Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		D	
		HAL032065	B. WING		R 11/12/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
BROOKD	ALE DURHAM	4434 BE	N FRANKLIN BOUI	_EVARD	
BROOKD	ALL DOKTAM	DURHAN	M, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
{D 000}	Initial Comments		{D 000}		
		sure Section conducted a complaint investigation on 2, 2019.			
D 367	10A NCAC 13F .1004 Administration	(j) Medication	D 367		
	(j) The resident's mer record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ador treatment; (5) reason or justificat medications or treatm documenting the result (6) date and time of a (7) documentation of medications or treatm omission, including re (8) name or initials of the medication or treasignature equivalent the documented and main administration record	any omission of tents and the reason for the ifusals; and, the person administering atment. If initials are used, a those initials is to be intained with the medication (MAR).			
	This Rule is not met	as evidenced by:			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:					
			B WING	B. WING		R	
		HAL032065	B. WING		11/	12/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
BROOKD	ALE DURHAM		FRANKLIN BO	ULEVARD			
	-	DURHAM	, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 367	Continued From page	e 1	D 367				
	interviews, the facility medical administratio accurate and comple residents (Residents inaccurate document						
	The findings are:						
	06/19/19 revealed dia back pain with sciation	at #4's current FL-2 dated agnoses included chronic a, chest pain at rest, high entia, and anxiety associated					
	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 anxietyFrom 09/01/19-09/14/19, there was documentation Clonazepam was administered at 9:00 am and 8:00 pmOn 09/15/19, there was documentation Clonazepam was not administered at 9:00 am and was administered at 8:00pmOn 09/16/19, there was documentation Clonazepam was not administered at 9:00 am and was administered at 8:00 pmOn 09/17/19, there was documentation Clonazepam was not administered at 9:00 am and was administered at 8:00 pm.						
	-On 09/18/19, there w	administered at 9:00 am					

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 2 of 18

	of Health Service Regul	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL032065	B. WING		R 11/12/2019	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
4434 BEN			N FRANKLIN BO	ULEVARD		
BROOKDALE DURHAM DURHAN			M, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	2	D 367			
	9:00 am and 8:00 pm. Review of Resident #-	zepam was administered at				
	revealed: -On 09/01/19, there w	vas documentation ned out at 9:00 am and 8:00				
		ned out at 8:30 am and 8:00				
		zepam was signed out at				
	Clonazepam was sign -On 09/15/19, there w	ned out at 8:00 am.				
	Clonazepam was signature -There was document Clonazepam remaine	tation 0 doses of				
	Review of Resident #- 09/19/19-09/30/19 rev -From 09/19/19-09/20	vealed:				
	documentation Clona: 8:00 am and 8:00 pm	zepam was signed out at				
	-On 09/21/19, there w Clonazepam was sigr -There was a blank er	ned out at 8:00 am.				
		ry and the 09/22/19 8:00				

Division of Health Service Regulation

8:00 am and 8:00 pm.

Clonazepam remained.

documentation Clonazepam was signed out at

-There was documentation 7 doses of

STATE FORM 6899 COJF12 If continuation sheet 3 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				R	
HAL032065 B. W		B. WING		11/12/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
BROOKDALE DURHAM 4434 BEN		I FRANKLIN BO	ULEVARD		
DURHAM,		I, NC 27704		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	2 3	D 367		
	and CSCS for Reside Clonazepam was doo on the eMAR and not on the CSCS. Review of pharmacy Resident #4 revealed	the September 2019 eMAR and #4, there were 4 times sumented as administered documented as signed out dispensing records for on 08/13/19, 09/18/19, and 60 Clonazepam tablets			
	dispensed on each da				
	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 tabletsThe label indicated it was 2 of 2 punch cards dispensed on 10/15/19.				
		nt #4 revealed she did not lated 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.				
	am revealed: -Resident #4's Clonar four days in mid-Sept	waiting for the pharmacy to			

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 4 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
		HAL032065	B. WING			R <b>12/2019</b>	
			1		117	12/2019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	•			
BROOKD	ALE DURHAM		N FRANKLIN BO I, NC 27704	ULEVARD			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
D 367	Continued From page	e 4	D 367				
	Refer to interview wit am.	h a MA on 11/12/19 at 8:00					
	Refer to interview wit 2:42 pm.	h the HWD on 11/12/19 at					
	Refer to interview wit pm.	h the ED on 11/12/19 at 3:08					
	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.						
		administration record re was an entry for Tramadol					
	Count Sheet (CSCS) revealed: -On 09/01/19, there was signed out at 12:3-On 09/02/19, there was signed out at 2:3-On 09/09/19, there was signed out at 3:3 or pm)On 09/10/19, there was signed out at 2:0-On 09/12/19, there was signed out at 2:3 or pm)On 09/15/19, there was signed out at 5:3-On 09/17/19, there was signed	vas documentation Tramadol 30 am. vas documentation Tramadol 30 (no documentation of am vas documentation Tramadol 30 am. vas documentation Tramadol 30 (no documentation of am vas documentation Tramadol 35 am. vas documentation Tramadol					
	was signed out at 4:3 -On 09/24/19, there v	0 pm. vas documentation Tramadol					

