notified. Interview with Resident #6's Nurse Practitioner (NP) on 02/12/20 at 9:30am revealed: -Resident #6 had been sent to the hospital on 02/03/20 and "he's passed away now". -Resident #6 had been a chronic dialysis patient and his scheduled dialysis sessions were on Tuesdays, Thursdays, and Saturdays. -Resident #6 refused his dialysis treatments on 01/28/20, 01/30/20, and 02/01/20. -Resident #6 had the right to refuse dialysis treatment and "they don't have to notify me". -She could not remember how the facility contacted her that Resident #6 missed three hemodialysis treatments. -She did not document when the facility called to notify her about concerns of residents. Telephone interview with a representative at the local dialysis center on 02/12/20 at 10:28am revealed: -Resident #6 received his last dialysis treatment	D 273	or responsible party will be notified immediately and documented in chart. If resident refuses procedures that could present dire medical consequences (such as dialysis, chemotherpy or transfusions) on two consecutive appointments, the resident will be transported for hospital eval. Also transporter and supervisors trained on quarantine and isolation policy, scheduled facility destination will be notified of resident status. Transportation vechile will be fully sanitized with Sterphene II aerosol spray, before and after each transport. Facility will limit residents riding together in same vechile for transportation on a management directed basis. Transporter must	3-11-2020 3-11-2020

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D 273	Continued From page 3 on 01/25/20. -Resident #6 was scheduled for hemodialysis on 01/28/20 with a documented note "refused". -Resident #6 was scheduled for hemodialysis on 01/30/20 and 02/01/20 with a documented note "was not transported". -A comment was documented in the computer system on 01/30/20 that said, "nursing home called and said they are in quarantine and not transporting any patients in or out". -Resident #6 had been known to miss hemodialysis occasionally, but not 3 times in a row. -When a person missed dialysis treatments, they could experience serious cardiac issues, breathing issues, and electrolyte imbalances. -There was documentation in the computer that the faciltiy called on 01/30/20 and said "patients are sick at the facility and will not transport patients for dialysis treatments". -She called the Administrator at the facility on 01/30/20 and informed her to put a mask on the residents receiving dialysis treatments and bring them for their scheduled sessions. -The Administrator told her on 01/30/20 dialysis treatments were offered and all three residents at the facility receiving hemodialysis refused. -She notified the Medical Director of the local dialysis center on 02/01/20 of the missed dialysis sessions. Telephone interview with Resident #6's HCPOA on 02/12/20 at 6:12pm revealed: -Resident #6 had been on hemodialysis for 7 years and "he wouldn't go occasionally, but most of the time he did because he knew that he had to have it in order to live". -The facility called her on 01/28/20 to notify her Resident #6 was "up all night throwing up" and refused to go to dialysis.	D 273	must use gloves, masks and/or gown as deemed necessary by Brockford Inn Management. Facility also implented Daily Flow sheet for nurse aide to fill in with any concerns. Flow sheet will be monitored daily by med-tech and administrator. In addition to daily flow sheet a med-tech shift status report implented with any concerns on resident with column of when notified, if sent to hospital and when returned or admitted and documented in chart. These forms are reviewed on daily basis monday - Friday by adminstrator, VP Ownership and/or managing consultant. In addition to revised	3-11-2020

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D 273	Continued From page 4 -A family member called the local dialysis center and they informed her Resident #6 had not had dialysis treatment in a week. -She went to the facility and spoke with the Owner/Vice President (VP) and he asked her to accompany him to the Administrator's office. -They informed her there were a lot of residents with the flu, the building was under a quarantine, and Resident #6 did not go to his scheduled dialysis sessions on 01/28/20, 01/30/20, and 02/01/20. -She insisted Resident #6 be sent to the hospital for evaluation because he needed to have blood levels drawn since he had missed 3 dialysis treatments. -She was not notified by the facility Resident #6 did not receive dialysis treatments on 01/30/20 or 02/01/20. -She accompanied Resident #6 to the hospital where he was emergently dialyzed for 4 hours. -Resident #6's Nephrologist assured her if he had not been brought to the hospital on 02/03/20 he would have died. -On 02/06/20 during Resident #6's dialysis treatment she received a call from Resident #6's Nephrologist saying his heart was racing and they could not get his heart rate down. -On 02/07/20 she received a phone call from someone at the hospital telling her Resident #6's heart rate was in "tombstone" rhythm. -Resident #6 had dialysis on 02/03/20, 02/04/20, 02/06/20, and was scheduled to have dialysis on 02/08/20 but after speaking with the Resident #6's Nephrologist and Resident #6 they decided to stop dialysis treatments. -Resident #6 died on 02/10/20. Interview with a Personal Care Aide (PCA) on 02/13/20 at 9:30am revealed: -Resident #6 had diarrhea once that she was	D 273	transportation policy, facility hired a more experienced transportor. Resident Care Coordinator position changed and will train on all new policies. Along with staff meetings transportation policy and procedure will be reviewed in monthly nursing dept. meeting and management meetings with review of resident rights. Adherance to policy will be monitored by administrator, VP/owner and/or managing consultant. The daily census flow sheet, med-tech status shift reports and medical charts will be reviewed for adherance Monday-Friday. _____	3-11-2020 3-11-2020

