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
	HAL041029	A. BUILDING: _____ B. WING _____	R 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SKEET CLUB	1560 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 07/08/26 through 07/10/26.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the rights of residents were maintained, including being treated with dignity and respect related to being served food within the scheduled meal service times. The findings are: Observation of the dining room at the lunch meal service on 07/08/26 at 12:00pm revealed: -There were 32 residents seated in the dining room waiting to be served. -There was one kitchen staff plating food from the kitchen for all 32 residents. -Two personal care aides (PCA) and two medication aides (MA) served the residents plates from the kitchen. -One MA called out orders to the kitchen staff from a list that was completed after breakfast. -The first plate for the lunch meal was served at 12:00pm and the last plate for the lunch meal was served at 1:05pm. -The last resident served had ordered a peanut butter and jelly sandwich.	D 338		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Preston, RN, MSN | TITLE: Executive Director | (X6) DATE: August 24, 2026

Reviewed and Acknowledged K.M. 08/24/26

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D 338	Continued From page 1 Interview with a resident after the lunch meal service on 07/08/26 at 1:10pm revealed: -She received her lunch meal at 12:55pm. -She did not like having to wait for her food, but it was almost a daily occurrence at the lunch meal which was scheduled to be served at noon. -There was usually only one server, and the wait was sometimes longer than one hour. -She had mentioned her concern in several resident council meetings, but nothing changed. Interview with a second resident after the lunch meal service on 07/08/26 at 1:20pm revealed: -She received her lunch meal at 12:56pm. -Lunch service always took longer because dinner was a light meal and breakfast was usually the same thing over and over again. -She waited 45 minutes to an hour to be served meals at times which made her agitated. -She was accustomed to things being in "black and white", but no one could give a clear answer as to why meals took so long to serve. Interview with a third resident after the lunch meal service on 07/08/26 at 1:32pm revealed: -It bothered her that meal service sometimes took a long time, but she never said anything about it because she "did not want to make trouble." -She could not recall the time she received her lunch meal. Interview with a fourth resident after the lunch meal service on 07/08/26 at 1:38pm revealed: -She received her lunch meal at 12:45pm. -She had asked to move to another table in the dining room to avoid being served last, but her request was denied. Interview with the cook on 07/08/26 at 2:15pm revealed:	D 338		

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D 338	Continued From page 2 -He was currently the only cook employed at the facility. -Lunch was scheduled to be served at 12:00 daily. -He served the resident meals one plate at a time after receiving the orders from the MA. -He was aware it took a long time for all the residents to be served their meals, but he served the resident meals according to when he heard the order called out. -He was not aware residents had complained about being served food late. Interview with the acting Dietary Manager (DM) on 07/09/26 at 2:40pm revealed: -The facility was currently without a DM and he, along with several other DMs from sister facilities , would visit to serve in the role until a permanent DM was hired. -The cook prepared the lunch meal from a list of orders that clinical staff were to complete at the breakfast meal or shortly thereafter. -The completed list of meal orders should be submitted to kitchen staff no later than 10:00am daily. -A MA or supervisor called out orders based on residents' diets (mechanical soft, puree, no added salt, etc.), and the cook plated the food. -Starters such as salad or soup were served first and delivered by table. -The entire process from start to finish should take no longer than 30 minutes. Interview with a PCA on 07/09/26 at 11:03am revealed: -She worked in the dining room daily for breakfast and lunch. -She assisted with setting up the tables, poured drinks and delivered plates of food to residents. -Two MAs plated the food and two PCAs	D 338		

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D 338	Continued From page 3 delivered the food to the tables. -MAs sometimes helped deliver food to tables, but no dietary staff plated food. -Residents placed lunch orders during breakfast and dinner orders during lunch. -There had been a delay of meal service times on some days, but it usually took 15 minutes between serving the first meal and the last meal. -She had never been the only staff member serving food in the dining room. Interview with a MA on 07/09/26 at 2:35pm revealed: -She verbally communicated food and diet orders to the cook during the lunch mealtime. -The cook plated the food for each resident. -One MA communicated food orders and another MA delivered food to the tables. -PCAs assisted with delivering food but mostly filled drink orders. -Lunch was usually served at 12:00pm and the last plate served an hour later. -The order of food delivery between tables was alternated daily. -She had never heard residents complain about food being served late. Interview with the Resident Care Coordinator (RCC) on 07/09/26 at 2:53pm revealed: -She was aware residents had to wait over an hour for their lunch meal on 07/08/26 because she was in the dining room. -The number of staff assigned to the dining room during the lunch meal varied but there were usually two MAs and two PCAs. -An MA called out the food orders, the cook plated the food, and another MA delivered the meals to the tables. -PCAs delivered drinks and cleared tables. -The length of meal service times depended on	D 338		

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D 338	Continued From page 4 who called out the food orders but usually took 15-17 minutes. -She had heard occasional complaints from residents regarding meal service times, but these were from residents who did not normally attend meals in the dining room. Interview with the Health and Wellness Coordinator (HWC) on 07/09/26 at 3:10pm revealed: -She was not aware residents had to wait over an hour for their lunch meal on 07/08/26. -She was not aware residents had complained previously about long wait times for meals. -There were usually two MAs, two PCAs and 2-3 managers who assisted daily with meals. -The lead MA called out food orders and the PCAs delivered food to the tables. -Managers helped serve drinks and perform other duties of a PCA. -Front tables, closest to the kitchen, were served first and the table orders were rotated for subsequent meals. -The service times for the middle tables remained the same. -It took approximately 30-40 minutes from start to finish to serve the lunch meal. Interview with the Health and Wellness Director (HWD) on 07/10/26 at 11:45am revealed: -There were normally four staff members in the dining room for lunch, including one member of management staff. -The MA submitted food orders, one PCA delivered the food and the other PCA managed drinks. -The order of table service was rotated every other day. -From start to finish, the meal service process should take approximately 30 minutes.	D 338		

