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 ______	04/22/2021

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 completed an annual survey on 04/21/21 and 04/22/21.	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 medication as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #1) related to insulin. The findings are: Review of Resident #1's current FL-2 dated 06/02/20 revealed diagnoses included diabetes, neuropathy, depression, anxiety, and chronic pain. Interview with Resident #1 during the initial tour on 04/21/21 at 9:55am revealed: -The facility "ran out of" my insulin last week. -The medication aide (MA) told her the insulin had been ordered and would be in the evening medication delivery on the day they ran out.	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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-She took one type of insulin during the day before meals and took a different insulin at night.
-The medication the facility missed was the insulin she took during the day.
-Her medication was not available for several days.

Review of Resident #1's medication orders dated 10/28/20 revealed an order for Humalog (a fast-acting insulin used to lower elevated blood sugar levels) 10 units three times daily before meals.
Review of Resident #1's electronic Medication Administration Record (eMAR) for April 2021 revealed:
-The Humalog 10 units was documented as "not available" on 04/14/21 at 6:00am with a fasting blood sugar (FSBS) of 221 at 11:00am and on 04/17/21 at 6:00am with a FSBS of 256 at 11:00am.
-The Humalog 10 units was documented as "not available" on 04/15/21 at 11:00am with a FSBS of 203 at 4:00pm and on 04/16/21 at 11:00am with a FSBS of 305 at 4:00pm.
-The Humalog 10 units was documented as "resident asleep" and "held, not given" on 04/18/21 at 6:00am.

Interview #2 with Resident #1 on 04/22/21 at 8:56am revealed:
-She was told by a MA last week that the facility had run out of her insulin.
-She did not feel any different not taking the insulin.
-It worried her that the facility did not have her medication.
-"I lost confidence that my health was being looked after."

Interview with the MA on 04/22/21 at 9:27am

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revealed:
-She documented on 04/15/21 at 11:00am that Resident #1's Humalog was not available to be administered.
-She documented on 04/16/21 at 11:00am that Resident #1's Humalog was not available to be administered.
-She was unable to locate Resident #1's Humalog on the medication cart.
-She also checked the refrigerator and could not find Resident #1's Humalog.
-She told one of the supervisors on both days that the Humalog for Resident #1 was not available but could not remember who she told or what they said.
-On 04/15/21 she called the pharmacy when she realized the Humalog was not available for administration and was told by a pharmacy representative the medication would be delivered that day.
-On 04/16/21 she called the pharmacy when she realized the Humalog was not available for administration and was told by a pharmacy representative the medication would be delivered that day.

Attempted phone interviews with the second MA on 04/22/21 at 9:50am and 10:57am were unsuccessful.

Interview with the Resident Care Coordinator (RCC) on 04/22/21 at 11:04am revealed:
-If a medication was low either she or the MA would call the pharmacy to reorder the medication.
-If the medication was out either she or the MA would call the pharmacy and ask for a stat (immediate) delivery.
-She had not been made aware by either MA that Resident #1 was out of Humalog.

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D 358	Continued From page 3 -If she had been aware on the first day Resident #1 was out of Humalog, she could have requested a stat order to the pharmacy and received the medication the same day. -"It is very dangerous for someone to go without insulin." Telephone interview with the Pharmacy Operations Manager from the facility's contracted pharmacy on 04/22/21 at 11:11am revealed: -There was no request for Humalog to be reordered for Resident #1 between 04/14/21 and 04/18/21. -Usually the facility staff would fax a request or occasionally call to let them know there was a medication they were running low on or were out. -The pharmacy kept records of the calls and faxes from each facility as medications were requested. -They did not have a record of a phone call or a fax from the facility requesting Humalog between 04/14/21 and 04/18/21. Telephone interview with Resident #1's Primary Care Physician (PCP) on 04/22/21 at 11:15am revealed Resident #1 may not need as much insulin as she had been receiving since there was no reaction to going without it. Interview with the Administrator on 04/22/21 at 11:22am revealed: -Humalog was always available in the facility since they had multiple residents on this medication. -If a MA found that a resident did not have Humalog it should have been called in to the pharmacy right then. -The facility tried not to borrow medications from other residents, but for insulin they should have borrowed the medication and documented it.	D 358		

