STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032065	A. BUILDING: _____ B. WING _____	R 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

(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 a follow-up survey and complaint investigation on November 6-8 and 12, 2019.	{D 000}		
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:	D 367		

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D 367	Continued From page 1 Based on observations, record reviews and interviews, the facility failed to assure electronic medical administration records (eMAR) were accurate and complete for 2 of 8 sampled residents (Residents #4 and #5), including inaccurate documentation of a narcotic used to treat moderate to severe pain and an anti-anxiety medication. The findings are: 1. Review of Resident #4's current FL-2 dated 06/19/19 revealed diagnoses included chronic back pain with sciatica, chest pain at rest, high blood pressure, dementia, and anxiety associated with depression. a. Review of Resident #4's current FL-2 dated 06/19/19 revealed there was an order for Clonazepam 0.5mg two times daily. (Clonazepam is used to treat anxiety.) Review of Resident #4's September 2019 eMAR revealed: -There was an entry for Clonazepam 0.5mg two times a day for anxiety. -From 09/01/19-09/14/19, there was documentation Clonazepam was administered at 9:00 am and 8:00 pm. -On 09/15/19, there was documentation Clonazepam was not administered at 9:00 am and was administered at 8:00pm. -On 09/16/19, there was documentation Clonazepam was not administered at 9:00 am and was administered at 8:00 pm. -On 09/17/19, there was documentation Clonazepam was not administered at 9:00 am and 8:00 pm. -On 09/18/19, there was documentation Clonazepam was not administered at 9:00 am and was administered at 8:00 pm.	D 367		

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D 367	Continued From page 2 -From 09/19/19-09/30/19, there was documentation Clonazepam was administered at 9:00 am and 8:00 pm. Review of Resident #4's Controlled Substance Count Sheet (CSCS) for 09/01/19-09/15/19 revealed: -On 09/01/19, there was documentation Clonazepam was signed out at 9:00 am and 8:00 pm. -On 09/02/19, there was documentation Clonazepam was signed out at 8:30 am and 8:00 pm. -From 09/03/19-09/13/19, there was documentation Clonazepam was signed out at 8:00 am and 8:00 pm. -On 09/14/19, there was documentation Clonazepam was signed out at 8:00 am. -On 09/15/19, there was documentation Clonazepam was signed out at 8:00 pm. -There was documentation 0 doses of Clonazepam remained. Review of Resident #4's CSCS for 09/19/19-09/30/19 revealed: -From 09/19/19-09/20/19, there was documentation Clonazepam was signed out at 8:00 am and 8:00 pm. -On 09/21/19, there was documentation Clonazepam was signed out at 8:00 am. -There was a blank entry line between the 09/21/19 8:00 am entry and the 09/22/19 8:00 am entry. -From 09/22/19-09/30/19, there was documentation Clonazepam was signed out at 8:00 am and 8:00 pm. -There was documentation 7 doses of Clonazepam remained.	D 367		

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D 367	Continued From page 3 Based on review of the September 2019 eMAR and CSCS for Resident #4, there were 4 times Clonazepam was documented as administered on the eMAR and not documented as signed out on the CSCS. Review of pharmacy dispensing records for Resident #4 revealed on 08/13/19, 09/18/19, and 10/15/19, there were 60 Clonazepam tablets dispensed on each date. Observation of Resident #4's medication on hand on 11/12/19 at 11:30 am revealed: -There was a punch card containing 11 of 30 Clonazepam tablets. -The label indicated it was 2 of 2 punch cards dispensed on 10/15/19. Interview with Resident #4 revealed she did not have any concerns related to her medication. Interview with a medication aide (MA) on 11/12/19 at 8:00 am revealed: -The 09/15/19 entry date on the CSCS was incorrect; it should have been documented as 09/14/19. -The medication was not available for administration on 09/15/19-09/18/19. -She should have documented on the eMAR it was not available. -The medication was delivered to the facility on 09/19/19. Interview with a second MA on 11/12/19 at 8:20 am revealed: -Resident #4's Clonazepam was not on hand for four days in mid-September. -The facility had been waiting for the pharmacy to dispense the medication.	D 367		

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Refer to interview with a MA on 11/12/19 at 8:00 am.

