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	HAL014014	A. BUILDING: _____ B. WING _____	R-C 10/28/2021

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 conducted an complaint investigation and a follow-up survey on 10/27/21-10/28/21.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents care and services were met related to clothing items not returned to 7 residents after laundering by facility staff. The findings are: Interviews with 7 residents during the initial tour on 10/27/21 from 10:10am to 10:45am revealed: -One resident had "a few" pieces of clothing not returned to her after giving to staff to wash. -A second resident had 5 pieces of clothing not returned to her after giving to staff to wash on 10/17/21 and had spent a lot of money on the clothing. -A third resident was missing a pair of black pants after giving to staff to wash. -A fourth resident was missing 30 pairs of socks over the last year after giving to staff to wash. -A fifth resident was missing a pair of pants and pajamas after giving to staff to wash. -A sixth resident was missing many items of clothing mostly consisting of socks and underwear and had just got back a pair of pants that were missing for several months. -A seventh resident was missing shirts, pants,	D 338		

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socks and underwear and only had 2 pairs of underwear to wear and had to go without wearing any underwear many times.
-Residents wrote their names inside the clothing in order for the clothing to be returned to them.
-Residents had informed staff of the missing clothing items and never received the items back.

Interview with a personal care aide (PCA) on 10/27/21 at 2:31pm revealed:
-The housekeepers were responsible for laundering the residents' clothing and returning the items back to the residents.
-Residents' names were written on the clothing.
-Some residents had complained about missing items.
-Sometimes the clothing was located and sometimes it was not.

Observation of the laundry room on 10/27/21 at 2:33pm revealed a laundry cart with clothing items hanging inside it.

Interview with a housekeeper on 10/27/21 at 2:34pm revealed:
-Residents' clothing was picked up for washing twice daily.
-After the items were washed and dried the clothing was placed on a cart and returned to the residents.
-Residents names were written on the inside of the clothing.
-Sometimes newly hired staff would give clothing items to the wrong resident.
-Clothing without a name was kept in the laundry room.
-There had been a lot of new laundry staff and that was one of the "issues" regarding missing clothing.

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D 338	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 10/27/21 at 3:00pm revealed: -Clothing was laundered daily. -Housekeeping was responsible for returning the items back to the residents. -Clothing was lost often. -Clothing was "mixed up". -The housekeeping staff may not be able to read the names on the items. -The current housekeeping staff was responsible for training newly hired staff. Interview with a second housekeeper on 10/28/21 at 8:10am revealed: -After residents' clothing was laundered the items were hung on a rack and returned to the residents. -He was not aware of any missing clothing items. Interview with the Administrator on 10/28/21 at 8:20am revealed: -Housekeeping picked up clothing from the residents everyday to launder. -Residents' clothing was labeled with their names but sometimes the ink faded. -Housekeeping was responsible for returned the items back to the residents. -Housekeeping would attempt to locate missing clothing items.	D 338		
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	D 358		

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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 1 of 5 sampled residents (#3) related to oxygen used to treat shortness of breath.

The findings are:

1. Review of Resident #3's current FL-2 dated 02/10/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease and congestive heart failure.
-An order for oxygen (O2) at 3 liters (L) nasal cannula (nc) continuously.

Observation of Resident #3's O2 concentrator on 10/27/21 at 10:53am revealed the O2 concentrator was set on 2L nc.

Interview with Resident #3 on 10/27/21 at 10:53am revealed:
-She wore O2 continuously due to being short of breath from chronic obstructive pulmonary disease.
-She could not remember who set up her O2 concentrator to administer 2L of O2 instead of 3L but she was short of breath "most of the time".
-Her portable oxygen tank was set to 3L nc when she ambulated because she had difficulty breathing with the O2 at 2L nc.

Review of Resident #3's August 2021 MARS revealed:
-There was an entry for O2 at 3L nc continuously

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for 1st, 2nd, and 3rd shifts.
-O2 at 3L nc was documented as administered continuously.

Review of Resident #3's September 2021 MARS revealed:
-There was an entry for O2 at 3L nc continuously for 1st, 2nd, and 3rd shifts.
-O2 at 3L nc was documented as administered continuously.

