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FORM APPROVI

Division of Health Service Regulation

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 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1668 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 and annual survey from October 29, 2024 to October 31, 2024.	D 000		
D 310	10A NCAC 13F .0804(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 serve therapeutic diets as ordered by the physician for 2 of 3 sampled residents (#1 and #2) with therapeutic diet orders for a carbohydrate controlled (CC) diet (#1) and low fat/ low cholesterol (#2) diet. The findings are: 1. Review of Resident #1's current FL-2 dated 01/24/24 revealed diagnoses included mild cognitive impairment, diabetes mellitus, hypertension, and hypothyroidism. Review of Resident #1's diet order form dated 01/24/24 revealed an order for a CC diet. Review of the therapeutic diet list posted in the kitchen dated 10/08/24 revealed Resident #1 was to be served a CC diet. Review of the CC menu for the lunch meal service on 10/29/24 revealed Resident #1 was to be served rosemary chicken with garlic and	D 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reenna A

TITLE: Executive Director

(X6) DATE: 12-13-24

Reviewed and Acknowledged
12-16-24
HRP

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D 310	Continued From page 1 lemon, Cajun red beans and white rice, green beans, a roll, margarine, sugar-free ice cream, water, and a diet beverage of choice. Observation of Resident #1's lunch meal service on 10/29/24 between 12:00pm and 1:00pm revealed: -Resident #1 was served rosemary chicken with garlic and lemon, Cajun red bean with brown rice, green beans, sugar-free ice cream, water, and coffee. -Resident #1 ate 100% of her meal without difficulty. -Resident #1 was not supposed to have been served brown rice with the Cajun red beans. Interview with Resident #1 on 10/30/24 at 10:20am revealed: -She was ordered a CC diet due to her diabetes. -Sometimes the kitchen served her regular meals like the other residents, but not always. -She had not experienced any symptoms recently and had not visited the hospital due to her diabetes. Interview with the Resident #1's primary care provider (PCP) on 10/30/24 at 12:20pm revealed: -She had ordered a CC diet for Resident #1 due to her diabetes mellitus. -She expected the facility to serve diets as ordered for all residents. -She expected possible hyperglycemia with headaches for Resident #1 if the facility failed to follow her diet for CC restrictions. Interview with a personal care aide (PCA) on 10/30/24 at 9:00am revealed: -The Dietary Manager (DM) plated the meals for residents and the facility staff were responsible for serving meals to the residents.	D 310		

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D 310	Continued From page 2 -She was aware Resident #1 was on a CC diet from the therapeutic diet list posted in the kitchen. -She was not aware Resident #1 had been served brown rice instead of white rice on 10/29/24 for the lunch meal because she had served the beverages. -She was not aware Resident #1 should have been served white rice instead of brown rice on 10/29/24 for the lunch meal according to CC therapeutic menu. Interview with a second PCA on 10/30/24 at 9:05am revealed: -The DM plated the meals for residents and the facility staff were responsible for serving meals to the residents. -She was aware Resident #1 was on a CC diet from the therapeutic diet list posted in the kitchen. -She was not aware of the CC therapeutic menu specific to Resident #1. -She was not aware Resident #1 should have been served white rice instead of brown rice on 10/29/24 for the lunch meal according to CC therapeutic menu. Interview with the DM on 10/30/24 at 9:15am revealed: -He was responsible for preparing residents meal plates according to the therapeutic menus located in the kitchen. -The facility staff were responsible for serving the residents meal plates according to the diet order report located in the kitchen. -He expected the diet order report to be used by the facility staff for all residents' dietary needs. -Resident #1's meal on 10/29/24 should have been served according to the instructions on the therapeutic menu and according to the physician's orders. -He was aware staff served Resident #1 brown	D 310		