Refer to interview with the HWD on 11/12/19 at 2:42 pm.

Refer to interview with the ED on 11/12/19 at 3:08 pm.

b. Review of Resident #4's current FL-2 dated 06/19/19 revealed there was an order for Tramadol 50mg every 6 hours as needed for pain.

Review of Resident #4's September 2019 electronic medication administration record (eMAR) revealed there was an entry for Tramadol 50mg every 6 hours as needed for pain management.

Review of Resident #4's Controlled Substance Count Sheet (CSCS) for 09/01/19-09/29/19 revealed:
-On 09/01/19, there was documentation Tramadol was signed out at 12:00 am.
-On 09/02/19, there was documentation Tramadol was signed out at 2:30 am.
-On 09/09/19, there was documentation Tramadol was signed out at 3:30 (no documentation of am or pm).
-On 09/10/19, there was documentation Tramadol was signed out at 2:00 am.
-On 09/12/19, there was documentation Tramadol was signed out at 2:30 (no documentation of am or pm).
-On 09/15/19, there was documentation Tramadol was signed out at 5:35 am.
-On 09/17/19, there was documentation Tramadol was signed out at 4:30 pm.
-On 09/24/19, there was documentation Tramadol

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was signed out at 4:30 (no documentation of am or pm).
-On 09/29/19, there was documentation Tramadol was signed out at 2:30 am.
-There was documentation 16 doses of Tramadol remained.

Based on review of the September 2019 eMAR and CSCS for Resident #4, there were 9 times Tramadol was signed out on the CSCS and not documented as administered on the eMAR.

Review of Resident #4's October 2019 eMAR revealed there was an entry for Tramadol 50mg every 6 hours as needed for pain management.

Review of Resident #4's CSCS for 10/05/19-10/28/19 revealed:
-On 10/05/19, there was documentation Tramadol was signed out at 7:00 pm.
-On 10/07/19, there was documentation Tramadol was signed out at 4:22 (no documentation of am or pm).
-On 10/16/19, there was documentation Tramadol was signed out at 7:00 pm.
-On 10/28/19, there was documentation Tramadol was signed out at 4:00 am.
-There was documentation 11 doses of Tramadol remained.

Based on review of the October 2019 eMAR and CSCS for Resident #4, there were 4 times Tramadol was signed out on the CSCS and not documented as administered on the eMAR.

Review of pharmacy dispensing records for Resident #4 revealed on 08/16/19 and 11/08/19, there were 30 Tramadol tablets dispensed on each date.

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Observation of Resident #4's medication on hand on 11/12/19 at 11:30 am revealed:
-There were 39 Tramadol tablets available.
-There was a punch card with a dispense date of 08/16/19 containing 9 of 30 Tramadol tablets.
-There was a second punch card with a dispense date of 11/08/19 containing 30 of 30 Tramadol tablets.

Interview with Resident #4 revealed she did not have any concerns related to her medication.

Refer to interview with a MA on 11/12/19 at 8:00 and 9:20 am.

Refer to interview with the Health and Wellness Director (HWD) on 11/12/19 at 2:42 pm.

Refer to interview with the Executive Director (ED) on 11/12/19 at 3:08 pm.

2. Review of Resident #5's current FL-2 dated 08/28/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), high blood pressure, depression, and anxiety.

Review of Resident #5's subsequent physician orders revealed:
-There was an order dated 10/03/19 for Lorazepam 0.5mg every 4 hours as needed for anxiety.
-There was an order dated 10/18/19 for Oxycodone 10mg every 4 hours as needed for pain and dyspnea (difficulty breathing).

a. Review of Resident #5's current FL-2 dated 08/28/19 revealed there was an order for Lorazepam 1mg every 4 hours as needed for anxiety.

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Review of Resident #5's September 2019 electronic medication administration record (eMAR) revealed there was an entry for Lorazepam 1mg every 4 hours as needed for anxiety.

