STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 a follow-up survey and complaint investigation from July 27, 2022 to July 28, 2022.	{D 000}		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide incontinence care to 1 of 5 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 06/16/22 revealed: -Diagnoses included dementia, osteoporosis, and cerebral vascular infarct. -Resident #2 was constantly disoriented. -Resident #2 was incontinent of bladder and bowel. Review of Resident #2's Care Plan dated 07/28/21 revealed: -Resident #2 required extensive assistance for toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers. -Resident #2 required two-person transfers.	D 269		

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D 269	Continued From page 1	D 269		

-Resident #2 was ambulatory with a wheelchair.

Review of the facility's assignment sheet (no date) for first shift (7am-3pm) revealed:
-Resident #2 required bathroom assistance with uncontrolled bladder/bowel episodes, protective undergarments and "skin" (no specific action listed).
-Resident #2 was to be showered on Mondays and Thursdays.

Observation of Resident #2 on 07/27/22 at 8:54am revealed:
-Resident #2 was seated in her wheel chair fully dressed beside her bed.
-The medication aide (MA) called for a personal care aides (PCA) in the hall to help transfer Resident #2 to her bed.
-The MA pulled down Resident #2's pants and brief to apply scheduled protective cream.
-Resident #2's sacrum and coccyx were reddened and blanched slightly when the MA pressed with one finger.
-The MA proceeded to apply scheduled protective cream to Resident #2's buttocks/sacrum.
-Resident #2 pulled away and said "Oh" when the cream was applied.
-Resident #2 appeared dry with no odder noted.

Record review and observations revealed Resident #2 was not interviewable.

Interview with Resident #2's Primary Care Provider(PCP) on 07/27/22 at 9:10am revealed:
-She was filling in for the week for the full time PCP.
-Resident #2 had a protective cream ordered scheduled 3 times a day.
-She did not see any records of staff reporting Resident #2 had non healing redness or a

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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D 269	Continued From page 2	D 269		

request for a skin evaluation.
-When staff reported or the PCP saw skin breakdown, a home health nurse skin/wound evaluation would be requested.
-She expected staff to give incontinence care and tell her of any skin issues so that she could adjust medications if she needed.

Confidential telephone interview on 07/28/22 at 8:00am revealed:
-Interviewee witnessed Resident #2 soaked with urine from day shift(7am-3pm) into evening shift(3pm-11pm) on numerous occasions until early July 2022.
-Interviewee would check Resident #2 first thing on evening shift because she was always wet.
-Resident #2 had some redness on her bottom and had a cream the MAs applied.
-Interviewee reported staff not performing incontinence care on Resident #2 to the previous Administrator but nothing was ever done.

Interview with a PCA on 07/28/22 at 9:00am revealed:
-PCAs perform rounds and incontinence checks every 2 hours.
-Staff receive assignment sheets at the start of each shift for the residents they were responsible for.
-Resident #2 had to be checked more frequently because she was a heavy wetter.
-She had a cream the MAs put on already, so she did not report her bottom being red.

Interview with a MA on 07/28/22 at 9:30am revealed:
-Resident #2 was incontinent of urine and stool and had to be checked every 2 hours and sometimes sooner.
-Staff perform skin assessments on shower days

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D 269	Continued From page 3	D 269		

but Resident #2 was assessed every two hours with incontinence checks.
-Any redness/bruising was reported to the Resident Care Coordinator (RCC) or Health and Wellness Director(HWD).
-Resident #2 had protective cream scheduled because she had redness, but she was not sure how long her bottom had been red.

Interview with another RCC on 07/28/22 at 10:00am revealed:
-Incontinent care rounds were routinely done every 2 hours and at shift change.
-Resident #2 had a fluid pill and could be wet between 2-hour checks, so staff usually checked her more often.
-She did not know Resident #2 had skin breakdown, but she had scheduled protective cream ordered because she was incontinent.

Interview with the Health and Wellness Director(HWD) on 07/28/22 at 2:00pm revealed:
-Resident skin assessments were performed by MAs and PCAs on shower days, 2 times a week.
-If any redness is noted, staff reported it to her or directly to the PCP.
-The PCP would routinely order a home health nurse skin evaluation.
-She had no report of skin issues for Resident #2 but knew she had a protective cream scheduled due to her incontinence.
-Resident #2 was incontinent and had a fluid pill that made her wet more often and could be wet between checks, so staff would check her more frequently.

Interview with the Administrator on 07/28/22 at 3:39pm revealed:
-He expected the staff to perform incontinence care every 2 hours or more frequently on

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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D 269	Continued From page 4 residents like Resident #2. -He had no reports of Resident #2 being left wet throughout any shift. -He expected staff to check for skin breakdown during incontinence checks and report any found to the HWD or himself so that other measures can be taken to heal and prevent further breakdown.	D 269		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B violation was not abated. Based on interviews and record reviews the facility failed to provide supervision for 2 of 5 sampled residents (#1 and #3) who sustained 21 falls in three months, three of which resulted in injuries (#3) and a resident who had a history of falls, sustained 3 falls one of which resulted in an injury (#1). The findings are: Review of the facility's Falls Management policy dated February 2022 revealed: -A fall risk assessment was to be performed upon	{D 270}		

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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{D 270}	Continued From page 5	{D 270}		

admission.
-Residents who sustained a fall should have a post-fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury.
-Communicate new interventions with care staff.
-Update the resident's personal service plan (PSP) with appropriate interventions.
-Update the Care Assignment sheet.
-Have the resident assessed for therapy, as appropriate.
-Review all falls at stand-up.

1. Review of Resident #3's current FL-2 dated 04/11/22 revealed:
-Diagnoses included dementia without behaviors, chronic kidney disease III, anxiety, gastroesophageal reflux disease (GERD).
-Resident #3 was constantly disoriented .
-Resident #3 was continent of bowel and bladder.
-Resident #3 used a walker to ambulate and required assistance with bathing and dressing.

Review of Resident #3's Personal Service plan and Assessment dated 06/05/22 revealed:
-She required reminders and assistance with toileting
-She required assistance with getting onto and off the toilet.
-Resident #3 required assistance with transfers.
-Resident #3 used a walker and wheelchair to ambulate.
-She had multiple falls, one of which resulted in staples to the back of her head.
-Physical therapy was in place and due to weakness, she was using her wheelchair.
-She needed reminders to lock the wheels on the wheelchair when transferring.

