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| BROOKDALE DURHAM | 4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704 |

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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey from 12/16/25 through 12/17/25. | {D 000} | | |
| {D 358} | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE B VIOLATION.<br><br>The Type B Violation was abated.<br>Non-compliance continues.<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) including errors in administering sliding scale insulin (SSI).<br><br>The findings are:<br><br>Review of Resident #5's current FL2 dated 10/30/25 revealed:<br>-Diagnoses included paraplegia, type 2 diabetes mellitus, arthrodesis status, and other specified diseases of the spinal cord.<br>-There was an order for Lispro (short acting insulin)100units/ml check fingerstick (FSBS) three times a day and inject per SSI parameters: FSBS 0-200= 0 units, 201-250= 1 units, 251-300= | {D 358} | | |

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| {D 358} | Continued From page 1<br>2 units, 301-350= 3 units, 351-400= 4 units, and 401-500= 5 units.<br><br>Review of Resident #5's signed physician's orders dated 12/04/25 revealed an order for Lispro for sliding scale of 1 unit per 50mg/dl above 200.<br><br>Review of Resident #5's December 2025 electronic medication administration record (eMAR) from 12/01/25 through 12/15/25 revealed:<br>-There was an entry from 12/01/25 to 12/05/25 for Lispro check FSBS three times a day before each meal and inject per SSI parameters: FSBS 0-200= 0 units, 201-250= 1 units, 251-300= 2 units, 301-350= 3 units, 351-400= 4 units, and 401-500= 5 units scheduled for 8:00am, 11:00am, and 5:00pm.<br>-There was another entry from 12/05/25 to 12/15/25 for Lispro check FSBS three times a day before each meal and inject per SSI parameters: FSBS 50-200= 1 units, 201-250= 1 units, 251-300= 2 units, 301-350= 3 units, 351-400= 4 units, and 401-500= 5 units scheduled for 8:00am, 11:00am, and 5:00pm.<br>-FSBS ranged from 89 to 257.<br>-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Lispro administered.<br>-Examples of Resident #5's FSBS values documented on the December 2025 eMAR but documentation for the different amount of Lispro administered were as follows:<br>-On 12/05/25 at 5:00pm, FSBS was 135 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR. | {D 358} | | |

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| {D 358} | Continued From page 2<br>-On 12/06/25 at 8:00am, FSBS was 178 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/07/25 at 11:00am, FSBS was 106 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/08/25 at 8:00am, FSBS was 141 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/08/25 at 5:00pm, FSBS was 144 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/09/25 at 5:00pm, FSBS was 168 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/10/25 at 8:00am, FSBS was 172 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/13/25 at 5:00pm, FSBS was 189 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-On 12/15/25 at 5:00pm, FSBS was 179 and 0 units of Lispro should have been administered but 1 unit of Lispro was documented as administered on the eMAR.<br>-There was no additional notes for the amount of Lispro administered for 12/05/25, 12/06/25, 12/07/25, 12/08/25, 12/09/25, 12/10/25, 12/13/25, and 12/15/25.<br><br>Observation of medications on hand for Resident #5 on 12/17/25 at 11:10am revealed Lispro insulin was available for administration with label and | {D 358} | | |

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| {D 358} | Continued From page 3<br>inject per SSI parameters: FSBS 50-200= 1 units, 201-250= 1 units, 251-300= 2 units, 301-350= 3 units, 351-400= 4 units, and 401-500= 5 units dispensed 09/01/25.<br><br>Interview with Resident #5 on 12/17/25 at 10:10am revealed:<br>-The medication aides (MA) completed her FSBS every day and sometimes her insulin changed.<br>-She was not sure how much insulin she received but she usually received insulin every day.<br>-She denied any current issues with low blood sugar levels or having experienced symptoms related to headaches or dizziness.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 12/17/25 at 10:25am revealed:<br>-Resident #5 had a current order dated 09/03/25 for Lispro check FSBS three times a day and inject per SSI parameters: FSBS 0-200= 0 units, 201-250= 1 units, 251-300= 2 units, 301-350= 3 units, 351-400= 4 units, and 401-500= 5 units.<br>-Resident #5's order had not been changed.<br>-The pharmacy dispensed 300units of Lispro on 09/01/25.<br><br>Telephone interview with Resident #5's endocrinologist on 12/17/25 at 11:37am revealed:<br>-Resident #5 had a current order for Lispro check FSBS three times a day and inject per SSI parameters: FSBS 0-200= 0 units, 201-250= 1 units, 251-300= 2 units, 301-350= 3 units, 351-400= 4 units, and 401-500= 5 units.<br>-Resident #5's order had not been changed on 12/04/25 and she expected the facility staff administer Resident #5's Lispro according to the existing SSI.<br>-She expected the facility staff to communicate with her if there was a discrepancy related to her | {D 358} | | |

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orders but no one from the facility had followed up with her.
-She expected a possible outcome for low blood sugar levels for Resident #5 if MAs continued to administer insulin when it should be held.
-She expected the Lispro to be administered per the SSI with parameters of 1 unit for every 50 increment BS levels starting at 201 and then change to 401-500 for the last unit to be administered to Resident #5.

