STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 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 an annual and a follow-up survey from 05/16/23 to 05/18/23.	D 000		
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 observations, record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs of 2 of 5 sampled residents (#1 and #5) related to dry, discolored feet and toenail care for long and discolored toenails (#1), and to notify the Primary Care Provider (PCP) of fingerstick blood sugars (FSBS) readings less than 60 and greater than 450 as ordered. The findings are: 1. Review of Resident #1's current FL-2 dated 07/26/23 revealed: -Diagnoses of heart failure, depression, anxiety with a history of sepsis. -The resident was semi-ambulatory using a wheel chair. -The resident needed personal care assistance with bathing. Observation of Resident #1 during the morning tour on 05/16/23 at 9:00am revealed: -Resident #1 was seated in her wheelchair removing her socks. -After removing her socks, she lightly rubbed the tops of her feet and separated her toes from each	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 1	D 273		

other.

Observation of Resident #1's feet and toenails on 05/16/23 at 9:33am revealed:
-The Resident's feet were a dark pink color and had dry, peeling skin.
-The Resident's toes were puffy and curved together.
-The Resident's toenail plates were thick, discolored yellow with brown spots, ragged edges, scraped nail plates that extended beyond the ends of her toes from one-quarter inch long to a one-half inch long.
-The third toe on Resident #1's left foot was curved into the toe beside it with the jagged nail plate pushing into the other toe.

Review of Resident #1's record revealed:
-There was a document titled Mycotic (diseased) Nail Debridement Services, dated 03/07/23, and signed by the facility podiatrist.
-Diagnoses were pain and cellulitis in left toe.
-Nail plates were described as discolored yellow and had an accumulation of debris under the nail plates that were greater than three mm thick.
-There was no documentation Resident #1's toenails were trimmed and buffed during the appointment.
-There were no other podiatry reports in Resident #1's records.

Interview with Resident #1 on 05/16/23 at 9:20am revealed:
-Her toenails grew fast making them longer and thicker and needed trimming often.
-She had a thick curved toenail that was pushing into the side of the toe beside it and it was uncomfortable at times.
-She had thick yellow toenails on both feet that were hard to trim and needed a podiatrist for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 2	D 273		

proper care.
-The facility had a podiatrist that came every three months to trim toe nails, but when he was at the facility, he did not trim her toenails.
-She asked the salon beautician to trim her toenails.
-Her left foot was sometimes uncomfortable because of the longer toenails rubbing together.
-The personal care aides (PCA) helped with her shower, mostly washing her back and the front of her legs.
-Staff did not pay much attention to her feet and never asked if she wanted to have the podiatrist trim her toenails.
-Resident #1 did not tell the PCA her toes and feet needed care; she just waited for an appointment for the podiatrist to trim her toenails.
-The podiatrist came on 03/07/23 but did not do foot care for her.
-Her toenails were not trimmed or buffed by the podiatrist on 03/07/23.
-She asked the salon beautician to trim her toenails.

Review of the weekly shower schedule for Resident #1 revealed she was to be given a shower on Tuesdays at 8:00pm and Saturdays at 8:00pm as of May 15, 2023.

Interview with a PCA on 05/17/23 at 2:00pm revealed:
-There was a schedule for residents to have showers twice weekly.
-Resident #1 was independent and could bathe herself.
-She would help wash Resident #1's back.
-Resident #1 would be assessed from head to toe, looking for bruises or wounds and checking her legs and feet.
-She last helped Resident #1 take a shower on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 3	D 273		

05/09/23 and she noticed the resident's toenails needed trimming.
-She asked the medication aide (MA) to look at Resident #1's feet.
-Resident #1 needed to be scheduled to see a podiatrist.

Interview with a second PCA on 05/17/23 at 3:35pm revealed:
-Resident #1 showered on second shift and she helped Resident #1 shower yesterday evening (05/16/23).
-The PCA helped Resident #1 wash her back, legs and feet.
-Every resident had the choice of seeing a podiatrist every three months for toenail trimming and care.
-Resident #1 had not complained of discomfort from her feet or toes.
-Resident #1's toenails were long, thickened and yellowed.
-Resident #1 needed to be assessed and treated by the podiatrist.

