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	HAL032065	A. BUILDING: _____ B. WING _____	R 09/18/2025

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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 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-up survey on 09/16/25 to 09/18/25.	D 000		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for fixtures which were used by residents. The findings are: Review of the facility's census report provided on 09/16/25 revealed 58 residents resided in the Assisted Living (AL) and 16 residents resided in the Special Care Unit (SCU) of the facility. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety issues memo revealed a hot water	D 113		

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D 113	Continued From page 1	D 113		

temperature of 120 degrees °F could cause first degree burns within 8 minutes and second degree burns within 10 minutes. A hot water temperature of 124°F could cause first degree burns within 2 minutes and second degree burns within 4.2 minutes. A hot water temperature of 125.6 °F could cause first degree burns within 45 seconds and second degree burns within 1.5 minutes (A first-degree burn is a superficial burn affecting the outer layer of skin. A second-degree burn affects both the outer and second layer of skin and may cause blistering.

Review of the facility's local Environmental Health Section inspection report dated 06/02/25 revealed:
-There were observations of water temperatures in several rooms with handwashing sinks above 116°F including faucets used by residents.
-Resident room 126 in the SCU had a water temperature of 125°F at the sink.
-The resident restroom in the hallway in the SCU had a water temperature of 118°F at the sink.
-The resident restroom in the hallway in the AL had a water temperature of 123°F at the sink.

Review of the facility's water temperature testing procedure and policy revealed:
-The facility standard for hot water temperatures range was 100°F to 115°F.
-Let the water run for at least three minutes before taking the reading.
-Test water temperatures in resident rooms, shower areas and hand sinks at common area restrooms.
-Check the water temperatures in the resident rooms on each of the wings of the facility on a rotating basis.
-Record results in the water temperature log.
-Note any discrepancies.

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D 113	Continued From page 2 -Adjust the water heater settings as required. -Reset as necessary. a. Observation of the hot water temperatures in three resident rooms in the SCU on 09/16/25 and 09/17/25 revealed: Observation of the hot water temperature in resident room 127 in the SCU on 09/16/25 at 9:25am revealed the water temperature at the sink was 121ºF. Observation of the hot water temperature in resident room 124 in the SCU on 09/16/25 at 9:28am revealed the water temperature at the sink was 121ºF. Observation of the hot water temperature in resident room 127 in the SCU on 09/17/25 at 9:10am revealed the water temperature at the sink was 121ºF. Observation of the hot water temperature in resident room 124 in the SCU on 09/17/25 at 9:13am revealed the water temperature at the sink was 117ºF. Observation of the hot water temperature in resident room 126 in the SCU on 09/17/25 at 9:15am revealed the water temperature at the sink was 117ºF. Interview with a personal care aide (PCA) in the SCU on 09/17/25 at 10:05am revealed: -She had not noticed that the water was too hot in the SCU when she bathed residents. -The residents had not complained about the water being too hot. -The residents had not gotten burned by hot water.	D 113		

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D 113	Continued From page 3 -She regulated the water at the tub and shower. -Some of the residents in the SCU could not tell her if the water was too hot. Interview with a medication aide (MA) in the SCU on 09/17/25 at 10:55am revealed: -The residents had not complained to her about the water being too hot at the sinks. -The residents had not had burns from hot water. -She had not noticed the water was too hot at the residents' sinks. b. Observation of the hot water temperatures in five resident rooms in the AL on 09/16/25 and 09/17/25 revealed: Observation of the hot water temperature in the kitchenette sink for resident room 313 on 09/16/25 at 8:22am revealed the water temperature was 122ºF. Observation of the hot water temperature in the bathroom sink for resident room 329 on 09/16/25 at 8:29am revealed the water temperature was 121ºF. Observation of the hot water temperature in the bathroom sink for resident room 220 on 09/16/25 at 8:47am revealed the water temperature was 125.8ºF with visible steam. Observation of the hot water temperature in the sink in resident room 230 on 09/16/25 at 8:52am revealed the water temperature was 120.5ºF. Observation of the hot water temperature in the sink in resident room 231 on 09/16/25 at 8:56am revealed the water temperature was 126.5ºF. Observation of the hot water temperature in the	D 113		

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D 113	Continued From page 4 sink in resident room 230 on 09/17/25 at 10:47am revealed the water temperature was 125.6ºF. Observation of the hot water temperature in the sink in resident room 220 on 09/17/25 at 10:50am revealed the water temperature was 122ºF. Observation of the hot water temperature in the sink in resident room 231 on 09/17/25 at 10:45am revealed the water temperature was 118ºF. Observation of the hot water temperature in the sink in resident room 313 on 09/17/25 at 11:32am revealed the water temperature was 122.2ºF. Observation of the hot water temperature in the sink in resident room 329 on 09/17/25 at 11:28am revealed the water temperature was 122.5ºF. Observation of the hot water temperature in the sink in resident room 335 on 09/17/25 at 8:45am revealed the water temperature was 124.3ºF. Interview with the resident who resided in room 230 on 09/16/25 at 8:52am revealed: -About a month ago the water was too cold, and someone adjusted the water temperature but now it was too hot. -He had spoken with the PCA about the hot water. -The PCA told him to be careful when using the hot water. -He had not been burned due to the hot water. Interview with the resident who resided in room 231 on 09/16/25 at 8:56am revealed: -The hot water got very hot. -The water had been hot for months. -The PCA who cared for her knew the water was hot.	D 113		

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D 113	Continued From page 5 -She had not been burned by the hot water. Interview with the private sitter for the resident who resided in room 313 on 09/16/25 at 8:24am revealed: -The water was hot, but she did not think anything about it because she could adjust the temperature. -She could not recall staff checking the water temperature. Interview with a PCA from the AL on 09/16/25 at 8:51am revealed: -She did not notice the water temperature being too hot. -She did not recall the residents complaining of the water being too hot. -She did not recall anyone checking the water temperatures. Interview with a MA from the AL on 09/17/25 at 7:10am revealed: -She had not noticed the water being too hot in the residents' rooms. -No residents or staff had complained to her about the water being too hot. Interview with the facility's contracted primary care provider (PCP) on 09/17/25 at 10:30am revealed: -There had not been any reports from staff of residents being burned from hot water. -Water temperatures over 116°F could scald a resident's skin. -Some of the residents in the facility would not be able to verbally communicate a complaint of a burn from water. -Some of the residents in the SCU would not be able to yell, complain or report hot water to the staff.	D 113		

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D 113	Continued From page 6 Interview with the Maintenance Director (MD) on 09/16/25 at 9:40am revealed: -He thought the state regulations for hot water temperature was 105 - 120 degrees F. -The facility's policy for the hot water temperature was 110 - 115 degrees F. -He did not realize the state regulations for hot water temperature was 110 - 116 degrees F. -He checked some water temperatures in some locations in the facility daily and some he checked weekly; locations were randomly selected. -There was one hot water heater and tank that supplied the entire building. -He kept water temperature logs with the date, the location and the water temperature. -Between the AL and the SCU he checked a total of twelve resident rooms a week. -He checked the water temperatures at sinks, bathtubs in the resident rooms and the spas. -He did not check the water temperatures in the residents' showers. -The showers all had scald guards (a built-in safety device on a shower that prevents hot water from reaching the resident) on them that automatically cut off so the residents would not get burned. -He thought the scald guard would shut off when the hot water temperature reached 125°F. -The closer the water source was to the hot water heater the higher the water temperature and the further away, the lower the temperature. -Last week there were temperatures above 120°F in the AL and it was corrected after he adjusted the mixing valve. -More residents complained about the water temperatures being too low and not hot enough. Interview with the facility's Maintenance Manager on 09/17/25 at 3:15pm revealed:	D 113		

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D 113	Continued From page 7 -He had not checked the water temperatures for today, 09/17/25. -He did not go back and recheck the water temperatures on the list of resident rooms with high temperatures from the day before, 09/16/25. -He took temperatures elsewhere in the facility that did not include the resident areas. -He adjusted the knob at the mixing valve at the hot water heater to adjust the temperature range for the water in the facility whenever the water temperatures were too high or too low. -The facility did not have a reoccurring issue with water temperatures or long-term issues with water temperatures. -The water temperatures in the facility were going to fluctuate. -When the water temperature fluctuated in the facility he would adjust the mixing valve; that was the purpose of the mixing valve. -The hot water heater was set at 145°F because the kitchen also pulled hot water from the same tank. -The mixing valve had a gauge that showed the temperature of the hot water at the valve after he adjusted the valve. -The temperature on the hot water heater had not been adjusted, and he could not set the temperatures for the mixing valve. -He would adjust the mixing valve and come back in 30 to 40 minutes to check the gauge to see if the temperature went up or down. -He just needed to adjust the mixing valve more times a day to maintain the temperatures at the resident areas. -He was the only staff at the facility who adjusted the water valve. -He would hate for a resident to get burned by hot water. -He had not heard of any complaints from staff of residents getting burned by hot water.	D 113		

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D 113	Continued From page 8 -He would get complaints of cold water from the residents if he adjusted the mixing valve and the water temperature dipped a little. -He preferred the water temperatures in the resident areas to be hot rather than cold. Interview with the Maintenance Manager on 09/18/25 at 11:30am revealed: -He contacted local plumbing company to look at the hot water mixing valve and they were at the facility today, 09/18/25. -The plumber from the local plumbing company said there was one valve turned off and the other valve needed to be repaired. -The plumber told him the temperature ranges for hot water should only go up or down 5°F and not the 30 to 50°F ranges he had been getting. Interview with the Administrator on 09/17/25 at 4:51pm revealed: -The facility's policy for the hot water temperatures range was 100°F to 115°F. -He knew the state regulation for hot water temperatures was 100°F to 116°F. -The Maintenance Manager took hot water temperatures once a week from various resident areas in the building and documented them in a log. -When the water temperature was out of range, the Maintenance Manager adjusted the mixing valve at the hot water heater to bring the hot water temperature within the correct range. -The hot water temperatures were not out of range every day. -The Maintenance Manager reported the weekly temperatures to the facility's corporate office. -The outside temperature affected the hot water temperatures inside the facility. -The local Environmental Health Section completed an inspection in June 2025 and had	D 113		

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told him about the hot water temperatures, but the Maintenance Manager adjusted the mixing valve, and the inspector did not cite the facility.
-He did not think there was a consistent issue with the hot water temperatures in the resident areas.
-If the hot water temperatures were constantly being adjusted to keep them within range, then it was a problem, and the Maintenance Manger needed figure out why it was happening.
-The residents in the AL complained about the water not being hot enough.
-He wanted the residents to be happy but not get burned.
-There were no reports from the residents or the staff of any of the residents being burned.
-If the hot water temperatures were 116°F or higher he would be concerned about the residents getting burned.
-If a resident had neuropathy, they might not feel the water temperature, and they could get burned.
-Some of the residents in the SCU could not complain about the hot water being too hot and could get burned.
-If there was a constant problem with regulating the hot water temperatures, he would have an outside plumbing company look at the hot water heater and mixing valve.

Interview with the Administrator on 09/18/25 at 11:50am revealed:
-He realized today, 09/18/25, that there was a pattern to the hot water temperatures in the resident areas and it was not just a "one-time thing".
-There was a plumber in the facility today, 09/18/25, and he had addressed some issues.
-He thought the issues were just here and there and the Maintenance Manager could control it by

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D 113	Continued From page 10 adjusting the valve. Based on observations and record reviews, the resident who resided in resident room 220 the resident was not interviewable. _____ The facility failed to ensure that water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) and a maximum of 116°F related to sink temperatures ranging from 118°F to 126.5°F in the AL, and 117°F to 121°F in the SCU. Skin in contact with a water temperature of 125.6°F could result in a first degree burn in 45 seconds and a second degree burn in 1.5 minutes. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/16/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 2, 2025.	D 113		
D 118	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be	D 118		

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within reach of a resident lying on the bed;
(4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and
(5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the electrical call bell system in the Assisted Living (AL) was maintained in an operating condition.

The findings are:

Observation of the front desk revealed no staff were seated at the front desk from 07:21am to 7:56am.

Interview with a resident on 09/16/25 at 8:39am revealed:
-Most days he was dependent on staff for bathing, dressing, and grooming.
-The response time by staff to the call bells varied.
-There was usually a longer response time to call bells after 8:00pm.
-After 8:00pm, the staff response times were 30 minutes or longer.
-Last night, 09/15/25, he pressed his pendant 4-5 times before staff responded almost 45-minutes later.