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D 310	Continued From page 3 rice instead of white rice for the lunch meal because he had not substituted the white rice for the brown rice on the meal plate for Resident #1. Interview with the Health and Wellness Coordinator (HWC) on 10/30/24 at 2:45pm revealed: -She expected facility staff and dietary staff to serve Resident #1 according to her diet orders for a CC therapeutic diet. -She expected staff to read the therapeutic diet list in the kitchen to serve residents' meals. -She and the Health and Wellness Director (HWD) reviewed residents' dietary orders and shared details with the DM to ensure residents diets were served as ordered. Interview with the HWD on 10/30/24 at 9:35am revealed: -She was not aware Resident #1 had been served brown rice instead of white rice on 10/29/24 for the lunch meal. -Resident #1 should have been served her meal on 10/29/24 as directed on the therapeutic diet list posted in the kitchen. -She and the HWC provided the diet list to the DM and expected residents to be served diets as ordered by their PCP. Interview with the Administrator on 10/30/24 at 9:45am revealed: -She expected staff to serve diets as ordered by the residents' PCP. -She expected staff to use the therapeutic diet list and the therapeutic menus to serve residents according to their respective physicians' orders. 2. Review of Resident #2's current FL-2 dated 07/23/24 revealed diagnoses included primary open angle glaucoma, cerebrovascular disease,	D 310		

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D 310	Continued From page 4 essential hypertension, and mixed hyperlipidemia. Review of Resident #2's diet order form dated 08/26/24 revealed there was an order for a low fat/ low cholesterol diet. Review of the therapeutic diet list posted in the kitchen dated 10/08/24 revealed Resident #2 was to be served a low fat/ low cholesterol diet. Review of the low fat/ low cholesterol menu for the lunch meal service on 10/29/24 revealed Resident #2 was to be served rosemary chicken with garlic and lemon, Cajun red beans and white rice, green beans, margarine, a roll, sugar-free ice cream, water, and a beverage of choice. Observation of Resident #2's lunch meal service on 10/29/24 between 12:00pm and 1:00pm revealed: -Resident #2 was served a grilled cheese sandwich with heart healthy wheat bread, regular flavored potato chips, Boston crème pie, water, and unsweetened tea. -Staff provided no direction to Resident #2 on her low fat/ low cholesterol diet. -Resident #2 ate about 100% of the meal without difficulty. -Resident #2 ate all the regular potato chips and 10% of the Boston crème pie. -Resident #2 was not supposed to have been served regular potato chips and Boston crème pie. Interview with Resident #2 on 10/30/24 at 12:22pm revealed: -She was not aware she was on any type of diet. -She could get whatever meals she wanted just as the other residents, but staff had not advised her of her diet.	D 310		

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D 310	Continued From page 5 -She had not experienced any symptoms or issues related to her blood pressure recently. Telephone interview with the Resident #2's primary care provider (PCP) on 10/31/24 at 8:45am revealed: -She had ordered a low fat/ low cholesterol diet for Resident #2 due to her diabetes mellitus and essential hypertension. -She expected the facility to serve diets as ordered for all residents. -She expected possible hyperglycemia with headaches for Resident #2 as well as increased hypertension with dizziness if the facility failed to follow her diet for low fat/ low cholesterol restrictions. Interview with a personal care aide (PCA) on 10/30/24 at 9:00am revealed: -The Dietary Manager (DM) plated the meals for residents and the facility staff were responsible for serving meals to the residents. -She was aware Resident #2 was on a low fat/ low cholesterol diet from the therapeutic diet list posted in the kitchen. -She was not aware Resident #2 had been served regular potato chips instead of green beans and Boston crème pie instead of a sugar-free ice cream on 10/29/24 for the lunch meal because she had served the beverages. -She was not aware Resident #2 should have been served green beans instead of regular potato chips and sugar-free ice cream instead of Boston crème pie on 10/29/24 for the lunch meal according to low fat/ low cholesterol therapeutic menu. Interview with a second PCA on 10/30/24 at 9:05am revealed: -The DM plated the meals for residents and the	D 310		