Interview with a MA on 05/18/23 at 9:10am revealed:
-When the PCAs helped residents to take a shower they were to make head to toe skin assessments and report any skin problems or discomfort to the Health and Wellness Director (HWD).
-For routine resident foot care, a resident would be scheduled to see the podiatrist every three months.
-The MA did not know if Resident #1 had been seen by a podiatrist for foot care or was scheduled to see the podiatrist on the next visit to the facility.
-The MA did not know of any podiatry care scheduled for Resident #1 other than the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 4	D 273		

scheduled visits every three months.
-The HWD scheduled residents' appointments with the podiatry team every three months.

Interview with the HWD on 05/18/23 at 9:07am revealed:
-There was routine podiatry care visits available every three months for residents who wanted the service.
-The PCAs and MAs knew to document on the assignment sheets or call her if there were any concerns about resident care.
-She was not aware Resident #1 had an acute toenail condition, causing discomfort, that required podiatry care.
-She expected to be notified by the MA that Resident #1 needed her toenails trimmed and podiatry care.

Attempted telephone interview with Resident #1's family member on 05/18/23 at 8:45am unsuccessful.

Attempted telephone interview with the podiatrist on 05/18/23 at 8:37am unsuccessful.

Interview with the Administrator on 05/18/23 at 9:10am revealed:
-The facility did not have a policy for podiatry care but had a routine of scheduling a visiting podiatrist to trim toenails and provide care for residents' feet.
-She had not been told of Resident #1's foot and toenail condition by the MA or the HWD.
-If she had known there was an acute need for podiatry service for Resident #1, she would have quickly obtained a podiatrist for the resident.
-She was concerned Resident #1 had not received the health care she needed.

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	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 5	D 273		

Interview with Resident #1's PCP on 05/18/23 at 12:00pm revealed:
-She was not made aware of the condition of Resident #1's feet.
-She was not made aware the podiatrist did not trim and buff Resident #1's toenails on 03/07/23.
-She did not receive update reports for podiatrist visits.
-She was notified on 05/18/23 to come to the facility to assess Resident #1's feet.
-She trimmed Resident #1's toenails and applied a topical antifungal medication.

2. Review of Resident #5's current FL-2 dated 01/18/23 revealed diagnosis included diabetes mellitus.

a. Review of Resident #5's current FL-2 dated 01/18/23 revealed there was an order to notify the PCP and endocrinologist if FSBS readings were less than 60.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry to notify the PCP and endocrinologist if FSBS readings were less than 60.
-There was a FSBS reading of 49 on 03/08/23 at 7:30am.
-There was a FSBS reading of 58 on 03/12/23 at 7:30am.

Review of Resident #5's March 2023 progress notes revealed there was no documentation that Resident #5's PCP or endocrinologist were notified of the low FSBS readings on 03/08/23 and 03/12/23.