Interview with another resident on 09/16/25 at

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D 118	Continued From page 12 8:49am revealed: -Staff did not always respond to the call bells in a timely manner. -He pressed his pendant for assistance at 7:08am on 09/16/25 and staff did not respond until 8:38am. -He was admitted to the facility after he suffered a stroke. -He had left-side weakness and needed assistance with bathing, dressing, and putting on his foot brace. -His wife usually helped him with his care because, staff would take too long to respond. Interview with a personal care aide (PCA) on 09/17/25 at 11:36am revealed: -She was a PRN staff. -She was provided with a walkie at the beginning of her shift and returned it at the end of her shift. -When the residents pulled their call bell, the front desk was alerted. -The front desk used the walkie to let staff know which resident pulled the call bell. -She responded to call bells within 15 minutes. -The receptionist worked from 8:00am to 5:00pm and another receptionist worked from 5:00pm to 8:00pm. -She would randomly check the front desk after 8:00pm to see if a call bell was pulled. -Staff were not assigned to sit at the front desk after 8:00pm. Interview with another PCA on 09/18/25 at 12:06pm revealed: -She worked from 7:00am to 3:00pm. -She received a walkie when she started working at the facility. -When the residents pressed their pendants, the front desk staff told staff the room number and location the pendant was pressed.	D 118		

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-The staff closest to the resident's room, responded.
-She responded to the residents within 15 minutes unless she was assisting another resident.
-She made 2-hour rounds.
-She had not heard any residents complain of staff not responding to the call bell.

Interview with a medication aide (MA) on 09/17/25 at 11:44am revealed:
-The PCAs and MAs were given walkies when they were hired.
-Some staff left the walkie at the facility, and some took them home.
-There were extra walkies in the facility to sign out if staff left their walkies at home.
-The PCAs made 2-hour rounds.
-When the residents pressed their pendant, the front desk was alerted.
-The front desk would call staff on their walkies to let them know where the pendant was pressed.
-The staff closest to the room responded to the residents.

Interview with a second MA on 09/17/25 at 12:12pm revealed:
-She worked from 7:00am to 3:00pm.
-The PCAs and MAs were assigned a walkie at the beginning of each shift.
-When the residents pressed their pendant, the front desk was alerted.
-The front desk staff called staff on their walkie to let them know which room needed assistance and where the residents pressed the pendant.
-Staff responded within 15 minutes.
-The PCAs made 2-hour rounds.
-She was not aware who sat at the front desk after 5:00pm, because she did not work after 3:00pm.

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BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

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D 118	Continued From page 14 Interview with the interim Resident Care Coordinator (RCC) on 08/17/25 at 11:40am revealed: -The PCAs made 2-hour rounds. -No residents complained about staff not responding to call bell. -The residents pressed their pendants, and the front desk was alerted. -The front desk staff used the walkie at the front desk to alert staff of the room and location where the pendant was pressed. -The receptionist was at the front desk from 8:00am to 8:00pm. -After 8:00pm, staff were alerted on a pager when staff pressed their pendant or pulled their call bell. -The second and third shift staff were assigned a walkie and a pager at the beginning of their shifts. Interview with the Receptionist on 09/17/25 at 11:56am revealed: -When the residents pressed their pendant or the pull-cord, the front desk was alerted. -She alerted staff using the walkie at the front desk. -She provided staff with the room number and location the pendant or pull-cord was pressed or pulled. -She worked Monday to Friday from 8:00am to 5:00pm. -She also worked when the other receptionists were not able to work. -Another receptionist worked Monday to Friday from 5:00pm to 8:00pm. -A third receptionist worked Saturday and Sunday from 8:00am to 2:00pm. -A fourth receptionist worked Saturday and Sunday from 2:00pm to 8:00pm. -After 8:00pm, the PCAs sat at the front desk. -She was not aware if there was a schedule for	D 118		

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D 118	Continued From page 15 the PCAs to sit at the front desk after 8:00pm. Interview with the Clinical Specialist on 09/18/25 at 9:05am revealed: -The residents have access to a pendant and a pull-cord. -When the pendant or pull-cord, the computer screen showed the room number and the location where the pendant or pull-cord was pressed or pulled. -The receptionist used the walkie at the front desk to alert all staff of the room number and location where the pendant or pull-cord was pressed or pulled. -The PCAs and MAs were assigned a walkie at the beginning of each shift. -During the hours of 8:00am to 8:00pm, a receptionist was seated at the front desk. -After 8:00pm, a PCA or MA checked the desk routinely during the night. -She was not sure if staff were assigned to be seated at the front desk after 8:00pm. Interview with the Health and Wellness Director (HWD) on 09/18/25 at 10:23am revealed: -The residents alerted staff for assistance by pressing their pendant. -The receptionist was alerted when the residents pressed their pendant. -The receptionist alerted staff using the walkie at the front desk. -The receptionist provided staff with the room number and location where the pendant was pressed. -The PCAs and MAs were assigned a walkie at the beginning of each shift. -All residents did not have a pendant, but pull-cords were in all rooms. -The receptionist was at the front desk from 8:00am to 8:00pm.	D 118		

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D 118	Continued From page 16 -After 8:00pm, care staff were assigned to sit at the front desk until 8:00am. -She was not sure if the staff assignment sheet would reflect staff seated at the front desk. -Staff were responsible for making 2-hour rounds. Interview with the Executive Director (ED) on 09/18/25 at 11:30am revealed: -The residents pressed their pendant, and the front desk was alerted. -The receptionist alerted staff with the walkie at the front desk. -The receptionist told the staff the room number and where the assistance was needed. -From 8:00am to 8:00pm a receptionist was seated at the front desk. -After 8:00pm, the staff would use the pager system. -Staff did not sit at the front desk after 8:00pm. -The PCAs and MAs on second and third shifts were assigned a walkie and a pager at the beginning their shifts. -When the residents pressed their pendant, the pager would be alerted.	D 118		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021	D 131		

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D 131	Continued From page 17	D 131		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure 1 of 6 sampled staff (A) were tested for tuberculosis (TB) disease upon hire.

The findings are:

Review of the facility's Personnel Policies and Rules and Regulations dated August 2016 revealed applicants shall provide documentation of a TB two-step skin test upon hire and another skin test after two weeks of employment.

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-She was hired on 02/12/24.
-There was no documentation of a TB skin test having been completed.

Interview with Staff A on 09/18/25 at 7:30am revealed:
-She started working at the facility in February 2024.
-She remembered having her first step TB skin test administered when she started working at the facility.
-She did not recall having a two-step TB skin test administered.

Interview with the interim Business Office Manager (BOM) on 09/17/25 at 4:25pm revealed:
-The BOM was responsible for ensuring the two-step TB skin test was completed after hire.
-Staff personal records were audited annually to ensure all paperwork was completed.
-She could not recall when the last audit was completed.

Interview with the Executive Director (ED) on

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D 131	Continued From page 18 09/18/25 at 11:30am revealed the previous BOM was responsible for ensuring a two-step TB skin was completed for new staff.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff D) had no substantiated findings on the North Carolina Health Care Personal Registry (HCPR) upon hire. The findings are: Review of Staff D's personnel record revealed: -Staff D was hired on 04/14/25 as a medication aide (MA). -There was no documentation a Health Care Personnel Registry (HCPR) review was completed upon hire. Interview with Staff D on 09/18/25 at 8:42am revealed: -She was hired in April 2025. -She did not know what an HCPR was. -She did not know if the facility checked the HCPR. Interview with the interim Business Office	D 137		

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D 137	Continued From page 19 Manager (BOM) on 09/17/25 at 4:25pm revealed: -The BOM was responsible for ensuring HCPR was checked prior to hire. -She ran a check on Staff D today, 09/17/25 and there were no unsubstantiated findings on the HCPR. Interview with the Executive Director (ED) on 09/18/25 at 11:30am revealed: -The previous BOM was responsible for checking the HCPR for all employees. -Staff D's HCPR should have been checked by the previous BOM. -He is responsible for checking the HCPR for employees now.	D 137		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status;	D 248		

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D 248	Continued From page 20 (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an initial assessment was completed within 72 hours of admission using the Resident Register for 1 of 5 sampled residents (#5). The findings are: Review of Resident #5's current FL2 dated	D 248		

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D 248	Continued From page 21 07/11/25 revealed: -Diagnoses included sequela of cerebrovascular disease, epilepsy, affective mood disorder and muscle weakness. -He was ambulatory. -There was an admission date of 03/26/25. Review of Resident #5's resident record revealed there were no pages of the Resident Register. Interview with the interim Business Office Manager (BOM) on 09/17/25 at 4:25pm revealed the Sales Department was responsible for ensuring the Resident Register was completed upon admission. Interview with the Sales Coordinator 09/18/25 at 8:45am revealed: -She and the Sales Manager were responsible for ensuring all initial paperwork for residents were completed upon admission. -The family was given the Resident Register to complete. -She was not able to locate the Resident Register. Interview with the Sales Manager 09/18/25 at 8:54am revealed: -She and the Sales Coordinator were responsible for ensuring all initial paperwork for residents were completed upon admission. -She was not able to locate the Resident Register. Interview with the Executive Director (ED) on 09/18/25 at 11:30am revealed the Sales Department was responsible for ensuring all initial paperwork was completed upon a residents' admission.	D 248		

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D 254	Continued From page 22	D 254		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;	D 254		

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D 254	Continued From page 23 (E) no response by the resident to the intervention for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) when a resident has been enrolled in hospice; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status; (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care.	D 254		

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D 254	Continued From page 24	D 254		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change in condition for 1 of 1 sampled residents (#4) who was admitted to hospice services.

The findings are:

Review of Resident #4's current FL2 dated 02/28/25 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, hypothyroid, atrial fibrillation, osteoarthritis, and gastroesophageal reflux disease.

Review of Resident #4's care plan dated 02/28/25 revealed:
-Resident #4 was independent with dressing, toileting, ambulation, bathing, dressing, grooming and transfers.
-Resident #4 utilized a walker and wheelchair.

Review of Resident #4's record on 09/16/25 revealed:
-Admission Resident #4 was admitted to hospice services on 05/14/25.
-There was no change in condition care plan completed following Resident #4's admission to hospice.

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D 254	Continued From page 25 Interview with the Area Clinical Specialist on 09/18/25 at 9:05am revealed: -The Health and Wellness Director (HWD) was responsible for ensuring Resident #4's care plan was completed. -She did not realize that the hospice admission required a change of condition care plan to be completed. -She did not complete chart audits to determine if the residents' care plans needed to be completed or updated since becoming the Clinical Specialist in July 2025. Interview with the HWD on 09/18/25 at 10:23am revealed: -She became the HWD one week ago. -She was responsible for completing care plans for residents within 30 days of admission and annually or if there was a change in condition. -She did not know a change in condition care plan was not completed for Resident #4 after she was admitted to hospice services in May 2025. -She did not complete any chart audits to determine if the residents' care plans needed to be completed. Interview with the Executive Director (ED) on 09/18/25 at 11:30am revealed: -The HWD was responsible for ensuring resident care plans were completed. -He was not aware the change in condition care plan was not completed for Resident #4.	D 254		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the	D 259		

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D 259	Continued From page 26	D 259		

resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.
(c) The care plan shall include the following:
(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;
(2) frequency of the services or tasks to be performed;
(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;
(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;
(5) a dated signature of the assessor upon completion; and
(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

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D 259	Continued From page 27	D 259		

This Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents had a completed care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed (#3).

The findings are:

Review of Resident #3's current FL-2 dated 05/28/25 revealed:
-Diagnoses included osteoporosis with current pathological fracture, peripheral autonomic neuropathy, venous insufficiency, rectal prolapse, and vertigo.
-Resident #3 was semi-ambulatory.
-There was no information related to orientation status.

Review of Resident #3's Resident Register revealed an admission date of 03/02/24.

Review of Resident #3's care plan dated 07/31/24 revealed:
-Resident #3 required limited assistance with toileting, bathing, dressing, and grooming.
-Resident #3 required extensive assistance with transfers and ambulation.
-Resident #3 utilized a wheelchair.
-The care plan was not signed by Resident #3's Primary Care Provider (PCP).

Interview with the Clinical Specialist on 09/18/25 at 9:05am revealed:
-The Health and Wellness Director (HWD) was responsible for ensuring the care plan was

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D 259	Continued From page 28 completed. -She was not aware the care plan was not completed. Interview with the HWD on 09/18/25 at 10:23am revealed: -She was responsible for completing care plans for residents within 30 days of admission and annually. -She did not know the resident care plan was not completed. -She was not aware if there had been any record audits completed to determine if residents' care plans needed to be completed since she became the HWD a week ago. Interview with the Executive Director (ED) on 09/18/25 at 11:30am revealed: -The HWD was responsible for ensuring resident care plans were completed. -He was not aware resident care plans were not completed.	D 259		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the	D 280		

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resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 2 of 5 residents (#2 and #4) had a Licensed Health Professional Support (LHPS) review upon admission and quarterly for tasks of monitoring blood glucose levels and administration through injection (#2), and a medication used to treat chronic obstructive pulmonary disease (COPD) (#4).