Review of Resident #3's Care Plan dated

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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{D 270}	Continued From page 6 05/16/22 revealed she was independent and could toilet, ambulate, dress and transfer on her own. Review of Resident #3's Care Plan dated 06/06/22 revealed: -She required limited assistance with toileting, dressing and ambulation. -She required supervision with transfers. Review of Resident #3's incident and accident reports, progress notes and post-fall evaluations forms revealed the resident had 25 falls between 05/05/22 and 07/15/22. a. Review of Resident #3's progress notes dated 05/05/22 to 05/29/22 revealed: -Resident #3 had five unwitnessed falls without injuries. -On 05/05/22, at 2:57pm, Resident #3 had an unwitnessed fall in another resident's room. Resident [#3] was found in a sitting on the floor and had no complaints of pain. -On 05/05/22, at 10:21pm, Resident #3 had a second fall in the hallway without any injuries or complaints of pain. -On 05/07/22, at 11:06am, Resident #3 had an unwitnessed fall near her dresser and bed in her room; she had no complaints of pain and no injuries. -On 05/25/22 At 2:46pm, Resident #3 was found on the floor in a common area in a sitting position; she did not complain of pain and there were no injuries. -On 05/29/22, at 10:08am, Resident #3 had a fall in her room beside her bed. -She was trying to get out of her recliner without putting the footrest down before standing. -She did not appear to have any injuries and no complaints of pain.	{D 270}		

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{D 270}	Continued From page 7 -She was administered an as needed medication for behaviors because she stated she was trying to get out of the facility to see her family. -Post fall note on 05/29/22, at 7:55pm, Resident #3 had a fall in the morning on first shift. -Staff continued to make sure resident was using her wheelchair and Resident #3 had no complaints of pain. Review of Resident #3's progress notes and post-fall evaluation forms revealed there was no documented increased supervision or interventions to prevent further falls. Review of Resident #3's incident and accident reports revealed there was no documentation that interventions were implemented or supervision was increased to prevent Resident #3 from falling. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at 11:42am was unsuccessful. Refer to telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm. Refer to telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am. Refer to interview with the Resident Care	{D 270}		

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{D 270}	Continued From page 8 Coordinator (RCC) on 07/28/22 at 2:36pm. Refer to interview with a medication aide (MA) on 07/28/22 at 3:50pm. Refer to interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm. Refer to interview with the Administrator on 07/28/22 at 4:07pm. b. Review of Resident #3's progress notes dated 05/15/22 revealed: -At 12:34pm, Resident #3 was found on the floor with her head bleeding; she denied any pain. -She was transported to the local emergency department (ED) by emergency medical services (EMS) due to her head injury. -She was transferring herself without assisted devices and without supervision. -At 3:57pm, Resident #3 returned from the ED with staples in her head; staff would continue to monitor. Review of Resident #3's hospital visit summary dated 05/15/22 revealed: -She was transported to the ED by EMS on 05/15/22 due to a fall. -She had a head injury and a laceration to her scalp and required staples. Review of a signed physician's order dated 05/11/22 revealed Resident #3 was ordered physical therapy. Review of a signed physician's order dated 05/12/22 revealed Resident #3 was ordered a urine analysis (UA); there were no results documented for the UA.	{D 270}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 9	{D 270}		

Review of Resident #3's progress notes and post-fall evaluation forms revealed there was no documented increased supervision or interventions.

Review of Resident #3's incident and accident report dated 05/15/22 revealed there was no documentation that interventions were implemented or supervision was increased to prevent Resident #3 from falling.

Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at 11:42am was unsuccessful.

Refer to telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm.

Refer to telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/28/22 at 2:36pm.

Refer to interview with a medication aide (MA) on 07/28/22 at 3:50pm.

Refer to interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm.

Refer to interview with the Administrator on

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{D 270}	Continued From page 10 07/28/22 at 4:07pm. f. Review of Resident #3's progress notes dated 06/08/22, 06/09/22 and 06/15/22 to 06/30/22 revealed: -Resident #3 had six unwitnessed falls without injuries. -On 06/08/22, at 8:59pm, Resident #3 was found on the floor in her room; she had no complaint of pain and no injuries. -She had her clothes packed and stated she needed to go across the street. -On 06/09/22, at 4:30pm, Resident #3 was found on the floor. -She stated she was going to the garage; she had no complaint of pain and no injuries. -On 06/15/22, at 7:45pm, Resident #3 was found on the floor beside her bed; she had no complaints of pain or injuries. -Staff would continue to monitor her throughout the shift. -On 06/24/22, at 10:17pm, Resident #3 was found on the floor by the medication aide (MA); she had no complaints of pain or injuries. -On 06/28/22, at 3:36pm, Resident #3 was found on the floor outside of the dining room; she had no complaints of pain or injuries. -[Staff] would continue to monitor. Review of Resident #3's progress notes and post-fall evaluation forms revealed there was no documented increased supervision or interventions. -On 06/29/22, there was no documentation of a fall. -On 06/30/22, Resident #3 was found on the floor by her bathroom; she had no complaints of pain or injuries. -[Staff] would continue to monitor. Review of Resident #3's incident and accident	{D 270}		

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 HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 11	{D 270}		

report dated 06/29/22 revealed:
-Resident #3 had an unwitnessed fall in her room beside her bed.
-She had no injuries.
-There were no documentation that interventions were implemented or supervision was increased to prevent Resident #3 from falling.

Review of Resident #3's incident and accident reports from 06/08/22 to 06/30/22 revealed there was no documentation that interventions were implemented or supervision was increased to prevent Resident #3 from falling.

Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at 11:42am was unsuccessful.

Refer to telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm.

Refer to telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/28/22 at 2:36pm.

Refer to interview with a medication aide (MA) on 07/28/22 at 3:50pm.

Refer to interview with the Health and Wellness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 270}	Continued From page 12 Director (HWD) on 07/28/22 at 3:02pm. Refer to interview with the Administrator on 07/28/22 at 4:07pm. h. Review of Resident #3's progress notes dated 06/10/22 revealed: -At 4:30am, Resident #3 had an unwitnessed fall. -She was in a sitting position on the floor when the medication aide (MA) went into her room to administer medication; she had no complaint of pain and no injuries. -She stated she was just trying to go "over there". -At 7:25pm, Resident #3 was found sitting on the floor in her room. -Resident #3 had a skin tear on her left elbow and right lower leg from her fall earlier in the day. -[Staff] will continue to monitor. Review of Resident #3's progress notes and post-fall evaluation forms revealed there was no documented increased supervision or interventions. Review of Resident #3's incident and accident report dated 06/10/22 revealed there was no documentation that interventions were implemented or supervision was increased to prevent Resident #3 from falling. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at	{D 270}		

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BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 13 11:42am was unsuccessful. Refer to telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm. Refer to telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am. Refer to interview with the Resident Care Coordinator (RCC) on 07/28/22 at 2:36pm. Refer to interview with a medication aide (MA) on 07/28/22 at 3:50pm. Refer to interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm. Refer to interview with the Administrator on 07/28/22 at 4:07pm. i. Review of Resident #3's progress notes dated 06/11/22 revealed there was no documentation of a fall. Review of Resident #3's incident and accident report dated 06/11/22 revealed: -Resident had an unwitnessed fall and was found in her room. -She had an injury to her head and bottom. -She was transported to the local emergency department (ED) by emergency medical services (EMS) due to her head injury. -There were no documentation interventions were implemented or increased supervision to prevent Resident #3 from falling. Review of Resident #3's hospital visit summary dated 06/11/22 revealed: -She was seen at the ED on 06/11/22 for a fall.	{D 270}		

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 14 -She was transported to the ED by local EMS because she hit her head when she fell. -She had a CT scan completed and was sent back to the facility without any injuries. Review of Resident #3's progress notes and post-fall evaluation forms revealed there was no documented that interventions were implemented or supervision was increased to prevent Resident #3 from falling. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at 11:42am was unsuccessful. Refer to telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm. Refer to telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am. Refer to interview with the Resident Care Coordinator (RCC) on 07/28/22 at 2:36pm. Refer to interview with a medication aide (MA) on 07/28/22 at 3:50pm. Refer to interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm. Refer to interview with the Administrator on	{D 270}		