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D 273	Continued From page 5 aware of during the week of the quarantine at the facility. -They could not send Resident #6 to dialysis because the facility was on quarantine due to an outbreak of illness. -Towards the end of the week of 01/26/20 through 02/01/20, Resident #6 "acted funny" but that was how he would act when he did not get his dialysis. -Resident #6 did not normally miss his scheduled dialysis treatments. Interview with the transport staff on 02/13/20 at 9:45am revealed: -She was responsible for transporting Resident #6 to his dialysis treatments. -She did not transport Resident #6 for dialysis treatment on 01/28/20, 01/30/20 and 02/01/20. Refer to the interview with the Nephrologist on 02/13/20 at 10:32am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/13/20 at 11:56am. Refer to the interview with the Administrator on 02/13/20 at 12:15pm. Refer to the interview with the Owner/VP on 02/13/20 at 12:45pm. 2. Review of Resident #5's current FL-2 dated 10/08/19 revealed diagnoses included diabetes, multiple myeloma, chronic pain, end-stage renal disease with hemodialysis, chronic obstructive pulmonary disease, congestive heart failure, cardiac dysrhythmias, and anxiety. Review of Resident #5's Resident Register revealed:	D 273		

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D 273	Continued From page 6 -An admission date of 06/25/19. -Resident #5 had a Health Care Power of Attorney (HCPOA). Review of Resident #5's hospital record dated 02/04/20 through 02/10/20 revealed: -Resident #5 was seen in the ER after receiving a hemodialysis treatment on 02/04/20 due to metabolic encephalopathy (an abnormality of brain function resulting from other internal organ failure) with altered mental status due to missing several dialysis treatments due to quarantining at the facility where she resided and was thought to have dialysis disequilibrium syndrome (an occurance of neurologic disorientation in patients receiving hemodialysis, attributed to cerebral edema). -Resident #5 received a hemodialysis treatment on 02/05/20 and was started on two antibiotics for her mental status. -On 02/06/20 Resident #5's mental status was back at baseline. -Resident #5 received another dialysis treatment on 02/07/20. -Resident #5 was discharged from the hospital on 02/10/20 to a skilled nursing facility. Review of the Nurses Notes at the facility for Resident #5 revealed: -Resident #5 refused dialysis treatment on 02/01/20. -There was no documentation Resident #5 refused dialysis treatment on 01/30/20. -There was no documentation on 01/30/20 or 02/01/20 that Resident #5's PCP, dialysis center, or HCPOA was notified of the refusal. -The Administrator had spoken to Resident #5's family on 02/04/20 about some concerns they had regarding dialysis and the family requested to be called if Resident #5 refused dialysis.	D 273		

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D 273	Continued From page 7 -On 02/04/20, Resident #5 was transported to the dialysis center and then admitted to the ER afterwards. Interview with Resident #5's Nurse Practitioner (NP) on 02/12/20 at 9:30am revealed: -Resident #5 just started receiving hemodialysis treatments on 01/21/20 and scheduled sessions were on Tuesdays, Thursdays, and Saturdays. -Resident #5 had the right to refuse dialysis treatment and "they don't have to notify me". -She could not remember how the facility contacted her that Resident #5 missed three hemodialysis treatments. -She did not document when the facility called to notify her about concerns of residents. Interview with the Administrator on 02/12/20 at 9:50am revealed: -Resident #5 started dialysis treatments on 01/21/20. -Resident #5 refused dialysis treatments on 01/28/20, 01/30/20, and 02/01/20. -The Medication Aide (MA) was responsible for notifying the dialysis center when a resident refused to attend the scheduled dialysis sessions. -The Resident Care Coordinator (RCC) was responsible for notifying the Primary Care Physician (PCP) when residents refused to attend their scheduled dialysis sessions. -Resident #5 was transported from the facility to the local dialysis center for her hemodialysis session on 02/04/20 and was admitted to the hospital afterwards. -The HCPOA for Resident #5 was notified of her refusal for dialysis treatment on 01/28/20. -She did not know why Resident #5's HCPOA was not notified of her refusal of dialysis treatment on 01/30/20 and 02/01/20.	D 273		