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D 310	Continued From page 6 facility staff were responsible for serving meals to the residents. -She was aware Resident #2 was on a low fat/ low cholesterol diet from the therapeutic diet list posted in the kitchen. -She was not aware of the low fat/ low cholesterol therapeutic menu specific to Resident #2. -She was aware Resident #2 should have been served green beans instead of regular potato chips and sugar-free ice cream instead of Boston crème pie 10/29/24 for the lunch meal, but she had not offered the low fat/ low cholesterol menu options because Resident #2 previously refused options from her low fat/ low cholesterol diet. Interview with the DM on 10/30/24 at 9:15am revealed: -He and the facility staff were responsible for serving the residents meal plates according to the diet order report located in the kitchen. -He expected the diet order report to be used by the facility staff for all residents' dietary needs. -Resident #2's meal on 10/29/24 should have been served according to the instructions on the therapeutic menu and according to the physician's orders. -He was aware staff served Resident #2 regular potato chips and Boston crème pie because he prepared the regular potato chips and Boston crème pie on Resident #2's meal plate. -He was aware Resident #2 should not be served regular potato chips and Boston crème pie but had not served Resident #2's meal according to the low fat/ low cholesterol therapeutic diet because she previously refused the low fat/ low cholesterol meal. Interview with the Health and Wellness Coordinator (HWC) on 10/30/24 at 2:45pm revealed:	D 310		

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D 310	Continued From page 7 -She was aware of Resident #2's low fat/ low cholesterol diet. -She was not aware staff had served Resident #2 regular potato chips instead of green beans and Boston crème pie instead of sugar-free ice cream on 10/29/24 for the lunch meal. -She and the Health and Wellness Director (HWD) reviewed residents' dietary orders and shared details with the DM to ensure residents diets were to be served as ordered. -She expected staff to serve Resident #2 according to her diet orders for a low fat/ low cholesterol diet. Interview with the HWD on 10/30/24 at 9:35am revealed: -She was not aware Resident #2 had been served regular potato chips instead of green beans and sugar-free ice cream instead of Boston crème pie on 10/29/24 for the lunch meal. -Resident #2 should have been served her meal on 10/29/24 as directed on the therapeutic diet list posted in the kitchen. -She and the HWC provided the diet list to the DM and expected residents to be served diets as ordered by their PCP. -She expected staff to serve residents according to their PCP's diet orders even if a resident had refused therapeutic diet meals previously. Interview with the Administrator on 10/30/24 at 9:45am revealed: -She expected staff to serve diets as ordered by the residents' PCP. -She expected staff to use the therapeutic diet list and the therapeutic menus to serve residents according to their respective physicians' orders.	D 310		

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D 358	Continued From page 8	D 358		
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 2 of 5 residents (#1 and #5) sampled residents including errors with an anti-hypertensive medication with blood pressure (BP) parameters to hold the medication related to BP and a nasal spray for supplementing calcium (#5) and administering 2 medications used to treat elevated blood sugars after the medications were discontinued (#1). The findings are: 1. Review of Resident #5's current FL-2 dated 06/19/24 revealed: -Diagnoses included presence of right artificial hip, hypoxemia, acute kidney failure, aftercare following joint replacement, and pain in right hip. Review of Resident #5's Resident Roster revealed the resident was admitted from a rehabilitation facility on 06/19/24. a. Review of Resident #5's current FL2 dated 06/19/24 revealed: -There was an order to check BP every week.	D 358		

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D 358	Continued From page 9 -There was an order for bumetanide (used to treat high blood pressure and/or fluid retention) 2 mg twice a day. Review of Resident #5's signed order summary report dated 07/24/24 revealed: -There was an order to check BP in the morning every Thursday for BP monitoring. -There was an order for bumetanide 2 mg twice a day. Review of Resident #5's faxed physician's order dated 07/25/24 revealed there was an order for bumetanide 2 mg in the morning and one tablet in the afternoon. Review of Resident #5's physician's order dated 08/01/24 revealed there was an order for bumetanide 2 mg in the morning and one tablet in the afternoon. Hold for systolic BP less than 90. Review of Resident #5's physician's order dated 10/23/24 revealed there was an order for bumetanide 2 mg in the morning and one tablet in the afternoon. Hold for systolic BP less than 90. Review of Resident #5 August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Bumetanide 2 mg give one tablet one time a day for fluid retention; Hold for systolic BP of less than 90 and scheduled for administration at 9:00am with documented administration daily for 31 of 31 opportunities from 08/01/24 to 08/31/24. -There was an entry for Bumetanide 1 mg give one tablet in the evening for fluid retention; Hold for systolic BP of less than 90 and scheduled for administration at 8:00pm with documented administration daily for 31 of 31 opportunities	D 358		