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{D 270}	Continued From page 15 07/28/22 at 4:07pm. o. Review of Resident #3's progress notes dated 07/01/22, 07/04/22 and 07/11/22 to 07/15/22 revealed: -On 07/01/22, at 7:45pm, Resident #3 was found on the floor in her room in front of her wheelchair near the bathroom; she had no complaints of pain or injuries. -On 07/03/22, at 1:56pm, Resident #3 had and unwitnessed fall; she was found in the hallway; she had no complaints of pain or injuries. -She stated she was "trying to get out of here". -On 07/03/22, at 7:35pm, Resident #3 had a second fall and was found lying on her back in her room; she had no complaints of pain or injuries but had a bruise and an abrasion to her back. -She had pulled all of her clothes out of her dresser. -[Staff] will continue to monitor. -On 07/04/22 there was no documentation of a fall. -On 07/04/22, there was a post fall note at 9:39pm Resident #3 had no complaints of pain. -She still had an abrasion and a bruise on her back from a fall earlier that day. -[Staff] would continue to monitor. -On 07/11/22, at 1:40pm, Resident #3 had an unwitnessed fall; she was found lying on the floor; she had no complaints of pain or injuries.. -She stated she fell out of her wheelchair. -[Staff] would continue to monitor. -On 07/12/22, Resident #3's family was notified she required a two person assist for transfer and sit to stand. -On 07/15/22, at 9:48pm, Resident #3 was found lying on the floor in the common area. -She could not verbalize what happened. -She had some complaints of pain in her back but	{D 270}		

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{D 270}	Continued From page 16	{D 270}		

did not have any injuries.
-[Staff] would continue to monitor.

Review of Resident #3's incident and accident report dated 07/04/22 revealed:
-At 5:50am, Resident #3 had an unwitnessed fall in her room near her bed.
-She had no apparent injuries.
-There were no documentation that interventions were implemented or supervision was increased to prevent Resident #3 from falling.

Review of Resident #3's post-fall evaluation form dated 07/11/22 revealed:
-There was no documented increased supervision.
-There was documentation Resident #3 had been ordered a wedge cushion to prevent her from sliding and getting out of her chair so easily.
-There was a note physical therapy continued for strength, transfer ability and safety.
-Resident #3 had a change in her cognitive status and change in the ability to transfer/ambulate due to decreased mobility and gait disturbance.

Review of a signed physician's order dated 07/06/22 revealed Resident #3 was ordered a walker with two wheels and a two-inch wedge cushion for her wheelchair.

Review of Resident #3's progress notes and post-fall evaluation forms revealed there was no documented increased supervision or interventions.

Review of Resident #3's incident and accident reports dated 07/01/22 to 07/04/22 and 07/11 to 07/15/22 revealed there was no documentation that interventions were implemented or supervision was increased to prevent Resident #3

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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{D 270}	Continued From page 17 from falling. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at 11:42am was unsuccessful. Refer to telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm. Refer to telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am. Refer to interview with the Resident Care Coordinator (RCC) on 07/28/22 at 2:36pm. Refer to interview with a medication aide (MA) on 07/28/22 at 3:50pm. Refer to interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm. Refer to interview with the Administrator on 07/28/22 at 4:07pm. _____ Telephone interview with the Physical Therapist (PT) from Resident #3's contracted physical therapy agency on 07/28/22 at 2:22pm revealed: -Resident #3 had been referred to and received physical therapy three separate times since she was admitted to the facility. -She was referred due to falls.	{D 270}		

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{D 270}	Continued From page 18 -Resident #3's goals were compensation and adapting to environment; to transfer with a rolling walker. -She had a rollator walker and it was taken away from her. -Sometimes Resident #3 would slide out of her wheelchair because it was not custom fitted to her; the wheelchair was temporary. -Resident #3 was currently using a wheelchair because she did not have the strength to stand and support her own weight. -Resident #3 would lean forward in her wheelchair and fall forward; she saw items on the floor that were not there. -Resident #3 had declined in her function and her cognition. -Her falls were not predictable or foreseeable because Resident #3 thought she could walk and would get up and try to walk. -Resident #3 had apraxia (difficulty with skilled movements even when the person has the desire to do them) due to her dementia. -Resident #3 had not reached her goals during her physical therapy. Telephone interview with a personal care aide (PCA) on 07/28/22 at 9:10am revealed: -She worked first and second shifts. -She knew Resident #3 was a considered a high fall risk because she was told at stand-up meetings by other staff. -She was told to "keep an eye" on Resident #3 due to her falls; she was not specifically told what keep an eye on her meant so she watched Resident #3 as much as she could. -She would keep Resident #3 with her while she did her tasks during her shift. -She also made sure Resident #3's wheelchair was locked so it would not roll away if she tried to stand; a medication aide (MA) had given her that	{D 270}		

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{D 270}	Continued From page 19	{D 270}		

advice.
-She would ask another PCA to watch Resident #3 when she was busy providing care to other residents.
-Resident #3 had to be watched because she was constantly trying to stand up; Resident #3 tried to do things on her own.
-Resident #3 had been found on the floor a lot; she did not know how often just that it was a lot.
-Resident #3 bruised easily and she was scared she would fall so she watched her as much as she could.
-She would move Resident #3 to the common area so she could be watched.
-She would remind Resident #3 to sit if she saw her trying to stand.
-Resident #3 tried to stand on her own when she went to the bathroom or she wanted to walk around.
-She was never told to increase supervision or increase frequency of checks for Resident #3.
-There were no discussions about with the staff after a fall; she would be told about a fall.
-She was told to monitor Resident #3, but she thought watching her was the same thing.
-She was never instructed by anyone to document or report anything after a fall.
-Resident #3 had one bad fall where she hit her head and went to the hospital.
-She had just checked on Resident #3 and she was asleep in her bed; she left the room and then heard another staff say Resident #3 had fallen and was bleeding.
-She also put Resident #3 back to bed in the early afternoon and after dinner because that seemed to be the times of the day when she tried to stand up and was restless.
-Resident #3 would go to the bathroom on her own but needed assistance with pulling her pants on and off.