Interview with Resident #5 on 05/19/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 6 11:30am revealed she did not recall any FSBS readings below 60. Interview with a medication aide (MA) on 05/19/23 at 12:40pm revealed: -Resident #5 had an order to call the PCP for a FSBS reading less than 60. -She could not remember if she had called the PCP for a FSBS reading below 60. -She could not remember if she had documented in Resident #5's progress note that the PCP had been notified of FSBS readings less than 60. Interview with the Health and Wellness Director (HWD) on 05/19/23 at 10:31am revealed: -The MAs should follow the PCP or Endocrinologist orders as written. -The MAs should call the PCP or Endocrinologist when Resident #5's FSBS reading was less than 60. -The MA should document in Resident #5's progress notes with each FSBS reading less than 60. Interview with the Administrator on 05/19/23 at 12:21pm revealed: -The MAs should call the PCP for FSBS readings less than 60 and document the notification in the progress notes. -The MAs were expected to follow the physician orders as written. Attempted telephone interview with Resident #5's Endocrinologist on 05/18/23 at 8:13am unsuccessful. b. Review of Resident #5's 6-month signed physician orders dated 02/08/23 revealed there was an order to check Resident #5's FSBS 30 minutes before meals and at bedtime and notify	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 7 the PCP if FSBS was greater than 450. Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check Resident #5's FSBS before meals and at bedtime. -There was a FSBS reading of 481 on 03/15/23 at 5:30pm. -There was a FSBS reading of 469 on 03/20/23 at 5:30pm. Review of Resident #5's April 2023 eMAR revealed: -There was an entry to check Resident #5's FSBS before meals and at bedtime. -There was a FSBS reading of 457 on 04/01/23 at 11:30am. -There was a FSBS reading of 483 on 04/03/23 at 11:30am. -There was a FSBS reading of 475 on 04/04/23 at 5:30pm. Review of Resident #5's March 2023 progress notes revealed there was no documentation that Resident #5's PCP or endocrinologist were notified of the elevated FSBS readings on 03/15/23, 03/20/23, 04/01/23, 04/03/23 and 04/04/23. Interview with a medication aide (MA) on 05/19/23 at 12:40pm revealed: -Resident #5 had an order to call the PCP for a FSBS reading greater than 450. -She could not remember if she had called the PCP for a FSBS reading greater than 450. -She could not remember if she had documented in Resident #5's progress notes that the PCP had been notified of an FSBS reading greater than 450.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 273	Continued From page 8 Interview with the Health and Wellness Director (HWD) on 05/19/23 at 10:31am revealed: -The MAs should follow the PCP or Endocrinologist orders as written. -The MAs should call the PCP or Endocrinologist when Resident #5's FSBS reading was greater than 450. -The MAs should document in Resident #5's progress notes with each FSBS reading greater than 450. Interview with the Administrator on 05/19/23 at 12:21pm revealed: -The MAs should call the PCP for FSBS readings greater than 450 and document the notification in the progress notes. -The MAs were expected to follow the physician orders as written. Attempted telephone interview with Resident #5's Endocrinologist on 05/18/23 at 8:13am unsuccessful.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 276	Continued From page 9	D 276		

physician orders for 1 of 5 sampled residents (#5) who had an order to recheck a fingerstick blood sugar (FSBS) within 30 to 60 minutes after a FSBS reading below 60 was obtained.

The findings are:

Review of Resident #5's current FL-2 dated 01/18/23 revealed diagnosis included diabetes mellitus.

Review of Resident #5's 6-month signed physician orders dated 02/18/23 revealed there was an order to recheck FSBS in 30 minutes to 1 hour for FSBS readings less than 60.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry to recheck FSBS readings less than 60 within 30 minutes to 1 hour after administration of a glucose chewable tablet.
-There was no documentation that Resident #5's FSBS was rechecked within 30 minutes to 1 hour for a FSBS reading below 60 on 03/08/23 with a FSBS reading of 49 or on 03/12/23 with a FSBS reading of 58.

Review of Resident #5's March 2023 progress notes revealed there was no documentation of Resident #5 's FSBS being rechecked on 03/08/23 or 03/12/23 after a FSBS reading below 60.

Interview with Resident #5 on 05/19/23 at 11:30am revealed:
-The MAs checked her FSBS four times daily.
-The medication aides (MA) had not rechecked her FSBS in the past three months.
-There was no need for the MA to recheck her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 10 FSBS; she did not have any low FSBS readings. Interview with a MA on 05/19/23 at 12:40pm revealed: -She did not remember rechecking Resident #5's FSBS after the first FSBS reading was less than 60. -She would have documented in Resident #5's progress notes if she rechecked Resident #5's FSBS. Interview with the Health and Wellness Director (HWD) on 05/19/23 at 10:31am revealed: -The MAs should recheck Resident #5's FSBS as ordered after a FSBS reading less than 60. -The MA should document the rechecked FSBS reading in Resident #5's progress notes. Interview with the Administrator on 05/19/23 at 12:21pm revealed: -The MAs should recheck Resident #5's FSBS within 30 minutes to 1 hour when the FSBS readings were less than 60. -The MAs were expected to follow the physician orders as written. Attempted telephone interview with Resident #5's Endocrinologist on 05/18/23 at 8:13am unsuccessful.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 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 280	Continued From page 11	D 280		

plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 1 of 5 sampled residents (#4) with LHPS tasks of inhalation medication by machine and for oxygen administration and monitoring.