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D 358	Continued From page 10 from 08/01/24 to 08/31/24. -There was an entry to check BP weekly in the morning on Thursday for BP monitoring scheduled for 6:30am with BP values documented on 08/01/24, 08/08/24, 08/15/24, 08/22/24 and 08/29/24 with the systolic BP range of 120 to 148. -There was no additional BP values documentation available for review. -There was no documentation for BP values for 31 doses of bumetanide 1 mg administered at 8:00pm from 08/01/24 to 08/31/24 and it could not be determined if Resident #5's bumetanide 1 mg should have been held for systolic BP less than 90. -There was no documentation for BP values for 26 doses of bumetanide 2 mg administered at 9:00am from 08/01/24 to 08/31/24 and it could not be determined if Resident #5's bumetanide 1 mg should have been held for systolic BP less than 90. Review of Resident #5 September 2024 eMAR revealed: -There was an entry for Bumetanide 2 mg give one tablet one time a day for fluid retention; Hold for systolic BP of less than 90 and scheduled for administration at 9:00am with documented administration daily for 30 of 30 opportunities from 09/01/24 to 09/30/24. -There was an entry for Bumetanide 1 mg give one tablet in the evening for fluid retention; Hold for systolic BP of less than 90 and scheduled for administration at 8:00pm with documented administration daily for 29 of 29 opportunities from 09/01/24 to 09/30/24. -There was an entry to check BP weekly in the morning on Thursday for BP monitoring and scheduled for 6:30am with BP values documented on 09/05/24, 09/12/24, 09/19/24,	D 358		

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D 358	Continued From page 11 and 09/29/24 with the systolic BP range of 120 to 126. -There was no additional BP values documentation available for review. -There was no documentation for BP values for 29 doses of bumetanide 1 mg administered at 8:00pm from 09/01/24 to 09/30/24 and it could not be determined if Resident #5's bumetanide 1 mg should have been held for systolic BP less than 90. -There was no documentation for BP values for 26 doses of bumetanide 2 mg administered at 9:00am from 09/01/24 to 09/30/24 and it could not be determined if Resident #5's bumetanide 1 mg should have been held for systolic BP less than 90. Review of Resident #5 October 2024 eMAR from 10/01/24 to 10/29/24 revealed: -There was an entry for bumetanide 2 mg give one tablet one time a day for fluid retention; Hold for systolic BP of less than 90 and scheduled for administration at 9:00am with documented administration daily for 29 of 29 opportunities from 10/01/24 to 10/29/24. -There was an entry for bumetanide 1 mg give one tablet in the evening for fluid retention; Hold for systolic BP of less than 90 and scheduled for administration at 8:00pm with documented administration daily for 29 of 29 opportunities from 10/01/24 to 10/29/24. -There was an entry to check BP weekly in the morning on Thursday for BP monitoring and scheduled for 6:30am with BP values documented on 10/03/24, 10/10/24, 10/17/24, and 10/24/24 with the systolic BP range of 130 to 139. -There was no additional BP values documentation available for review. -There was no documentation for BP values for	D 358		