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{D 270}	Continued From page 20 -All the residents were on two-hour checks; none of the residents were checked more often than that. -She had noticed a change in Resident #3's condition since she was admitted to the facility. -She had not received any training on resident falls or instructions on what to do after a fall. Interview with a medication aide (MA) on 07/28/22 at 3:50pm revealed: -Resident #3 fell mostly in the early evening after dinner. -Resident #3 would hallucinate and try to stand and walk around. -When Resident #3 was left alone she would stand and fall. -She tried to keep Resident #3 where she could always see her. -If she saw Resident #3 try to stand up, she would tell her to sit back down; Resident #3 could be stopped if she was caught trying to stand. -Resident #3's falls were always the same; she fell on her bottom or slid to the floor. -She would take her breaks in Resident #3's room so she could keep an eye on her. -She could not recall how often she had found Resident #3 on the floor after a fall; she had found her asleep on the floor after a fall. -Sometimes she would give Resident #3 some laundry to fold and she would be okay for a while; she needed to keep her hands busy. -Sometimes keeping her hands busy would help and sometimes it would not. -The last activity ended at 3:00pm so the staff would come up with ideas to keep her busy. -The staff could not watch Resident #3 twenty-four hours a day; she needed someone to be with her all the time. -Resident #3 required two staff to transfer her from her wheelchair.	{D 270}		

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{D 270}	Continued From page 21 -Resident #3 did not straighten her legs and could not support her own weight when she stood up. -She took it upon herself to check on Resident #3 more often than the required two hours because she did not want Resident #3 to fall and get hurt. Interview with the Resident Care Coordinator (RCC) on 07/28/22 at 2:36pm revealed: -Resident #3 had been falling since she was admitted to the facility about three months ago. -She had different interventions since Resident #3 fell so often. -She had reached out to the family to ask about things to keep her busy; she liked the baby dolls but still had falls. -She was packing her clothes and trying to leave when she was first admitted, and she would fall. -Resident #3 would hear the phone ring and try to get up to answer it and fall. -All of Resident #3's falls were the same; she would try to stand up and would fall. -It did not matter where Resident #3 was trying to stand up, bed, chair, recliner or bedroom she would fall when she stood. -Resident #3 had a cushion for her wheelchair was ordered ; she was not sure of the date the cushion was ordered. -A urine analysis (UA) was ordered for Resident #3 but she was not sure if it was collected and she did not know when the order was written. -Increased monitoring was put into place to prevent Resident #3 from falling. -Increased monitoring included checking on the resident more often and more eyes on the resident. -No staff were assigned to monitor or conduct checks on Resident #3 after a fall; increased monitoring was everyone's responsibility. -The more eyes that were on Resident #3 the more likely a fall would be prevented.	{D 270}		

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{D 270}	Continued From page 22 -When staff saw Resident #3, they were to encourage her to not stand up; if staff saw her attempting to stand then they were to stop her. -Resident #3 fell when she stood up; it took three to four staff to get Resident #3 up off the floor after a fall. -Staff were required to check on residents every two hours; staff were not told how often monitoring was increased but staff were told they could always check more often. -When Resident #3 would fall it would be discussed at the stand-up meetings; staff would discuss things to do to prevent her falls. -She knew Resident #3 had done physical therapy, but she did not know how often. -Monitoring or checks were not documented. -The staff were doing all they could do to prevent Resident #3 from falling. -She was scarred Resident #3 was going to fall and maybe have a severe injury. -Resident #3 needed more care than one person could give her. Interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm revealed: -She had only been working at the facility for a few weeks. -Resident #3 tried to stand up and walk and would fall; she was hard to redirect. -She would try to lean forward and would fall or slide to the floor. -There was basically one on one with staff because the staff always needed to see her. -The facility did not do chair or bed alarms. -There had been discussions with the family about a higher level of care. -The family thought she could benefit from physical therapy and could be a one person assist. -The facility did not have two person assist for	{D 270}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 23 residents for the safety of the resident and the staff during a transfer. Interview with the Administrator on 07/28/22 at 4:07pm revealed: -Resident #3's falls were sporadic; there was no rhyme or reason to her falls. -She had good days and bad days. -The management team had looked at Resident #3's falls for trends and tried to provide interventions based on her trends. -The electric cord for her recliner had been removed and staff took their meal breaks in her room. -Resident #3 had done physical therapy for months but he could not say if it had prevented falls because she had fallen even while on physical therapy. -He knew the facility still needed to come up with interventions to prevent her from falling. -On 06/17/22 her medications had been adjusted to prevent falls and the same day she had a fall. -On 06/14/22 there was a care plan meeting with the family to get more information about Resident #3 to help prevent falls, but she continued to fall. -He was not sure how often checks were done when they were increased. -He did not know what else to do for Resident #3; he felt the facility had done everything they could do for Resident #3. 2. Review of Resident #1's current FL-2 dated 02/09/22 revealed: -Diagnoses included dementia, chronic kidney disease II, hyperlipidemia, spinal stenosis, and hypertension. -She was constantly confused. -She was incontinent of bowel and bladder. -She required assistance with bathing and dressing.	{D 270}		

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{D 270}	Continued From page 24	{D 270}		

Review of Resident #1's personal service plan (PSP) and plan of care dated 07/08/22 revealed:
-Resident #1 used oxygen equipment.
-Resident #1 took seven or more medications.
-Resident #1 took benzodiazepine medications (medications that can contribute to falls in older adults).
-Resident #1 needed help in the bathroom.
-Resident #1 was incontinent of bowel and required assistance.
-Resident #1 was to be assisted using the bathroom schedule; approximately every 2-4 hours during the day and as needed during the night.
-Resident #1 required escort assistance secondary to memory impairment and physical impairment.
-Resident #1 had fallen in the last twelve months.
-Resident #1 had fallen with harm/injury with emergency room (ER) treatment/assessment (Severity Code 4).
-Resident #1 used a walker as a mobility aide.
-Resident #1 required supervision with eating and toileting, extensive assistance with ambulation, and limited assistance with personal hygiene, bathing, grooming, and transferring.

Review of Resident #1's incident and accident reports, progress notes, and post-fall evaluation forms from 06/13/22-07/27/22 revealed the resident had 3 falls between 06/30/22-07/27/22.

Review of Resident #1's Primary Care Provider's (PCP) progress note dated 06/15/22 revealed:
-Reason for the visit was fall.
-Resident #1's hospital records were reviewed.
-Fall precautions were in place.
-Increase staff monitoring.

Observation of Resident #1 on 07/27/22 at

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{D 270}	Continued From page 25 7:42am revealed: -Resident #1 was sitting in her recliner. -Resident #1 had abrasions on her forehead and nose. -Resident #1 had a two-inch laceration on the bridge of her nose and the inner brow of her left eye. -Resident #1 had red and purple orbital bruising of her left eye and bruising on her forehead and the bridge of her nose. Interview with Resident #1 on 07/27/22 at 7:42am revealed: -She had a fall "the other day." -She went to the hospital. -She did not break anything. -Her face looked worse than it felt; she was having no pain. -She fell outside, "I think I slipped on the ice." -She did not need assistance; she could do everything for herself. -No one told her to call for assistance before walking. Observation of Resident #1 on 07/28/22 at 3:04pm revealed: -Resident #1 was asleep in her recliner chair with her legs elevated. -She was wearing oxygen. -Resident #1's walker was sitting in front of her chair. -Resident #1's oxygen tubing was laying on the floor in front of the walker and was raised off the floor in multiple places creating a potential tripping hazard. a. Review of Resident #1's post-fall evaluation form dated 06/30/22 revealed: -The form was initiated by a medication aide (MA).	{D 270}		

