

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURHAM		STREET ADDRESS, CITY, STATE, ZIP CODE 4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704			
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on May 28-30, 2024.	D 000		7/10/24	
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk or other equivalent dairy products were served three times daily to residents in the Assisted Living (AL) and Special Care Unit (SCU). The findings are: Review of the facility's census revealed a census of 50 residents in the Assisted Living (AL) and 17 in Special Care Unit (SCU). Review of the facility's daily menu for 05/28/24 and 05/29/24 revealed: -Milk was listed to be served for the breakfast,	D 299			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

STATE FORM

544

KZV511

If continuation sheet 4 of 39

Reviewed and acknowledged
07/23/24

KC

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D 299	Continued From page 1 lunch, and dinner meal service. -There were no equivalent dairy products listed on the menu to be served on 05/28/24 or 05/29/24. Observation of the refrigerator in facility kitchen on 05/29/24 at 2:46pm revealed there were 6 gallons of whole milk. 1. Observation of the lunch service meal in the AL on 05/28/24 between 12:02pm and 12:35pm revealed: -There was one empty preset glass at each placesetting. -The dietary aides asked the residents what they wanted to drink; water, tea or lemonade. -Residents were not offered milk. Observation of the lunch service meal in the AL on 05/29/24 between 11:50am and 12:20pm revealed: -There was one empty preset glass at each placesetting. -The dietary aides asked the residents what they wanted to drink; water, tea or lemonade. -Residents were not offered milk. Interview with a resident on 05/28/24 at 3:58pm revealed: -She was served milk at every meal because she requested it so much the staff automatically gave it to her. -The staff did not ask the other residents at her table if they wanted milk to drink. Interview with two residents at on 05/29/24 at 11:55am revealed: -If the facility offered milk at lunch time, they would drink it. -Sometimes they wanted milk and sometimes	D 299			

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D 299	Continued From page 2 they did not, but they were never asked if they wanted milk at lunchtime. Interview with the dietary aide on 5/28/24 at 12:15pm revealed: -Milk was only offered at breakfast and dinner. -She only offered tea, lemonade or water at lunchtime. -There was one resident that got milked at lunchtime because everyone knew she wanted 2 glasses of milk. -She did not know why milk was not offered at lunchtime. Interview with the Dietary Manager on 05/29/24 at 3:14pm revealed: -Milk was offered for breakfast daily. -Dietary staff used a beverage list to determine what beverages were to be served. -Residents could always ask the staff for milk if they wanted milk with their meal. -She did not know dairy products should be served to residents three times daily. Refer to interview with the Administrator on 05/29/24 at 3:30pm. 2. Observation of the lunch service meal in the SCU on 05/28/24 between 12:00pm and 12:48pm revealed: -There were 15 residents present in the dining room. -Water and juice were preset before the meal. -Residents were not offered milk. Observation of the lunch service meal in the SCU on 05/29/24 between 12:05pm and 12:37pm revealed: -There were 15 residents present in the dining room.	D 299			

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D 299	Continued From page 3 -Water and juice were preset before the meal. -Residents were not offered milk. Interview with 2 residents on 05/29/24 between 12:37pm and 12:45pm revealed: -One resident was not offered milk 2 times daily with each meal, but she would not drink milk if offered. -Second resident was not offered milk 2 times daily with each meal, but he would drink if it was offered to him. Interview with a personal care aide (PCA) on 05/29/24 at 12:49pm revealed: -Milk was given at breakfast only, but not at lunch or dinner. -Residents would let the staff know if they wanted milk during lunch or dinner. -When residents requested milk, a staff that were not providing feeding assistance would go to the kitchen to get the milk. Interview with a second PCA on 05/29/24 at 1:12pm revealed: -The residents always get milk at breakfast, but do not ask for milk with other meals. -The residents are always served water and another beverage. Interview with a dietary aide on 05/29/24 at 3:04pm revealed: -The dietary staff were responsible to send milk on the meal carts for SCU residents. -She used a beverage list to determine what beverages were needed to send to the SCU. -Residents got milk at breakfast. -She was not aware all residents in SCU were supposed to receive milk with all meals. Interview with the Dietary Manager on 05/29/24 at	D 299			

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D 299	Continued From page 4 3:14pm revealed: -The dietary staff were responsible to send milk on the meal carts for SCU residents. -Milk was sent on the meal carts from the kitchen for breakfast daily. -Dietary staff used a beverage list to determine what beverages were to be sent to SCU. -Residents could always ask the staff for milk if they wanted milk with their meal. -She did not know dairy products should be served to residents in SCU three times daily. Refer to interview with the Administrator on 05/29/24 at 3:30pm. Interview with the Administrator on 05/29/24 at 3:30pm revealed: -She was not aware that milk had not been served for lunch on 05/28/24 and 05/29/24 in the AL or the SCU. -If milk was not sent on meal carts, she expected staff to go to the kitchen door and ask for milk for the residents. -She expected milk to be served to residents for meals according to the menu.	D 299		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the	D 344		

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D 344	Continued From page 5 forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (#3) related to a calcium supplement. The findings are: Review of Resident #3's current FL-2 dated 05/06/24 revealed: -Diagnoses included atrial fibrillation, hypertension, anemia, depression, and osteoporosis. -There was an order for calcium carbonate with vitamin D 10mcg daily. -There was an order for calcium oral tablet daily that did not include a dosage or frequency. Review of Resident #3's May 1 to May 28, 2024 electronic medication administration record (eMAR) revealed: -There was an entry for calcium carbonate with vitamin D 10mcg daily scheduled to be administered at 8:00am. -There was an entry for calcium oral tablet give one tablet by mouth one time a day scheduled to be administered at 8:00am. -Calcium oral tablet was documented as administered from 05/07/24 to 05/17/24, 05/22/24, and 05/28/24. -Calcium oral tablet was documented as refused on 05/25/24 and 05/26/24. -Calcium oral tablet was documented as "other, see nurse's notes" from 05/18/24 to 05/21/24, 05/23/24, 05/24/24, and 05/27/24.	D 344		