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D 358	Continued From page 12 29 doses of bumetanide 1 mg administered at 8:00pm from 10/01/24 to 10/29/24 and it could not be determined if Resident #5's bumetanide 1 mg should have been held for systolic blood pressure less than 90. -There was no documentation for BP values for 24 doses of bumetanide 2 mg administered at 9:00am from 10/01/24 to 10/29/24 and it could not be determined if Resident #5's bumetanide 1 mg should have been held for systolic BP less than 90. Observation of Resident #5's medications on hand on 10/31/24 at 11:15am revealed: -There was one bingo card of bumetanide 1 mg label one tablet every evening dispensed on 10/21/24 for 28 tablets with 18 tablets remaining. -There was one bingo card of bumetanide 2 mg label one tablet every evening dispensed on 10/21/24 for 28 tablets with 17 tablets remaining. Interview with a medication aide (MA) on 10/31/24 at 10:35am revealed: -She administered Resident #5's bumetanide when it appeared on the eMAR screen. -She only took BP and recorded the value on Thursday when it appeared on the computer eMAR screen. -The Health and Wellness Director (HWD) routinely double-checked orders entered into the facility's eMAR system if orders were entered by MAs or the HWD entered orders directly into the eMAR system herself. -The bingo cards sent by the contracted pharmacy for Resident's bumetanide 2 mg and 1 mg did not have information regarding hold for systolic BP less than 90. -She overlooked the eMAR statement for hold bumetanide per BP parameters. -If the eMAR had prompted for a BP value, she	D 358		

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	HAL041039	A. BUILDING: _____ B. WING _____	R 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1660 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 358	Continued From page 13 would have known to obtain a BP before administering bumetanide and look for the hold parameters. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/31/24 at 10:45am revealed: -The pharmacy did not generate the facility's eMARs. -The facility was responsible for entering orders that would be linked to parameters such as holding a medication per BP parameters. -Since this facility generated their own eMARs, the facility's eMARs information did not interface electronically with the pharmacy's medication profile used to provide Resident #5's medications. -Bumetanide 2 mg labeled to administer every morning was dispensed for 28 tablets on 07/29/24, 08/19/24, 09/16/26, and 10/14/24 per cycle fill before the resident ran out of medication and would have been for administration beginning one week later. -Bumetanide 1 mg labeled to administer every evening was dispensed for 28 tablets on 07/29/24, 08/19/24, 09/16/26, and 10/14/24 per cycle fill before the resident ran out of medication and would have been for administration beginning one week later. Telephone interview with Resident #5's primary care provider (PCP) on 10/31/24 at 11:05am revealed: -She reviewed Resident #5's outside provider encounter notes and orders and signed for documentation of review. -Resident #5 should have BP checks before administering bumetanide per the orders. Telephone interview with the triage nurse at Resident #5's cardiology clinic on 10/31/24 at	D 358		

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BROOKDALE HIGH POINT NORTH AL (NC)	1588 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 358	Continued From page 14 11:15 revealed: -Resident #5 was ordered BP checks prior administering bumetanide and hold if systolic BP less than 90 as a standard precaution. -The facility should be checking BP and administering bumetanide as ordered. Interview with Resident #5's family member on 10/31/24 at 11:40am revealed: -The family member was active in Resident #5's care. -Resident #5 had a cardiologist that made most of his medication changes and the facility's contracted PCP reviewed and renewed medication orders. -Resident #5's BP had been mostly stable with the systolic BP running over 90 all the times she had been with him at appointments. -The facility should be checking BP if the order said to do so. Interview with Resident #5 at 2:02pm revealed he knew staff took his BP a lot but he did not know if it was 2 times a day every day. Interview with the HWD on 10/31/24 at 4:10pm revealed: -The MAs could enter medication or treatment orders into the facility's eMAR system. -The HWD entered most orders into the facility's eMAR system. -The contracted pharmacy was supposed to receive all medications orders to ensure the pharmacy was sending correct medication. -The facility was responsible for ensuring the eMAR had the correct medication orders and were administered correctly. -Routinely, the HWD was responsible to conduct audits of residents' medication orders compared to the eMAR and medication and had to ensure	D 358		