Review of Resident #5's CSCS for 09/01/19-09/20/19 revealed:
-On 09/02/19, there was documentation Lorazepam was signed out at 7:50 pm.
-On 09/06/19, there was documentation Lorazepam was signed out at 9:30 am.
-On 09/10/19, there was documentation Lorazepam was signed out at 3:30 pm.
-There was documentation 10 doses of Lorazepam remained.

Review of Resident #5's CSCS for 09/21/19-09/30/19 revealed:
-On 09/25/19, there was documentation Lorazepam was signed out at 7:15 pm.
-There was documentation 28 doses of Lorazepam remained.

Based on review of the September 2019 eMAR and CSCS for Resident #5, there were 4 times Lorazepam 1mg was signed out on the CSCS and not documented as administered on the eMAR.

Review of pharmacy dispensing records for Resident #5 revealed on 08/14/19, there were 60 Lorazepam 1mg tablets dispensed.

Review of Resident #5's October 2019 eMAR revealed:
-There was an entry for Lorazepam 0.5mg every 4 hours as needed for anxiety.

Review of Resident #5's Controlled Substance

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D 367	Continued From page 8 Count Sheet (CSCS) for 10/06/19-10/30/19 revealed: -On 10/10/19, there was documentation Lorazepam was signed out at 10:00 am. -On 10/12/19, there was documentation Lorazepam was signed out at 8:00 pm. -On 10/16/19, there was documentation Lorazepam was signed out at 8:00 pm. -On 10/21/19, there was documentation Lorazepam was signed out at 6:30 (no documentation of am or pm). -There was documentation 13 doses of Lorazepam remained. Based on review of the October 2019 eMAR and CSCS for Resident #5, there were 4 times Lorazepam 0.5 mg was signed out on the CSCS and not documented as administered on the eMAR. Review of Resident #5's November 2019 eMAR revealed: -There was an entry for Lorazepam 0.5mg every 4 hours as needed for anxiety. Review of Resident #5's Controlled Substance Count Sheet (CSCS) for 11/02/19-11/11/19 revealed: -On 11/03/19, there was documentation Lorazepam was signed out at 7:00 pm. -On 11/04/19, there was documentation Lorazepam was signed out at 5:30 am and 8:00 pm. -On 11/05/19, there was documentation Lorazepam was signed out at 8:00 pm. -On 11/07/19, there was documentation Lorazepam was signed out at 8:00 am and 8:00 pm. -On 11/08/19, there was documentation Lorazepam was signed out at 8:00 pm.	D 367		

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D 367	Continued From page 9 -There was documentation 17 doses of Lorazepam remained. Based on review of the November 2019 eMAR and CSCS for Resident #5, there were 7 times Lorazepam 0.5mg was signed out on the CSCS and not documented as administered on the eMAR. Review of pharmacy dispensing records for Resident #5 revealed on 10/03/19, there were 60 Lorazepam 0.5mg tablets dispensed. Observation of Resident #5's medication on hand on 11/12/19 at 10:45 am revealed: -There was a punch card containing 9 of 30 Lorazepam tablets. -The label indicated it was 2 of 2 punch cards dispensed on 10/03/19. Interview with Resident #5 on 11/06/19 at 10:57 am revealed: -She had no problems receiving medication when she needed it. -She received Lorazepam when she requested it. Interview with a MA on 11/12/19 at 12:30 pm revealed: -She did not know why she had not documented administration of Resident #5's Lorazepam. -She was "possibly sidetracked." Refer to interview with a MA on 11/12/19 at 8:00 am and 9:20 am. Refer to interview with HWD on 11/12/19 at 2:42 pm. Refer to interview with ED on 11/12/19 at 3:08 pm.	D 367		