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D 344	Continued From page 6 Observation of Resident #3's medications on hand on 05/28/24 at 3:10pm revealed: -There was a bottle of over-the-counter calcium carbonate with vitamin D 10mcg available for administration. -There was no other calcium available for administration to Resident #3. Interview with a representative from the facility's contracted pharmacy on 05/29/24 at 9:20am revealed: -Resident #3 had an order for calcium carbonate with vitamin D 10mcg once a day. -The pharmacy did not dispense the calcium carbonate with vitamin D 10mcg. -There was no other order for calcium for Resident #3. Interview with Resident #3 on 05/30/24 at 12:10pm revealed he did not know about another order for calcium; he knew he took one calcium pill daily. Interview with Resident #3's family member on 05/28/24 at 3:40pm revealed: -Resident #3 had one calcium medication that he took that she provided from the drug store. -She was aware of the other physician's order for calcium but Resident #3 did not take two calcium supplements. -It came up every time she took Resident #3 to the doctor, and she did not understand why it had not been removed. Interview with a Medication Aide (MA) on 05/30/24/ at 11:15am revealed: -Resident #3 only had one calcium medication, the calcium carbonate with vitamin D 10mcg. -Resident #3's daughter brought the	D 344		

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D 344	Continued From page 7 over-the-counter medication in for him. -She called Resident #3's Primary Care Providers (PCP) office about the second calcium order but could not recall when. -She did not document the telephone call to Resident #3's PCP. -She did not call the pharmacy to ask about the other calcium medication. -She did not let anyone know about the other calcium order that needed to be clarified. -Resident #3 did not refuse his medications. -When a medication was not available or needed to be clarified, she should call the pharmacy and let the Resident Care Coordinator (RCC) know. Interview with the RCC on 05/30/24 at 11:30am revealed: -When a resident is admitted, the FL-s are reviewed by either her or the Health and Wellness Director (HWD) -If there is something that needs to be clarified, they use the FL-2 addendum form and send the FL-2 and the addendum to the pharmacy. -The calcium order for Resident #3 should have been clarified on admission. -The MAs should not continue to document see notes. -The MA should have called the pharmacy to see why the medication was not available. -The MA should have let the RCC or HWD know that there was an order that needed to be clarified. Interview with the HWD on 05/30/24 at 1:30pm revealed: -She was not aware Resident #3 had a calcium order that needed clarification and that Resident #3 only had one calcium medication available. -She reviewed FL-2's when a resident is admitted along with the RCC.	D 344			

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D 344	Continued From page 8 -If clarification is needed, the FL-2 addendum form is used, and both are faxed to pharmacy. -When the MAs administer the medication, they should compare medications on hand to the eMAR. -If MAs don't have medication, they should reach out to the pharmacy and let her or the RCC know so that could follow up. Interview with the Administrator on 05/30/24 at 2:20pm revealed: -The HWD and RCC were supposed to complete eMAR to medication cart audits every 2 weeks. -Any concerns should be identified during the audits and corrected at that time.	D 344			
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed a resident take their medications (Resident #3). The findings are: Review of the facility's Medication and Treatment	D 366			

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D 366	Continued From page 9 -General Guidelines for Medication Administration revised October 2023 revealed residents should be observed taking the medication. Observation of Resident #3 on 05/28/24 at 9:30am during the initial facility tour revealed: -Resident #3 was in the hallway with a medication cup that contained multiple pills. -There was not a MA present observing Resident #3 take his medications. Interview with Resident #3 at 9:30am revealed: -The MA brought him his medication while he was in his room. -She gave him the cup of medications and left. -He realized he was missing one of his medications and went out into the hallway with his medication cup to look for the MA. -He saw the Activity Director (AD) in the hallway and asked her to locate the MA. -Some of the MA's left his medications in his room and did not stay while he took them. Interview with the MA on 05/28/24 at 3:10pm revealed: -Resident #3 did not self-administer his medications. -She took Resident #3's morning medications to his room to administer them and realized she forgot one of his pills and left the medication in the room to go get the medication. -She was not supposed to leave medications in residents' rooms. -She was supposed to watch the residents take their medications. Interview with the Resident Care Coordinator (RCC) on 05/30/24 at 10:50am revealed: -The process for medication administration for residents that did not self-administer their	D 366			

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D 366	Continued From page 10 medications was the MA administered the medications and watched the resident while they took the medications. -Medications were not to be left in residents' rooms. -MAs were to watch the residents take the medications to ensure compliance. -A resident could forget to take the medication if left in the resident's room. -Medications could be dropped on the floor and a dose missed if left in the resident's room. -Resident #3 did not self-administer his medications. -If the MA noticed an error in the medications, she should have brought the cup of medications with her out of the room. -All the MA's knew medications were not to be left in residents' rooms; they all received on-going training. Interview with the Health and Wellness Director on 05/30/24 at 1:30pm revealed: -Resident #3 did not self-administer his medications. -MAs were to go into the room and watch the residents take their medications. -It was important for MAs to watch residents take their medications for safety and compliance. -The MAs knew they had to stay with the residents and make sure they took their medications. -Medications could not be left in resident rooms. Interview with the Administrator on 05/30/224 at 2:20pm revealed: -She expected the MAs to administer medications and stay with the resident to make sure they took the medication.	D 366		