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BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 26 -At 7:05am, Resident #1 was found lying on her right side near the door to the hallway. -Resident #1's walker was lying on the floor beside the resident and her oxygen tubing was under her. -Resident #1 complained of the right upper leg and right elbow pain but stated it was the usual pain she had for a long time. -Resident #1 reported she was trying to get someone so she could eat. -Resident #1 was not aware of the location of her oxygen tubing and would become entangled. -Resident #1's oxygen concentrator was moved to the corner on the left side of the resident to reduce the risk of tripping on her oxygen tubing if she got up and walked to the door. -Resident #1 had a recent ER visit after a fall last week, 06/12/22, striking her head on her concentrator, and received two staples. -The risk factors that contributed to the fall were documented as environmental factors and compliance with safety issues. -Service plan intervention included removing clutter from the resident's environment to verify safe walkways. -The intervention for increased frequency of monitoring was not marked. -Resident #1's personal service plan was reviewed but no new changes. -The form was signed by the Health and Wellness Director on 06/30/22. Review of Resident #1's progress notes revealed there was no documentation of increased supervision to prevent Resident #1 from falling. Interview with a MA on 07/27/22 at 3:25pm revealed: -She did not recall the details about Resident #1's fall on 06/30/22, but she recalled Resident #1	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 270}	Continued From page 27 having a fall because her oxygen tubing was stuck in the recliner. -She also recalled Resident #1 having a fall when she was trying to pull the oxygen connector out of the outlet. -Resident #1 wanted to move the oxygen tank, so it was moved. b. Review of Resident #1's post-fall evaluation form dated 07/10/22 revealed: -At 11:00am, Resident #1 was found lying between her recliner chair and an oxygen concentrator. -Resident #1's recliner footrest was not all the way in. -Resident #1's walker was sitting beside the chair. -Resident #1 complained of right hip pain and pain on the right side of her head. -Resident #1 stated she was trying to get water. -A cup of water was noted to be sitting next to her chair on the table. -Resident #1 stated she did not use her walker because she did not have far to go. -Resident #1's family was notified and asked for the resident to be monitored, rather than sending her to the hospital. -The risk factor that contributed to the fall was documented as compliance with safety issues. -Service plan interventions newly added to Resident #1's personal service plan to reduce the risk of future falls were documented as educating the resident on the use of their emergency call system and reminding the resident to use her assistive device. -The intervention for increased frequency of monitoring was not marked. -Resident #1's personal service plan was reviewed but no new changes. -The form was signed by the Health and Wellness Director on 07/10/22.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 270}	Continued From page 28 Review of Resident #1's progress notes revealed: -On 07/11/22 at 3:14pm revealed Resident #1's post-fall status was the resident had no complaints of pain or discomfort. -There was no other documentation related to Resident #1's fall. -There was no documentation of increased supervision. The staff member who completed the post fall form was not available for interview on 07/27/22. c. Review of Resident #1's post-fall evaluation form dated 07/25/22 revealed: -At 12:20pm, Resident #1 was found on the floor next to her bed. -Resident #1 complained of shoulder and nose pain -Resident #1 stated she did not remember what she was doing prior to the fall. -The risk factor that contributed to the fall was documented as compliance with safety issues. -Service plan interventions newly added to Resident #1's personal service plan to reduce the risk of future falls was documented as reminding the resident to use an assistive device, increasing the frequency of monitoring, and verifying devices were in good working order and applied correctly. -Additional comments were to keep the call bell within reach and increase rounds and the Resident continues to have falls. Will discuss changes in the level of care with the family. -The form was signed by the Health and Wellness Director on 07/27/22. Review of Resident #1's progress notes revealed: -On 07/25/22 at 12:50pm, Resident #1 was found on the floor when the personal care aide (PCA) was making rounds for lunch. Resident #1 had a	{D 270}		

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 29	{D 270}		

laceration above her nose and left eyebrow.
-Resident #1 was transported by emergency medical services to the emergency department (ED).
-On 07/26/22 at 2:49pm, there was documentation that Resident #1's face was swollen and bruised. No complaints of pain or discomfort. Continue to monitor.
-There was no other documentation related to Resident #1 and falls.

Review of Resident #1's ED after visit summary dated 07/25/22 revealed:
-Resident #1 was seen in the ED for a fall.
-CT scans were performed of Resident #1's facial bones, head, and spine.
-Laceration repair was performed with derma bond (a topical skin adhesive for wound repair).

Interview with a medication aide (MA)/PCA on 07/28/22 at 9:10am revealed:
-She had found Resident #1 laying on the floor with blood on her head when she walked by the resident's room.
-She was not assigned to Resident #1 that day but was walking by to get another resident up for lunch.
-The staff assigned to Resident #1 was in the dining room.
She thought Resident #1 had gotten tangled up in her oxygen cord.
-Resident #1 was not as physically as stable as she used to be.
-When Resident #1 first moved in, she used her call bell, but she did not use it anymore.
-She had seen Resident #1's oxygen tubing stretched across the hallway and the resident would be in the television room.
-Resident #1 was not supposed to walk by herself.

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 30	{D 270}		

-She was told Resident #1 was a high fall risk and could not walk by herself (she did not recall who told her or when).
-She was supposed to check on Resident #1 every 2-4 hours.
-She had been told to keep an eye on Resident #1 a little more frequently.
-She was not told how often, but her interpretation was every hour.
-Resident #1 liked her bathroom door open; she did not know if she liked the lights to be turned on or off.
-Sometimes Resident #1's bathroom lights would be on and when she went by later the lights would be turned off.
-She did not know if staff had turned the lights off or if Resident #1 had turned the lights off.
-Resident #1 liked to keep her wheelchair and walker within reach.
-For all residents who were fall risks, the staff were told to keep a closer eye on the residents but were not told anything else, "nothing specific."

Interview with Resident #1's primary care provider (PCP) on 07/27/22 at 12:35am revealed:
-Today was the first time she had seen Resident #1.
-She knew Resident #1 had a history of falls.
-She would review Resident #1's medication list to see if there were medications that could contribute to the falls.
-She would check to ensure Resident #1 did not have a urinary tract infection (UTI) as sometimes a fall may be the only sign of a UTI.
-She would recommend a chair alarm; she did not know if the facility allowed chair alarms.
-If the facility did not allow chair alarms, Resident #1 would possibly need a higher level of care.
-Resident #1 should not be up at all on her own.
-Physical therapy was ordered for Resident #1 on

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 31	{D 270}		

04/27/22 for balance and safety.
-She would contact Resident #1's mental health provider to discuss medications that could contribute to falls.
-Her goal would be to increase Resident #1's safety.

Interview with a medication aide (MA)/personal care aide (PCA) on 07/27/22 at 2:50pm revealed:
-Resident #1 would get up and walk without assistance and that was probably why the resident fell.
-Resident #1 needed someone with her when she was walking because she would get tripped up in her oxygen tubing.
-She did not recall being told to do anything different with Resident #1 related to fall prevention/supervision.
-She did not know where Resident #1 liked to keep her wheelchair.
-She thought Resident #1 liked to keep the bathroom door open.
-Resident #1 liked to keep the bathroom light turned off.
-The MA told her to keep checking on Resident #1 to make sure she was not getting up and walking.
-Resident #1 had not fallen on her shift.

Interview with another MA/PCA on 07/27/22 at 3:08pm revealed:
-Resident #1 fell because she tripped up trying to step over her oxygen cord.
-She checked on Resident #1 every 1-2 hours.
-No one had her to do anything different related to the care/supervision of Resident #1.
-No one told her to increase the frequency of her checks on Resident #1.