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D 273	Continued From page 8 Telephone interview with a representative at the local dialysis center on 02/12/20 at 10:28am revealed: -Resident #5 had previously received dialysis treatments on 01/18/20, 01/21/20, 01/23/20, 01/25/20, and 01/28/20. -Resident #5 had missed dialysis treatment on 01/30/20 and 02/01/20 with a comment in the computer system that documented, "nursing home called and said they are in quarantine and not transporting any patients in or out". -When a person missed dialysis treatments, they could experience serious cardiac issues, breathing issues, and electrolyte imbalances. -She called the Administrator at the facility on 01/30/20 and informed her to put a mask on the residents receiving dialysis treatments and bring them for their scheduled sessions. -The Administrator told her on 01/30/20 dialysis treatments were offered and all three residents at the facility receiving hemodialysis refused. -She notified the Medical Director of the local dialysis center on 02/01/20 of the missed dialysis sessions. Telephone interview with the HCPOA for Resident #5 on 02/12/20 at 11:02am revealed: -Resident #5 was recently started on dialysis treatments three times per week. -The facility did not call to notify her that Resident #5 missed her dialysis treatments. -She was not allowed to visit Resident #5 at the facility due to the quarantine. -She went to visit Resident #5 on 02/04/20 because she had a scheduled dialysis treatment and she found Resident #5 was lying halfway off the bed and disoriented. -After Resident #5 was transported to the local dialysis center, she was informed by the front desk staff upon arrival that Resident #5 had	D 273		

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D 273	Continued From page 9 missed her dialysis treatments on 01/30/20 and 02/01/20. -Resident #5 became unresponsive after her dialysis session on 02/04/20 and she was told by Resident #5's physician that she had "too many toxins in her body" from not receiving dialysis for a week and was sent to the hospital by ambulance. -She went to the facility after Resident #5 was admitted to the hospital on 02/04/20 and was informed by the Owner that "he was sorry. The facility was under quarantine and he made that call not to transport" Resident #5 for dialysis treatment. -She told the Owner "that was not okay" and she was to be informed when Resident #5 was not dialyzed. -The Administrator and Owner called her after she got home on 02/04/20 and said the reason Resident #5 did not go to dialysis treatment was because she did not want to go. -She asked the Owner why he said it was his call not to transport Resident #5 for dialysis treatment since the facility was under a quarantine and he told her he was misinformed. (She did not know what he meant by saying he was misinformed). Interview with a personal care aide (PCA) on 02/13/20 at 9:30am revealed Resident #5 did not go for her dialysis treatments because the facility was on quarantine for an outbreak of illness. Interview with the transport staff on 02/13/20 at 9:45am revealed: -She was responsible for transporting Resident #5 to her dialysis treatments. -She did not transport Resident #5 for dialysis treatment on 01/30/20 and 02/01/20. Refer to the interview with the Nephrologist on	D 273		

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D 273	Continued From page 10 02/13/20 at 10:32am. Refer to the interview with the RCC on 02/13/20 at 11:56am. Refer to the interview with the Administrator on 02/13/20 at 12:15pm. Refer to the interview with the Owner/VP on 02/13/20 at 12:45pm. 3. Review of Resident #8's current FL-2 dated 05/13/19 revealed diagnoses included end-stage renal disease with hemodialysis, diabetes, hypertension, hemiplegia, hemiparesis of the right dominant side from a cerebrovascular accident. Review of Resident #8's Resident Register revealed: -An admission date of 05/09/19. -He had a Health Care Power of Attorney (HCPOA). Review of an Absence Record for the local dialysis center where Resident #8 received hemodialysis revealed: -Resident #8 was a no show on 01/28/2020 and reason was documented as "patient refused to attend treatment". -Resident #8 was a no show on 01/30/20 and reason was documented as "patient refused to attend treatment" with a comment the facility called and said, "patients are sick at the facility and will not transport patients for dialysis treatments". -Resident #8 was a no show on 02/01/20 and reason was documented as "Illness or trauma gastrointestinal upset" with a comment after no show, spoke with the Medication Aide (MA) at the facility and she reported Resident #8 was very	D 273		