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D 376	Continued From page 11	D 376		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review, and interview, the facility failed to assure compliance with the physicians' orders and the facility's policies and procedures for self-administration of medications for 2 of 3 sampled residents (#1, #4) with orders to self-administer a diuretic (#1, #4) a blood pressure medication and a blood thinner (#4). The findings are: Review of the facility's policy for self-administrated medications dated August 2023 revealed: -Residents who desired to self-administer medication should be permitted to do so if the admitting physician verified it was appropriate, and the Nurse had confirmed the resident's	D 376		

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D 376	Continued From page 12 ability. -The physician would be notified if the resident could not successfully pass the self-administration medication review criteria. -An evaluation would be conducted by the Nurse of their residents cognitive physical and visual ability to carry out self-administration. -The self-administration of medication evaluation would be completed using the Self-administration of Medications Review form initially, quarterly, and with the change in resident condition. -The Nurse would print out a list of the residents' medication from the electronic medication administration record (eMAR) for the evaluation. -The resident's ability to self-administer medications would be determined by means of a skill evaluation; the resident should be able to identify the medication either by reading the label on the medication bottle or identifying the pill in a pill organizer, state the purpose of each medication, state what time the medication was to be taken, and the proper dosage and route of each medication. -If the resident successfully passed the self-medication evaluation an order would be obtained from the physician and would be reflected on the Physician Plan of Care. -If the resident was unable to successfully pass the self-medication evaluation, the resident would no longer be allowed to self-administer medication and an alternative plan would be devised. -The resident, the resident's physician and their responsible party would be made aware that the resident was no longer able to self-administer medication. -The medications would be secured for staff assistance with administration. -The facility would assume full responsibility for medication administration if the resident was	D 376			

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D 376	Continued From page 13 unable to successfully pass the self-administration of medication review evaluation. 1. Review of Resident #1's FL-2 dated 12/21/23 revealed: -Diagnoses included lymphedema, chronic atrial fibrillation, and elevated blood pressure. -There was an order for spironolactone (a diuretic used to treat high blood pressure) 25mg half a tablet (12.5mg) once daily. Review of Resident #1's physician's orders dated 03/20/24 revealed there was an order for unsupervised self-administering of his medications. Review of Resident #1's current self-administering medication evaluation dated 03/12/24 revealed: -The instructions included printing a list of medications from the resident's electronic medication administration record (eMAR) and placing a checkmark in the appropriate box for each of the listed items. -The resident had to be able to demonstrate basic competency in each step by being "able with assist" or "fully capable" in each applicable step prior to receiving initial or continued approval for self-administration of medications or staff supervised administration of medication. -There was documentation Resident #1 was fully capable with identification of the medication, stated what each medication was for, stated what time medications were to be taken, stated the proper dosage for each medication, and measured the appropriate amount of medication from the container. -There had been no change in medications since the last self-administration of medication review.	D 376		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE DURHAM		STREET ADDRESS, CITY, STATE, ZIP CODE 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 376	Continued From page 14 -The medication profile was complete in his record. -There was a physician order to self-administer medication. -Resident #1 was approved to self-administer medications. -The document was electronically signed and dated by the Health and Wellness Director (HWD) on 05/29/24. Review of Resident #1's March 2024 eMAR revealed: -There was an entry for spironolactone 25mg half tablet once daily in the morning scheduled at 9:00am; unsupervised self-administration. -The was no medication aide (MA) documentation of administration. -There was documentation of U-SA (unsupervised self-administration) of the spironolactone daily from 03/01/24 to 03/31/24. Review of Resident #1's April 2024 eMAR revealed: -There was an entry for spironolactone 25mg half tablet once daily in the morning scheduled at 9:00am; unsupervised self-administration. -The was no medication aide (MA) documentation of administration. -There was documentation of U-SA (unsupervised self-administration) of the spironolactone daily from 04/01/24 to 04/30/24. Review of Resident #1's May 2024 eMAR from 05/01/24 to 05/28/24 revealed: -There was an entry for spironolactone 25mg half tablet once daily in the morning scheduled at 9:00am; unsupervised self-administration. -The was no medication aide (MA) documentation of administration. -There was documentation of U-SA	D 376		

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D 376	Continued From page 15 (unsupervised self-administration) of the spironolactone daily from 05/01/24 to 05/28/24. Observation of Resident #1's medication on hand on 05/28/24 at 4:14pm revealed: -Resident #1 stored his medication in a drawer in his kitchenette in his room. -His medications were in bottles. -There was no spironolactone available for administration. Observation of Resident #1's room on 05/29/24 at 12:25pm revealed: -Resident #1 and a MA were in his room. -His medication drawer was open, and the MA was looking at the bottles of medications in the drawer. -Some of the bottles were empty. -Resident #1 told the MA he could not find the empty bottle of spironolactone. -He told the MA he stopped taking the spironolactone anyway because it did not work. -He told the MA it was for his incontinence. Telephone interview with a representative from Resident #1's mail order pharmacy on 05/30/24 at 10:15am revealed 45 tablets of spironolactone were dispensed for Resident #1 on 07/10/24; there were no other dispense dates. Telephone interview with a Registered Nurse (RN) from Resident #1's primary care provider (PCP) on 05/30/24 at 9:40am revealed: -She did not see an order for Resident #1 to self-administer medications but that did not mean the PCP had not signed something while at the facility. -She did not know how the PCP evaluated a resident for self-administration of medications. -Spironolactone was a diuretic but she could not	D 376			

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STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE DURHAM