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D 367	Continued From page 10 b. Review of Resident #5's current FL-2 dated 08/28/19 revealed there was an order for Oxycodone 5mg every 6 hours as needed for pain. Review of Resident #5's September 2019 eMAR revealed: -There was an entry for Oxycodone 5mg every 6 hours as needed for pain or dyspnea. -There was no documentation of administration of Oxycodone. Review of Resident #5's CSCS for 09/02/19-09/30/19 revealed: -On 09/02/19, there was documentation Oxycodone was signed out at 1:30 am. -On 09/12/19, there was documentation Oxycodone was signed out at 2:00 am. -On 09/17/19, there was documentation Oxycodone was signed out at 7:00 pm. -On 09/30/19, there was documentation Oxycodone was signed out at 12:00 am. -There was documentation 9 doses remained. Based on review of the September 2019 eMAR and CSCS for Resident #5, there were 4 times Oxycodone 5mg was signed out on the CSCS and not documented as administered on the eMAR. Review of Resident #5's October 2019 eMAR revealed: -There was an entry for Oxycodone 5mg every 6 hours as needed for pain or dyspnea. -There was documentation the order was discontinued on 10/18/19 at 8:59 pm. Review of Resident #5's CSCS for 10/05/19-10/14/19 revealed:	D 367		

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-On 10/05/19, there was documentation Oxycodone was signed out at 4:00 pm.
-On 10/07/19, there was documentation Oxycodone was signed out at 7:00 pm.
-On 10/12/19, there was documentation Oxycodone was signed out at 8:00 pm.
-On 10/13/19, there was documentation Oxycodone was signed out at 8:00 pm.
-There was documentation 2 doses of Oxycodone remained.

Review of Resident #5's CSCS for 10/16/19-10/18/19 revealed:
-On 10/18/19, there was documentation Oxycodone was signed out at 9:30 pm.
-There was documentation 28 doses of Oxycodone remained.

Based on review of the October 2019 eMAR and CSCS for Resident #5, there were 5 times Oxycodone 5mg was signed out on the CSCS and not documented as administered on the eMAR.

Review of pharmacy dispensing records for Resident #5 revealed on 10/15/19, there were 60 Oxycodone 5mg tablets dispensed.

Review of Resident #5's CSCS for Oxycodone 5mg for 10/16/19-10/19/19 revealed:
-There was documentation 25 doses of Oxycodone remained and were sent back to the pharmacy on 10/21/19 as a result of the 10/18/19 order increasing the dose to 10mg.

Review of Resident #5's second CSCS for Oxycodone 5mg revealed there was documentation 30 doses were returned to the pharmacy on 10/21/19 as a result of the 10/18/19 order increasing the dose to 10mg.

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D 367	Continued From page 12 Review of Resident #5's October 2019 eMAR revealed: -There was an entry dated 10/18/19 at 9:30 pm for Oxycodone 10mg every 4 hours as needed for pain or dyspnea. Review of Resident #5's CSCS for Oxycodone 10mg for 10/19/19-10/31/19 revealed: -On 10/21/19, there was documentation Oxycodone was signed out at 8:00 pm. -On 10/27/19, there was documentation Oxycodone was signed out at 9:00 pm. -There was documentation 15 doses of Oxycodone remained. Based on review of the October 2019 eMAR and CSCS for Resident #5, there were 2 times Oxycodone 10mg was signed out on the CSCS and not documented as administered on the eMAR. Review of pharmacy dispensing records for Resident #5 revealed on 10/18/19, there were 150 Oxycodone tablets dispensed. Review of Resident #5's CSCS for Oxycodone 10mg revealed there was documentation 30 doses were returned to the pharmacy on 10/19/19. Review of Resident #5's CSCS for Oxycodone 10mg revealed there was documentation 30 doses were returned to the pharmacy on 10/19/19. Review of Resident #5's CSCS for Oxycodone 10mg revealed there was documentation 30 doses were returned to the pharmacy on 10/19/19.	D 367		

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BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