The findings are:

1. Review of Resident #4's current FL2 dated 08/04/22 revealed diagnoses included muscle atrophy, chronic obstructive pulmonary disease (COPD), and atrial fibrillation.

a. Review of Resident #4's current FL2 dated 08/04/22 revealed an order for ipratropium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 280	Continued From page 12 bromide solution 0.02% inhale three times a day. Review of Resident #4's LHPS evaluation dated 05/16/23 revealed: -There was documentation for inhalation medication by machine as a marked task. -There were no recommendations documented on the LHPS evaluation. -There were no LHPS evaluations since 08/12/22. Review of Resident #4's LHPS evaluation dated 08/12/22 revealed: -There was documentation for inhalation medication by machine as a marked task. -There were no recommendations documented on the LHPS evaluation. -The LHPS evaluation was only partially completed. Review of Resident #4's April 2023 medication administration record (MAR) revealed: -There was an entry for ipratropium bromide solution 0.02% inhale one application three times a day scheduled at 8:00am, 4:00pm and 9:00pm. -There was documentation ipratropium bromide solution 0.02% was documented as administered three times daily from 04/01/23 to 04/30/23. Review of Resident #4's May 2023 MAR from 05/01/23 to 05/16/23 revealed: -There was an entry for ipratropium bromide solution 0.02% inhale one application three times a day scheduled at 8:00am, 4:00pm and 9:00pm. -There was documentation ipratropium bromide solution 0.02% was documented as administered three times daily from 05/01/23 to 05/16/23. Attempted interview with Resident #4 on 05/17/23 at 2:20pm unsuccessful.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 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 280	Continued From page 13	D 280		

Refer to the interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:00am.

Refer to the interview with the Administrator on 05/18/23 at 12:10pm.

b. Review of Resident #4's current FL2 dated 08/04/22 revealed there was an order for continuous oxygen administration at 2 liters per minute.

Review of a physician's order for Resident #4 dated 02/28/23 revealed there was an order to increase Resident #4's continuous oxygen administration to 4 liters per minute.

Review of Resident #4's LHPS evaluation dated 05/16/23 revealed:
-There was documentation for oxygen administration and monitoring as a marked task.
-There were no recommendations documented on the LHPS evaluation.
-There were no LHPS evaluations since 08/12/22.

Review of Resident #4's LHPS evaluation dated 08/12/22 revealed:
-There was documentation for oxygen administration and monitoring as a marked task.
-There were no recommendations documented on the LHPS evaluation.
-The LHPS evaluation was only partially completed.

Observation in Resident #4's room on 05/17/23 at 2:20pm revealed Resident #4 was wearing a nasal cannula and the oxygen concentrator was set at 4 liters per minute continuously as ordered.

Attempted interview with Resident #4 on 05/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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D 280	Continued From page 14 at 2:20pm unsuccessful. Refer to the interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:00am. Refer to the interview with the Administrator on 05/18/23 at 12:10pm. _____ Interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:00am revealed: -She completed the residents' LHPS evaluations as she was a Registered Nurse (RN). -The initial LHPS evaluation for Resident #4 dated August 2022 was incomplete because a computer had locked out while the evaluation was being completed. -Resident #4 required continuous oxygen administration since she was admitted to the facility in August 2022. -She was aware that LHPS evaluations were required to be completed quarterly, but she was not aware that Resident #4's LHPS evaluations were not done until 05/16/23. -There were no completed LHPS evaluations for Resident #4 between 08/12/22 and 05/16/23. -She was responsible to ensure that the residents' LHPS evaluations were completed quarterly. Interview with the Administrator on 05/18/23 at 12:10pm revealed: -The last LHPS evaluation for Resident #4 prior to 05/16/23 was dated August 2022 and it was incomplete. -She was not aware that the residents' LHPS evaluations were required to be completed quarterly. -She was not aware that Resident #4's LHPS evaluations were not completed quarterly.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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D 280	Continued From page 15 -The HWD completed the residents' LHPS evaluations as she was a RN. -The HWD was responsible to ensure that the residents' LHPS evaluations were completed quarterly.	D 280		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 6 sampled residents (#5 and #6) who had an order for an inhaler twice daily, an order for an as needed medication to be administered for blood sugars less than 60, a pain medication (#5) and a resident who received a medication to prevent skin irritation and breakdown (#5). The findings are: 1. Review of Resident #5's current FL-2 dated 01/18/23 revealed diagnoses included diabetes mellitus, hypertension, vitamin D deficiency, vitamin B deficiency, and hypertension. a. Review of Resident #5's current FL-2 dated 01/18/23 revealed there was an order to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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D 358	Continued From page 16	D 358		

administer a glucose (used to treat a low blood sugar reading) tablet for fingerstick blood sugar (FSBS) readings less than 60.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for glucose tablets for FSBS reading less than 60.
-There was no documentation glucose tablets were administered on 03/08/23 with a FSBS reading of 49 or on 03/12/23 with a FSBS reading of 58.