Interview with a third MA/PCA on 07/27/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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{D 270}	Continued From page 32 3:25pm revealed: -When she worked with Resident #1, she checked on her every 30-60 minutes because the resident was a fall risk. -She took Resident #1 to the bathroom every hour, no one told her to, she just did it. -The nurse told the staff at the standup meeting to keep an eye on Resident #1, but she did not recall when they were told. -She thought they were supposed to check on Resident #1 every thirty minutes and ask her if she needed anything. -She did not document on Resident #1 unless the resident was having a bad day. -Resident #1 needed someone with her when she walked around. -Resident #1 got up every minute. -If Resident #1 had something on her mind, she was going to get up. -Resident #1 liked to keep her wheelchair by her window, and if it was not placed there the resident would get up and move it. -Resident #1 liked her clock tilted a certain way and if it was not like she wanted it, she would get up and move it. -Resident #1 wanted her bathroom light turned off and the door closed, and if it was not done, she would get up and close it herself. -Resident #1's walker should be placed in front of her chair. -Resident #1 did not remember to use her call bell. Interview with the Health and Wellness Director (HWD) on 07/27/22 at 3:13pm revealed: -She was new to the facility and did now know "a whole lot" about Resident #1. -She knew Resident #1 could not follow guidelines because of her cognition. -Resident #1 did not recall she needed to ask for	{D 270}		

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	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 33	{D 270}		

assistance and kept trying to get up on her own, and that was why she fell.
-Resident #1 needed a higher level of care.
-Resident #1's oxygen tubing was a safety issue because it increased the risk of falling.
-She had discussed the need for a higher level of care with the Administrator after Resident #1's fall on 07/25/22.
-She had not talked to Resident #1's family about a change in the level of care; she did not know if the Administrator had.
-She would expect hourly monitoring of Resident #1.
-If the MA and the PCA both saw the resident every hour, the resident would at least be seen four times per shift.
-Resident #1 needed monitoring at least every thirty minutes.
-She had asked the Administrator about bed/chair alarms today after talking to the PCP about interventions for Resident #1.
-She and the PCP also reached out to the mental health provider on 07/27/22 about titrating Resident #1's Ativan (used to treat anxiety) but the MH provider said the Ativan was put in place because Resident #1 was anxious about not being able to breathe.
-Resident #1 was unsteady on her feet and a chair alarm may not work to prevent falls.

Telephone interview with Resident #1's mental health provider on 07/27/22 at 5:12pm revealed:
-She knew Resident #1 was considered a fall risk.
-She had changed Resident #1's Ativan from 0.5mg twice a day to 0.25mg three times a day to stretch out the coverage period, decrease Resident #1's sleepiness by lowering the dose, and also thought lowering the dose would help with fall prevention.
-The facility staff thought Resident #1 was having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 34	{D 270}		

increased anxiety and therefore getting out of her chair more and discussed increasing her anti-anxiety medication.
-She did not want to increase Resident #1's anxiety medication because it would increase her risk of falls.

Interview with Resident #1's physical therapy assistant (PTA) on 07/28/22 at 2:17pm revealed:
-They had started working with Resident #1 on 05/12/22 for strengthening, gait, and safety with oxygen.
-Resident #1 had a lot of falls because she would become entangled in her oxygen cord.
-They currently were focusing on working with Resident #1 without oxygen, to see if she needed to wear the oxygen at all times and were monitoring her oxygen levels at the request of her pulmonologist.
-If Resident #1 could come off her oxygen her falls would be decreased because of the cord which caused falls.
-Resident #1 got up when she wanted to.
-The only way to prevent falls was to provide 24/7 coverage with constant eyes on Resident #1.

Telephone interview with Resident #1's family member on 07/28/22 at 2:30pm revealed:
-She was aware Resident #1 had multiple falls.
-She thought the falls were a result of memory and forgetting she was not supposed to get up and forgetting she wore oxygen.
-The pulmonologist had tried to wean Resident #1 off oxygen, because her oxygen level was maintained while off of the oxygen for about an hour, but then her oxygen levels would start dropping.
-She did not think anything could be done differently to prevent Resident #1 from falling.
-Resident #1 could not be tied to her chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 35 -No one had discussed a change in the level of care for Resident #1. Interview with the Administrator on 07/27/22 at 4:05pm revealed: -He and the HWD talked on 07/25/22, Resident #1 needed to go to skilled care. -They had tried every avenue to keep Resident #1 safe. -They thought Resident #1's oxygen tubing was too short and when the resident walked without it she was getting light-headed, so they lengthened the cord and now she was getting tangled up in the tubing. -They had increased monitoring of Resident #1 from 2-4 hours to 1-2 hours. -They had tried to keep consistent caregivers with Resident #1 so they would know her routine. -Ideally, Resident #1 needed eyes on her at all times. -Usually, the HWD would contact the family about changes in the level of care. -He did not know if the HWD had contacted Resident #1's family member about a change in the level of care. _____ The facility failed to provide adequate supervision for 2 of 5 sampled residents (#1, #3). Resident #3 had 21 falls in 3 months without interventions implemented to prevent falls which resulted in Resident #3 continuing to have falls including a fall with bruises and abrasions, multiple skin tears and staples to her scalp; Resident #2 who had a history of falls and did not have consistently increased supervision from all staff, which resulted in the resident having 3 falls between 06/30/22-07/25/22 and suffered multiple lacerations and bruising to her face. This failure was detrimental to the health, safety, and welfare of residents and constitutes an Unabated Type B	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 270}	Continued From page 36 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 07/28/22. CORRECTION DATE FOR THE UNABATED TYPE B VIOLATION SHALL NOT EXCEED AUGUST 27, 2022. FOLLOW UP TO A TYPE B VIOLATION	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5 sampled residents (#3) who had an order for a urine analysis (UA). The findings are: Review of Resident #3's current FL2 dated 04/11/22 revealed diagnoses included dementia without behaviors, chronic kidney disease III, anxiety, and gastroesophageal reflux disease (GERD). Review of Resident #3's signed physician's order dated 05/12/22 revealed and order to collect urine	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