**4434 BEN FRANKLIN BOULEVARD
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D 376	Continued From page 16 say why it was ordered for Resident #1 because the cardiologist had ordered the spironolactone. Telephone interview with a RN from Resident #1's cardiologist office on 05/29/24 at 3:55pm revealed: -Resident #1 was ordered a half a tablet of spironolactone 25mg once daily on 07/10/23. -He was supposed to take the medication for a year. -The cardiologist office sent the order to the pharmacy on 07/10/23; the pharmacy dispensed 45 tablets on the same date. -Once the office sent the initial order for the medication to the pharmacy, they did not do anything else. -The order should have been refilled three more times. -Resident #1 was due for his annual appointment in July 2024. -Spironolactone was a potassium sparing diuretic, it kept some potassium in the blood so it would not go too low. -If Resident #1 was not administered the spironolactone as ordered he could experience increased blood pressure, arrhythmia, and/or shortness of breath. -Resident #1 had diagnoses of irregular heartbeat, essential hypertension, pulmonary hypertension, and atrial fibrillation. -She expected the cardiologist's order to be followed and for the facility to notify the cardiologist if Resident #1 stopped taking his spironolactone. -The cardiologist was not involved with evaluation for the ability to self-administer medications. Interview with Resident #1 on 05/28/24 at 4:10pm revealed: -He did not have any spironolactone tablets in his	D 376		

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D 376	Continued From page 17 room, and he did not take it anymore. -The spironolactone was ordered for his incontinence and it was supposed to remove water from his system. -He stopped taking the spironolactone because it did not work; he was still incontinent. -He reordered his own medications by notifying his primary care provider (PCP) when he needed a medication refill; the PCP would then notify the pharmacy he needed a refill. -He did not reorder the spironolactone tablets because they did not work; he stopped taking the spironolactone when the tablets ran out. -He thought he took it for thirty days; he did not remember when he stopped taking the medication. -The staff did not come to check on his medications and they did not ask him if he took his medications. Interview with a MA on 05/29/24 at 12:25pm revealed: -The HWD told her to look for Resident #1's spironolactone in his room today, on 05/29/24. -He did not have any spironolactone and he kept all his empty bottles, but he did not have an empty bottle of spironolactone. -Resident #1 told her he could not find the empty spironolactone bottle. -He did not take it anymore. -She had not checked on Resident #1's medications before; she knew he had a lot of vitamins. -She had not asked about his spironolactone before today, on 05/29/24. -He had all his medications according to the eMAR. -She did not document his medications on the eMAR because he self-administered all his medications.	D 376		

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D 376	Continued From page 18 -He could take his medications okay by himself because he was alert and he knew his medications; he just could not find one today. Interview with another MA on 05/30/24 at 12:45pm revealed: -Resident #1 had not complained about not having medications to take. -He did not complain of shortness of breath. Interview with the HWD on 05/29/24 at 3:40pm revealed: -She told an MA to go into Resident #1's room earlier today, on 05/29/24, to look for his spironolactone. -She sent the MA to look for the spironolactone after being asked for the spironolactone discontinue orders and she could not find the order. -The MA could not find Resident #1's spironolactone. -Resident #1 told the MA he could not find the spironolactone bottle, so he had stopped self-administering it. -She did not find a discontinue order for Resident #1's spironolactone so he should still be taking it. -He did not share with anyone that he stopped taking the spironolactone. -She contacted Resident #1's cardiologist today, 05/29/24 and was told he still needed to take the spironolactone, so she requested a new order. Refer to the interview with a MA on 05/30/24 at 12:45pm. Refer to the interview with a second MA on 05/30/24 at 1:08pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/30/24 at 10:55am.	D 376		

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BROOKDALE DURHAM

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D 376	Continued From page 19 Refer to the interview with the Health and Wellness Coordinator (HWC) on 05/30/24 at 3:00pm. Refer to the second interview with the HWD on 05/30/24 at 1:35pm. Refer to the interview with the Administration on 05/30/24 at 2:20pm. 2. Review of Resident #4's FL-2 dated 11/14/23 revealed diagnoses included chronic heart failure, atrial fibrillation, cardiac pacemaker and thrombocytosis (a condition in which the blood has too many platelets). Review of Resident #4's physician's orders dated 05/28/24 revealed an order for unsupervised self-administer of his medications. Review of Resident #4's current self-administering medication evaluation dated 03/12/24 revealed: -The instructions included printing a list of medications from the resident's electronic medication administration record (eMAR) and placing a checkmark in the appropriate box for each of the listed items. -The resident had to be able to demonstrate basic competency in each step by being "able to assist" or "fully capable" in each applicable step prior to receiving initial or continued approval for self-administration of medications or staff supervised administration of medication. -There was documentation Resident #1 was fully capable with identification of the medication, stated what each medication was for, stated what time medications were to be taken, stated the proper dosage for each medication, and	D 376		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2024
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D 376	Continued From page 20 measured the appropriate amount of medication from the container. -There had been no change in medications since the last self-administration of medication review. -The medication profile was complete in his record. -There was a physician order to self-administer medication. -Resident #4 was approved to self-administer medications. -The document was electronically signed and dated by the Health and Wellness Director (HWD) on 05/29/24. a. Review of Resident #4's FL-2 dated 11/14/23 revealed an order for anagrelide (a blood thinner used to treat thrombocytosis) 0.5mg one tablet three times daily. Review of Resident #4's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for anagrelide 0.5mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm; unsupervised self-administration (U-SA). -The was no medication aide (MA) documentation of administration. -There was documentation of U-SA of the anagrelide daily from 03/01/24 to 03/31/24. Review of Resident #4's April 2024 eMAR revealed: -There was an entry for anagrelide 0.5mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm; U-SA. -The was no MA documentation of administration. -There was documentation of U-SA of the anagrelide daily from 04/01/24 to 04/30/24. Review of Resident #4's May 2024 eMAR from	D 376		