Interview with a MA on 12/17/25 at 11:25am revealed:
-She was aware that Resident #5's Lispro insulin parameters were incorrect on the eMAR but she had not informed the Resident Care Coordinator (RCC) due to being overwhelmed with her work.
-She did not know who reviewed the order and changed the entry for Resident #5's Lispro SSI parameters in the eMAR.
-She could not say why Lispro insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #5's endocrinologist.
-The RCC was responsible for completing eMAR audits but she had not been informed of any medication errors.

Interview with a second MA on 12/17/25 at 3:10pm revealed:
-The MAs and the RCC entered orders on the eMAR but she did not know who entered the different SSI parameters for Resident #5 on 12/05/25.
-She was aware Resident #5's Lispro insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #5's endocrinologist.
-She had informed the RCC but was not sure why the entry was not corrected on the eMAR to

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reflect the correct SSI parameters for Resident #5.
-The RCC and the Health and Wellness Director (HWD) were responsible for completing eMAR audits but she had not been informed of any medication errors.

Interview with the RCC on 12/17/25 at 10:50am revealed:
-She and the MAs entered orders on the eMAR but she did not know who entered the different SSI parameters for Resident #5 on 12/05/25.
-She was not aware the SSI parameters were changed for Resident #5 on 12/05/25 on the eMAR.
-She was not aware Resident #5's Lispro insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #5's endocrinologist.
-The HWD was responsible for auditing the eMARs for exceptions because she was overwhelmed with working as an MA.

Interview with the Clinical Specialist on 12/17/25 at 4:20pm revealed:
-She was the interim HWD due to there not being an active HWD at the facility.
-The MAs, the RCC or the HWD entered orders on the eMAR then one of the other two checked the entry for errors.
-New orders and order changes were documented on a tracking form 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 physician orders.
-The MAs should have questioned the different

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| {D 358} | Continued From page 6<br><br>SSI parameter entry from 12/05/25 and followed up with the physician and the RCC.<br>-She was not aware Resident #5's Lispro insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #5's endocrinologist because she thought the entry was correct from 12/05/25.<br>-The RCC was responsible for completing the eMAR audits quarterly for exceptions.<br><br>Interview with the Administrator on 12/17/25 at 4:20pm revealed:<br>-He was not aware Resident #5's Lispro insulin amounts were administered differently than the SSI parameter requirements.<br>-The HWD would be responsible for auditing the residents' eMARs quarterly.<br>-The RCC and the HWD would be responsible for ensuring medication errors were addressed with MAs and corrected.<br>-He expected the MAs, the RCC, and HWD to clarify medication orders to ensure MAs administered medications as ordered by the provider. | {D 358} | | |
| {D 371} | 10A NCAC 13F .1004 (n) Medication Administration<br><br>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.<br><br>This Rule is not met as evidenced by: | {D 371} | | |

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| {D 371} | Continued From page 7<br><br>Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass.<br><br>The findings are:<br><br>Observation of the morning medication pass on 12/17/25 between 8:20am and 8:58am revealed:<br>-The medication aide (MA) administered medications to a resident.<br>-The MA returned to the medication cart and donned gloves without performing hand hygiene.<br>-The MA administered an eyedrop medication to another resident.<br>-The MA removed her gloves and returned to the medication cart without performing hand hygiene.<br>-The MA prepared oral medications for administration for a third resident.<br>-The MA grabbed a plastic spoon from a container on the medication cart and set the spoon down on top of the medication cart.<br>-The MA picked up the spoon and used the same spoon to administer oral medications to a resident.<br>-The spoon was discarded and no hand hygiene was performed.<br>-The MA prepared medications for a fourth resident, including oral medications.<br>-The MA grabbed another plastic spoon from the container on the medication cart and again set the spoon down on top of the medication cart.<br>-The MA picked up the second spoon and used that same spoon to administer oral medications to a resident.<br><br>Interview with the MA observed during the morning medication pass on 12/17/25 at 2:52pm revealed:<br>-She did not know it was an issue of infection | {D 371} | | |

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| {D 371} | Continued From page 8<br>control when she set a spoon on top of the medication cart and then used the spoon to administer oral medications to a resident.<br>-She should have held the spoon and not set it down on the medication cart.<br>-She should have sanitized her hands or performed hand hygiene before and after administering eyedrops.<br><br>Interview with the Clinical Specialist on 12/17/25 at 4:23pm revealed:<br>-She did not know the MA observed during the medication pass set a spoon down on top of the medication cart and used the same spoon to administer medications to a resident two separate times.<br>-She did not know the MA observed during the medication pass did not perform hand hygiene before and after administering eyedrops to a resident.<br>-She would have expected the MA to not contaminate the spoons before administering medications to the residents.<br>-She expected the MAs to perform hand hygiene before and after administering eyedrops.<br><br>Interview with the Administrator on 12/17/25 at 4:50pm revealed:<br>-He did not know the MA observed during the medication pass set a spoon down on top of the medication cart and used the same spoon to administer medications to a resident two separate times.<br>-He did not know the MA observed during the medication pass did not perform hand hygiene before and after administering eyedrops to a resident.<br>-The MA could not set a spoon on a dirty surface and then administer medications to a resident with the same spoon. | {D 371} | | |

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| {D 371} | Continued From page 9<br>-He expected the MAs to perform hand hygiene before and after administering eyedrops to a resident. | {D 371} | | |