Observation of Resident #5's medications on hand on 05/18/23 at 10:02am revealed:
-There were 10 of 10 glucose chewable tablets dispensed on 02/22/23 available for administration.
-The bottle of glucose chewable tablets was un-opened and sealed with plastic.

Telephone interview with a representative at the facility's contracted pharmacy on 05/17/23 at 3:06pm revealed:
-The pharmacy had an order for glucose 4mg chewable tablets for a FSBS reading less than 60.
-The pharmacy dispensed 10 glucose tablets on 02/22/23.
-The pharmacy had only dispensed glucose chewable tablets once for Resident #5.

Review of eMAR documentation, medications dispensed and medications on hand between 02/22/23 and 05/18/23 revealed there were 10 glucose chewable tablets dispensed on 02/22/23 and available for administration on 03/08/12 and 03/12/28 when Resident #5's FSBS readings were below 60, with 10 of 10 tablets remaining as

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	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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D 358	Continued From page 17 of 05/16/23. Interview with Resident #5 on 05/18/23 at 11:30am revealed: -She had not had any low FSBS readings in three months. -She had not received any glucose chewable tablets in the last three months. Interview with a medication aide (MA) on 05/18/23 at 12:40pm revealed: -She did not know if she had administered glucose chewable tablets to Resident #5. -If she did administer glucose chewable tablets to Resident #5, she would have documented on the eMAR and in the progress notes. Interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am revealed: -The MAs should administer glucose chewable tablets to Resident #5 for FSBS reading less than 60 and document the medication administration on the eMAR -There was no place on the eMAR to document when glucose chewable tablets were administered. -The MAs should have documented in the progress notes when glucose chewable tablets were administered. -The MAs probably administered orange juice to Resident #5 for low FSBS readings. -The MAs should follow the physician orders and administer the glucose chewable tablet instead of the orange juice. Interview with the Administrator on 05/18/23 at 12:21pm revealed: -The MAs should administer glucose chewable tablets as ordered for FSBS readings less than 60.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 18 -The MAs should document when Resident #5 was administered a glucose chewable tablet on the eMAR and in the progress notes. Attempted telephone interview with Resident #5's Endocrinologist on 05/18/23 at 8:13am unsuccessful. Refer to the interview with a medication aide (MA) on 05/17/23 at 10:05am. Refer to the interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am. b. Review of Resident #5's current FL-2 dated 01/18/23 revealed there was an order to administer acetaminophen 325mg (used to treat pain) 2 tablets every 12 hours as needed for pain. Review of Resident #5's April 2023 electronic medication administration record (eMAR) from 04/29/23 to 04/30/23 revealed: -There was an entry for acetaminophen 325mg 2 tablets every 12 hours as needed for pain. -There was no documentation acetaminophen was administered on 04/29/23 and 04/30/23. -There was no entry for acetaminophen 325mg 2 tablets every 6 hours as needed for pain, not to exceed 8 tablets in 24 hours. Review of Resident #5's May 2023 eMAR from 05/01/23 to 05/15/23 revealed: -There was an entry for acetaminophen 325mg 2 tablets every 12 hours as needed for pain. -There was no documentation acetaminophen was administered from 5/01/23 to 05/15/23. -There was no entry for acetaminophen 325mg 2 tablets every 6 hours as needed for pain, not to exceed 8 tablets in 24 hours.	D 358		