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D 376	Continued From page 21 05/01/24 to 05/28/24 revealed: -There was an entry for anagrelide 0.5mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm; U-SA. -The was no MA documentation of administration. -There was documentation of U-SA of the anagrelide daily from 05/01/24 to 05/28/24. Observation of Resident #4's medications on hand on 05/29/24 at 2:25pm revealed: -His medications were stored in the medicine cabinet in his bathroom. -His medications were dispensed in bottles. -Two hundred and seventy tablets of anagrelide 0.5mg one tablet three times daily dispensed on 2/27/24. -There were 80 tablets available for administration. Interview with Resident #4 on 05/29/24 at 2:20pm revealed: -He received his anagrelide from a mail order pharmacy; his other medications came from a local pharmacy. -He called the pharmacy when he needed a refill of a medication, or he called his PCP when he needed a refill and the PCP would contact the pharmacy. -He took anagrelide because he made too many platelets. -He was supposed to take the anagrelide three times a day but sometimes he would forget to take it until bedtime so he would take all three tablets [doses] at one time. -He had never asked his physician if he could take all three tablets [doses] at one time. -The instructions on the bottle did not say he could not take all three anagrelide tablets at one time. -He took all three anagrelide tablets [doses] at	D 376			

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D 376	Continued From page 22 one time the "other night". -He forgot "here and there" or "every so often" to take the anagrelide and he would take all three anagrelide doses at one time when he had an "off or unusual days". -He did not let staff know when he took three doses of anagrelide at one time. -He never told his physician he took three doses of anagrelide at one time. -He did not feel any different after he took all three doses of his anagrelide at one time. -A long time ago the "program director" [HWD] looked at his medication and told him to keep it in bottles and not place into a medication divider. -The "program director" [HWD] came to is room yesterday, on 05/28/24, and checked his medications; she reminded him to keep his door locked. Telephone interview with a representative from Resident #4's mail order pharmacy on 05/30/24 at 9:20am revealed: -Resident #4 had a current order for anagrelide 0.5mg three times daily. -Two hundred and seventy tablets were dispensed on 09/11/23 and two hundred and seventy tablets were dispensed on 12/08/23. Telephone interview with a representative from Resident #4's preferred pharmacy on 05/30/24 at 9:35am revealed Resident #4 did not have an order for anagrelide 0.5mg three times daily. Telephone interview with the pharmacist from the facility's contracted pharmacy on 05/30/24 at 9:50am revealed: -Anagrelide was ordered for a resident when they had too many platelets in the blood cells. -Missed doses of anagrelide should not be combined and taken at one time because the	D 376		

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D 376	Continued From page 23 medication would not be consistent in the blood. -Anagrelide was typically ordered for three to four times daily to keep a constant amount of the medication in the blood. Telephone interview with the Registered Nurse (RN) from Resident #4's primary care provider's (PCP) office on 05/30/24 at 11:30am revealed: -Resident #4 was ordered anagrelide by Resident #4's oncologist office so the PCP did not follow the order; but she could see his laboratory work was done every two weeks and his counts were within range. -If he was missing a dose of a medication the physician should have been notified and asked before taking the missed dose with the next scheduled dose to be sure there would not be any outcomes. Interview with a MA on 05/30/24 at 12:45pm revealed: -Resident #4 had never told her he forgot to take his anagrelide and missed a dose. -He never told her he took all three doses at one time. -If she was made aware, he missed any doses of medication she would have documented it, called his PCP and the HWD. Interview with a second MA on 05/30/24 at 1:08pm revealed Resident #4 had never told her he missed a dose of medication or that he "doubled" up on his medications; she would have reported it to the HWD if he had told her. Interview with the Resident Care Coordinator (RCC) on 05/30/24 at 10:55am revealed: -Staff had not reported to her that Resident #4 was confused or was forgetting to take his medications.	D 376		

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D 376	Continued From page 24 -She was not aware Resident #4 needed to be reassessed for the ability to self-administer his medications; she had not been included in any discussion about a reevaluation. Interview with the HWD on 05/30/24 at 1:35pm revealed: -Resident #4 had been in and out of the hospital recently and she had noticed a physical decline in him. -There had been discussion with the Administrator and the HWC before last week about the facility staff administering his medication. -She had attempted to reach Resident #4's Power of Attorney (POA) last week to discuss his recent decline and their concerns but was only able to leave a message. -She sent a request to Resident #4's PCP yesterday, on 05/29/24, asking for an order for the facility to administer his medication and discontinue the self-administer order. -She realized yesterday that the request had not been sent to the PCP. -She had not completed a new self-administration evaluation for Resident #4. -She did not realize he was missing doses of his anagrelide and taking three tablets at a time; he never told any staff. Attempted telephone interview with Resident #4's oncologist on 05/30/24 at 1:30pm was unsuccessful. b. Review of Resident #4's hospital discharge summary dated 05/21/24 revealed an order for metoprolol (used to treat high blood pressure) 25mg once daily. Review of Resident #4's May 2024 eMAR from	D 376		