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 5 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL032065	B. WING		R <b>11/12/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BROOKDALE DURHAM			FRANKLIN BO	ULEVARD	
		DURHAM,	NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 5	D 367		
	or pm)On 09/29/19, there w was signed out at 2:3 -There was document remained.	tation 16 doses of Tramadol			
	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.				
	revealed there was ar	4's October 2019 eMAR n entry for Tramadol 50mg ded 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 pmOn 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 pmOn 10/28/19, there was documentation Tramadol was signed out at 4:00 amThere was documentation 11 doses of Tramadol remained.				
	CSCS for Resident #4 Tramadol was signed	te October 2019 eMAR and 4, there were 4 times out on the CSCS and not nistered on the eMAR.			
	Resident #4 revealed	dispensing records for on 08/16/19 and 11/08/19, dol tablets dispensed on			

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 6 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
HAL032065		B. WING		11/12/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKDALE DURHAM		FRANKLIN BO	ULEVARD			
DURHAM,		·				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 6	D 367			
	Observation of Residential Observation of Reside	ent #4's medication on hand am revealed: adol tablets available. card with a dispense date of of 30 Tramadol tablets. punch card with a dispense aining 30 of 30 Tramadol on the second of an amount of a management of a mana				
	-There was an order of Oxycodone 10mg ever pain and dyspnea (diffusion a. Review of Residen 08/28/19 revealed the	ery 4 hours as needed for fficulty breathing). t #5's current FL-2 dated				

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 7 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED	
			A. BOILDING.	A. Boilbino.		R
		HAL032065	B. WING			12/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE DURHAM		N FRANKLIN BO 11, NC 27704	ULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	(eMAR) revealed theil Lorazepam 1mg ever anxiety.  Review of Resident # 09/01/19-09/20/19 re-On 09/02/19, there we Lorazepam was signe-On 09/10/19, there we Lorazepam was signe-On 09/10/19, there we Lorazepam was signe-There was document Lorazepam remained.  Review of Resident # 09/21/19-09/30/19 re-On 09/25/19, there we Lorazepam was signe-There was document Lorazepam was signe-There was document Lorazepam remained.  Based on review of the and CSCS for Reside Lorazepam 1mg was and not documented eMAR.  Review of pharmacy Resident #5 revealed.  Review of Resident # revealed:	administration record re was an entry for ry 4 hours as needed for re was an entry for ry 4 hours as needed for re was documentation red out at 7:50 pm. red out at 9:30 am. red out at 3:30 pm. red out at 3:30 pm. red out at 3:30 pm. red out at 7:15 pm. red out at 7:	D 367			
	Review of Resident #	5's Controlled Substance				

Division of Health Service Regulation

STATE FORM 6899 C0JF12 If continuation sheet 8 of 18

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL032065	B. WING		11/12/2019	
		11AE032003			11/12/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DDOOKD	ALE DUDUAM	4434 BE	N FRANKLIN BO	ULEVARD		
BROOKDA	ALE DURHAM	DURHAI	M, NC 27704			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				- ,		
D 367	Continued From page	e 8	D 367			
	Count Shoot (CSCS)	for 10/06/19-10/30/19				
	revealed:	101 10/00/19-10/30/19				
	-On 10/10/19, there w	as documentation				
	Lorazepam was signe					
	-On 10/12/19, there w					
	Lorazepam was signe					
	-On 10/16/19, there w					
	Lorazepam was signe					
	-On 10/21/19, there w	•				
	Lorazepam was signe					
	documentation of am	or pm).				
	-There was document	tation 13 doses of				
	Lorazepam remained	•				
		e October 2019 eMAR and				
	CSCS for Resident #5					
		as signed out on the CSCS				
		as administered on the				
	eMAR.					
	Davious of Davidant #	5's November 2019 eMAR				
	revealed:	55 November 2019 eWAR				
		or Lorazepam 0.5mg every				
	4 hours as needed for	· · · · · · · · · · · · · · · · · · ·				
	Thouse do mooded to	and the second				
	Review of Resident #	#5's Controlled Substance				
	Count Sheet (CSCS)					
	revealed:					
	-On 11/03/19, there w	as documentation				
	Lorazepam was signe	ed out at 7:00 pm.				
	-On 11/04/19, there w					
	Lorazepam was signe	ed out at 5:30 am and 8:00				
	pm.					
	-On 11/05/19, there w	as documentation				
	Lorazepam was signe					
	-On 11/07/19, there w					
	Lorazepam was signe	ed out at 8:00 am and 8:00				

Division of Health Service Regulation

-On 11/08/19, there was documentation Lorazepam was signed out at 8:00 pm.