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D 358	Continued From page 19 Observation of Resident #5's medications on hand on 05/17/23 at 10:42am revealed: -There was a blister pack with 12 of 60 acetaminophen tablets remaining dispensed on 04/29/23. -The directions on the prescription label read administer 2 tablets every 6 hours as needed for pain, not to exceed 8 tablets in 24 hours. -There was no blister pack of acetaminophen with a prescription label that read 2 tablets every 12 hours as needed. Telephone interview with a representative at the facility's contracted pharmacy on 05/17/23 at 3:06pm revealed: -The pharmacy had an order for acetaminophen 325mg 2 tablets every 6 hours as needed for pain, not to exceed 8 tablets within 24 hours dated 04/29/23. -The pharmacy dispensed 60 acetaminophen tablets on 04/29/23. -The pharmacy did not have an order for acetaminophen 325mg 2 tablets every 12 hours as needed for pain. Review of eMAR documentation, medications dispensed and medications on hand between 04/29/23 to 05/16/23 revealed: -There were 60 acetaminophen 325mg tablets dispensed on 04/29/23. -There were 12 of 60 acetaminophen 325mg tablets dispensed on 04/29/23 available for administration. -There was no documentation acetaminophen 325mg was administered from 04/29/23 to 05/16/23, and there should have been 60 tablets remaining. Interview with Resident #5 on 05/18/23 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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D 358	Continued From page 20 11:30am revealed: -She received 2 acetaminophen 325mg twice daily, in the morning and in the evening. -She did not ask for any additional acetaminophen because she did not need it. Interview with a medication aide (MA) on 05/18/23 at 9:37am revealed: -She did not remember administering acetaminophen as needed for pain to Resident #5. -Resident #5 had a scheduled order for acetaminophen 325mg 2 tablets twice daily. -Resident #5 did not ask for acetaminophen for pain. -She thought the as needed order for acetaminophen was discontinued. -When an as needed medication was administered, the MA would document on the eMAR and document in Resident #5's progress notes the effectiveness of the as needed medication. Telephone interview with Resident #5's Primary Care Provider (PCP) on 05/17/23 at 4:35pm revealed: -Resident #5 was ordered acetaminophen 325mg 2 tablets every 12 hours as needed for pain. -Resident #5 had a scheduled order for acetaminophen 325mg 2 tablets twice a day. -She did not have an order for acetaminophen 325mg 2 tablets every 6 hours. -She did not know who ordered acetaminophen 325mg 2 tablets every 6 hours. -If Resident #5 was administered too much acetaminophen it could lead to liver toxicity. Interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am revealed: -The MAs should follow the orders as entered on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 21	D 358		

the eMAR.
-The MAs should have noticed the order on the eMAR was different from the instructions on the prescription label of the dispensed medication.
-She did not know why there was no entry on the eMAR for acetaminophen 325mg 2 tablets every 6 hours.
-The MAs should be documenting on the eMAR when an as needed medication was administered.

Interview with the Administrator on 05/18/23 at 12:21pm revealed:
-The MAs should document on the eMAR each time a medication was administered.
-The MAs should have noticed the instructions on the eMAR and the instructions on the prescription label on the dispensed medication were different, and then notified the pharmacy.
-The MAs could not tell the last time Resident #5 had been administered acetaminophen 325mg if it was not documented.
-The MAs could administer acetaminophen doses too close together or too many tablets in a 24-hour period.

Attempted telephone interview with the physician who prescribed acetaminophen 325mg 2 tablets every 6 hours as needed on 05/18/23 at 8:41am unsuccessful.

Refer to the interview with a medication aide (MA) on 05/17/23 at 10:05am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am.

c. Review of Resident #5's signed 6-month physician orders dated 02/18/23 revealed there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 358	Continued From page 22	D 358		

was an order for Symbicort 160-4.5 9 (used to maintain airflow) administer 2 inhalations twice daily and rinse mouth with water after use.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 120 inhaler 160-4.5mcg 2 puffs twice daily with a scheduled administration time of 8:00am and 6:00pm.
-There was documentation Symbicort was administered twice daily from 03/01/23 to 03/31/23.

Review of Resident #5's April 2023 eMAR revealed:
-There was an entry for Symbicort 120 inhaler 160-4.5mcg 2 puffs twice daily with a scheduled administration time of 8:00am and 6:00pm.
-There was documentation Symbicort was administered twice daily from 04/01/23 to 04/30/23.

Review of Resident #5's May 2023 eMAR from 05/01/23 to 05/15/23 revealed:
-There was an entry for Symbicort 120 inhaler 160-4.5mcg 2 puffs twice daily with a scheduled administration time of 8:00am and 6:00pm.
-There was documentation Symbicort was administered twice daily from 05/01/23 to 05/15/23.