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D 376	Continued From page 25 05/01/24 to 05/28/24 revealed: -There was an entry for metoprolol 25mg once daily scheduled at 9:00am; U-SA . -The was no MA documentation of administration . -There was documentation of U-SA of the metoprolol daily from 05/22/24 to 05/28/24. Observation of Resident #4's medications on hand on 05/29/24 at 2:25pm revealed: -Resident #4's medication were stored in a medicine cabinet in his bathroom. -There was no metoprolol 25mg available for administration. Observation of Resident #4's blood pressure taken by a MA on 05/30/24 at 10:45am revealed it was 114/62. Telephone interview with a representative from Resident #4's mail order pharmacy on 05/30/24 at 9:20am revealed they did not have an order for metoprolol 25mg once daily for Resident #4. Telephone interview with a representative from Resident #4's preferred pharmacy on 05/30/24 at 9:35am revealed Resident #4 did not have an order for metoprolol 25mg once daily. Telephone interview with the pharmacist from the facility's contracted pharmacy on 05/30/24 at 9:50am revealed: -The facility was responsible for entering the medication orders on the eMAR. -Metoprolol was usually ordered for high blood pressure or heartbeat. -Outcomes from not administering metoprolol as ordered could include increased blood pressure and/or a racing heartbeat. Telephone interviews with the RN from Resident	D 376		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 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 376	Continued From page 26 #4's PCP office on 05/30/24 at 11:30am revealed: -Resident #4 had not been seen by the PCP since his hospital discharge on 05/21/24. -Resident #4 was admitted to the hospital on 05/16/24 for uncontrollable nose bleeds. -He was administered the metoprolol while in the hospital and an order to continue the metoprolol 25mg once daily was written in the discharge summary. -Metoprolol was to control blood pressure and Resident #4 was at increased risk of heart failure if he was not administered the metoprolol as ordered. -The PCP expected the medication orders from the hospital to be followed as written for Resident #4. -She did not know if Resident #4 was able to administer his own medications; she did not know about an order for self-administering medications. -The facility had requested a medication list on 05/29/24; there was no other contact from the facility documented. Interview with Resident #4 on 05/29/24 at 2:20pm revealed: -He had a recent stay at the hospital. -He did not have any new medication orders after he was discharged from the hospital. -The hospital [staff] did not tell him to take new medication. -He took care of his own medications; he ordered them from the pharmacy and went to pick them up with his family. -He called the pharmacy when he needed a refill on a medication, or he called his PCP when he needed a refill and the PCP would contact the pharmacy. -He was brought back to the facility by ambulance; he did not give anyone at the facility any paperwork from the hospital.	D 376			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2024
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D 376	Continued From page 27 -He did not take metoprolol; he did not know what it was. -He did not have any blood pressure issues. -A long time ago the "program director" [HWD] looked at his medication and told him to keep it in bottles and not place into a medication divider. -The "program director" [HWD] came to his room yesterday, 05/28/24, and checked his medications; she reminded him to keep his door locked. Interview with a MA on 05/30/24 at 1:08pm revealed: -New medication orders for residents with self-administration orders were entered in the eMAR by the MAs. -The staff did not order Resident #4's medications he ordered his medications from his own pharmacy. -If Resident #4 had told her he was out of a medication she would have ordered it for him. Interview with the RCC on 05/30/24 at 10:55am revealed: -She did not know Resident #4 did not have his metoprolol available for self-administration. -If the metoprolol was on the eMAR on the start date then the facility had the new orders. -The MA who entered the medication order on the eMAR should have followed through with the order to make sure the medication was in the facility. Interview with the HWD on 05/30/24 at 1:35pm revealed: -Resident #4 had been in and out of the hospital recently and she had noticed a physical decline in him. -There had been discussion with the Administrator and the HWC before last week	D 376		

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D 376	Continued From page 28 about the facility staff administering his medication. -She had attempted to reach Resident #4's POA last week to discuss his recent decline and their concerns but was only able to leave a message. -She sent a request to Resident #4's PCP yesterday, on 05/29/24, asking for an order for the facility to administer his medication and discontinue the self-administer order. -She realized yesterday that the request had not been sent to the PCP. -She had not completed an new self-administration evaluation for Resident #4. -She was not aware Resident #4 had new medication orders on his hospital discharge paperwork, so she did not know he was not taking them. -His medications should have been in the facility 24 hours after he got the new order. -He never reported not having his medication to the staff. c. Review of Resident #4's hospital discharge summary dated 05/21/24 revealed an order for spironolactone (a diuretic used to treat high blood pressure) 25mg half a tablet (12.5mg) once daily. Review of Resident #4's May 2024 eMAR from 05/01/24 to 05/28/24 revealed: -There was an entry for spironolactone 25mg half tablet once daily scheduled at 8:00am; U-SA. -The was no MA documentation of administration. -There was documentation of U-SA of the spironolactone daily from 05/22/24 to 04/28/24. Observation of Resident #4's medications on hand on 05/29/24 at 2:25pm revealed: -Resident #4's medication were stored in a medicine cabinet in his bath room. -There was no spironolactone 25mg available for	D 376			

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D 376	Continued From page 29 administration. Telephone interview with a representative from Resident #4's mail order pharmacy on 05/30/24 at 9:20am revealed they did not have an order for spironolactone 25mg half tablet once daily for Resident #4. Telephone interview with a representative from Resident #4's preferred pharmacy on 05/30/24 at 9:35am revealed Resident #4 did not have an order for spironolactone 25mg half a tablet once daily. Telephone interview with the pharmacist from the facility's contracted pharmacy on 05/30/24 at 9:50am revealed: -The facility was responsible for entering the medication orders on the eMAR. -Spironolactone was a diuretic. -Outcomes from not administering spironolactone as ordered included swelling and/or congestive heart failure. Telephone interviews with the RN from Resident #4's PCP office on 05/30/24 at 11:30am revealed: -Resident #4 had not been seen by the PCP since his hospital discharge on 05/21/24. -Resident #4 was admitted to the hospital on 05/16/24 for uncontrollable nose bleeds. -He was administered the spironolactone while in the hospital and an order to continue the spironolactone once daily was written in the discharge summary. -Spironolactone was a diuretic and used to treat high blood pressure; if not administered as ordered he was at risk for increased fluid retention and increased risk of heart failure. -The PCP expected the medication orders from the hospital to be followed as written for Resident	D 376		