Review of Resident #3's October 2021 MARS revealed:
-There was an entry for O2 at 3L nc continuously for 1st, 2nd, and 3rd shifts.
-O2 at 3L nc was documented as administered continuously from 10/01/21 through 10/26/21 all three shifts and first shift on 10/27/21.

Interview with a medication aide (MA) on 10/27/21 at 2:44pm revealed:
-Resident #3 had an order to wear oxygen continuously but she could not remember if the order was to administer 2L or 3L nc.
-She documented on the MAR the O2 concentrator administered O2 at 3L nc to Resident #3.
-She did not look to see what Resident #3's O2 concentrator was set on just that she wore the oxygen when she documented the O2 as administered on the MAR.
-She knew she was supposed to check Resident #3's O2 concentrator to make sure it was administering 3L before documenting the O2 at 3L nc, but she only looked to make sure Resident #3 was wearing the nasal cannula tubing in her nose.

Observation of Resident #3's O2 concentrator on 10/28/21 at 9:00am revealed the O2 at 2L nc was

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D 358	Continued From page 5 being administered to Resident #3. Interview with Resident #3 on 10/28/21 at 9:00am revealed: -The O2 concentrator was set to 2L and had never been changed by the facility staff. -She could not remember who had set the O2 concentrator to administer the oxygen at 2L. -Her portable O2 tank was set to deliver O2 at 3L which she used with ambulation due to getting short of breath. Interview with the Resident Care Coordinator (RCC) on 10/28/21 at 9:30am revealed: -The facility's policy for medication administration was for the MA to look at the O2 concentrator to check the setting and it was correct, make sure the resident was wearing the nasal prongs in the nose, and document on the MAR the O2 was administered at the correct liters. -She did not know why the MAs documented Resident #3 was being administered O2 at 3L when the O2 concentrator was set to 2L. Interview with the Administrator on 10/28/21 at 9:45am revealed: -The MAs were supposed to document on the MAR the amount of oxygen being administered to residents and check the O2 concentrator to make sure it was set to deliver the amount of oxygen ordered. -The MAs were responsible for checking the MARs for accuracy. -She expected staff to document and administer the correct dosage of oxygen to residents as ordered. Interview with the primary care provider (PCP) on 10/28/21 at 11:15am revealed: -The facility had called this morning to get an	D 358		

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D 358	Continued From page 6 order to decrease Resident #3's O2 to 2L nc from 3L nc because she had been stable on 2L nc. -He was not aware Resident #3 was administered O2 at 2L instead of 3L as ordered. -The Administrator told him Resident #3 turned the oxygen level down herself to administer 2L nc instead of 3L nc as ordered.	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 the accuracy of the Medication Administration Records (MARS) for 2 of 5 sampled residents (Resident #3 and #5)	D 367		

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related to documenting the administration of oxygen (#3) and an antidepressant medication dosage (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 02/10/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease and congestive heart failure.
-An order for oxygen (O2) at 3 liters (L) nasal cannula (nc) continuously.

Observation of Resident #3's O2 concentrator on 10/27/21 at 10:53am revealed the O2 concentrator was set on 2L nc.

Interview with Resident #3 on 10/27/21 at 10:53am revealed:
-She wore O2 continuously due to being short of breath from chronic obstructive pulmonary disease.
-She could not remember who set up her O2 concentrator to administer 2L of O2 instead of 3L but she was short of breath "most of the time".

Review of Resident #3's August 2021 MARS revealed:
-There was an entry for O2 at 3L nc continuously for 1st, 2nd, and 3rd shifts.
-O2 at 3L nc was documented as administered continuously.

Review of Resident #3's September 2021 MARS revealed:
-There was an entry for O2 at 3L nc continuously for 1st, 2nd, and 3rd shifts.
-O2 at 3L nc was documented as administered continuously.

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Review of Resident #3's October 2021 MARS revealed:
-There was an entry for O2 at 3L nc continuously for 1st, 2nd, and 3rd shifts.
-O2 at 3L nc was documented as administered continuously from 10/01/21 through 10/26/21 all three shifts and first shift on 10/27/21.