Observation of Resident #5's medications on hand on 05/17/23 at 10:44am revealed:
-There was a Symbicort inhaler in a zip-lock bag with a dispensed date of 03/07/23.
-The directions on the prescription label read inhale 2 puffs twice daily and rinse mouth after use.
-There were 15 of 120 inhalations remaining in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 358	Continued From page 23 the inhaler. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/17/23 at 3:06pm revealed: -The pharmacy had an order for Symbicort 120 inhaler 160-4.5mcg 2 puffs twice daily. -The pharmacy dispensed Symbicort 120 inhaler on 02/11/23, 03/07/23, and 03/31/23. -Symbicort 120 inhaler would last 30 days when ordered 2 puffs twice daily. Review of eMAR documentation, medications dispensed and medications on hand between 03/07/23 to 05/16/23 revealed: -There were 2 Symbicort 120 inhalers 160-4.5 dispensed from 03/07/23 to 05/16/23. -Two inhalers would last 60 days, from 03/08/23 to 05/06/23. -There should have been no Symbicort available for administration from 05/06/23 to 05/16/23, but there was 1 inhaler with 15 inhalations remaining, when there should have been zero. Interview with Resident #5 on 05/18/23 at 11:30am revealed: -She received her Symbicort twice a day. -The MA would give her the inhaler and she would administer it herself. -She administered 2 puffs in the morning and 2 puffs in the evening. -She thought she had received it twice daily. -She could not recall any day that she did not get the inhaler. -She was not experiencing any difficulty breathing. Telephone interview with Resident #5's Primary Care Provider (PCP) on 05/17/23 at 4:35pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 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 24	D 358		

-Symbicort Inhaler was used to help Resident #5 breathe easier.
-Resident #5 could have difficulty breathing if Symbicort inhaler was not administered as ordered.

Interview with the Health and Wellness Coordinator (HWC) on 05/18/23 at 10:51am revealed:
-The Symbicort inhaler on the medication cart was the inhaler dispensed on 03/31/23.
-The Symbicort inhaler was dispensed in a box which was too big for the top drawer of the medication cart, so the inhaler was removed and placed in the zip lock bag with the prescription label that was dispensed on 03/07/23.
-Resident #5 would ask for her medications.
-She did not know why the inhaler dispensed on 03/31/23 was still on the medication cart and had 15 inhalations remaining as of 05/18/23.

Interview with the Administrator on 05/18/23 at 12:21pm revealed:
-It appeared the MAs had not administered the medication as ordered.
-The medication should remain in the original dispensing bag or zip lock bag with the accurate dispensed date.
-The MAs were expected to administer the Symbicort inhaler as ordered.

Refer to the interview with a medication aide (MA) on 05/17/23 at 10:05am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am.

2. Review of Resident #6's current FL-2 dated 10/28/22 revealed diagnoses included difficulty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1568 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 25	D 358		

walking, muscle weakness, chronic peripheral venous insufficiency, chronic gout, congestive heart failure, and chronic kidney disease.

Review of Resident #6's current FL-2 dated 10/28/22 revealed there was an order for moisture barrier cream apply to groin area every 12 hours as needed.

Observation of Resident #6's room on 05/16/23 at 9:12am to 2:34pm revealed:
-Resident #6 was seated in her wheelchair, alone in her room.
-There was a medicine cup about 1/5 full of white cream sitting on the nightstand.
-There was no medication aide (MA) present.
-At 10:25am, the medicine cup about 1/5 full of white cream remained on the nightstand.
-Resident #6 was in her room, but there was no MA present.
-At 12:29pm, the medicine cup about 1/5 full of white cream remained on the nightstand.
-Resident #6 was not in her room and the door was unlocked.
-At 1:03pm, the medicine cup about 1/5 full of cream remained on the nightstand.
-Resident #6 was not in her room and the door was unlocked.
-At 2:34pm, the medicine cup about 1/5 full of cream remained on the nightstand.
-Resident #6 was in her room, but there was no MA present.

