STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032065	A. BUILDING: _____ B. WING _____	R 09/04/2024

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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 09/04/24.	D 000		
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 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 record reviews, observations, and interviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (Resident #2) related to an order for a medication used to treat an underactive thyroid. The findings are: Review of the facility's Medication Administration Policy dated July 2024 revealed: --Follow the seven rights of medication administration, right medication, right dose, right time, right route, right resident, right documentation, and right to refuse. -Follow the pharmacy medication label and manufacturer directions for each medication prescribed.	D 344		

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-Medication directions on the physicians' order and the pharmacy label should correlate with the medication directions on the medication administration record (MAR).

Review of Resident #2's current FL2 dated 05/23/24 revealed:
-Diagnoses included Alzheimer's dementia, hypothyroidism, dysphagia, hypertension, stage 3 chronic kidney disease, and diabetes mellitus type 2.
-There was an order for Levothyroxine (used to treat an underactive thyroid) 112 micrograms (mcg) once daily.

Review of Resident #2's physician's orders dated 08/21/24 revealed an order for Levothyroxine 112 mcg once daily.

Review of Resident #2's July 2024 electronic MAR (eMAR) revealed:
-There was an entry for Levothyroxine 112 mcg once daily with a scheduled administration time of 6:00am.
-There was documentation Levothyroxine 112mcg was administered daily on 07/01/24-07/03/24, 07/05/24-07/28/24, and 07/31/24.
-Exceptions were documented as medication unavailable on 07/04/24, 07/29/24, and 07/30/24.

Review of Resident #2's August 2024 eMAR revealed:
-There was an entry for Levothyroxine 112 mcg once daily with a scheduled administration time of 6:00am.
-There was documentation Levothyroxine 112mcg was administered daily on 08/01/24-08/25/24 and 08/30/24-08/31/24.
-There were exceptions documented as

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medication unavailable on 08/26/24-08/29/24.

Review of Resident #2's September 2024 eMAR from 09/01/24-09/04/24 revealed:
-There was an entry for Levothyroxine 112 mcg once daily with a scheduled administration time of 6:00am.
-There was documentation Levothyroxine 112mcg was administered at 6:00am daily on 09/01/24-09/04/24.

Observation of Resident #2's medications on hand on 09/04/24 at 1:50pm revealed:
-There was a punch card labeled for Levothyroxine 112mcg with a start date of 08/30/24.
-The directions on the label were to administer one tablet daily on Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday.
-Twenty-four tablets were dispensed, and 18 tablets remained on the punch card.

Telephone interview with a representative from the facility's contracted pharmacy on 09/04/24 at 2:21pm and 3:56pm revealed:
-Resident #2's current order for Levothyroxine was to administer 112mcg on Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday.
-The current order was received on 05/03/23.
-The signed physician's orders dated 08/21/24 were received but the order for daily must have been overlooked.
-In the system, she could see the facility input an order change on 06/14/23 with the new directions to administer the medication daily.
-The pharmacy was not alerted when the facility made changes in the eMAR system.
-She reviewed all the documents received from the facility related to Resident #2 from 05/03/23-current and the order change input by

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the facility staff on 06/14/23 was not received at the pharmacy until the signed physician's orders were received dated 08/21/24.
-When Resident #2's Levothyroxine 112mcg was received at the facility, the facility should have clarified the order when the pharmacy label did not match the eMAR.
-The facility staff had multiple opportunities to clarify the order as the medication was not lasting the entire batch and the staff were requesting additional tablets of the Levothyroxine before the next batch was delivered.
-The facility staff had faxed a request for additional tablets of Levothyroxine on 07/30/24 and 05/06/24.
-The pharmacy staff responded to the facility via fax, the date the next batch was to be delivered, and requested how many tablets were needed until the next batch was delivered.
-There was no response from the facility for the request dated 05/06/24.
-The facility staff responded to the request dated 07/30/24, that three tablets of Levothyroxine were needed.
-On 07/30/24, three additional tablets of Levothyroxine were dispensed to the facility.
-There was no documentation of the order being clarified.
-Twenty-four tablets of Levothyroxine were dispensed for Resident #2 on 05/31/24, 06/28/24, 07/29/24, and 08/26/24; the batch start dates would be a few days after the dispensed date.

Telephone interview with a medication aide (MA) on 09/04/24 at 4:33pm revealed:
-She administered Resident #2's Levothyroxine at 6:00am daily.
-She administered Resident #2's medication by pulling the medication card, comparing the label to the eMAR, and then administered the

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medication.
-She did not recall if the label on Resident #2's Levothyroxine matched the eMAR.
-If the label did not match the eMAR, she would fax the pharmacy to let the pharmacy staff know the label did not match the eMAR.
-She recalled faxing the pharmacy because there were not enough tablets available for the medication to be administered until the next batch was delivered.
-She remembered this because they did not have to request medications be refilled early very often with batched medication.
-She recalled Resident #2's Levothyroxine did not have 28 tablets on the medication card and the resident always finished this medication before the next batch was delivered.
-She did not notice Resident #2's Levothyroxine medication card did not have directions to administer the medication daily compared to the eMAR.

Interview with the Health and Wellness Director (HWD) on 09/04/24 at 5:08pm revealed:
-The MAs were responsible for matching the medication cards to the eMAR when medications were administered.
-If the label on a medication card did not match the order in the resident's eMAR, the MA should reach out to the primary care provider (PCP) to get clarification on the order.
-The MA was supposed to notify her or someone in management when a medication was not on the medication cart.
-When she was notified a medication was not on the medication cart, she investigated why the medication had run out before the next batch.
-She was not aware Resident #2's Levothyroxine label did not match the eMAR and the resident had been running out of medication before the

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D 344	Continued From page 5 next batch was filled. -If the MA had read Resident #2's Levothyroxine card completely, the MA would have noted the label did not match and would need to be clarified. Interview with the Administrator on 09/04/24 at 5:20pm revealed: -Batched medication was delivered to the facility every 28 days. -The MA should cross-reference the medication label with the eMAR to ensure the label and eMAR matched. -If the medication label and the eMAR did not match, the MA should make sure there were no other medication cards for the same medication, and if there were no other medication cards, the MA should ask the pharmacy for clarification and let a manager know. Based on observation, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's PCP on 09/04/24 at 4:24pm was unsuccessful.	D 344		