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D 376	Continued From page 30 #4. -She did not know if Resident #4 was able to administer his own medications; she did not know about an order for self-administering medications. -The facility had requested a medication list on 05/29/24; there was no other contact from the facility documented. Interview with Resident #4 on 05/29/24 at 2:20pm revealed: -He had recently been discharged from the hospital after staying for about five days. -He was not taking any new medications; the hospital did not tell him to take any new medications. -He did not know what spironolactone was and he did not take anything like that. -He was brought back to the facility by ambulance; he did not give anyone at the facility any paperwork from the hospital. -A long time ago the "program director" [HWD] looked at his medication and told him to keep it in bottles and not place into a medication divider. -The "program director" [HWD] came to his room yesterday, 05/28/24, and checked his medications; she reminded him to keep his door locked. Interview with a MA on 05/30/24 at 1:08pm revealed: -New medication orders for residents with self-administering orders were entered in the eMAR by the MAs. -The staff did not order Resident #4's medications he ordered his medications from his own pharmacy. -If Resident #4 had told her he was out of a medication she would have ordered it for him. Interview with the Resident Care Coordinator	D 376			

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D 376	Continued From page 31 (RCC) on 05/30/24 at 10:55am revealed: -She did not know Resident #4 did not have his spironolactone available for self-administration. -If the spironolactone was on the eMAR on the start date then the facility had the new orders. -The MA who entered the medication order on the eMAR should have followed through with the order to make sure the medication was in the facility. Interview with the HWD on 05/30/24 at 1:35pm revealed: -Resident #4 had been in and out of the hospital recently and she had noticed a physical decline in him. -There had been discussion with the Administrator and the HWC before last week about the facility staff administering his medication. -She had attempted to reach Resident #4's POA last week to discuss his recent decline and their concerns but was only able to leave a message. -She sent a request to Resident #4's PCP yesterday, 05/29/24, asking for an order for the facility to administer his medication and discontinue the self-administer order. -She realized yesterday that the request had not been sent to the PCP. -She had not completed a new self-administration evaluation for Resident #4. -She was not aware Resident #4 had new medication orders on his hospital discharge paperwork, so she did not know he was not taking them. Refer to the interview with a MA on 05/30/24 at 12:45pm. Refer to the interview with a second MA on 05/30/24 at 1:08pm.	D 376		

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D 376	Continued From page 32 Refer to the interview with the RCC on 05/30/24 at 10:55am. Refer to the interview with the Health and Wellness Coordinator (HWC) on 05/30/24 at 3:00pm. Refer to the second interview with the HWD on 05/30/24 at 1:35pm. Refer to the interview with the Administration on 05/30/24 at 2:20pm. Interview with a MA on 05/30/24 at 12:45pm revealed: -She did nothing with new medication orders for the residents who had orders to self-administer their medications; the Health and Wellness Coordinator (HWC) entered them in the eMAR. -The MAs did not enter anything in the eMAR for the administration of medications for the residents with orders to self-administer their medications. -The MAs did not look at the residents who were self-administering medications and they did not count them. -She did not ask the residents with self-administration orders if they took their medications or if they needed their medications refilled. -The HWC and the Health and Wellness Director (HWD) set up orders in the eMAR and checked on the residents with self-administration orders. Interview with a second MA on 05/30/24 at 1:08pm revealed: -She did nothing for the residents with self-administration orders for medications. -She did not look at medications the family	D 376			

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D 376	Continued From page 33 members brought in for the residents with self-administering orders. -She was not required to see if the residents had their medications if they had self-administering orders. -She did not ask the residents with self-administering orders if they took their medicine. -She was not required to document on the eMAR for residents with orders to self-administer medications. Interview with the RCC on 05/30/24 at 10:55am revealed: -She periodically checked on the residents who had orders to self-administer medications. -She checked to see if their doors were locked and if they were "good"; she asked them how it was going or if they had any questions. -If she noticed any increased confusion in a resident, she would report it to the HWD and the PCP. -Once a week, she checked the medication for the residents who had orders for self-administration and whose medication came from the facility's contracted pharmacy when the medication was delivered. -She did not look at the medication for the residents who had orders for self-administration with medicines ordered from other pharmacies. -When a resident had new orders or a change in orders, she or the HWD checked the orders and then gave them to the MAs. -The facility used a medication order tracking form to ensure new orders for medication were entered in the eMAR and ordered from the pharmacy. -The MAs were responsible for entering the new medication orders in the eMAR. -The MA who entered the order into the eMAR	D 376			

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D 376	Continued From page 34 was also responsible for making sure the medication was in the facility; even for the residents who self-administered their medications. -If the medication was not in the facility then the MA was responsible for contacting the family or the pharmacy to try to get the medication ordered for the resident. -When a family was responsible for bringing medication into the facility for the resident and the medication was not available for self-administration, she would contact the family and the PCP to attempt to bring the medication. -There was currently no system to track medication refills for the medications the family brought in for the residents who had orders to self-administer. -The family was required to bring in a new order with in 24 hours of receiving a new order. -So far, she had not experienced a missed order for any residents. -Hospital discharge orders were considered new orders if there were new medications ordered. Interview with the HWC on 05/30/24 at 3:00pm revealed: -The residents were evaluated by the HWD for self-administration of medication. -The MAs checked in on the residents with self-administration orders daily to see if they took their medications. -She did not have any reports from the MA's about residents not taking medications or forgetting to take them. -If a resident reported to an MA that they forgot to take a medication she would reeducate the resident after notifying the PCP. -The MAs did not check medications available or check to see if residents had medication when they had orders to self-administer.	D 376			