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D 358	Continued From page 4 -Both MA's responsible for not administering the Humalog to Resident #1 were both new to medication administration.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 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 were accurate for 2 of 6 sampled residents (#4 and #6) related to a medication used to treat pain (#4) and a medication used to treat dizziness (#6).	D 367		

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The findings are:

1. Review of Resident #4's current FL2 dated 04/09/2021 revealed diagnoses included Alzheimer's Disease, diabetes, hyperlipidemia, schizophrenia, and pneumonia.

Review of Resident #4's Physician's Plan of Care from the local hospice provider dated 12/18/20 revealed a physician's order for morphine 100mg/5ml give 0.25ml to 0.5ml every 2 hours as needed (used to treat pain).

Review of Resident #4's December 2020, January 2021, March 2021, and April 2021 Medication Administration Records (MARs) revealed there was no entry for morphine 100mg/5ml give 0.25ml to 0.5ml every 2 hours as needed.

Observation of Resident #4's medications on hand on 04/21/21 at 3:30 pm revealed:
-There was a bottle of morphine sulfate 100 mg/5mL in the locked narcotic drawer on the medication cart with a label from a local pharmacy with Resident #4's name on the medication label.
-There was approximately 29ml of morphine sulfate 100mg/5ml available for administration to the resident.

Review of Resident #4's 2020 Controlled Substance Count Sheet (CSCS) revealed:
-The facility received 30ml of morphine 100mg/5ml for Resident #4 on 12/18/20.
-Resident #4 received 0.5ml of morphine 100mg/5ml on 04/15/21 and the remaining quantity was 29.5ml.

Telephone interview with a pharmacist from a

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local pharmacy on 04/21/21 at 3:40 pm revealed:
-The pharmacy filled the prescription for morphine for Resident #4 on 12/18/20.
-The order came from a physician from the local hospice.
-The pharmacy filled the prescription one time.
-The pharmacy did not know why the morphine was not on the facility MAR.
-The pharmacy was the back-up pharmacy and were not responsible for updating the facility MARs.

Telephone interview with a supervisor from the facility's contracted pharmacy on 04/21/21 at 4:26 pm revealed:
-She did not see an order for morphine for Resident #4 on file.
-The process for updating MARs started with the facility faxing the physician orders that were filled by another pharmacy to the facility's contracted pharmacy.
-If the morphine order had been handwritten on the MAR, the pharmacy would have updated the MAR for the next month.
-If neither the facility or Hospice had sent an order, the pharmacy would not have known to update the MAR.
-The pharmacy did not have a record that the order for morphine was written on the MAR returned from the facility since December 2020.

Interview with a medication aide (MA) on 04/22/21 at 9:51 am revealed:
-Sometimes the Administrator or the Owner of the facility audits the medication cart against the MARs.
-The Resident Care Coordinator (RCC) audited the medications using the MARs.
-If a resident had medications ordered from Hospice, Hospice sent the orders to the facility

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and the MAs put the medications in the carts when the medications were delivered to the facility.
-The MAs were supposed to tell the RCC when medications were not on the MARs.
-The RCC was responsible for adding medication orders to the MARs.

Interview with a second MA on 04/22/21 at 10:00am revealed:
-The Special Care Coordinator (SCC) or the RCC audit the medication carts.
-The MAs were not responsibility for auditing the medication carts.
-She did not know what might have happened with Resident #4's morphine order and why it was not on the MAR.