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D 273	Continued From page 11 sick and could not transport to dialysis, and "I emphasized the importance of either coming to dialysis or seeking treatment at the ER. She verbalized understanding". Review of the Nurses Notes at the facility for Resident #8 revealed: -A note documented on 02/04/20 as a late entry for 02/01/20 stated Resident #8 refused dialysis. -There was no documentation that Resident #8 refused treatment on 01/28/20 or 01/30/20. -There was no documentation that Resident #8's HCPOA was notified of the missed dialysis treatments. -There was no documentation that Resident #8 was sent to the ER for dialysis treatment since he was not able to attend his scheduled sessions at the local dialysis center on 01/28/20, 01/30/20, and 02/01/20 as per the recommendation from the dialysis center. Interview with Resident #8's Nurse Practitioner (NP) on 02/12/20 at 9:30am revealed: -Resident #8 refused his dialysis treatments on 01/28/20, 01/30/20, and 02/01/20 due to illness. -Resident #8 had the right to refuse dialysis treatment and "they don't have to notify me". -She could not remember how the facility contacted her that Resident #8 missed three hemodialysis treatments. -She did not document when the facility called to notify her about concerns of residents. Telephone interview with a representative from the local dialysis center where Resident #8 received hemodialysis on 02/12/20 at 10:28am revealed: -Resident #8 was a no show on 01/28/2020 and reason was documented as "patient refused to attend treatment".	D 273		

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	HAL014014	A. BUILDING: _____ B. WING _____	02/13/2020

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 273	Continued From page 12 -Resident #8 was a no show on 01/30/20 and reason was documented as "patient refused to attend treatment" with a comment the facility called and said, "patients are sick at the facility and will not transport patients for dialysis treatments". -Resident #8 was a no show on 02/01/20 and reason was documented as "Illness or trauma gastrointestinal upset" with a comment after no show, spoke with the Medication Aide (MA) at the facility and she reported Resident #8 was very sick and could not transport to dialysis, and "I emphasized the importance of either coming to dialysis or seeking treatment at the ER. She verbalized understanding". Attempted telephone interview with Resident #8's HCPOA on 02/12/20 at 1:00pm was unsuccessful. Interview with Resident #8 on 02/13/20 at 9:20am revealed: -He had the flu the week the facility was on quarantine. -He did not go to dialysis that week "I missed 3 times". -The facility did not take him to his dialysis treatments because "I had a bad cough". -He did not know if the facility notified his NP or Nephrologist of the missed hemodialysis sessions. -He did not know if the facility notified his HCPOA of the missed hemodialysis sessions. Interview with the transport staff on 02/13/20 at 9:45am revealed: -She was responsible for transporting Resident #8 to his dialysis treatments. -She did not transport Resident #8 for dialysis treatment on 01/28/20, 01/30/20 and 02/01/20.	D 273		

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 _____	02/13/2020

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

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D 273	Continued From page 13 Refer to the interview with the Nephrologist on 02/13/20 at 10:32am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/13/20 at 11:56am. Refer to the interview with the Administrator on 02/13/20 at 12:15pm. Refer to the interview with the Owner/VP on 02/13/20 at 12:45pm. _____ Interview with the Nephrologist on 02/13/20 at 10:32am revealed: -He was Resident #5's, Resident #6's, and Resident #8's Nephrologist. -He was informed by the dialysis center on 02/03/20 that Resident #5, Resident #6, and Resident #8 were not transported by the facility for their hemodialysis sessions the week of 01/26/20 through 02/01/20 because the facility was under a quarantine. -The facility had "almost three patients that died". -Resident #6 would have died at the facility had his HCPOA not shown up and demanded he be sent to the ER. -It was not an "executive decision" that the staff at the facility could decide to not transport patients to dialysis for treatment if the building was under quarantine. -He expected the facility to bring Resident #5, Resident #6, and Resident #8 to their scheduled dialysis sessions since it was a "life sustaining proposition". Interview with the RCC on 02/13/20 at 11:56am revealed: - Resident #5, Resident #6, and Resident #8 did	D 273		