The findings are:

1. Review of Resident #2's current FL-2 dated 08/14/25 revealed:
-Diagnoses included type 2 diabetes mellitus with ketoacidosis without coma, hyperglycemia, acute kidney failure, hypoxemia, pleural effusion and chronic diastolic congestion heart failure.
-There was an order for Lantus (a long acting insulin used to manage blood sugars) injection daily.
-There was an order for Humalog 100 units/ml 5 units (a short acting insulin used to manage blood sugars) three times a day and a sliding scale insulin (SSI) three times a day 201 to 250 - 1 unit, 251 to 300 - 2 units, 301 to 350 - 3 units, 351 to 400 - 4 units, and 400 to 500 - 5 units and call the Primary Care Provider (PCP).

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D 280	Continued From page 30 -There was an order for Freestyle Libre 3 sensor (a sensor for monitoring blood sugar readings). Review of Resident #2's signed physician order dated 09/03/25 revealed an order for Humalog 100units/5ml inject 4 units 15 minutes before lunch and 6 units 15 minutes before breakfast and dinner. Review of Resident #2's Resident Registry revealed an admission date of 08/24/25. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Freestyle Libre 3 sensor apply one sensor to upper arm every 28 days for blood glucose monitoring unsupervised self-administration. -There was documentation that the Freestyle Libre 3 sensor was applied on 07/22/25. -There was an entry for Lantus 100 units/ml inject 18 units every morning with a scheduled administration time of 8:00am. -There was documentation Lantus insulin was administered 31 of 31 opportunities from 07/01/25 to 07/31/25. -There was an entry for Humalog insulin 100 unit/ml inject 5 units 15-20 minutes prior to the meal with a scheduled time of 8:00am, 12:00pm, and 5:00pm. -There was documentation Humalog insulin was administered 31 of 31 opportunities from 07/01/25 to 07/31/25 at 8:00am and 12:00pm, and 30 of 31 opportunities at 5:00pm. -There was an entry for Humalog 100units/ml SSI for a blood sugar reading of 201 to 250 - 1 unit, 251 to 300 - 2 units, 301 to 350 - 3 units, 351 to 400 - 4 units, and 400 to 500 - 5 units and call the PCP.	D 280		

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-There was documentation the SSI was administered 17 of 19 opportunities from 07/01/25 to 07/31/25.

Review of Resident #2's August 2025 eMAR revealed:
-There was an entry for Freestyle Libre 3 sensor apply one sensor to upper arm every 28 days for blood glucose monitoring unsupervised self-administration.
-There was documentation that the Freestyle Libre 3 sensor was applied on 08/19/25.
-There was an entry for Lantus 100 units/ml inject 18 units every morning with a scheduled administration time of 8:00am.
-There was documentation Lantus insulin was administered 31 of 31 opportunities from 08/01/25 to 08/31/25.
-There was an entry for Humalog insulin 100 unit/ml inject 5 units 15-20 minutes prior to the meal with a scheduled time of 8:00am, 12:00pm, and 5:00pm.
-There was documentation Humalog insulin was administered 30 of 31 opportunities from 08/01/25 to 08/30/25 at 8:00am, 12:00pm, and 5:00pm.
-There was an entry for Humalog 100units/ml SSI for a blood sugar reading of 201 to 250 - 1 unit, 251 to 300 - 2 units, 301 to 350 - 3 units, 351 to 400 - 4 units, and 400 to 500 - 5 units and call the PCP.
-There was documentation the SSI was administered 23 of 28 opportunities from 08/01/25 to 08/31/25.

Review of Resident #2's September 2025 eMAR from 09/01/25 to 09/16/25 revealed:
-There was an entry for Freestyle Libre 3 sensor apply one sensor to upper arm every 28 days for blood glucose monitoring unsupervised

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self-administration.
-There was documentation that the Freestyle Libre 3 sensor was applied on 09/16/25.
-There was an entry for Lantus 100 units/ml inject 18 units every morning with a scheduled administration time of 8:00am.
-There was documentation Lantus insulin was administered 16 of 16 opportunities from 09/01/25 to 09/16/25.
-There was an entry for Humalog insulin 100 unit/ml inject 5 units 15-20 minutes prior to the meal with a scheduled time of 8:00am, 12:00pm, and 5:00pm.
-There was documentation Humalog insulin was administered 3 of 3 opportunities from 09/01/25 to 09/03/25 at 8:00am, 12:00pm, and 5:00pm.
-There was an entry for Humalog insulin 100 unit/ml inject 6 units 15-20 minutes prior to the meal with a scheduled time of 8:00am and 5:00pm.
-There was documentation Humalog insulin was administered 26 of 26 opportunities from 09/04/25 to 09/16/25.
-There was an entry for Humalog insulin 100 unit/ml inject 4 units 15-20 minutes prior to the meal with a scheduled time of 12:00pm.
-There was documentation Humalog insulin was administered 11 of 13 opportunities from 09/04/25 to 09/16/25.

Review of Resident #2's record review revealed there were no LHPS assessments completed for LHPS tasks.

Refer to the interview with the Clinical Specialist on 09/18/25 at 9:15am.

Refer to the interview with the HWD 11:15am.

Refer to the interview with the Administrator on

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D 280	Continued From page 33 09/18/25 at 2:21pm. 2. Review of Resident #4's current FL2 dated 02/28/25 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD). -There was an entry for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (a medication used to treat COPD) inhale 3ml every six hours as needed for wheezing. Review of Resident #4's signed physician's order dated 04/21/25 revealed there was an order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (a medication used to treat COPD) inhale 3ml two times daily for wheezing/shortness of breath. Review of Resident #4's signed physician's order dated 07/19/25 revealed there was an order for oxygen 4 liters per minute via nasal cannula for shortness of breath. Review of Resident #4's electronic medication administration record (eMAR) for July 2025 revealed: -There was an entry for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML that was administered 37 out of 37 opportunities. -There was an entry for oxygen 2 liters per minute (LPM) via Nasal Canula (NS) that was administered 55 out of 55 opportunities. Review of Resident #4's licensed health professional support (LHPS) assessments revealed: -There was no LHPS assessment completed for July 2025 for the inhalation medication by machine. -There was no LHPS assessment completed for	D 280		

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D 280	Continued From page 34 July 2025 for oxygen administration and monitoring. Refer to the interview with the Clinical Specialist on 09/18/25 at 9:15am. Refer to the interview with the HWD 11:15am. Refer to the interview with the Administrator on 09/18/25 at 2:21pm. _____ Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed: -If the Health and Wellness Director (HWD) was a Registered Nurse (RN), she would be responsible for completing the LHPS assessment. -If the HWD was not an RN, the Area Clinical consultant or the District Director of Clinical Services would be responsible for completing the LHPS assessments. -The LHPS assessment schedule should be printed from the computer and given to the RN who was to complete the LHPS assessments. -The LHPS assessment was to be completed within 30 days of admission, 30 days of a new task, and quarterly. -She did not know Resident #2 did not have an LHPS assessment completed since admission. -Resident #2 should have had a LHPS assessment within 30 days of admission and quarterly thereafter. Interview with the HWD 11:15am revealed: -She did not know who was responsible for the LHPS assessment. -She knew an RN had to complete the LHPS assessment. -She was not an RN and had only worked for the facility for one week.	D 280		

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D 280	Continued From page 35 Interview with the Administrator on 09/18/25 at 2:21pm revealed: -The RN was to ensure the MAs were proficient with all LHPS task. -He expected the RN to complete the LHPS assessment with 30 days of admission and when a new task was ordered and every quarter.	D 280		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 4 residents (#2, #8, #9, #10) observed during the morning medication pass including errors with a diuretic (#2), a thyroid medication (#8), an inhaler (#9), and an eye drop (#10); and 3 of 5 sampled residents (#1, #2, and #4) for record review including errors with a medication for memory, a laxative, an estrogen cream, and an antifungal medication (#1); a diuretic and an insulin (#2); and a medication used to prevent bloating (#4). The findings are:	D 358		

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1. The medication error rate was 15% as evidenced by the observation of 4 errors out of 27 opportunities during the 8:00am medication pass on 09/17/25.

Review of the facility's medication administration policy dated 05/2025 revealed:
-The medication aides (MA) should administer medication at the right time.
-The MA should check the residents' medication record and confirm the specified time for administration.

a. Review of Resident #2's current FL-2 dated 08/14/25 revealed:
-Diagnoses included type 2 diabetes mellitus with ketoacidosis without coma, hyperglycemia, acute kidney failure, hypoxemia, pleural effusion and chronic diastolic congestive heart failure.
-There was an order for torsemide 20mg (used to treat fluid retention) every 24 hours as needed (PRN) for weight gain greater than 2 pounds above 176.9 in 24 hours or 5 pounds in a 7-day span.

Observation of the morning medication pass on 09/17/25 at 7:55am revealed:
-The MA obtained Resident #2's weight during the morning medication pass.
-Resident #2 weighed 180.2 pounds.
-The MA administered 12 pills to Resident #2; she did not administer the PRN dose of torsemide 20mg for weight gain of 2 pounds greater than 176.9.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) for 09/17/25 revealed:
-There was an entry for order for torsemide 20mg

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every 24 hours PRN for weight gain greater than 2 pounds above 176.9 in 24 hours or 5 pounds in a 7-day span.

-There was no documentation torsemide 20mg PRN was administered to Resident #2 for a weight gain of 3.3 pounds.

Observation of Resident #2's medication on hand on 09/17/25 at 8:00am revealed:
-There was a punch card with 15 of 28 torsemide 20mg tablets dispensed on 02/14/25 with a PRN sticker placed on the prescription label which previously read to administer torsemide 20mg daily.
-There was a hand written note on the punch card that read, "directions changed".

Telephone interview with a representative from the facility's contacted pharmacy on 09/17/25 at 3:28pm revealed:
-Resident #2 had an order for torsemide 20mg every 24 hours PRN for weight gain greater than 2 pounds above 176.9 in 24 hours or 5 pounds in a 7-day span dated 05/25/25.
-The pharmacy dispensed 30 torsemide 20mg tablets for PRN usage on 03/20/25 and 05/25/25.
-The facility returned the medication card with the torsemide 20mg tablets PRN that was dispensed on 05/25/25.

Interview with Resident #2 on 09/17/25 at 11:41am revealed:
-She had a kidney transplant about 20 years ago.
-She had taken fluid pills for a long time.
-She denied complaints of swelling in her feet and legs or shortness of breath.
-She received a scheduled dose of torsemide 20mg daily and sometimes she would get a second dose based on her weight.

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-She did not receive a second dose of torsemide today.
-She did not know the parameters for her weight gain or when she should get a second dose of torsemide.
-The MA would administer a second dose of torsemide if she needed it.

Interview with the MA on 09/17/25 at 10:59am revealed:
-Resident #2's weight was checked daily because she retained fluid and had a kidney transplant years ago.
-She was weighed at the same time each morning.
-Resident #2's weight was 180.2 that morning.
-She had not administered torsemide 20mg PRN to Resident #2 for weight gain.
-She did not know there was an order to give Resident #2 torsemide 20mg PRN for weight gain.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-The MA should have administered torsemide 20mg PRN for Resident #2's weight gain.
-The MA must read the orders on the eMAR and administer medications as ordered.

Interview with the Health and Wellness Director (HWD) 11:15am revealed:
-Resident #2 could have shortness of breath or swelling in her legs if she retained fluid.
-She expected the MAs to administer torsemide PRN when Resident #2 had weight gain as ordered.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 09/17/25 at 3:13pm was unsuccessful.

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D 358	Continued From page 39 Refer to the interview with the Administrator on 09/18/25 at 2:21pm. b. Review of Resident #8's current FL-2 dated 08/21/24 revealed diagnoses included congestive heart failure, chronic pain, hypothyroidism, hypertension, and chronic anemia. Review of Resident #8's signed physician orders dated 07/21/25 revealed there was an order for levothyroxine 100mcg (used to treat hypothyroidism) one tablet every morning on an empty stomach. Observation of the morning medication pass on 09/17/25 at 8:50am revealed: -The MA prepared 9 medications for administration and administered the 9 medications to Resident #8. -One of the medications was levothyroxine 100mcg to be administered on an empty stomach. Review of Resident #8's September 2025 eMAR on 09/17/25 revealed: -There was an entry for levothyroxine 100mcg one tablet every morning on an empty stomach with a scheduled administration time of 8:00am. -There was documentation that levothyroxine was administered on 09/17/25. Telephone interview with a representative from the facility's contacted pharmacy on 09/17/25 at 3:28pm revealed: -Resident #8 had an order for levothyroxine 100mcg take one tablet every morning on an empty stomach dated 07/21/25. -The pharmacy dispensed a 10-day supply of levothyroxine tablets for Resident #8 on 07/21/25	D 358		

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until the cycle fill for the next month started.
-The pharmacy dispensed a 28 day supply of levothyroxine tablets on 08/01/25 and 08/29/25.