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D 358	Continued From page 15 medications were administered as ordered. -She had been without a Health and Wellness Coordinator (HWC) who assisted the HWD with audits and staffing scheduling. -She had not routinely done resident medication audits in a few months since she was filling the HWC and HWD staffing requirements. -She did not know Resident #5 should have BP checks prior to administration of bumetanide per physician's orders dated 08/01/24. -She did not know Resident #5 was administered bumetanide with obtaining a blood pressure in order to determine if the medication should have been held. Refer to the interview with the Administrator on 10/31/24 at 11:00 am. b. Review of Resident #5's current FL2 dated 06/19/24 revealed there was an order for calcitonin (used to stop bone break and loss) 200 units/spray nasally every day both nostrils. Review of the contracted pharmacy's medication alert sheet dated 08/20/24 revealed: -The pharmacy documentation noted according to manufacturer dosing instructions calcitonin nasal spray is to be administered as one spray in one nostril daily, alternating nostril daily. -The pharmacy noted the pharmacy would be dispensing the medication labeled according to the manufacturer's dosing instructions. Telephone interview with the managing pharmacist at the contracted pharmacy on 10/31/24 at 10:45am revealed: -The pharmacy corrected the administration instructions on calcitonin nasal spray prior to sending the medication from the FL2 order.	D 358		

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D 358	Continued From page 16 -There was no documentation that the pharmacy contacted the resident's primary care provider for correcting the dosage because the administration directions were such a common error from providers. -The facility was sent the information sheet alerting the facility that a change had been made to the calcitonin administration instructions. -The facility was responsible for correcting the electronic medication administration record (eMAR) since the pharmacy did not generate the facility's eMAR (per the facility's contract). -Calcitonin nasal spray 200units with instructions to use on spray in alternating nostrils once daily was dispensed on 06/20/24, 07/24/24, 08/28/24, and 09/20/24 for a 28 days supply with the correction administration. Review of Resident #5's medications received from his previous facility revealed 2 bottles were sent from the previous facility (no date on the form). Observation of medication on hand for administration to Resident #5 on 10/31/24 revealed: -There was a partial bottle of calcitonin nasal spray 200 units/spray on the medication cart. -The bottle was label dispensed on 09/18/24 with instruction to spray one spray in alternating nostrils once daily. -The bottle was label opened 10/21/24. Review of Resident #5's medication renewal orders dated 07/24/24 and 10/23/24 revealed an order for calcitonin 200 units/spray nasally every day both nostrils. Review of Resident #5's August 2014, September 2014, and October 2024 (from 10/01/24 to	D 358		

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D 358	Continued From page 17 10/30/24) eMARs revealed: -There was an entry for Calcitonin nasal solution 1 spray in both nostril one time a day for osteoporosis scheduled for administration at 9:00am daily. -Calcitonin nasal spray was documented as administered daily from 08/01/24 to 10/30/24. Interview with a first shift medication aide (MA) on 10/31/24 at 10:35am revealed: -She administered Resident #5's calcitonin nasal spray when she worked the medication cart containing his medications. --She routinely administered medications according to the directions displayed on the eMAR display. -The HWD was responsible for ensuring medication orders were correct even if she did not enter the orders. -The MA had not noticed the directions for administration were different than the eMAR instructions and had not informed the HWD of the difference. Telephone interview with Resident #5's primary care provider (PCP) on 10/31/24 at 11:05am revealed: -She provided PCP care for Resident #5. -She routinely reviewed all medication orders upon admission and any outside provider visits. -She signed medication renewals for Resident #5's calcitonin on 07/24/24 and 10/23/24. -She was not familiar with the standard medication dosing of one spray daily in each alternating nostril but signed the medication renewals on 07/24/24 and 10/23/24 for one spray in each nostril daily. -If the contracted pharmacy had provided the correct dosing instructions the facility should be administering calcitonin nasal spray according to	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH AL (NC)	1589 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 358	Continued From page 18 the correct dosing. Interview with Resident #5's on 10/31/24 at 11:40am revealed the facility staff had been administering his calcitonin nasal spray as 2 sprays, one in each nostril, daily. Interview with the HWD on 10/31/24 at 4:10pm revealed: -The facility entered medication and treatment orders into the eMAR system not the contracted pharmacy. -She entered most of the admission orders into the eMAR system unless a resident was admitted when she was not on duty at the facility. -She entered Resident #5's order for calcitonin from the 08/19/24 FL-2. -She had never seen the contracted pharmacy information sheet regarding the change to calcitonin administration directions to adhere to the manufacturer's dosing. -She was not aware Resident #5's calcitonin was administered incorrectly according to the directions on the pharmacy packaging and manufacturer's directions. -No MA staff had informed the administration directions on the eMAR did not match the pharmacy directions on the calcitonin medication bottle label. Refer to the interview with the Administrator on 10/31/24 at 11:00 am. 2. Review of Resident #1's current FL-2 dated 01/24/24 revealed: -Diagnoses included hypertension, and Diabetes Mellitus Type 2. -There was an order for glimepiride 4mg (used to treat high blood sugar levels caused by type 2 diabetes) one tablet twice a day.	D 358		