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{D 273}	Continued From page 37 for a urine analysis (UA). Review of Resident #3's progress notes from 05/11/22 to 07/17/22 revealed there was no documentation of a urine collection or UA results. Review of Resident #3's electronic medication administration record (eMAR) from 05/12/22 to 07/27/22 there was no documentation of a urine collection or a urine analysis results. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 07/28/22 at 10:27am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/28/22 at 1:44pm was unsuccessful. Telephone interview with a representative from Resident #3's primary care provider's (PCP) office on 07/28/22 at 1:48pm revealed: -There was an order from the PCP for a UA for Resident #3 dated 05/12/22. -There were no results from a UA for Resident #3 from 05/12/22 to 07/27/22. Interview with a lab technician from the facility's contracted lab on 07/28/22 at 2:06pm revealed: -There was no documentation of results from a UA for Resident #3 from 05/12/22 to 07/27/22. -There was no documentation a urine collection for Resident #3 was received from the facility from 05/12/22 to 07/27/22. Interview with a medication aide (MA) on	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 273}	Continued From page 38 07/28/22 at 3:50pm revealed: -The MAs could request UA be ordered by the PCP when a resident had behaviors or falls or the PCP saw the number of falls in a record and would request a UA. -Resident #3 was probably ordered a UA due to the number of falls she had. -When the PCP ordered the UA, the MA would place the request for a urine collection on the eMAR. -The order for the urine collection remained on the eMAR until the urine was collected from the resident; then the request for the urine collection would be documented on the eMAR by a MA. -She could not recall a time when Resident #3 had an order to collect urine for a UA, but with the number of falls Resident #3 had in the past few months she was not suprised Resident #3 had an order for a UA. Interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm revealed: -She did not know why Resident #3 did not have results for a UA. -If Resident #3's PCP had ordered a UA then it should have been done. -The MAs were responsible for placing the order to collect urine on the eMAR and then document on the eMAR once the urine was collected. -The order for Resident #3's UA must have "fallen under the rug" and was missed so it was never done. Interview with the Administrator on 07/28/22 at 4:07pm revealed: -He thought the UA for Resident #3 was completed when it was ordered on 05/12/22 as part of the steps taken by the facility when a resident had multiple falls. -He remembered discussing the results with the	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 273}	Continued From page 39 family. -He thought the MA had collected the urine and sent it out for a UA as ordered. -There should have been documentation on the eMAR for the collection of the urine. -He was pretty sure the results were negative. -It was difficult to get lab results from the facility's contracted lab; usually the PCP let the staff know the results and if an antibiotic was needed. -He expected the MAs to enter the order to collect the urine on the eMAR and to document on the eMAR once the urine was collected.	{D 273}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 6 resident sampled (#6) who had orders for a 2gm sodium diet. The findings are: Observation of the storage areas in the kitchen on 07/28/22 at 8:00am revealed there was no low sodium beef base and no whole wheat bread	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 310}	Continued From page 40	{D 310}		

available for service.

Observation of the lunch meal on 07/27/22 at 12:04pm revealed:
-Resident #6 was served corn chowder, meatloaf with gravy, mashed potatoes and a dinner roll.
-Resident #6 ate 100 percent of his corn chowder, meatloaf with gravy, mashed potatoes and the dinner roll.

Observation of the breakfast meal on 07/28/22 at 8:28am revealed:
-Resident #6 was served scrambled eggs, a piece of white toast, two strips of bacon and a sausage patty.
-Resident #6 ate 100 percent of his scrambled eggs, his white toast, the bacon and the sausage patty.

Review of Resident #6's current FL-2 dated 06/16/22 revealed:
-Diagnoses included heart failure, atrial flutter, hypotension, gastroesophageal reflux disease, chronic kidney disease and dementia.
-There was an order for a no added salt diet.

Review of Resident #6's signed physician's diet order dated 06/22/22 revealed there was an order for a 2gm sodium diet.

Review of the facility's therapeutic diet lunch menu dated Wednesday, 07/27/22 revealed:
-There was a 2gm sodium diet listed as a therapeutic diet option.
-The regular lunch menu included corn chowder, meat loaf with gravy, mashed potatoes, green beans and a dinner roll.
-The 2gm sodium diet lunch menu omitted the corn chowder, substituted the meatloaf and gravy with low sodium mushroom gravy and meatloaf,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 310}	Continued From page 41 and substituted the dinner roll with a whole grain roll. Review of the facility's therapeutic diet breakfast menu dated Thursday, 07/28/22 revealed: -There was a 2gm sodium diet listed as a therapeutic diet option. -The regular breakfast menu included scrambled eggs, bacon strips, and wheat toast. -The 2gm sodium diet breakfast menu substituted the bacon strips with a beef patty, and a piece of whole wheat toast. Interview with Resident #6 on 07/28/22 at 8:35am revealed: -He ate what he was served because the food was good. -He was hungry in the mornings and he liked bacon. Attempted telephone interview with Resident #6's family member on 07/28/22 at 11:28am was unsuccessful. Telephone interview with Resident #6's primary care provider (PCP) on 07/28/22 at 1:51pm revealed: -Resident #6 was ordered a 2gm sodium diet due to heart disease. -If Resident #6 did not receive a 2gm sodium diet as ordered it could exasperate his heart condition. -She expected PCP orders to be followed as written. Interview with the cook on 07/27/22 at 8:26am revealed he served sausage patties to the residents; he never served beef patties for breakfast and he did not add salt to the food when he prepared the meals.	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 310}	Continued From page 42 Interview with the Kitchen Manager (KM) on 07/28/22 at 12:40pm revealed: -He was familiar with the 2gm sodium diet and he knew there were residents who were ordered the 2gm sodium diet. -The cook took out portions of meatloaf before adding salt and should have prepared the gravy with low sodium beef base. -He was not aware the therapeutic diet menu substituted beef patties in place of sausage and bacon. -Resident #6 should not have been served the corn chowder. -He did not have whole wheat dinner rolls available for service to the residents who were ordered a 2gm sodium diet. -He had served the bacon and sausage that morning for breakfast and did not reference the therapeutic menu. Interview with the Health and Wellness Director (HWD) on 07/28/22 at 3:02pm revealed she was not involved in the diet orders for residents. Interview with the Administrator on 07/28/22 at 4:07pm revealed: -He was not aware there were residents who were ordered a 2gm sodium diet. -He knew the 2gm sodium diet was a hard diet to follow because it was restrictive and required a list of low sodium items. -The kitchen staff were expected to follow all diet orders as written by the PCP and the therapeutic diet menus. -Resident #6 should have been served the items on the 2gm sodium therapeutic diet menu. -He was concerned the therapeutic diet orders were not followed because the PCP had ordered the diet for Resident #6 for a reason.	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 310}	Continued From page 43 -The 2gm sodium diet should have been followed no matter how hard it was to follow.	{D 310}		
{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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents, (#1) related to anti-anxiety medication and a supplement. The findings are: Review of Resident #1's current FL-2 dated 02/09/22 revealed diagnoses included dementia, chronic kidney disease II, hyperlipidemia, spinal stenosis, and hypertension. a. Review of Resident #1's physician's order dated 05/03/22 revealed there was an order to administer Lorazepam 0.5mg (used to treat anxiety) take ½ tablet (0.25mg) three times daily. Review of Resident #1's 06/13/22-06/30/22 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg twice	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 44	{D 358}		

daily with a scheduled administration time of 8:00am and 8:00pm.
-Lorazepam 0.5mg was documented as administered at 8:00am and 8:00pm from 06/13/22-06/29/22.
-There was an entry for Lorazepam 0.25mg three times daily with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm.
-Lorazepam 0.25mg was documented as administered at 8:00am, 12:00pm, and 8:00pm on 06/30/22.

Review of the facility's Controlled Substance Count Sheet (CSCS) for Resident #1's Lorazepam revealed:
-The directions were handwritten in as Lorazepam 0.25mg take ½ tablet (0.25mg) three times daily.
-Twenty-eight tablets were received at the facility on 05/04/22.
-Lorazepam 0.25mg was documented as administered twice daily at 8:00am and 8:00pm from 06/13/22-06/29/22.
-Lorazepam 0.25mg was documented as administered three times daily at 8:00am, 12:00pm, and 8:00pm from 06/29/22-07/26/22.