Review of an email from the Pharmacist at the facility's contracted pharmacy dated 09/18/25 revealed:
-Levothyroxine should be taken on an empty stomach because food and certain nutrients could decrease or delay levothyroxine's absorption in the gut.
-Levothyroxine should be administered at the same time each day to ensure effective treatment.

Observation of Resident #8's medication on hand revealed there was a punch card with 8 of 30 levothyroxine tablets 100mcg available for administration dispensed on 08/29/25.

Interview with Resident #8 on 09/17/25 at 8:55am revealed:
-She ate breakfast that morning, 09/17/25, in the dining room around 8:00am.
-She usually ate breakfast in the dining room each morning.
-She received her medications after breakfast, when she returned to her room.

Interview with the MA on 09/18/25 at 11:11am revealed:
-She did not know why the levothyroxine had to be administered on an empty stomach.
-She thought Resident #8 did not want to be awakened at 6:00am for the medication, so the time of administration was changed to 8:00am.
-Resident #8 used to not eat breakfast, so 8:00am administration was appropriate.
-She did not know Resident #8 ate breakfast that morning at 8:00am.

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D 358	Continued From page 41 Interview with Resident #8's PCP on 09/17/25 at 10:20am revealed: -He was not sure why levothyroxine was given on an empty stomach, but he thought it had to do with absorption. -He expected the staff to follow orders as written. Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed: -The medication should be scheduled earlier in the morning, before breakfast. -She would have expected the MAs to notice the order of administering on an empty stomach and let the HWD or Resident Care Coordinator (RCC) know so the time of administration could be changed. -She expected the MAs to administer the medications as ordered. Interview with the HWD on 09/18/25 at 11:15am revealed: -Levothyroxine should be scheduled before breakfast was served. -The MAs should have noticed that levothyroxine was scheduled at 8:00am and that was after breakfast was served. -She expected the MAs to administer medications as ordered. Refer to the interview with the Administrator on 09/18/25 at 2:21pm. c. Review of Resident #9's current FL-2 dated 06/05/24 revealed diagnoses included metabolic encephalopathy, difficulty walking, and cognitive communication deficit. Review of Resident #9's signed physician orders dated 03/12/25 revealed there was an order for	D 358		

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D 358	Continued From page 42 Advair 115-21 mcg/act (used to reduce inflammation in the airways and making it easier to breathe) 2 inhalations every 12 hours for chronic obstructive pulmonary disease (COPD); may use spacer to administer/rinse mouth after use. Observation of the morning medication pass on 09/17/25 at 8:43am revealed: -The MA removed an Advair inhaler from the top drawer of the medication cart. -The MA attached a spacer to the inhaler, placed the mouthpiece into Resident #9's mouth and instructed Resident #9 to inhale while the MA administered the medication. -The MA did not have Resident #9 rinse her mouth with water after the administration of the inhaler, as ordered. Review of Resident #9's September 2025 eMAR on 09/17/25 revealed: -There was an entry for Advair 115-21 mcg/act 2 inhalations every 12 hours for COPD; may use spacer to administer/rinse mouth after use with a scheduled administration time of 9:00am. -There was documentation that Advair was administered on 09/17/25. Telephone interview with a representative from the facility's contacted pharmacy on 09/17/25 at 3:28pm revealed: -Resident #9 had an order for Advair 115-21 mcg/act 2 inhalations every 12 hours COPD; may use spacer to administer/rinse mouth after use. -The pharmacy dispensed the most recent Advair inhaler on 09/12/25. Observation of Resident #9's medication on hand on 09/17/25 at 8:39am revealed there was an Advair inhaler in a zip-locked bag with a	D 358		

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prescription label that read, "Inhale 2 inhalations into lungs every 12 hours for COPD; rinse mouth after use".

Interview with the MA on 09/18/25 at 11:11am revealed:
-She had tried to get Resident #9 to rinse her mouth after administration of the inhaler, but she was never successful.
-Resident #9 usually took her inhaler immediately after she took her pills; she would have water at that time.
-She would drink the water, but not rinse her mouth.

Interview with Resident #9's PCP on 09/17/25 at 10:20am revealed:
-Advair had a steroid in it and it could cause thrush in the mouth.
-Resident #9 had an increased chance of getting thrush (a yeast infection of the mouth and throat) in her mouth if she did not rinse her mouth after using the Advair inhaler.
-He expected orders to be followed as written.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-Resident #9 could develop thrush if her mouth was not rinsed after the administration of the Advair inhaler.
-She expected the MAs to administer medications as ordered.

Interview with the HWD on 09/18/25 at 11:15am revealed she expected the MAs to have Resident #9 rinse her mouth after the inhalation of Advair to reduce the medication remaining in the mouth.

Refer to the interview with the Administrator on 09/18/25 at 2:21pm.

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D 358	Continued From page 44 Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable. d. Review of Resident #10's current FL-2 dated 08/21/24 revealed: -Diagnoses included congestive heart failure, hypertension, osteoarthritis, malignant neoplasm of the breast, hypothyroidism, and gastro-esophageal reflux disease (GERD). -There was an order for Refresh eye drops .05% (used to treat dry eyes) instill one drop into each eye three times daily. Review of Resident #10's signed physician orders dated 11/24/24 revealed there was no order for Refresh eye drops. Observation of the morning medication pass on 09/17/25 at 8:30am revealed: -There was an entry on the eMAR for Refresh eye drops 0.05% instill one drop into each eye three times daily for dry eyes. -The MA administered Refresh eye drops one drop to each eye. Review of Resident #10's September 2025 eMAR on 09/17/25 revealed: -There was an entry for Refresh eye drops 0.05% instill one drop into each eye three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Refresh eye drops were administered on 09/17/25 at 8:00am. Telephone interview with a representative from the facility's contacted pharmacy on 09/17/25 at 3:28pm revealed: -Resident #1 had an order for Refresh eye drops	D 358		

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one drop in each eye three times daily dated 04/10/24.
-The pharmacy dispensed 90 individual vials of Refresh eye drops on 07/04/25, 08/01/25, and 08/29/25.

Observation of Resident #10's medication on hand on 09/18/25 at 8:35am revealed there was an opened box of Refresh eye drops dispensed on 08/30/25 available for administration.

Interview with the MA on 09/18/25 at 11:11am revealed:
-She did not know Resident #10 did not have a current order for Refresh eye drops.
-Someone failed to remove the Refresh eye drops from the eMAR.
-If the Refresh eye drops were not on the signed physician orders then they should have been removed from the eMAR.
-The 6-month signed physician orders were the updated orders and if a current medication was not on the 6-month signed physician orders then it was discontinued and it was to be removed from the eMAR.
-The facility did not need a separate discontinue order; if it was not on the signed 6-month physician's order, it was automatically discontinued.

Interview with the HWD on 09/18/25 at 11:15am revealed:
-If there was no order for Refresh eye drops, it should have been removed from the eMAR.
-Chart audits should be done to compare orders to the eMAR and ensure they were correct; she did not know who was responsible for the chart audits.

Attempted telephone interview with Resident

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D 358	Continued From page 46 #10's PCP on 09/17/25 at 2:58pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #10 was not interviewable. Refer to the interview with a MA on 09/18/25 at 12:05pm. Refer to the interview with RCC on 09/18/25 at 11:11am. Refer to the interview with the Administrator on 09/18/25 at 2:21pm. 2. Review of Resident #2's current FL-2 dated 08/14/24 revealed diagnoses included type 2 diabetes mellitus with ketoacidosis without coma, hyperglycemia, acute kidney failure, hypoxemia, pleural effusion and chronic diastolic congestive heart failure. a. Review of Resident #2's current FL-2 dated 08/14/25 revealed: -There was an order to obtain weight daily and to administer torsemide 20mg as needed (PRN) for a weight gain of 2 pounds or greater than 176.9 or 5 pounds in a 7-day span. -There was an order for torsemide 20mg every 24 hours PRN for weight gain greater than 2 pounds above 176.9 in 24 hours or 5 pounds in a 7-day span. Review of Resident #2's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry to obtain daily weights and to administer torsemide 20mg every 24 hours PRN for weight gain greater than 2 pounds above	D 358		

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176.9 in 24 hours or 5 pounds in a 7-day span with a scheduled time of 8:00am.
-There was documentation Resident #2's weight was obtained daily from 08/01/25 to 08/31/25.
-There were 4 of 31 days that Resident #2's weight was 2 pounds greater than 176.9 pounds, ranging from 178.9 pounds to 181.4 pounds.
-There was an entry for torsemide 20mg one tablet PRN for weight gain of 2 pounds or greater than 176.9 or 5 pounds in a 7-day span.
-There was documentation that torsemide 20mg PRN was administered 1 of 4 days as ordered when the recorded weight was 2-pounds greater than 176.9 pounds.
-There was no documentation that torsemide 20mg PRN was administered 3 of 4 days as ordered when the recorded weight was 2-pounds greater than 176.9 pounds.

Review of Resident #2's September 2025 eMAR from 09/01/25 to 09/16/25 revealed:
-There was an entry to obtain weight daily and to administer torsemide 20mg PRN for a weight gain of 2 pounds or greater than 176.9 or 5 pounds in a 7-day span with a scheduled time of 8:00am.
-There was documentation Resident #2's weight was obtained daily from 09/01/25 to 09/16/25.
-There were 12 of 16 days that Resident #2's weight was 2 pounds greater than 176.9 pounds, ranging from 179 pounds to 182.2 pounds.
-There was an entry for torsemide 20mg one tablet PRN for weight gain of 2 pounds or greater than 176.9 or 5 pounds in a 7-day span.
-There was documentation that torsemide 20mg PRN was administered 4 of 12 days as ordered when the recorded weight was 2-pounds greater than 176.9 pounds.
-There was no documentation that torsemide 20mg PRN was administered 8 of 12 days as

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D 358	Continued From page 48 ordered when the recorded weight was 2-pounds greater than 176.9 pounds. Observation of Resident #2 medication on hand on 09/17/25 at 8:00am revealed: -There was a punch card with 15 of 28 torsemide 20mg tablets dispensed on 02/14/25 with a PRN sticker placed on the prescription label which previously read torsemide 20mg daily. -There was a hand written note on the punch card that read, "directions changed". Telephone interview with a representative from the facility's contacted pharmacy on 09/17/25 at 3:28pm revealed: -Resident #2 had an order for torsemide 20mg every 24 hours PRN for weight gain greater than 2 pounds above 176.9 pounds in 24 hours or 5 pounds in a 7-day span. -The pharmacy dispensed 30 torsemide 20mg tablets for PRN usage on 03/20/25 and 05/25/25. -The facility returned a medication card of torsemide 20mg tablets PRN that was dispensed on 05/25/25. Interview with the medication aide (MA) on 09/17/25 at 10:59am revealed: -Resident #2's weight was checked daily because she retained fluid and had a kidney transplant years ago. -She was weighed at the same time each day. -She had not administered torsemide 20mg PRN to Resident #2 for weight gain. -She did not know there was an order to give Resident #2 torsemide 20mg PRN for weight gain. Interview with Resident #2 on 09/17/25 at 11:41am revealed: -She had a kidney transplant about 20 years ago.	D 358		

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-She has taken fluid pills for a long time.
-She denied complaints of swelling in her feet and legs or shortness of breath.
-She received a scheduled dose of torsemide 20mg daily and sometimes she would get a second dose based on her weight.
-She did not know the parameters for her weight and when she should get a second dose of torsemide.
-The MAs would administer a second dose of torsemide if she needed it.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-The MA should have administered torsemide 20mg PRN for Resident #2's weight gain.
-The MA must read the orders on the eMAR and administer medications as ordered.
-Resident #2 could have complications with edema and shortness of breath if she retained too much fluid.

Interview with the Health and Wellness Director (HWD) on 09/18/25 at 11:15am revealed:
-Resident #2 could have shortness of breath or swelling in her legs if she retained fluid.
-She expected the MAs to administer torsemide PRN as ordered when Resident #2 had weight gain.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 09/17/25 at 3:13pm was unsuccessful,

Refer to the interview with the Administrator on 09/18/25 at 2:21pm.

b. Review of Resident #2's current FL-2 dated 08/14/24 revealed:
-There was an order to check Resident #2's

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fingerstick blood sugar (FSBS) three times daily.
-There was an order to administer Lispro insulin 100 unit/ml (a rapid acting insulin used to manage blood sugars) sliding scale insulin (SSI) as follows - FSBS reading of 201 to 250 - 1 unit; 251 to 300 - 2 units; 301 to 350 - 3 units; 351 to 400 units - 4 units; greater than 400 - 5 units and call the physician.