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D 358	Continued From page 19 -There was an order for pioglitazone (used to treat high blood sugar levels) 30mg once daily. Review of Resident #1's signed physician's orders dated 07/24/24 revealed: -There was an order for fingerstick blood sugar (FSBS) checks 4 times a day, before meals and at bedtime, and a rapid acting insulin used with sliding scale administration. -There was an order for glimepiride 4mg one tablet twice a day. -There was an order for pioglitazone 30mg once daily. Review of Resident #1's local hospital discharge summary dated 10/12/24 revealed: -Resident #1 was admitted to the hospital for shortness of breath and fluid buildup. -There was an order to discontinue glimepiride 4 mg and pioglitazone 30 mg "due to her age and risk for hypoglycemia". Review of Resident #1's transition of care visit notes with the resident's primary care provider (PCP) dated 10/16/24 revealed: -Resident #1's hospital discharge summary was reviewed in the visit notes. -Resident #1's hemoglobin A1C (a test to measure blood sugar levels over an extended period of time) laboratory result was 7.5. (Laboratory test results included information that HgbA1C values greater than 6.4 indicate diabetic and a value less than 7.0 represented control for adults with diabetes.) -Stop glimepiride and pioglitazone were included in the medication changes ordered by the PCP. Observation of medications on hand for administration for Resident #1 on 10/31/24 at 11:15am revealed:	D 358		

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D 358	Continued From page 20 -There were 37 of 56 tablets remaining of glimepiride 4 mg that were dispensed on 10/21/24 cycle fill. -There were 18 of 28 tablets remaining of pioglitazone 30 mg that were dispensed on 10/21/24 cycle fill. Review of Resident #1's October 2024 electronic medication administration record (eMAR) from 10/01/24 to 10/29/24 revealed: -FSBS values documented on the eMAR ranged from 63 to 491. -There was an entry for glimepiride 4 mg two times a day scheduled for administration at 8:00am and 5:00pm. -Glimepiride 4 mg was documented as administered two times a day from 8:00am on 10/01/24 to 8:00am on 10/29/24 (discontinued on the hospital discharge summary 10/12/24 and PCP visit notes on 10/16/24). -There were 25 doses of glimepiride 4 mg from 10/16/24 to 10/29/24 documented as administered after discontinued. -There was an entry for pioglitazone 30 mg one time a day for diabetes mellitus II scheduled for administration at 9:00am daily. -Pioglitazone 30 mg was documented one time daily from 9:00am on 10/01/24 to 9:00am on 10/29/24 (discontinued on the hospital discharge summary 10/12/24 and PCP visit notes on 10/16/24). -There were 13 doses of pioglitazone 30 mg from 10/16/24 to 10/29/24 documented as administered after discontinued. Telephone interview with Resident #1's PCP on 10/30/24 at 12:30pm revealed: -She reviewed Resident #1's hospital discharge summary when she came to the facility for scheduled visit on 10/16/24.	D 358		