Observation of Resident #1's medication on hand on 07/27/22 at 10:52am revealed:
-There was a punch card labeled 2 of 3 with a dispense date of 06/01/22 for Lorazepam 0.5mg, take ½ tablet (.25mg) three times daily; 28 (1/2 tablets) tablets were dispensed on each punch card for a total of 84 ½ tablets.
-There was 1 (1/2) tablet available to be administered from the card dated 06/01/22.
-There were three punch cards with a dispense date of 06/29/22 for Lorazepam 0.5mg with the directions take ½ tablet (.25mg) three times daily; 28 (1/2 tablets) tablets were dispensed on each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 358}	Continued From page 45	{D 358}		

punch card for a total of 84 ½ tablets.
-There were 28 ½ tablets available on each of the three punch cards dispensed on 06/29/22.
-There were three punch cards with a dispense date of 07/27/22 for Lorazepam 0.5mg with the directions take ½ tablet (.25mg) three times daily; 28 (1/2 tablets) tablets were dispensed on each punch card for a total of 84 ½ tablets.
-There were 28 ½ tablets available on each of the three punch cards dispensed on 07/27/22.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/27/22 at 3:34pm revealed:
-Resident #1's order for Lorazepam 0.25mg three times daily had been in place since 04/06/22.
-Lorazepam 0.50mg (1/2 tablets) were dispensed on 04/06/22, 04/27/22, 05/25/22, 06/22/22, and 07/20/22, each dispensing was a 28-day supply if administered three times per day as ordered.
-The facility entered its orders into the eMAR system.
-The pharmacy profiled the order they received, but it was not linked to the facility's eMARs.
-The last time Resident #1's Lorazepam was dispensed with the directions to administer twice a day was on 02/28/22; thirty tablets were dispensed for a 15-day supply.

Telephone interview with Resident #1's mental health provider on 07/27/22 at 5:12pm revealed:
-Resident #1's Lorazepam was changed from 0.5mg twice a day to 0.25mg three times a day to stretch out the coverage period instead of the higher dose.
-If Resident #1's Lorazepam was administered at 8:00am it would wear off in about four hours and Resident #1 would have increased anxiety, so she thought if she lowered the dosage and increased it to three times a day, Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 358}	Continued From page 46	{D 358}		

would not be as sleepy but would have more coverage.
-She thought the lower dose more often, would help with Resident #1's increased anxiety that had been reported.
-She was concerned the medication had not been administered as ordered and was the reason staff had reported increased anxiety.
-She expected her orders to be administered as written.

Interview with a medication aide (MA) on 07/28/22 at 11:44am revealed:
-She read the medication label and compared it to the eMAR and if it did not match, she went to the nurse.
-She did not recall seeing Resident #1's Lorazepam label and eMAR not matching.
-She recalled there being a punch card for Resident #1's Lorazepam with the directions to administer it twice a day.
-She did not catch Resident #1's Lorazepam order was for three times daily when she only administered the medication once during her shift.

Interview with another MA on 07/28/22 at 12:02pm revealed:
-She was the one who entered the order for Resident #1's Lorazepam to be administered three times daily instead of twice daily beginning 06/30/22.
-She did not recall if another MA had questioned the eMAR and label not matching or if she had been administering a medication that day and saw that it did not match.
-She had not seen Resident #1's order dated 05/03/22.
-She recalled there being "confusion" with the order and she had it clarified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 47 -She would have expected a MA to have noticed the label did not match the eMAR and asked for it to be clarified. Interview with the Health and Wellness Director (HWD) on 07/28/22 at 12:15pm revealed: -MAs could enter orders into the eMAR. -There was supposed to be a second and third check by two other staff members to verify the order had been entered correctly. -The MAs should use three checks before administering medication, including looking at the medication on the eMAR, pulling the medication from the medication cart that was listed on the eMAR, and then making sure the eMAR medication/directions and the medication label matched. -If the label did not match the eMAR, the MAs were supposed to question why it did not match, and "check the orders." -She thought the staff had become complacent. -She expected the six rights of medication administration to be used when administering medication and if there was any question, do not administer the medication, and seek clarification. Interview with the Administrator on 07/28/22 at 12:38pm revealed: -He expected staff to use the new order tracking form to ensure orders were implemented as written. -He expected the MAs to compare the medication to the eMAR and the CSCS and if either did not match, the MA should go back and check the order. -For whatever reason, Resident #1's mental health provider had changed the Lorazepam order and he was concerned it was missed. b. Review of Resident #1's current FL-2 dated	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 48 02/09/22 revealed an order to administer Eldertonic 15ml before meals (a multivitamin product used to treat or prevent vitamin deficiency). Review of Resident #1's 06/13/22-06/30/22 electronic medication administration record (eMAR) revealed: -There was an entry for Eldertonic 15ml with a scheduled administration time of 7:30am, 11:30am, and 4:30pm. -Eldertonic was documented as administered at 7:30am, 11:30am, and 4:30pm from 06/13/22-06/30/22. Review of Resident #1's 07/01/22-07/26/22 eMAR revealed: There was an entry for Eldertonic 15ml with a scheduled administration time of 7:30am, 11:30am, and 4:30pm. -Eldertonic was documented as administered at 7:30am, 11:30am, and 4:30pm from 07/01/22-07/26/22. -There were exceptions documented on 07/07/22 at 7:30am and 11:30am the medication was not in the facility. Review of Resident #1's progress notes dated 07/02/22 revealed the Eldertonic was not available and the MA would contact the pharmacy to refill. Observation of Resident #1's medication on hand on 07/27/22 at 10:52am revealed: -There was a bottle of Eldertonic give 15ml before each meal. -The container contained liquid, though it could not be determined how much because the container was solid brown.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 49	{D 358}		

Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/27/22 at 3:34pm revealed:
-Resident #1's Eldertonic was dispensed on 06/04/22, 06/21/22, and 07/07/22.
-Each time a 473ml bottle was dispensed and the bottle would last 10.5 days if 15ml was administered three times a day as ordered.
-Eldertonic was a geriatric vitamin.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 07/28/22 at 10:00am was unsuccessful.

Interview with a medication aide (MA) on 07/28/22 at 11:44am revealed:
-Medications are on cycle fill except for some that had to be ordered through the eMAR when they get low.
-The pharmacy would deliver anything ordered that night to the facility.

Interview with the Health and Wellness Director on 07/28/22 at 12:15pm revealed:
-MAs reordered medications not on cycle fill through the eMAR.
-She expected medications should be ordered when they start to get low so that the resident did not run out.
-She expected resident medications to be administered as ordered.
-She expected the six rights of medication administration to be used when administering medication and if there was any question, do not administer the medication, and seek clarification.

Interview with the Administrator on 07/28/22 at 12:38pm revealed:
-He expected staff to use the new order tracking form to ensure orders were implemented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 50 written. -Most medications are filled on a cycle date from pharmacy, some have to be ordered as they get low. -He expected the MAs to reorder medications before they run out. -He expected all medications to be administered as ordered.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and health care. The findings are: 1. Based on interviews and record reviews the facility failed to provide supervision for 2 of 5 sampled residents (#1 and #3) who sustained 21 falls in three months, three of which resulted in injuries (#3) and a resident who had a history of falls, sustained 3 falls one of which resulted in an injury (#1). . [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type B Violation)].	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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