Interview with a medication aide (MA) on 10/27/21 at 2:44pm revealed:
-Resident #3 had an order to wear oxygen continuously but she could not remember if the order was to administer 2L or 3L nc.
-She documented on the MAR the O2 concentrator administered O2 at 3L nc to Resident #3.
-She did not look to see what Resident #3's O2 concentrator was set on just that she wore the oxygen when she documented the O2 as administered on the MAR.
-She knew she was supposed to check Resident #3's O2 concentrator to make sure it was administering 3L before documenting the O2 at 3L nc, but she only looked to make sure Resident #3 was wearing the nasal cannula tubing in her nose.

Observation of Resident #3's O2 concentrator on 10/28/21 at 9:00am revealed the O2 at 2L nc was being administered to Resident #3.

Interview with Resident #3 on 10/28/21 at 9:00am revealed:
-The O2 concentrator was set to 2L and had never been changed by the facility staff.
-She could not remember who had set the O2 concentrator to administer the oxygen at 2L.

Interview with the Resident Care Coordinator (RCC) on 10/28/21 at 9:30am revealed:

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D 367	Continued From page 9 -The facility's policy for medication administration was for the MA to look at the O2 concentrator to check the setting and it was correct and document on the MAR the O2 was administered at the correct liters. -She did not know why the MAs documented Resident #3 was being administered O2 at 3L when the O2 concentrator was set to 2L. Interview with the Administrator on 10/28/21 at 9:45am revealed: -The MAs were supposed to document on the MAR the amount of oxygen being administered to residents and check the O2 concentrator to make sure it was set to deliver the amount of oxygen ordered. -The MAs were responsible for checking the MARs for accuracy. -She expected staff to document and administer the correct dosage of oxygen to residents as ordered. 2. Review of Resident #4's current FL-2 dated 10/07/21 revealed: -Diagnoses included depression. -There was an order for sertraline 25mg daily, a medication used to treat depression. Review of Resident #4's resident register revealed he was admitted to the facility on	D 367		

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D 367	Continued From page 10 10/20/21. Review of a signed physician order dated 10/26/21 revealed Resident #4's sertraline was increased to 50mg daily. Review of Resident #4's October 2021 medication administration record (MAR) revealed: -There was an entry for sertraline 25mg one tablet daily. -There was documentation Resident #4 was administered sertraline 25mg one tablet daily at 10:00am from 10/21/21 to 10/26/21. -The sertraline 25mg entry was lined out and documented as changed on 10/26/21. -There was an entry dated 10/26/21 for sertraline 30mg one tablet daily. -There was documentation Resident #4 was administered sertraline 30mg one tablet daily at 10:00am on 10/27/21. Observation on 10/27/21 at 2:16pm of medications available for administration for Resident #4 revealed: -There was a bubble pack containing sertraline 50mg tablets. -The label indicated 30 tablets were dispensed on 10/26/21. -There were 29 tablets remaining in the bubble pack. Interview with the medication aide (MA) on 10/27/21 at 2:38am revealed: -She was trained to compare the resident's MAR with the pharmacy medication label three times before administering the medication. -She compared Resident #4's sertraline label and the MAR but missed the dosages did not match. -If medication labels did not match the MAR, she would contact the Resident Care Coordinator	D 367		

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D 367	Continued From page 11 (RCC) or the Memory Care Unit Coordinator (MCC) for clarification. Interview with the RCC on 10/27/21 at 3:04pm revealed: -She was responsible to fax new medication orders to the pharmacy and transcribe the order onto the resident's MAR. -She thought the dosage on Resident #4's sertraline order dated 10/26/21 was 30mg because of the primary care physician's (PCP) handwriting. -Medications arrived from the pharmacy on second or third shift and it was the responsibility of the MA receiving the medication to compare it with the MAR before placing it in the medication cart. -MAs were trained by the RN to compare medication labels with the MAR three times before administering a medication to the resident. Interview with the Administrator on 10/28/21 at 9:43am revealed: -The MAs were trained by the RN on medication administration prior to passing medications to residents. -The MAs were trained to compare medication labels with the resident's MAR three times before administering a medication. -The third shift MA was trained to compare the label of new medications received from the pharmacy with the PCP's order and the MAR before placing it in the medication cart for administration. -She did not know why Resident #4's sertraline was placed in the medication cart when the dosages did not match. -She did not know why the MA that administered Resident's #4 sertraline 50mg did not identify the discrepancy.	D 367		

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D 367	Continued From page 12 Attempted interview with Resident #4 on 10/27/21 at 10:32am revealed the resident was not interviewable.	D 367		