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D 358	Continued From page 21 -She added the order to discontinue Resident #1's glimepiride 4 mg and pioglitazone 30 mg per the hospital discharge summary in agreement to the resident's age and increased possibility for hypoglycemia. -She expected the facility to discontinue glimepiride 4 mg and pioglitazone 30 mg as ordered. -Since Resident #1 had no documented blood sugars below 63 for October 2024, she felt there had been no detriment to the Resident #1's health due to failure to discontinue the medications. Interview with the Health and Wellness Director (HWD) on 10/30/24 at 4:05pm revealed: -The facility entered medication and treatment orders into the eMAR system not the contracted pharmacy. -She entered most of the admission orders into the eMAR system unless a resident was admitted when she was not on duty at the facility. -Resident #1 was discharged back to the facility on 10/12/24 which was a weekend day, and she was not in the facility. -The medication aide on duty on a weekend was responsible to review the hospital discharge for medication changes and make any changes to the eMAR, fax the hospital discharge summary to the contracted pharmacy, and place the discharge summary in a folder for the HWD to review and check for accuracy of order changes. -After reviewing the hospital discharge, the HWD would place the discharge paperwork in the resident's record. -She had not seen the hospital discharge paperwork Resident #1 dated 10/12/24. -The MA had faxed the discharge to the contracted pharmacy but did not correct the eMAR and mistakenly filed the discharge paperwork in Resident #1's record.	D 358		

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D 358	Continued From page 23 pharmacist at the contracted pharmacy on 10/31/24 at 10:45am revealed: -The pharmacy did not generate the facility's eMAR. -The pharmacy used information received for the facility including medication orders, hospital discharge summaries, and PCP encounter notes to create a medication profile for the residents. -The medication profile was used to dispense medications for the residents on a monthly cycle fill schedule. -The pharmacy received the hospital discharge summary dated 10/12/24 and discontinued glimepiride 4 mg and pioglitazone 30 mg in Resident #1's pharmacy medication profile on 10/14/24. -The cycle fill medications dated 10/21/24 were processed by the pharmacy one week prior to the date to ensure medications arrived at the facility prior to previously dispensed cycle fill medications running out. -The facility was responsible for correcting the eMAR since the pharmacy did not generate the facility's eMAR (per the facility's contract). -The facility would be responsible for removing any medications that were discontinued from date of cycle fill to current date. Refer to the interview with the Administrator on 10/31/24 at 11:00 am. Interview with the Administrator on 10/31/24 at 11:00 am revealed: -The HWD or the Health and Wellness Coordinator (HWC) were responsible to ensure medications were administered as ordered. -The HWD should be double checking any eMAR entries made by MAs prior to the medication being put on the medication cart for administering.	D 358		

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D 358	Continued From page 24 -The HWD would be responsible for audits of medications, medications orders and eMAR documentation to ensure the medications were administered correctly.	D 358		

The following is a summary of the Plan of Correction for Brookdale High Point North AL. This Plan of Correction is in regards to the Corrective Action Report dates October 31, 2024. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F .0904(e)(4) 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.

- The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on current residents prescribed diet orders to verify the Dining Services Manager and dining staff have the current physician ordered diet. The Health & Wellness Director/Nurse/Executive Director/designee and/or Dining Services Manager will provide retraining on diets for associates who serve resident meals. Dining associates will be trained on the preparation of therapeutic diets per our menu manager platform. The Health & Wellness Director will also provide a copy of the nutrition tracker and diet orders to the dining department monthly. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will review resident diets weekly for 6 weeks. Plan of correction to be completed by December 31, 2024.

10A NCAC 13F. 1004 Medication Administration

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.

- The Health & Wellness Director/Nurse/Executive Director or designee will rein-service medication aids & LPN's on the 7 rights of medication administration, to be completed by December 31, 2024. The Health & Wellness Director/Nurse/Executive Director or designee will review the New Order Tracking forms to verify accuracy and transcription of physician orders twice weekly for 6 weeks. Plan of correction to be completed by December 31, 2024.

Reonna Hargrave, Executive Director