STATE FORM 6899 C0JF12 If continuation sheet 9 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		HAL032065	B. WING		R 11/12/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
BROOKDALE DURHAM		FRANKLIN BO NC 27704	ULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 367	and CSCS for Reside Lorazepam 0.5mg wa and not documented eMAR.  Review of pharmacy Resident #5 revealed Lorazepam 0.5mg ta  Observation of Reside on 11/12/19 at 10:45 -There was a punch Lorazepam tabletsThe label indicated it dispensed on 10/03/1  Interview with Reside am revealed: -She had no problems she needed itShe received Loraze  Interview with a MA or revealed: -She did not know who administration of Reside in the received with a mand 9:20 am.	tation 17 doses of  ne November 2019 eMAR ent #5, there were 7 times as signed out on the CSCS as administered on the  dispensing records for on 10/03/19, there were 60 blets dispensed.  ent #5's medication on hand am revealed: card containing 9 of 30  a was 2 of 2 punch cards 9.  ent #5 on 11/06/19 at 10:57 as receiving medication when epam when she requested it. en 11/12/19 at 12:30 pm ent was 10 of 10	D 367	DETIGIENCI)	
	Refer to interview with pm.	h ED on 11/12/19 at 3:08			

Division of Health Service Regulation

STATE FORM 6899 C0JF12 If continuation sheet 10 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL032065		B. WING		R 11/12/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	1=.==.
4434 BEN			N FRANKLIN BO		
BROOKDALE DURHAM DURHAM,			/I, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	e 10	D 367		
	08/28/19 revealed the	t #5's current FL-2 dated ere was an order for y 6 hours as needed for			
	revealed: -There was an entry f hours as needed for p	5's September 2019 eMAR for Oxycodone 5mg every 6 pain or dyspnea. The nentation of administration of			
	Review of Resident # 09/02/19-09/30/19 rev-On 09/02/19, there w Oxycodone was signed-On 09/12/19, there w Oxycodone was signed-On 09/17/19, there w Oxycodone was signed-On 09/30/19, there w Oxycodone was signed-On 09/30/19, there w Oxycodone was signed-There was document	vealed: vas documentation ed out at 1:30 am. vas documentation ed out at 2:00 am. vas documentation ed out at 7:00 pm. vas documentation			
	and CSCS for Reside Oxycodone 5mg was	ne September 2019 eMAR ent #5, there were 4 times signed out on the CSCS as administered on the			
	revealed:	tation the order was 8/19 at 8:59 pm.			

Division of Health Service Regulation

10/05/19-10/14/19 revealed:

STATE FORM 6899 COJF12 If continuation sheet 11 of 18

Division of Health Service Regulation

DIVISION OF FIGARITY SERVICE REGULATION				1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			1	_	_		
			B. WING		R		
		HAL032065	D. WING		11/12	2/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
	-		I FRANKLIN BO	,			
BROOKDA	ALE DURHAM			OLEVARD			
		DURHAM	, NC 27704				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE	
TAG	REGULATORT OR E	100 IDENTIL TING IN CINIMATION)	TAG	DEFICIENCY)	WATE		
D 367	Continued From page	e 11	D 367				
	On 10/05/10 there	an decompositorios					
	-On 10/05/19, there w						
	Oxycodone was signed						
	-On 10/07/19, there w						
	Oxycodone was signed						
	-On 10/12/19, there w	vas documentation					
	Oxycodone was signed						
	-On 10/13/19, there w	vas documentation					
	Oxycodone was signed	ed out at 8:00 pm.					
	-There was document	tation 2 doses of					
	Oxycodone remained	l.					
	, , , , , , , , , , , , , , , , , , , ,						
	Review of Resident #	5's CSCS for					
	10/16/19-10/18/19 rev						
	-On 10/18/19, there w						
	Oxycodone was signed						
	-There was document						
	Oxycodone remained						
	D	0.1.10040NAD1					
		ne October 2019 eMAR and					
	CSCS for Resident #5						
		signed out on the CSCS					
	and not documented	as administered on the					
	eMAR.						
	•	dispensing records for					
		on 10/15/19, there were 60					
	Oxycodone 5mg table	ets dispensed.					
		5's CSCS for Oxycodone					
	5mg for 10/16/19-10/	19/19 revealed:					
	-There was document	tation 25 doses of					
	Oxycodone remained	and were sent back to the					
	•	9 as a result of the 10/18/19					
	order increasing the o						
	<b>0</b>	<b>5</b>					
	Review of Resident #	5's second CSCS for					
	Oxycodone 5mg reve						
		ses were returned to the					
		9 as a result of the 10/18/19					

Division of Health Service Regulation

order increasing the dose to 10mg.