Interview with the SCC on 4/22/21 at 10:40 am revealed:
-She was not responsible for auditing the MARs.
-She checked the medications on the MAR to the medications in the cart when she ordered medications from the pharmacy.
-If a medication was not on the MAR, she would not know to look for it in the cart.
-If Resident #4's morphine was sent over from Hospice, the RCC should have added it to the MAR.
-One of the MAs should have caught the error when counting the medication cart at the end or beginning of a shift.

Interview with RCC on 4/22/21 at 10:15 am revealed:
-She, the Administrator, and the owner audited medications the MARs and medication carts.
-She audited the medication cart using the MARs an average of "two times a week".
-She did not know Resident #4 had morphine

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available on the medication cart.
-She "must have missed it" when doing her audit.
-She thought she saw the morphine in the cart, but only looked "for what is on the MAR", because "that's all that's supposed to be in the cart".
-If a MA saw the medication, but realized it was not on the MAR, the facility procedure was for the MA to notify the RCC.
-She did not know the morphine was not on the MAR.

Interview with the Administrator on 04/22/21 at 8:55am revealed:
-She did not know Resident #4 had morphine available on the cart and the medication was not entered on the MAR.
-The MA was suppose to notify the Administrator or the RCC if a medication was not entered on the MAR.
-The MA was "probably new" and did not know the medication was supposed to be on the MAR.

Based on observation, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/21 at 3:15pm.

Refer to the interview with the Administrator on 04/21/21 at 3:20pm.

2. Review of Resident #6 current FL2 dated 03/24/21 revealed diagnoses included hypothyroidism, bipolar disorder, and anxiety.

Review of a physician's order for Resident #6 dated 04/06/21 revealed meclizine 12.5mg every 8 hours for 14 days

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D 367	Continued From page 9 Observation of the morning medication pass on 04/21/21 at 10:27am revealed Resident #6 was administered meclizine (treats dizziness) 12.5mg one tablet. Review of Resident #6's Medication Administration Record (MAR) for April 1 - 21, 2021 revealed: -There was a handwritten entry for meclizine 12.5mg every 8 hours with administration times of 10:00am and 6:00pm. -There was no stop date. -There was documentation the meclizine had been administered on 04/07/21 - 04/20/21 at 10:00am and 6:00pm and on 04/21/21 at 10:00am. Observation of Resident #6's medications on hand on 04/21/21 at 3:00pm revealed: -There was one bubble pack of meclizine 12.5mg tablets with a dispensed date of 04/06/21. -There were 42 tablets dispensed with 13 remaining in the bubble pack. -The printed instructions on the bubble pack were to take one tablet every 8 hours for 14 days. Interview with the Medication Aide (MA) on 04/21/21 at 3:17pm revealed: -The Resident Care Coordinator (RCC) was responsible for transcribing new medication orders on the MAR. -She had always read the label on the bubble pack before administering medications. -She did not know the meclizine should have been given every 8 hours and for only 14 days. -She did not know why she had not read the label on the meclizine bubble pack to compare it with the MAR.	D 367		

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Interview with the Resident Care Coordinator (RCC) on 04/21/21 at 3:15pm revealed:
-She thought the administration times of 10:00am and 6:00pm were "every 8 hours".
-She had written the order on the MAR wrong.

Based on observation, interviews, and record reviews it was determined that Resident #6 was not interviewable.

Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/21 at 3:15pm.

Refer to the interview with the Administrator on 04/21/21 at 3:20pm.

____

Interview with the RCC on 04/21/21 at 3:15pm revealed:
-When new orders were received she was responsible for faxing the order to the pharmacy.
-She would then transcribe the order on the MAR.
-Second and third shift MAs were responsible for auditing the medications and comparing them with the MAR.

Interview with the Administrator on 04/21/21 at 3:20pm revealed:
-The MAs were trained to compare the label on the bubble pack with the MAR three times before administration of the medications.
-The RCC was responsible for faxing new orders to the pharmacy and then transcribing the order on the MAR.
-Third shift was responsible for comparing the medications and the orders when medications arrived from the pharmacy.