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 _____	02/13/2020

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

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D 273	Continued From page 14 not go for their dialysis sessions the week of 01/26/20 through 02/01/20 due to being sick and refusals. -The facility had a policy to always transport residents to dialysis even when sick and on quarantine except when the resident refused. -She or the MA were responsible for notifying the HCPOA and the Primary Care Physician or NP if a resident refused to go to dialysis. -She did not know why all of the resident's refusals to go to dialysis, or notifications of refusals were not documented in the nurses notes. Interview with the Administrator on 02/13/20 at 12:15pm revealed: - Resident #5, Resident #6, and Resident #8 refused dialysis treatments the week of 01/26/20 through 02/01/20. -The facility was on quarantine the week of 01/26/20 through 02/01/20. -She did not know why the dialysis center had documented the facility refused to transport Resident #5, Resident #6, and Resident #8 to their scheduled dialysis treatments because the building was quarantined. -The charge nurse at the dialysis center called her and asked if the facility was refusing and she said, "oh no, the residents are refusing". -The Owner/VP suggested to her to cancel transport for the resident's at the facility when it was quarantined but she informed him they had to go ahead and transport. -It was the transport staffs responsibility to call and notify the dialysis center when Resident #5, Resident #6, and Resident #8 refused dialysis. -It was the MA's responsibility to notify family if a resident refused treatment and document it in the nurses notes. -It was the RCC's responsibility to call and notify	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 15 the PCP or NP when a resident refused treatments. -There was no policy for resident's refusing treatments such as dialysis. Interview with the Owner/VP on 02/13/20 at 12:45pm revealed: -He was informed by the Administrator that Resident #5, Resident #6, and Resident #8 refused their dialysis treatments the week of 01/26/20 through 02/01/20 when the facility was quarantined. -It was a mutual decision between him, the Administrator, and Resident #6's family to send him to the hospital for evaluation because "something didn't seem right with him". -The Administrator was responsible for "all medical stuff" at the facility. -His responsibility was to provide technical assistance and make sure the Administrator performed her job duties. -He had suggested to the Administrator they hold transport for all residents the week the facility was quarantined from 01/26/20 through 02/01/20 and she informed him they were not allowed to. -He did not know why the dialysis center had documented Resident #5, Resident #6, and Resident #8 would not be transported by the facility to their scheduled dialysis treatments because the facility was quarantined. _____ The failure of the facility to ensure 3 of 3 residents receiving hemodialysis were transported to treatments when the facility was under quarantine resulted in Resident #6 experiencing critical lab values related to kidney function, leading to an abnormal heart rhythm; Resident #6 decided to discontinue dialysis	D 273		

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 _____	02/13/2020

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D 273	Continued From page 16 treatment on 02/08/20 and died on 02/10/20; and Resident #5 who experienced metabolic encephalopathy and altered mental status. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/12/20 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 14, 2020.	D 273		
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 referral and follow up for 3 of 3 sampled residents (#5, #6, and #8) who did not receive dialysis treatments due to the facility being quarantined during an outbreak of illness, resulting in two of the residents being hospitalized (#5 and #6). [Refer to tag 0273 10A NCAC 13F .0902(b). (Type A1 Violation)]	D912		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

RECEIVED
MAR 16 2020
ADULT CARE LICENSURE SECTION
RALEIGH

Certified Mail and Electronic Mail
Certified # 7018 0040 0000 2245 9899

March 5, 2020

Jennifer Gates, President
Camelot Manor, Inc, Licensee
Brockford Inn
56 N. Highland Avenue
Granite Falls, NC 28630

brockfordinnoffice@gmail.com

Re: Annual and Complaint Investigation completed February 13, 2020 ASPEN Event ID YJV611, Complaint ID NC00160600
Type A1 Violation

Facility:	**Brockford Inn**
Licensure Number:	**HAL-014-014**
County:	**Caldwell**

Dear Ms. Gates:

Thank you for the cooperation and courtesy extended during the survey completed February 13, 2020 by staff with the Adult Care Licensure Section and the Caldwell County Department of Social Services.

Based on the survey findings, 1 of 4 complaint allegations was substantiated resulting in deficiencies 10A NCAC 13F .0902(b).

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Type A1 Violation

- Type A1 rule violation is cited for **10A NCAC 13F .0902(b)** and **G.S. § 131D-21 Resident Rights.**
- Type A1 Violations must be **corrected** within 30 days from the exit date of the survey, which is March 14, 2020.
- Information regarding any penalty recommendation and imposition for the violations will be mailed to you separately.

As set forth in G. S. 131D-34 where the facility has a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of no less than $1,000 or more than $20,000 for Adult Care facilities of 7 or more beds for each Type A1 Violation identified.

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to $1,000 for each day that the violation continues beyond the time specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by March 26, 2020. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by March 26, 2020. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency. Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 919-594-4240. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Julie Grooms, RN

Julie Grooms, RN Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies

cc: Felicia Wood, Supervisor, Caldwell County DSS
Denise Coffey, Administrator w/enclosures included in certified mail # 7018 0040 0000 2245 9899
Darlene Penland, Team Supervisor, West 1 Region, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: http://info.ncdhhs.gov/dhsr/customerservice.html
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)