Review of Resident #2's August 2025 eMAR revealed:
-There was an entry to check Resident #2's FSBS three times daily with a scheduled time of 6:00am, 11:00am and 5:00pm.
-There was an entry to administer Lispro insulin 100 unit/ml sliding scale insulin as follows - FSBS reading of 201 to 250 - 1 unit; 251 to 300 - 2 units; 301 to 350 - 3 units; 351 to 400 units - 4 units; greater than 400 - 5 units and call the physician.
-There was documentation Resident #2's FSBS was greater than 201 or greater 5 of 93 opportunities with examples as follows:
-On 08/06/25 at 6:00am, the FSBS reading was 256 and 0 units of Lispro were documented as administered; 2 units should have been administered per the SSI order.
-On 08/19/25 at 6:00am, the FSBS reading was 219 and 0 units of Lispro were documented as administered; 2 units should have been administered per the SSI order.
-On 08/23/25 at 5:00pm, the FSBS reading was 248 and 0 units of Lispro were documented as administered; 2 units should have been administered per the SSI order.
-On 08/26/25 at 6:00am, the FSBS reading was 325 and 0 units of Lispro were documented as administered; 3 units should have been administered per the SSI order.
-On 08/28/25 at 6:00am, the FSBS readings was

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242 and 0 units of Lispro were documented as administered; 2 units should have been administered per the SSI order.

Observation of Resident #2's medication on hand on 09/16/25 at 3:20pm revealed;
-There was an opened Lispro pen on the medication cart that contained 120 of 300 ml in the insulin pen.
-There were three unopened pens in the refrigerator with dispensed dates of 08/14/25, 09/01/25, and 09/03/25.

Telephone interview with a representative from the facility's contacted pharmacy on 09/17/25 at 3:28pm revealed:
-Resident #2 had an order for Lispro insulin 100 unit/ml sliding scale insulin as follows - FSBS reading of 201 to 250 - 1 unit; 251 to 300 - 2 units; 301 to 350 - 3 units; 351 to 400 units - 4 units; greater than 400 - 5 units and call the physician.
-The pharmacy dispensed 2 pens on 08/24/25, 1 pen on 09/01/25, and 2 pens on 09/03/25; each pen contained 3ml/300 units of insulin.

Interview with a MA on 09/17/25 at 7:10am revealed:
-She administered Resident #2's Lispro SSI when the FSBS reading was greater than 200.
-She thought the amount of insulin she administered was documented on the eMAR.
-She knew she documented the amount of SSI she administered in the progress notes.

Interview with Resident #2 on 09/17/25 at 11:41am revealed:
-She wore a sensor and received her FSBS readings on her phone.
-She would show the MAs her FSBS reading

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three times a day and the MA would administer her insulin.
-She received a scheduled dose of insulin three times daily; she did not think she received any extra insulin.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-The MAs should administer the SSI as ordered.
-Resident #2 was a diabetic and she could have an elevated FSBS.
-She expected the MAs to administer Resident #2's SSI insulin as ordered.

Interview with the Health and Wellness Director (HWD) on 09/18/25 at 11:15am revealed:
-She was not sure what happened with the Lispro documentation.
-If the MA entered the FSBS correctly, the amount of Lispro needed would show on the computer.
-Resident #2 should be administered the SSI as ordered to help manage her FSBS readings.

Attempted telephone interview with Resident #2's PCP on 09/17/25 at 3:13pm was unsuccessful.

Refer to the interview with a MA on 09/18/25 at 12:05pm.

Refer to the interview with RCC on 09/18/25 at 11:11am.

Refer to the interview with the Administrator on 09/18/25 at 2:21pm

3. Review of Resident #1's current FL-2 dated 05/06/25 revealed:
-Diagnoses included mild dementia, untreated osteoarthritis, anxiety, constipation, and

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hyperlipidemia.
-She resided in the Special Care Unit (SCU).

a. Review of Resident #1's current FL-2 dated 05/06/25 revealed there was an order for memantine (used to treat dementia) 10mg twice daily.

Review of Resident #1's six month signed physician's orders dated 06/03/25 revealed there was an order for memantine 10mg once daily.

Review of Resident #1's physician's after visit summary dated 08/03/25 revealed there was an order for memantine 10mg twice daily.

Review of Resident #1's July 2025 electronic medication administration summary (eMAR) revealed:
-There was an entry for memantine 10mg once daily scheduled at 8:00am.
-There was documentation Resident #1 was administered memantine 10mg once daily 31 of 31 opportunities from 07/01/25 to 07/31/25.
-There were no other entries for memantine.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for memantine 10mg once daily scheduled at 8:00am.
-There was documentation Resident #1 was administered memantine 10mg once daily 31 of 31 opportunities from 08/01/25 to 08/31/25.
-There were no other entries for memantine on the August 2025 eMAR.

Review of Resident #1's September 2025 from 09/01/25 to 09/16/25 revealed:
-There was an entry for memantine 10mg once daily scheduled at 8:00am.

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(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 358	Continued From page 54 -There was documentation Resident #1 was administered memantine 10mg once daily 16 of 16 opportunities from 09/01/25 to 09/16/25. -There were no other entries for memantine. Observation of Resident #1's medication on hand on 09/16/25 at 12:39pm revealed: -There was a punch card with 28 tablets of memantine 10mg dispensed on 08/29/25. -The order on the memantine 10mg punch card was administer twice daily. -There was a morning sticker on the punch card, and it was labeled card 2 of 2; 9 tablets of memantine were available for administration in the punch card. -There were no other punch cards with memantine 10gm available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 09/16/25 at 2:54pm revealed: -Resident #1 had a current order dated 05/06/25, for memantine 10mg twice daily. -Resident #1's order had not been changed. -The pharmacy dispensed 56 tablets of memantine, a 28-day supply, in two punch cards on 07/04/25, 08/01/25 and 08/29/25. -Resident #1's memantine was on a cycle fill. -Memantine was used to treat dementia. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/25 at 9:00am revealed: -The facility entered the residents' medication orders on the eMAR. -The facility or the physician faxed the orders to the pharmacy. -The facility only returned one punch card of Resident #1's memantine and that was in May 2025; there were 23 tablets in the card.	D 358		

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-There were no documented conversations with the facility about Resident #1's memantine.
-Memantine was used to treat dementia, it helped with cognitive function and helped the resident's memory.
-Memantine was ordered twice daily because it only stayed in the body for 12 hours.
-The pharmacy did not receive the 6-month physician's order sheet dated 06/02/25 from the facility.
-It was hard to say what an outcome would be from not receiving the second dose of memantine because it would depend on Resident #1's level of dementia.

Interview with a medication aide (MA) on 09/16/25 at 4:30pm revealed:
-She only worked the evening shift.
-She had not administered Resident #1 an evening dose of memantine because the resident did not have an evening dose scheduled.
-She had not paid attention to the order on the punch card of memantine because she had not administered it to Resident #1.
-Resident #1's memantine was only on the eMAR one time and it was scheduled for the mornings.

Interview with a second MA on 09/17/25 at 10:20am revealed:
-The medication orders on the eMAR were correct.
-She compared the order on the medication card to the order in the eMAR.
-She did not know if Resident #1's memantine order was twice a day because she only administered morning medications and she did not see the evening medication schedule when she administered medications.

Interview with Resident Care Coordinator (RCC)

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D 358	Continued From page 56 on 09/17/25 at 10:55am revealed: -She worked as a MA and had only been the RCC for a few weeks. -The MAs entered the orders into the eMAR when there was a new order or an order change. -The order on the medication card was checked against the eMAR for accuracy when the medications were delivered form the pharmacy by the MA who received the medication delivery. -If there was an error on the medication card the MA would contact the pharmacy. -If the physician signed the 6-month physician's order sheet and did not make any changes, then that became the new order for a medication; there was no need for a discontinued order. -The 6-month order sheet was faxed to the pharmacy. -There was no discontinue order for Resident #1's memantine because the physician signed the 6-month order and the medication was administered according to the order. -Resident #1's FL-2 had the order for memantine as twice daily, but the 6-month signed order was dated 06/03/25 so that was the order that was in the eMAR. -Resident #1's memantine was ordered for once daily; she knew that because it was on the eMAR as once daily. -The 6-month physician's orders were generated from the eMAR and if the eMAR was incorrect then the physician would have to catch the error. -She did not see the flaw in the system because the physician signed the 6-month orders. -Resident #1 had not had any new orders or changes for her memantine since the 06/03/25 order. -If the pharmacy sent two medication cards for Resident #1, she sent the second card back to the pharmacy because the order on the eMAR was the correct order and it was only ordered	D 358		

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D 358	Continued From page 57 once daily. -She did not compare the order on the medication to the order on the eMAR when she administered medications. -She followed the orders on the eMAR when she administered Resident #1 her medications. -Resident #1's after visit reports dated 08/03/25 and 08/11/25 were electronically signed by the physician and were considered the current medication orders. -Resident #1's memantine 10mg was ordered for twice daily on the 08/11/25 after visit report. -She did not know why the memantine was still on the eMAR for once daily if the order had changed. Interview with the Clinical Specialist on 09/18/25 at 10:40am revealed: -The MAs, the RCC or the Health and Wellness Director (HWD) entered orders from FL-2s on the eMAR and anyone who did not do the entry checked the entry for errors. -New orders and order changes had a tracking form that was used and then signed off on by the RCC or the HWD for accuracy. -The point of the tracking form was to prevent errors in the medications, at some point the facility stopped using the tracking forms. -The eMAR should always be correct and have the same information on it as the medication label. -If the eMAR was correct the audit would be correct and so would the 6-month physician's orders. -The MAs should be reading the medication label and then the eMAR as part of the steps when administering medications. -The order in the eMAR would match the order on the medication. -"Twice daily" would be on the eMAR entry for either a morning or evening administration.	D 358		

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D 358	Continued From page 58 -If the MAs compared the medication label to the eMAR they would have seen the error and should have questioned it. -The MAs should have questioned why they were having to consistently send a full medication card back to the pharmacy. -She was concerned Resident #1 was not getting her medications as ordered; they were underdosing the resident. Interview with the HWD on 09/17/25 at 12:00pm revealed: -The medication orders on the FL-2s were entered into the eMAR by the MAs or the RCC. -There were date stamps and the name of the staff who entered the medication orders on the eMAR. -Resident #1's memantine 10mg was entered on the eMAR on 05/08/25 by the former RCC as scheduled for once daily. -The incorrect entry on the eMAR should have been discovered by the MAs when they administered the memantine or during a cart audit by the pharmacy or the RCC. -The MAs should have compared the order on the medication card to the order on the eMAR. -If the orders did not match then the MAs should have contacted the physician or the pharmacy; they should not have continued to administer it incorrectly. -If the order was incorrect on the eMAR then the 6-month orders that were printed based on the eMAR entry would also be incorrect. -The incorrect order on the 6-month physician's order was started by the facility's error on the eMAR and should have been discovered and corrected. -The physician's after-visit summary was considered a current order because it was signed and sent to the facility and the pharmacy.	D 358		

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D 358	Continued From page 59 -The after-visit summaries from 08/03/25 and 08/11/25 should have corrected the memantine error. -She was concerned Resident #1 had not been administered her medications correctly since the FL-2 was entered incorrectly on 05/08/25; that was a long time to have a medication error, and it should have been found by the facility before now. Attempted telephone interviews with Resident #1's primary care provider (PCP) on 09/16/25 at 3:25pm and 09/17/25 at 2:35pm were unsuccessful. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. b. Review of Resident #1's current FL-2 dated 05/06/25 revealed there was an order for polyethylene glycol powder (used to treat for constipation) 17mg in fluid once daily. Review of Resident #1's 6-month signed physician's orders dated 06/03/25 revealed there was an order for polyethylene glycol powder 17mg in fluid once daily. Review of Resident #1's physician's after visit summary dated 08/03/25 revealed there was an order for polyethylene glycol powder 17mg in fluid once daily. Review of Resident #1's physician's after visit summary dated 08/11/25 revealed there was an order for polyethylene glycol powder 17mg in fluid once daily. Observation of Resident #1's medication on hand	D 358		