Interview with Resident #6 on 05/16/23 at 9:12am revealed:
-The white cream in the medication cup was for her bottom.
-She sat in a wheelchair all day and she did not want to get a sore on her bottom.
-The medication aide (MA) brought the white

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26	D 358		

cream last night, but she had not used any.
-She planned to apply the cream to her bottom today.
-The MAs would leave the cream in a medicine cup in her room, so she would have the cream when needed.
-She could not keep the tube of cream in her room.
-She did not use the cream every day, only when needed.

Review of Resident #6's May electronic medication administration record (eMAR) from 05/01/23 to 05/15/23 revealed:
-There was an entry for moisture barrier cream apply to groin topically every 12 hours as needed for rash.
-There was no documentation that moisture barrier cream had been applied to Resident's groin for rash.
-There was no entry for moisture barrier cream to be applied to Resident #6's bottom.

Observation of Resident #6's medications on hand on 05/18/23 at 10:06am revealed:
-There was a tube of moisture barrier cream about 3/4 full available for administration.
-The prescription label read apply to affected area topically as needed for incontinence.

Telephone interview with a representative at the facility's contracted pharmacy on 05/17/23 at 3:06pm revealed:
-The pharmacy had an order for moisture barrier cream apply to groin twice daily as needed for rash.
-A tube of moisture barrier cream was dispensed on 03/10/23.
-The pharmacy had only dispensed a tube of moisture barrier cream once.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041039	A. BUILDING: _____ B. WING _____	R 05/18/2023

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D 358	Continued From page 27 Interview with a medication aide (MA) on 05/18/23 at 9:37am revealed: -She had never left moisture barrier cream in Resident #6's room. -She would apply the moisture barrier cream to Resident #6's bottom when requested. -She did not realize the order for the moisture barrier cream was for Resident #6 -She knew that the moisture barrier cream had been left in Resident #6's room for the personal care aides (PCA) to apply. Interview with a second MA on 5/19/23 at 1:10pm revealed: -She worked 2nd shift and had administered moisture barrier cream to Resident #6. -Resident #6 requested moisture barrier cream for her bottom because she did not want to get a sore on her bottom. -When Resident #6 requested moisture barrier cream, she would dispense the cream in a medication cup and placed it at Resident #6's bedside. -The PCAs would assist Resident #6 with applying the moisture barrier cream to Resident #6's sacrum. -She knew she could not leave the tube of moisture barrier cream in Resident #5's room, but she thought it was fine to leave a small amount in a medication cup for the PCA to apply. -She thought she documented the administration of the moisture barrier cream on the eMAR. -She did not notice the as needed order for the moisture barrier cream was for a rash to the groin and not to Resident #6's bottom. Interview with the Health and Wellness Coordinator (HWC) on 05/18/23 at 10:51am revealed:	D 358		

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D 358	Continued From page 28	D 358		

-The MAs should not leave medications at the bedside to be administered later.
-The MAs should administer medications while in the room with the resident.
-She did not know the MAs left moisture barrier cream at Resident #6's bedside for administration.

Interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am revealed:
-The MA should not leave medications in Resident #6's room for someone else to administer.
-The MA should apply the moisture barrier cream to Resident #6 before leaving the room.

Interview with the Administrator on 05/18/23 at 12:21pm revealed:
-The MAs should not leave medication at the resident's bedside.
-The MAs were expected to administer the medication while with the resident.

Refer to the interview with a medication aide (MA) on 05/17/23 at 10:05am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am.

_____

Interview with a medication aide (MA) on 05/17/23 at 10:05am revealed:
-The pharmacy dispensed all scheduled medications that were dispensed in blister packs on cycle fill, every 28 days.
-The MA would have to re-order all as needed medications and all scheduled inhalers and creams.
-The MA would use the pharmacy re-order form to re-order needed medications.

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 358	Continued From page 29 -The MA would pull the re-order sticker or hand-write the medication needed on the pharmacy re-order form and fax to the pharmacy. Interview with the Health and Wellness Director (HWD) on 05/18/23 at 10:31am revealed: -The pharmacy would audit the medication cart, but she was not sure how often. -The third shift MAs audit the medication carts at the request of the Health and Wellness Coordinator or the HWD. -The MAs would check to see that the medications were in the correct drawer, the medications listed on the electronic Medication Administration Record (eMAR) were on the medication cart and available for administration, and the medications were dated when opened.	D 358		