(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 13 Observation of Resident #5's medication on hand on 11/12/19 at 10:45 am revealed: -There were 33 Oxycodone 10mg tablets available. -There was a punch card containing 3 of 30 Oxycodone tablets. -The label indicated it was 1 of 2 punch cards dispensed on 10/18/19. -There was a second punch card containing 30 of 30 Oxycodone tablets. -The label indicated it was 2 of 2 punch cards dispensed on 10/18/19. Interview with Resident #5 on 11/06/19 at 10:57 am revealed: -She had no problems receiving medication when she needed it. -She requested and received Oxycodone when she had pain in her back. Refer to interview with a MA on 11/12/19 at 8:00 am and 9:20 am. Refer to interview with the HWD on 11/12/19 at 2:42 pm. Refer to interview with the ED on 11/12/19 at 3:08 pm. Interview with a MA on 11/12/19 at 8:00 am revealed: -She could not explain why she did not document on the eMAR after administering the medication. -She had trained a new employee in September of 2019 and may have been moving too fast to document correctly. Second interview with a MA on 11/12/19 at 9:20 am revealed the medication did not get	D 367		

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 367	Continued From page 14 documented in the eMAR sometimes because she did not click the correct symbol in the software program. Interview with the HWD on 11/12/19 at 2:42 pm revealed: -She expected documentation on the CSCS and the eMAR to match. -She randomly audited the eMARs and the CSCS. -She had two MAs assisting her with auditing the eMARs and the CSCS. -She had conducted a documentation training session with the MAs on 10/31/19. Interview with the ED on 11/12/19 at 3:08 pm revealed: -She expected orders to be followed as written and documented on the eMAR. -The HWD and MAs audited the eMARs and CSCS. -Her expectation was to have audits performed each month.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews and review of	D 371		

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D 371	Continued From page 15	D 371		

the facility's medication and treatment policy, the facility failed to assure medications were administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment.

The findings are:

The facility's medication and treatment policy dated March 2018 revealed:
-Infection control and prevention practices based on the Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene.
-Associates should wash their hands or use hand sanitizer prior to medication administration for each resident.

Observation on 11/07/19 at 8:11 am on the medication cart on Hall 3 revealed:
-The medication aide (MA) had already drawn up insulin in the syringe.
-The MA put on a pair of gloves and administered the insulin injection to a resident.
-The MA pulled down the safety-lok on the insulin syringe and disposed of the insulin syringe into the sharps container.
-She took her gloves off, but she did not wash or sanitizer her hands prior to giving medications to another resident.
-There was hand sanitizer on the medication cart

Interview with a medication aide (MA) on 11/07/19 at 11:45 am revealed:
-The MA thought she washed her hands after pulling off gloves and before administering medications to another resident.
-She should have washed her hands prior to putting on gloves and administering insulin to a

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D 371	Continued From page 16	D 371		

resident.
-She should have washed her hands after disposing of the gloves in the waste basket.
-She should have washed her hands prior to administering medications to another resident.
-She should sanitizer her hands after administering medications to each resident.
-She should wash her hands after she administered medications to the third or fourth residents

Interview with the Health and Wellness Director (HWD) on 11/08/19 at 3:10 pm revealed:
-She did not know the MA did not wash her hands after administering insulin injection to a resident and pulling off gloves on 11/07/19 during the morning medication pass.
-She did not know a MA administered medications to another resident without washing hands on 11/07/19 during the morning medication pass.
-The MA should have washed her hands prior to putting on gloves and administering insulin to another resident and after disposing of the gloves in the waste basket.
-The MA should have washed her hands prior to pouring and administering medications to another resident.
-The MAs should sanitizer their hands prior to administering medications to each residents and wash hands after administering medication to the third resident.
-The MAs were taught hand hygiene during medication administration training.

Interview with the Executive Director (ED) on 11/12/19 at 11:25 am revealed:
-She did not know a MA did not wash her hands after administering insulin injection to a resident and pulling off gloves on 11/07/19 during the

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D 371	Continued From page 17 morning medication pass. -She did not know the MA administered medications to another resident without washing hands on 11/07/19 during the morning medication pass. -The MAs should wash hands prior to putting on gloves and after pulling off gloves. -Hand sanitizer or a sink should be near the medication cart. -The HWD, Licensed Professional Nurse (LPN) and the supervisors were responsible for training the MAs on hand hygiene for the administration of medications.	D 371		