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D 358	Continued From page 60 on 09/16/25 at 12:39pm revealed: -There was a 510gm bottle of polyethylene glycol dispensed on 07/07/25. -The order on the bottle of polyethylene glycol was administer 17gm once daily in 4 to 8 ounces of fluid. -There was no open date on the bottle of polyethylene glycol. -There was three quarters of the bottle of polyethylene glycol available for administration. -There were no other bottles of polyethylene available for administration. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for polyethylene glycol powder 17mg mix in fluid once daily scheduled at 8:00am. -There was documentation Resident #1 was administered polyethylene glycol once daily 31 of 31 opportunities from 07/01/25 to 07/31/25. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for polyethylene glycol powder 17mg mix in fluid once daily scheduled at 8:00am. -There was documentation Resident #1 was administered polyethylene glycol once daily 31 of 31 opportunities from 08/01/25 to 08/31/25. Review of Resident #1's September 2025 eMAR from 09/01/25 to 09/16/25 revealed: -There was an entry for polyethylene glycol powder 17mg mix in fluid once daily scheduled at 8:00am. -There was documentation Resident #1 was administered polyethylene glycol 16 of 16 opportunities once daily from 09/01/25 to 09/16/25.	D 358		

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D 358	Continued From page 61 Telephone interview with a representative from the facility's contracted pharmacy on 09/16/25 at 2:54pm revealed: -Resident #1 had a current order polyethene glycol 17mg once daily mix in fluid. -The pharmacy dispensed a 30-day supply of polyethylene glycol on 05/07/25 and 07/07/25. -Resident #1's polyethylene glycol was not on a cycle fill; the facility requested refills. -Polyethylene glycol was a laxative and was used to treat constipation. Interview with a MA on 09/17/25 at 10:20am revealed: -Resident #1 took her polyethylene glycol every morning without refusals. -She mixed the polyethylene in a cup of water and Resident #1 drank it without problems. -Resident #1 had a bottle of polyethylene glycol on the medication cart with her name on it; that was the bottle she used. -Resident #1 did not complain of constipation. Interview with the RCC on 09/17/25 at 11:05am revealed: -She worked as a MA and had only been the RCC for a few weeks. -She administered Resident #1 her polyethylene glycol every morning by mixing it into the resident's nutritional supplement drink. -Resident #1 never refused the polyethylene glycol. -The MAs were administering the polyethylene glycol to Resident #1 because they were documenting they were administering Resident #1 her polyethylene glycol. -She did not know why Resident #1 still had a bottle of polyethylene glycol dispensed on 07/07/25 available for administration.	D 358		

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D 358	Continued From page 62 Interview with the Clinical Specialist on 09/18/25 at 10:55am revealed: -If there was a bottle of polyethylene glycol dispensed on 07/07/25 and it was still three fourths full she was concerned Resident #1 was not administered the medication. -The MAs probably were not administering Resident #1's polyethylene glycol every day as ordered, they were using another resident's medication, or the family brought it in. -She had not been told if Resident #1 was constipated. -The MAs should administer Resident #1's medications as ordered. Interview with the HWD on 09/17/25 at 12:00pm revealed: -Resident #1's polyethylene glycol was not being administered as ordered if she had almost a full bottle and it had been dispensed on 07/07/25. -The MAs should not have documented the medication as administered on the eMAR if they were not administering it. -She expected the MAs to administer Resident #1's medications as ordered. Attempted telephone interviews with Resident #1's PCP on 09/16/25 at 3:25pm and 09/17/25 at 2:35pm were unsuccessful. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. c. Review of Resident #1's current FL-2 dated 05/06/25 revealed there was an order for estradiol 0.01% cream (used to treat symptoms of urinary incontinence) to apply a pea sized amount to the urethra daily.	D 358		

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D 358	Continued From page 63 Review of Resident #1's six month signed physician's orders dated 06/03/25 revealed there was an order for estradiol 0.01% cream insert one drop vaginally at bedtime. Review of Resident #1's physician's after visit summary dated 08/03/25 revealed there was an order for estradiol 0.01% cream to apply a pea sized amount to the urethra nightly. Observation of Resident #1's medication on hand on 09/16/25 at 12:39pm revealed: -There was a 42.5gm tube of estradiol 0.01% cream dispensed on 07/20/25. -The order on the tube was to apply a pea size amount to the urethral opening once daily. -There was an applicator in a sealed cellophane bag and there was no open date on the tube. -There was one third of the tube of estradiol cream available for administration. -There were no other tubes of estradiol cream available for administration. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for estradiol 0.01% cream insert one drop vaginally at bedtime scheduled at 8:00pm. -There was documentation Resident #1 was administered her estradiol cream 31 of 31 opportunities at bedtime from 07/01/25 to 07/30/25. -There was no other documentation for Resident #1's estradiol cream. -There were no other entries for estradiol cream. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for estradiol 0.01% cream	D 358		

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insert one drop vaginally at bedtime scheduled at 8:00pm.
-There was documentation Resident #1 was administered her estradiol cream at bedtime 31 of 31 opportunities from 08/01/25 to 08/31/25.
-There was no other documentation for Resident #1's estradiol cream.
-There were no other entries for estradiol cream.

Review of Resident #1's September 2025 eMAR from 09/01/25 to 09/16/25 revealed:
-There was an entry for estradiol 0.01% cream insert one drop vaginally at bedtime scheduled at 8:00pm.
-There was documentation Resident #1 was administered her estradiol cream at bedtime 15 of 15 opportunities from 09/01/25 to 09/15/25.
-There was no other documentation for Resident #1's estradiol cream.
-There were no other entries for estradiol cream.

Telephone interview with a representative from the facility's contracted pharmacy on 09/16/25 at 2:54pm revealed:
-Resident #1 had a current order dated 05/06/25, for estradiol cream 0.01% apply a pea size to the urethral opening once daily.
-Resident #1's order had not been changed.
-The pharmacy dispensed a 30-day supply of estradiol cream on 05/07/25, and 07/20/25.
-Resident #1's estradiol cream was not on cycle fill; the facility staff requested a refill when needed.
-Estradiol cream was ordered for vaginal dryness or irritation.

Interview with a MA on 09/16/25 at 4:30pm revealed:
-She administered Resident #1's evening medications.

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-She applied the estradiol cream every evening to Resident #1.
-She used her gloved fingertip to the opening of resident #1's urethra.
-She did not know why there was still a tube of estradiol cream available from 07/20/25, for administration.

Interview with the RCC on 09/17/25 at 11:05am revealed:
-She worked as a MA and had only been the RCC for a few weeks.
-She was confident the MAs were applying Resident #1's estradiol cream daily because they were documenting it on the eMAR.
-She could tell when a cream was being applied as ordered because she could see there was some missing out of the tube; there was no way of telling how much was used or supposed to be left in the tube.
-She could not say why Resident #1's tube of estradiol cream was still being used out of the tube dispensed on 07/20/25.

Interview with the Clinical Specialist on 09/18/25 at 10:40am revealed:
-The MAs should be administering Resident #1's medication as ordered.
-The amount of estradiol cream in the tube from 07/20/25 showed the MAs were either not administering it as ordered, or they were not applying the correct amount.
-There should not be a tube of estradiol cream dispensed on 07/20/25 on the medication cart; it should have been used up.
-She was not sure why Resident #1 was ordered the estradiol cream, but it was not going to be effective if it was not applied.

Interview with the HWD on 09/17/25 at 12:00pm

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revealed:
-Resident #1's estradiol cream was documented on the eMAR as administered.
-The MAs should not have been documenting the administration of the medication if they were not administering it.
-Resident #1's tube of estradiol cream dispensed on 07/20/25 should have been emptied and reordered if it had been administered as ordered.

Attempted telephone interviews with Resident #1's PCP on 09/16/25 at 3:25pm and 09/17/25 at 2:35pm were unsuccessful.

Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.

d. Review of Resident #1's physician's order dated 06/02/25 revealed there was an order for ketoconazole 2% cream (used to treat fungal infections) apply to redness on buttocks once daily.

Review of Resident #1's physician's after visit summary dated 08/03/25 revealed there was an order for ketoconazole 2% cream apply to redness on buttocks twice daily.

Review of Resident #1's physician's after visit summary dated 08/11/25 revealed there was an order for ketoconazole 2% cream apply to redness on buttocks twice daily.

Review of Resident #1's July 2025 eMAR revealed:
-There was an entry for ketoconazole 2% cream apply to buttocks at bedtime scheduled at 8:00pm.
-Ketoconazole was documented as administered

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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
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once daily at bedtime 31 of 31 opportunities from 07/01/25 to 07/31/25.
-There was documentation of location of application for Resident #1's ketoconazole cream; it was applied to both buttocks once daily at bedtime from 07/01/25 to 07/31/25.
-There were no other entries for Resident #1's ketoconazole cream.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for ketoconazole 2% cream apply to buttocks at bedtime scheduled at 8:00pm.
-Ketoconazole was documented as administered 31 of 31 opportunities once daily at bedtime from 08/01/25 to 08/31/25.
-There was documentation of location of application for Resident #1's ketoconazole cream; it was applied to both buttocks once daily at bedtime from 08/01/25 to 08/31/25.
-There were no other entries for Resident #1's ketoconazole cream.

Review of Resident #1's September 2025 eMAR from 09/01/25 to 09/16/25 revealed:
-There was an entry for ketoconazole 2% cream apply to buttocks at bedtime scheduled at 8:00pm.
-Ketoconazole was documented as administered once daily at bedtime 15 of 15 opportunities from 09/01/25 to 09/15/25.
-There was documentation of location of application for Resident #1's ketoconazole cream; it was applied to both buttocks once daily at bedtime from 09/01/25 to 09/15/25.
-There were no other entries for Resident #1's ketoconazole cream.

Observation of Resident #1's medication on hand

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on 09/16/25 at 12:39pm revealed:
-There was a 60gm tube of ketoconazole 2% cream dispensed on 07/20/25.
-The order on the tube was to apply a thin layer to redness on buttocks at bedtime.
-The foil seal was still intact, and the tube was not opened.
-There were no other tubes of ketoconazole 2% cream available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 09/16/25 at 2:54pm revealed:
-Resident #1 had a current order dated 05/06/25, for ketoconazole 2% cream apply a thin film to buttocks daily at bedtime.
-Resident #1's order had not been changed.
-The pharmacy dispensed a 30-day supply of 60gms of ketoconazole 2% cream on 06/02/25 and 07/20/25.
-Resident #1's ketoconazole 2% cream was not on a cycle fill; the facility staff had to request a refill.
-Ketoconazole was an antifungal cream.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/25 at 9:00am revealed:
-The staff at the facility entered the residents' medication orders on the eMAR.
-The staff at the facility or the physician faxed the orders to the pharmacy.
-The staff at the facility faxed an order on 05/30/25 for Resident #1's ketoconazole 2% cream apply nightly.
-The pharmacy did not have the second order dated 06/02/25 with the order for ketoconazole to be applied twice daily.
-If Resident #1 was not administered the second dose of ketoconazole cream it would take longer

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D 358	Continued From page 69 to clear the fungal infection. Interview with a MA on 09/16/25 at 4:30pm revealed: -She administered Resident #1's evening medications. -She applied the ketoconazole cream every evening to Resident #1. -She did not know why there was an unopened tube of ketoconazole cream available for administration. Interview with the RCC on 09/17/25 at 11:05am revealed: -She worked as a MA and had only been the RCC for a few weeks. -The resident's PCP sent new medication orders to the pharmacy and the pharmacy sent a copy of the order to the facility. -The MAs entered the orders into the eMAR when there was a new order or an order change. -The order on the medication label was checked against the eMAR for accuracy when the medications were delivered from the pharmacy by the MA who received the medication delivery. -If there was an error on the medication label the MA would contact the pharmacy. -Resident #1's ketoconazole cream was ordered once daily; she knew that because it was on the eMAR as once daily. -She did not compare the order on the medication to the order on the eMAR when she administered medications. -She followed the orders on the eMAR when she administered medications. -Resident #1's after visit summaries dated 08/03/25 and 08/11/25 were electronically signed by the physician and were considered the current medication orders. -Resident #1's ketoconazole was on the eMAR as	D 358		

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once daily at bedtime.
-She thought another MA had entered the ketoconazole order on the eMAR.
-The order on the eMAR was incorrect according to the order dated 06/03/25 and the signed orders on the after-visit summary from Resident #1's PCP dated 08/11/25.
-The Health and Wellness Director (HWD) should have caught Resident #1's ketoconazole was not on the eMAR correctly.
-She was confident the MAs were applying Resident #1's ketoconazole cream daily.
-She could not say why the tube of ketoconazole cream was not opened.