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D 376	Continued From page 35 -When a resident had a self-administration order, the residents were in control of when the medication was supposed to be taken, what the medication was for and that the medication was ordered. -The families or residents were responsible for giving her, the HWD, or the RCC the paperwork for the order. -The MAs put the new order in the eMAR and made a copy of the paperwork so it could go in the resident's record. -Sometimes the resident would notify her or a MA that they were almost out of their medication and the facility could call the pharmacy and see when it was due to come in. -The facility was not responsible for following up on medication orders for residents who were self-administering medications. Interview with the HWD on 05/29/24 at 3:40pm revealed: -Some residents were admitted with an order for self-administration. -She evaluated residents with self-administration orders every quarter or when there was a change in condition. -She would sit down face to face with the residents individually in their room with their medication list and the medication in front of the resident. -The resident had to know what the medication was used for, why they took the medication, the dosage and the frequency. -If the resident could not answer the questions, she did a brief interview for mental status (BIMS). -The facility's self-administration evaluations "trumped" the PCP's order for self-administration; if the facility did not believe the resident could safely self-administer their medication then the facility staff would begin to administer the	D 376			

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D 376	Continued From page 36 medications. -She asked the residents to provide all the medications they were taking, and she would compare them to the eMAR to make sure there were orders for all the medications and that orders and medications were correct. -A change in condition could be if the resident could no longer answer the questions concerning their medications was successful with the BIMS. -The MAs were supposed to go into the residents' rooms at least once daily and ask the resident if they had taken their medications. -The MAs did not enter anything about administering medications on the eMAR for the residents with self-administering orders. Second interview with the HWD on 05/30/24 at 1:35pm revealed: -The facility was not supposed to do anything for the residents who had orders to self-administer their medications. -The residents were evaluated quarterly for self-administration and there was nothing that could be done outside of the quarterly evaluations. -The residents or the families were supposed to give the facility staff any new orders, after visit summaries or hospital discharge paperwork. -The facility had been using a new process for new order tracking for about 3 weeks. -The new order tracking process included all residents' orders. -The MAs were responsible for entering new orders for medication into the eMAR and faxing the medication order to the pharmacy. -The physician usually faxed medication orders to the pharmacy as well. -The MAs were responsible for checking medications for the residents with self-administration orders to see if new	D 376			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE DURHAM

**4434 BEN FRANKLIN BOULEVARD
DURHAM, NC 27704**

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D 376	Continued From page 37 medications were in the facility. -When a medication was identified as not being in the facility the MAs were supposed to notify her or the RCC. -She would instruct the MA to notify the pharmacy, the family and the PCP. -The facility staff did not go into the residents' rooms between quarters and ask about medications or check on medications and their levels. -If a resident had an order for self-administering medications the resident or their family were responsible for ordering the medication and making sure it was in the facility. Interview with the Administration on 05/30/24 at 2:20pm revealed: -There was no oversight for the residents with self-administration of medication orders other than ensuring the medications were stored under lock and key. -The resident was responsible for medication ordering and dosing. -If there was a problem the resident was responsible for reporting it to the HWD, RCC or the MA. -Residents were assessed quarterly for self-administration of medications; there was no follow-up until the next evaluation and any discrepancies would be caught at the next quarterly evaluation. -The resident and the families were responsible for giving the facility new orders. -The resident and the families should ensure the medications were in the facility for the residents with self-administration orders. -She could not account for the family not bringing in medication for the residents. -The RCC and the HWC were responsible for doing weekly medication cart audits including the	D 376		

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D 376	Continued From page 38 medications for the residents who had orders for self-administration. -There was nothing she could do for medication issues the residents with self-administration orders until the facility was administering their medications. The facility failed to ensure two residents who, self-administered medications, were following the physicians orders including one resident, who had lymphedema and hypertension and was not taking a diuretic ordered to reduce fluid and decrease blood pressure because he thought it was for incontinence (#1), and another resident, who had hypertension, and chronic heart failure and did not know he had an order for a diuretic or a blood pressure medication and did not have the medication to take and the resident also had a medication used to reduce the number of platelets in the blood, in which he would forget to take (#4). This failure was detrimental to the health, safety and welfare of the residents which constitutes a type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2024.	D 376			

The following is a summary of the Plan of Correction for Brookdale Durham. This Plan of Correction is in regards to the Corrective Action Report dated 6/20/24. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F .0904(d)(3) Nutrition and Food Service

The Dining Services Manager or designee will monitor each meal service for four weeks, verifying that milk is served as outlined in the menu. To assist with ongoing compliance, the Dining Services Manager or designee will conduct a retraining with associates who assist with meal services.

10A NCAC 13F .1002(a) Medication Orders

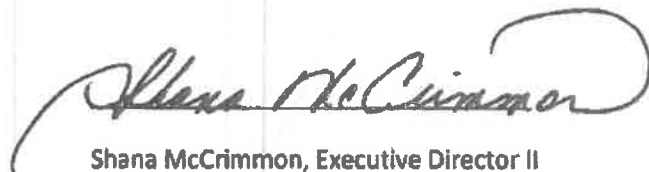
The Health & Wellness Director or designee will audit current resident's medication administration records to verify that physician's orders requiring clarification are updated with the resident's primary care provider on file. To assist with ongoing compliance, the Health & Wellness Director or designee will conduct a retraining with medication technicians and community clinical leadership regarding medication order clarification procedures.

10 NCAC 13F .1004i Medication Administration

The Health & Wellness Director or designee will conduct medication administration audits for four weeks. To assist with ongoing compliance, the Health & Wellness Director or designee will conduct a medication administration retraining for community med techs.

10A NCAC 13F .1005 Self Administration of Medications

The Health & Wellness Director or designee will continue to conduct self-administration audits for approved self-administration residents quarterly.



Shana McCrimmon, Executive Director II