STATE FORM 6899 C0JF12 If continuation sheet 12 of 18

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
HAL032065		B. WING		R 11/12/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE DURHAM		I FRANKLIN BO , NC 27704	ULEVARD		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	N (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
D 367	Continued From page	e 12	D 367			
	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 pmOn 10/27/19, there was documentation Oxycodone was signed out at 9:00 pmThere 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.						
		5's CSCS for Oxycodone was documentation 30 to the pharmacy on				
	Review of Resident #5's CSCS for Oxycodone 10mg revealed there was documentation 30 doses were returned to the pharmacy on 10/19/19.					

Division of Health Service Regulation

STATE FORM 6899 C0JF12 If continuation sheet 13 of 18

Division of Health Service Regulation

DIVISION	of Health Service Regu	iation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HAL032065		B. WING		11	R 11/12/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	TE ZIP CODE	·	
			N FRANKLIN BO			
BROOKD	ALE DURHAM		I, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page 13		D 367			

Division of Health Service Regulation

am revealed the medication did not get

STATE FORM 6899 COJF12 If continuation sheet 14 of 18

Division of Health Service Regulation

DIVISION	or riealin Service Regu	iation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		' '	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	A. BUILDING:		COMPLETED	
					R	
		HAL032065	B. WING		11/1	2/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
		4434 BE	N FRANKLIN BOI	JLEVARD		
BROOKD	ALE DURHAM	DURHAI	M, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 14	D 367			
	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 CSCSShe 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:					
	and documented on t -The HWD and MAs a CSCS.	to be followed as written he eMAR. audited the eMARs and to have audits performed				
D 371	10A NCAC 13F .1004 Administration	r(n) Medication	D 371			
	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 Based on observation	as evidenced by: ns, interviews and review of				

Division of Health Service Regulation

STATE FORM 6899 C0JF12 If continuation sheet 15 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
JEHN ON ON WESTON		A. BUILDING: _			
HAL032065		B. WING		R 11/12/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BBOOKD	ALE DUDUAM	4434 BEN	FRANKLIN BO	ULEVARD	
BROOKD	ALE DURHAM	DURHAM,	NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
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 hygieneAssociates should wash their hands or use hand sanitizer prior to medication administration for each resident.				
	insulin in the syringeThe MA put on a pair the insulin injection to -The MA pulled down syringe and disposed the sharps containerShe took her gloves sanitizer her hands pranother residentThere was hand sani	all 3 revealed: (MA) had already drawn up of gloves and administered			
	at 11:45 am revealed: -The MA thought she pulling off gloves and medications to anotherShe should have was	washed her hands after before administering			

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 16 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
HAL032065		A. BUILDING:			00 22.25	
		B. WING	B. WING			
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
DDOOKDALE DUDUAM	4434 BE	N FRANKLIN BOUI	LEVARD			
BROOKDALE DURHAM	DURHAM	M, NC 27704				
PREFIX (EACH DEFICIENCY N	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
residentShe should have wash disposing of the gloves -She should have wash administering medication -She should wash her hadministered medication residents  Interview with the Healtt (HWD) on 11/08/19 at 3 -She did not know the Mafter administering insuland pulling off gloves or morning medication pass -She did not know a MAmedications to another hands on 11/07/19 durin passThe MA should have we putting on gloves and another resident and affin the waste basketThe MA should have we pouring and administering medication wash hands after administering medication wash hands after administration wash hands after administration administrationThe MAs were taught has medication administration.	AME OF PROVIDER OR SUPPLIER  ROOKDALE DURHAM  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 371  Continued From page 16  resident.  -She should have washed her hands after disposing of the gloves in the waste basketShe should have washed her hands prior to administering medications to another residentShe should sanitizer her hands after administering 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 medications to another resident without washing hands on 11/07/19 during the morning medication passThe 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 basketThe MA should have washed her hands prior to pouring and administering medications to another residentsThe MA should sanitizer their hands prior to administering medications to each residents and wash hands after administering medication to the					

Division of Health Service Regulation

STATE FORM 6899 COJF12 If continuation sheet 17 of 18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED				
					R				
		HAL032065	B. WING		11/	/12/2019			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
BROOKD	ALE DURHAM	4434 BEN DURHAM,	FRANKLIN BO NC 27704	ULEVARD					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE			
D 371	hands on 11/07/19 dupassThe MAs should was gloves and after pullir -Hand sanitizer or a smedication cartThe HWD, Licensed and the supervisors w	e MA administered er resident without washing uring the morning medication sh hands prior to putting on	D 371						

Division of Health Service Regulation

STATE FORM 6899 C0JF12 If continuation sheet 18 of 18