Interview with the Clinical Specialist on 09/18/25 at 10:40am revealed:
-The MAs, the RCC or HWD entered new orders on the eMAR and anyone who did not do the entry checked the entry for errors.
-New orders and order changes had a tracking form that was used and then signed off on by the RCC or the HWD for accuracy.
-The point of the tracking form was to prevent errors in the medications, at some point the facility stopped using the tracking forms.
-The eMAR should always be correct and have the same information on it as the medication label.
-If the new order was not faxed to the pharmacy for the ketoconazole, then the order on the label would be incorrect as well.
-The unopened tube of ketoconazole meant the medication was either not administered at the amount ordered or was not administered as ordered.
-She was concerned Resident #1 was not getting her medications as the PCP ordered them; they were underdosing the resident.
-The MAs should not be documenting the

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D 358	Continued From page 71 administration the eMAR if they were not applying the cream. Interview with the HWD on 09/17/25 at 12:15pm revealed: -Resident #1's eMAR entry for her ketoconazole once daily was not the correct order. -Resident #1's most recent order for ketoconazole to be administered twice daily was not entered on the eMAR. -Resident #1's after-visit summary dated 08/03/25 should have been entered onto the eMAR and sent to the pharmacy and the error would have been corrected. -She did not know why the pharmacy did not have the correct order; the previous RCC or an MA should have sent the current order to the pharmacy. -The ketoconazole was not being administered correctly because the PCP wrote the order for administer twice daily. Attempted telephone interviews with Resident #1's PCP on 09/16/25 at 3:25pm and 09/17/25 at 2:35pm were unsuccessful. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with a MA on 09/18/25 at 12:05pm. Refer to the interview with RCC on 09/18/25 at 11:11am. Refer to the interview with the Administrator on 09/18/25 at 2:21pm. _____ Interview with another MA on 09/18/25 at	D 358		

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D 358	Continued From page 72 12:05pm revealed: -She entered orders into the computer system. -She did not know if there was a system to check entries entered into the computer system by the MAs. -She tried to get the MA or RCC to check the entries she entered. -There was no schedule for MAs to do medication cart audits. -When she had time, she would make sure there were dates on eye drops and creams when they were opened. -She saw the RCC and another MA do medication cart audits occasionally. Interview with RCC on 09/18/25 at 11:11am reviewed: -The MAs, RCC, HWC, and HWD could enter medication orders into the eMAR. -Whoever received the order was the one who entered the order into the eMAR. -There was no check and balance system in place to verify the orders were entered correctly into the eMAR. -She would ask another MA or the HWC or HWD to check all orders she entered into the eMAR. -The facility had a new order tracking system that used to be in place, but it had not been used in a couple of months. -The new order tracking system was a check system from the time the order arrived in the facility until the medication was delivered to the facility. -She audited medication carts when she had time; there was no schedule for auditing the medication carts. -She looked for expired and discontinued medications and comp when she audited the medication carts. -She had never seen the HWC or HWD audit a	D 358		

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D 358	Continued From page 73 medication cart. Interview with the Administrator on 09/18/25 at 2:21pm revealed: -He expected the MAs to administer medications as ordered. -He expected the MAs to follow facility policies related to medication administration. -The MAs were responsible for medication cart audits; he did not know if there was a schedule for the MAs to follow. -The pharmacy did a quarterly medication cart audit. -He did not think the medication carts had been audited as frequently as they should have been. 4. Review of Resident #4's current FL2 dated 02/28/25 revealed diagnoses included chronic obstructive pulmonary disease (COPD) and gastroesophageal reflux disease (GERD). Review of Resident #4's physician order dated 03/11/25 revealed there was an order for simethicone (a medication used to prevent bloating) 250mg by mouth one time a day for bloating; do not crush. Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for simethicone 250mg daily scheduled at 8:00am. -Simethicone was documented as administered 30 out of 31 opportunities. Review of Resident #4's August 2025 eMAR revealed: -There was an entry for simethicone 250mg daily	D 358		

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scheduled at 8:00am.
-Simethicone was documented as administered 31 out of 31 opportunities.

Review of Resident #4's September 2025 eMAR from 09/01/25 through 09/16/25 revealed:
-There was an entry for simethicone 250mg daily scheduled at 8:00am.
-Simethicone was documented as administered 16 out of 16 opportunities.

Observation of Resident #4's medications on hand on 09/16/25 at 4:40pm revealed:
-There was one over-the-counter bottle of simethicone 80mg tablets available for administration.
-The bottle was half full.

Telephone interview with a representative from the facility's contracted pharmacy on 09/17/25 at 2:37pm revealed:
-Resident #4 had a current order for simethicone 250mg daily.
-The pharmacy had no record of dispensing simethicone to the facility for Resident #4.

Interview with Resident #4 on 09/18/25 at 9:10am revealed:
-She was not aware of what medications are were administered to her everyday.
-She had not had any symptoms of stomach bloating.

Interview with the Resident Care Coordinator (RCC) on 09/18/25 at 11:15am revealed:
-She was newly promoted from the medication aide (MA) position to the RCC position.
-She did not recall the last time that she worked on Resident #4's medication cart.
-She did not know that Resident #4 was being

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administered simethicone 80mg instead of 250mg.
-It was expected for the medication on the cart to match the order on the eMAR before administration.

Interview with a MA on 09/18/25 at 12:27pm revealed:
-She did not notice that Resident #4's simethicone was the wrong dose.
-She had administered simethicone 80mg to Resident #4 instead of simethicone 250mg.
-She should have checked that the medication bottle matched the order.
-It was her understanding that the Health and Wellness Coordinator (HWC) did the medication cart audits.

Interview with another MA on 09/18/25 at 12:42pm revealed:
-She did not notice that Resident #4's simethicone on the medication cart did not match the order.
-She assumed that the simethicone was the correct dosage because Resident #4's family member purchased the medication.

Interview with the Clinical Specialist on 09/18/25 at 12:53pm revealed:
-She did not know that the wrong dose of simethicone was being administered to Resident #4.
-The pharmacy did quarterly medication cart audits, checking for accuracy of medications, but she was not sure if the cart with Resident #4's medications was checked during the last audit.
-It was expected that the MA's used the three checks of medication administration.

Interview with the Health and Wellness Director

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D 358	Continued From page 76 (HWD) on 09/18/25 at 2:02pm revealed: -She was not aware that the wrong dose of simethicone had been administered to Resident #4. -It was expected that the medication be checked three times before administration. Interview with the Administrator on 09/18/25 at 2:15pm revealed: -He was not aware that the wrong dose of simethicone had been administered to Resident #4. -He expected that the correct medication would be administered as ordered. Attempted telephone interview with Resident #4's family member on 09/18/25 at 1:30pm was unsuccessful. Attempted telephone interview with Resident #4's primary care provider (PCP) on 09/17/25 at 2:50pm was unsuccessful. _____ Interview with a MA on 09/18/25 at 12:05pm revealed: -She entered orders into the computer system. -She did not know if there was a system to check entries entered into the computer system by the MAs. -She tried to get a second MA or RCC to check the entries she entered. -There was no schedule for MAs to do medication cart audits. -She saw the RCC and another MA do medication cart audits occasionally. Interview with RCC on 09/18/25 at 11:11am reviewed: -The MAs, RCC, HWC, and HWD could enter medication orders into the eMAR.	D 358		

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-Whoever received the order was the one who entered the order into the eMAR.
-There was no check and balance system in place to verify the orders were entered correctly into the eMAR.
-She would ask another MA or the HWC or HWD to check all orders she entered into the eMAR.
-The facility had a new order tracking system that used to be in place, but it had not been used in a couple of months.
-The new order tracking system was a check system from the time the order arrived in the facility until the medication was delivered to the facility.
-She audited medication carts when she had time; there was no schedule for auditing the medication carts.
-She looked for expired and discontinued medications when she audited the medication carts.
-She had never seen the HWC or HWD audit a medication cart.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-She did not know if there was a schedule for medication cart audits.
-The HWD, the HWC, the RCC, and the MAs should be routinely auditing the medication carts.
-The Pharmacist did a quarterly medication cart audit.
-The medication cart audits would be helpful to ensure all the medications on the eMAR were on the medication cart for administration.
-Physician orders where entered into the computer system by the HWD, the HWC, the RCC, and the MAs.
-The staff that entered the order would initiate a new order tracking form, which tracked the order until the medication was delivered by the

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pharmacy.
-Unfortunately, the new order tracking form was not being utilized at that time.
-A high turn over rate of staff happened and the form stopped being used.

Interview with the Administrator on 09/18/25 at 2:21pm revealed:
-He expected the MAs to administer medications as ordered.
-He expected the MAs to follow facility policies related to medication administration.
-The MAs were responsible for medication cart audits; he did not know if there was a schedule for the MAs to follow.
-The pharmacy did a quarterly medication cart audit.
-He did not think the medication carts had been audited as frequently as they should have been.

_____
The facility failed to ensure medications were administered as ordered related to a resident who was to receive an as needed fluid medication for weight gain and a sliding scale insulin that was not administered as ordered, placing the resident at risk for _____ (#2); an inhaler that was administered and the resident's mouth was not rinsed after administration resulting in the potential for thrush; a thyroid medication ordered to be administered on an empty stomach and was administered after breakfast resulting in the the potential for the medication to be ineffective (#__); a resident who received the wrong dose of a medication used to help prevent bloating which placed the resident at risk for symptoms of bloating (#4). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.

_____
The facility provided a plan of protection in

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D 358	Continued From page 79 accordance with G.S. 131D-34 on 09/17/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 2, 2025.	D 358		
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 and interviews, the facility failed to ensure infection control measures were implemented during a morning medication pass as evidenced the medication aides (MA) failing to wash their hands and handling medication without wearing gloves. The findings are: Review of the facility's hand washing policy dated 10/2021 and the infection control policy dated 05/2025 revealed: -Hand washing and hand hygiene were the primary means to prevent the spread of infections. -The MAs should wash or sanitize their hands before preparing and handling medications and before and after donning and doffing gloves. -When applying gloves, remove one glove from	D 371		

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the dispensing box at a time, touching only the top of the cuff.
-The MAs should wear gloves when anticipating contact with blood or body fluids.
-The administration of an inhaler may involve potential exposure to infectious material.

Observation of the morning medication pass on 09/17/25 between 7:50am and 8:50am revealed:
-At 7:50am, the MA placed her bare hand into a container of medication to retrieve a scoop of medication, poured the medication into a cup, and returned her hand into the container to return the scoop.
-The MA did not wash her hands or donned gloves prior to scooping the medication from the container.
-At 7:55am, the MA asked the housekeeper to give her some gloves because she did not have any on the medication cart.
-The housekeeping, used her bare hands, picked up a hand full of gloves and gave them to the MA, dropping one of the gloves on the floor, which was picked up and placed with the other gloves.
-The MA donned a pair of gloves, without washing her hands, administered an insulin injection, doffed the gloves and did not wash her hands.
-At 8:30am, the second MA donned gloves without washing her hands and administered an eye drop.
-At 8:43am, the second MA administered an inhaler without donning gloves or washing her hands after the administration of the inhaler.

Interview with a MA on 09/17/25 at 10:59am revealed:
-She thought she sanitized her hands before and after donning and doffing gloves.
-She knew she should was her hands before and after donning and doffing gloves.

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D 371	Continued From page 81 -She did not know she should not get gloves from the housekeeper, and that she should have gotten a new box. -She understood now that all the gloves had been touched by her and the housekeeper. Interview with the second MA on 09/18/25 at 11:11am revealed: -She did not wear gloves when administering inhalers. -She was not aware she needed to wear gloves when administering inhalers. -Gloves were worn to prevent contact with secretions. -She could possibly come in contact with secretions when administering an inhaler. Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed: -The MAs should wash their hands with soap and water or use a hand sanitizer before and after donning and doffing gloves. -Gloves should be worn when administering an injection, checking a FSBS, administering an eye drop and an inhaler, and if there was a chance that the MA may touch a medication. -Gloves should be worn if there was any chance of coming in contact with secretions or bodily fluids. -The MA could cause cross contamination if they were not washing their hands or wearing gloves when needed. -The MA should have washed her hands and donned gloves before placing her hand inside a container to retrieve a scoop of medication. -The MA should have retrieved a new box of gloves for the medication cart. -The gloves should not be removed from the original box; they could become contaminated.	D 371		

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D 371	Continued From page 82 Interview with the Health and Wellness Director (HWD) 11:15am revealed: -The MAs should wash their hands before and after donning and doffing gloves. -The MAs should not touch medications or contaminate medications with their hands; they should use gloves when handling medications. -The MA should have donned a glove before placing her hand in the medication container. -The medication container was contaminated and needed to be disposed. -A new box of gloves should have been obtained and placed on the medication cart. -All the gloves handled by the housekeeper and given to the MA were contaminated. -The MAs should wear gloves when there was a potential to come in contact with secretions. Interview with the Administrator on 09/18/25 at 2:21pm revealed: -The MAs should not place their bare hands inside a container of medication. -The MAs should wash their hands before and after donning and doffing gloves. -The MAs could transfer germs from one place to another if they did not wash their hands or wear gloves when preparing and administering medications. -The MAs should follow the facility policies regarding hand washing, gloves, and infection precautions when administering medications.	D 371		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to	D 375		

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D 375	Continued From page 83 self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure compliance with the facility's policies and procedures for self-administration of medications as evidenced of not having a self-administration assessment completed on 1 of 1 sampled residents (#3). The findings are: Review of the facility's Self-Administration of Medications policy dated 10/2024 revealed: -The resident would be evaluated upon move-in and counseled at least monthly to determine the capability to safely and timely self-administration of medications as prescribed by their Primary Care Provider (PCP). -A staff member would be trained to assess the resident for self-administration of medications. -The trained staff would obtain a prescribed medication list as ordered by the PCP. -The trained staff would conduct a self-administration evaluation upon move-in to the facility to determine if the resident was recommended for the self-administration program. -The trained staff would counsel the resident at	D 375		

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least once a month to determine if the resident continued to be capable of self-administration of medications and complete the review of the monthly medication capability review form and place in the resident's record.

Review of Resident #3's current FL-2 dated 05/28/25 revealed diagnoses included osteoporosis with current pathological fracture, peripheral autonomic neuropathy, venous insufficiency, rectal prolapse, and vertigo.

Observation of Resident #3's room on 09/16/25 at 8:28am revealed:
-There were zip-locked bags of medication lying on a table in the living room.
-The first row had 5 zip-locked bags each containing 4 pills.
-Each zip-locked bag had a note that documented the day of the week, the month, and the word "dinner".
-The second row had 4 zip-locked bags each containing 6 pills.
-Each zip-locked bag had a note that documented the day of the week, the month, and the work "breakfast".
-There was no resident's name or the name of the medications documented on the note.

Interview with Resident #3 on 09/16/25 at 11:33am revealed:
-She lived in the room with her husband, but he was currently in rehabilitation; he had been gone since 08/05/25.
-She took her own medications.
-Her daughter prepared her medications in zip-locked bags, labeled them with the date they were to be taken, and placed them on the table.
-She prepared the medications for breakfast and dinner, for a week at a time.

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-She did not know where the medication bottles were; she thought her daughter may have them with her.

Telephone interview with Resident #3's family member on 09/17/25 at 5:15pm revealed:
-Resident #3's spouse used to administer her medications to her.
-Resident #3's spouse was admitted to the hospital on 08/05/25 and transferred to rehabilitation.
-Resident #3's spouse would be returning to the facility next week.
-She prepared the medications for Resident #3 and placed the pills in zip-locked bags and labeled them with the day and meal the medications were to be taken.
-The medication bottles were secured in a locked box in Resident #3's room.
-She had a current list of Resident #3's medications for review.
-Resident #3 would take her medications from the zip-locked bag with breakfast and dinner.
-There had been no problems with Resident #3 taking her medications since she started preparing them.

Interview with a medication aide (MA) on 09/18/25 at 7:10am revealed:
-She did not administer medications to Resident #3.
-Resident #3 self-administered her medications and her spouse administered his medications.
-She did not go in Resident #3's room a lot since she did not administer her medications.
-She had assisted Resident #3 to the bathroom occasionally and had not noticed any zip-locked bags of medications on Resident #3's table.
-If she had seen the zip-locked bags of medication she would have told the Resident

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Care Coordinator (RCC).
-She was not aware Resident #3's spouse administered her medications and since he had left the facility, she did not know Resident #3's family member was preparing her medications.

Interview with another MA on 09/18/25 at 12:05pm revealed:
-She had seen medications in Resident #3's room.
-Resident #3 spouse was administering medications to Resident #3.
-Resident #3's family member prepared Resident #3's medications since Resident #3's husband had been out of the facility.
-She thought her medications were kept in a medicine planner next to her bed.
-She had not noticed the zip-locked bags of medication on the tablet in the living room.

Interview with RCC on 09/18/25 at 11:11am reviewed:
-Resident #3 self-administered her medications.
-The Health and Wellness Director(HWD) was responsible for assessing Resident #3 to ensure she could administer her medication correctly.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-Resident #3's did not self-administer her medications, her spouse administered the medications to her.
-Resident #3's spouse was admitted to the hospital on 08/05/25 and then moved to a rehabilitation center; he was expected to return to the facility on 09/23/25.
-She did not know who was administering Resident #3's medications since her spouse was out of the facility.
-She thought the MAs were administering

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Resident #3's medications.
-No staff or family approached her to discuss how Resident #3 would be administered her medications after her spouse was out of the facility.
-She did not know why Resident #3 could not self-administer her medications.
-She did not need a self-administer assessment because she did not self-administer medications.
-She did not know how Resident #3 was being administered her medications until she was informed by the surveyor on 09/17/25.
-She expected the MAs to let her know that Resident #3's medication needed to be prepared for administration.

Interview with the HWD 11:15am revealed:
-The resident had to pass the self-administration assessment.
-The resident was required to have an order to self-administer.
-The HWD was responsible for completing the self-administration assessment.
-She did not know Resident #3 did not have a self-administration assessment.
-She did not know Resident #3's medications were being prepared by her daughter and Resident #3 was administering her medications.

Interview with the Administrator on 09/18/25 at 2:21pm revealed:
-There was an approval process the residents had to pass before they could self-administer medications.
-The HWD was responsible completing an assessment on each resident who wanted to self-administer their medications.
-The Resident had to know their medications and why they were taking the medication.
-The self-administration assessment had to be

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D 375	Continued From page 88 completed quarterly to ensure the resident was still able to self-administer their medications . Attempted telephone interview with Resident #3's PCP on 09/17/25 at 2:58pm was unsuccessful.	D 375		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that medications were stored safely and securely for 1 of 1 residents (#3) who had medications prepared in a zip-lock bag and lying on the living room table and the resident's door was not locked when there was no one in the room. The findings are: Review of the facility's Self-Administration of Medications policy dated 10/2024 revealed: -A staff member would be trained to assess the resident for self-administration of medications. -The trained staff would counsel the resident at least once a month to determine if the resident was capable of safely securing the self-administration medications. Review of Resident #3's current FL-2 dated	D 378		

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D 378	Continued From page 89 05/28/25 revealed diagnoses included osteoporosis with current pathological fracture, peripheral autonomic neuropathy, venous insufficiency, rectal prolapse, and vertigo. Observation of Resident #3's room on 09/16/25 at 8:30am revealed: -There were 7 zip-locked bags on the living room table with medications in each zip-locked bag, -Resident #3's door was unlocked, and she was not in the room. Observation of Resident #3's room on 09/17/25 at 12:15pm revealed: -There were 7 zip-locked bags on the living room table with medications in each zip-locked bag, -Resident #3's door was unlocked, and she was not in the room. Interview with Resident #3 on 09/17/25 at 11:30am revealed: -Her family member prepared her medications every week. -She took medications twice daily, at breakfast and dinner. -Her family member placed her medications in a zip-locked bag for each day, separating the daily medications into two zip-locked bags. -Her family member labeled each bag with the day of the week, the date of the month, and whether the medication was for breakfast or for dinner. -She took her medications as prepared by her family member. -She kept the zip-locked bags on her table so she could see them. -She did not lock her door when she went to meals. Interview with Resident Care Coordinator (RCC)	D 378		

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on 09/18/25 at 11:11am reviewed:
-Medications in rooms should be secured in a lock box.
-If medications in a room were left unattended, another resident could enter the room and take the medications.

Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed:
-She did not know Resident #2 had zip-locked bags of medication on her table in her room.
-She did not know who prepared them or what the medications were.
-She did not know if Resident #2 took her medications as she should.
-Anyone could walk into her room and pick up the medications and take them.
-Medications should be stored in a locked box.
-If the medications were visible, the door should be locked when Resident #2 left the room.

Interview with the Health and Wellness Director (HWD) 11:15am revealed:
-Medications that were kept in residents' rooms were kept in a locked box.
-Medications should not be left out in the resident's room.
-If medications were left out in the resident's room, the door should be locked when the resident was not in their room.
-She did not know Resident #3 had medications in zip-locked bag lying on her table in her room.
-She would have expected the MA to notice this and let the Health and Wellness Coordinator (HWC) and HWD know this.

Interview with the Administrator on 09/18/25 at 2:21pm revealed:
-Residents who self-administered their medications should keep their medications in a

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D 378	Continued From page 91 locked box in their room. -The staff should ensure residents were aware that medications were to be secured in a locked box. -He expected the residents to lock their bedroom doors when they left their room if medications were not in a locked box. -When medications were left out in the resident's room, other residents or staff could enter the room and get the medication. -He did not know Resident #3 had medications in zip-locked bags on a table in her room. -He did not know Resident #3 did not have a self-administration order to administer her medications. -He expected the HWD to ensure self-administration assessment were completed per policy and the staff to alert the HWD when medications were not secured.	D 378		
D 400	10A NCAC 13F .1009 (a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's	D 400		

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D 400	Continued From page 92 orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 2 of 5 sampled residents (#3 and #4). The findings are: 1. Review of Resident #3's current FL-2 dated 05/28/25 revealed diagnoses included osteoporosis with current pathological fracture, peripheral autonomic neuropathy, venous insufficiency, rectal prolapse, and vertigo. Review of Resident #3's signed physician orders dated 05/28/25 revealed there was an order for Resident #3 to self-administer medications.	D 400		

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D 400	Continued From page 93 Review of the quarterly pharmacy medication review for Resident #3 dated 06/17/25 revealed a recommendation to ensure completion of a self-administration evaluation for all medications that Resident #3 self-administered per facility policy. Refer to the interview with the Clinical Specialist on 09/18/25 at 9:15am. Refer to the interview with Resident Care Coordinator (RCC) on 09/18/25 at 11:11am. Refer to the interview with the Health and Wellness Director (HWD) on 09/18/25 at 11:15am. Refer to the Interview with the Administrator on 09/18/25 at 2:21pm. 2. Review of Resident #4's current FL2 dated 02/28/25 revealed: -Diagnoses included chronic obstructive pulmonary disease and gastroesophageal reflux disease. -There was an order for Protonix (a medication to help with acid reflux) 40mg, take a half tablet daily. Review of the quarterly pharmacy medication review for Resident #4 dated 03/04/25 revealed a recommendation to ensure the electronic medication administration record (eMAR) matched the medication card dispensed from the pharmacy to prevent medication errors. Review of Resident #4's medication card from the pharmacy revealed the label was for Protonix 20mg take one tablet by mouth daily.	D 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 400	Continued From page 94 Review of Resident #4's September 2025 eMAR revealed there was an entry for Protonix 40mg take one half tablet (20mg) by mouth daily. Refer to the interview with the Clinical Specialist on 09/18/25 at 9:15am. Refer to the interview with Resident Care Coordinator (RCC) on 09/18/25 at 11:11am. Refer to the interview with the Health and Wellness Director (HWD) on 09/18/25 at 11:15am. Refer to the Interview with the Administrator on 09/18/25 at 2:21pm. _____ Interview with the Clinical Specialist on 09/18/25 at 9:15am revealed: -The Health and Wellness Director (HWD), the Health and Wellness Coordinator (HWC), and the Resident Care Coordinator (RCC) were responsible for following up with recommendations from the pharmacist. -The recommendation should be sent to the primary care provider (PCP). -When the response for the recommendation was returned, the HWD, HWC, RCC or medication aide (MA) should enter the changes into the eMAR system and update the orders. -A order tracking sheet should be completed when a new order was entered. Interview with RCC on 09/18/25 at 11:11am revealed: -The pharmacy medication recommendations were sent to the PCP. -The PCP would agree or disagree with the pharmacist's recommendations	D 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 400	Continued From page 95 -If any new orders were written, whoever received the order would enter it into the eMAR. Interview with the HWD on 09/18/25 at 11:15am revealed: -The pharmacy recommendation should be reviewed by the HWC or HWD and sent to the PCP if needed. -When the recommendation has been reviewed by the PCP, the HWC or HWD would enter the changes into the eMAR and fax the recommendation to the pharmacy. Interview with the Administrator on 09/18/25 at 2:21pm revealed: -The pharmacy reviewed the charts and eMARs for irregularities. -They prepare recommendations for the PCP to review and agree or disagree with. -The HWD was responsible for reviewing the pharmacy review recommendations and forwarding to the PCP. -Once the pharmacy reviews were returned to the facility from the PCP, any new orders or changed orders would be added to the eMAR and the order would be faxed to the pharmacy.	D 400		