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D 338	Continued From page 5 Interview with the Administrator on 07/10/26 at 12:25pm revealed: -She was not aware residents had to wait over an hour for their lunch meal on 07/08/26. -Lunch was the largest meal and it was an "all hands-on deck" event daily. -All MAs, all PCAs and two managers were expected to be in the dining room for lunch. -All other staff were expected to inquire whether help was needed with the lunch meal. -One MA called out food orders, a cook plated the food, and PCAs and managers delivered food to the tables. -Meal table service was rotated daily. -Residents had expressed concern in previous resident council meetings about long wait times for meals but she was not aware the residents had complained recently. -She expected all resident meals to be served within 30 minutes of the scheduled meal time.	D 338		
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 review, the facility failed to administer medications as ordered for 1 of 5 sampled	D 358		

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D 358	Continued From page 6 residents (#4) including a nonsteroidal anti-inflammatory drug and a vitamin. The findings are: Review of Resident #4's current FL2 dated 06/27/26 revealed: -Diagnoses included hypertension, myasthenia gravis and dementia. -He was intermittently confused. a. Review of Resident #4's FL2 dated 04/21/26 revealed there was an order for aspirin (a medication used to prevent heart attack or stroke) 81mg take 1 tablet daily. Review of Resident #4's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg take 1 tablet daily scheduled for administration at 9:00am. -There was documentation aspirin was administered from 05/01/26 to 05/19/26 and from 05/24/26 to 05/31/26. -There was documentation Resident #4 was out of the facility from 05/20/26 to 05/23/26. Review of Resident #4's June 2026 eMAR revealed: -There was an entry for aspirin 81mg take 1 tablet daily scheduled for administration at 9:00am. -There was documentation aspirin was administered from 06/01/26 to 06/12/26, from 06/17/26 to 06/23/26 and from 06/28/26 to 06/30/26. -There was documentation Resident #4 was out of the facility from 06/13/26 to 06/16/26 and from 06/25/26 to 06/27/26. Review of Resident #4's July 2026 eMAR from	D 358		

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D 358	Continued From page 7 07/01/26 to 07/08/26 revealed: -There was an entry for aspirin 81mg take 1 tablet daily scheduled for administration at 9:00am. -There was documentation aspirin was administered from 07/01/26 to 07/08/26. Observation of the medications on hand for Resident #4 on 07/09/26 at 4:15pm revealed: -There was a full aspirin 81mg medication card available for administration on the medication cart. -The aspirin 81mg medication card had 28 of 28 tablets remaining with a dispensed date of 06/19/26. -There were two other medications with a dispensed date of 06/19/26 with 16 of 28 tablets and 15 of 28 tablets remaining on the medication cart. -There were 7 doses of aspirin administration that were unaccounted for including the days that Resident #4 was out of the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/10/26 at 8:50am revealed: -Resident #4 had a current order on file for aspirin 81mg take 1 tablet daily. -Aspirin 81mg was dispensed on 06/12/26, 05/15/26 and 04/17/26 for a quantity of 28 tablets each which was a 28-day supply. Attempted interview with Resident #4 on 07/10/26 at 9:25am was unsuccessful. Attempted telephone interview with a medication aide (MA) on 07/10/26 at 11:11am was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 07/10/26 at 10:50am revealed:	D 358		

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D 358	Continued From page 8 -She administered medications to Resident #4. -She did not know if Resident #4's aspirin order was discontinued and restarted. -She did not think staff were administering aspirin to Resident #4 in June 2026. Interview with the Administrator on 07/10/26 at 12:30pm revealed: -She did not know Resident #4's aspirin medication card was full on the medication cart. -She did not know there were 7 doses of Resident #4's aspirin that were unaccounted for in the last 3 months. Attempted telephone interview with Resident #4's primary care provider (PCP) on 07/10/26 at 10:11am was unsuccessful. Refer to the interview with the Health and Wellness Coordinator (HWC) on 07/10/26 at 11:22am. Refer to the interview with the Health and Wellness Director (HWD) on 07/10/26 at 11:36am. Refer to the interview with the Administrator on 07/10/26 at 12:30pm. b. Review of Resident #4's FL2 dated 04/21/26 revealed there was an order for multivitamin (a medication used to treat vitamin deficiencies) take 1 tablet daily. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for multivitamin take 1 tablet daily scheduled for administration at 4:00pm from 05/01/26 to 05/23/26. -There was a second entry for multivitamin take 1	D 358		

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D 358	Continued From page 9 tablet daily scheduled for administration at 9:00am from 05/24/26 to 05/31/26. -There was documentation multivitamin was administered from 05/01/26 to 05/18/26 and from 05/26/26 to 05/31/26. -There was documentation Resident #4 was out of the facility from 05/19/26 to 05/23/26. -There was documentation multivitamin was not available for administration on 05/24/26 and 05/25/26. Review of Resident #4's June 2026 eMAR revealed: -There was an entry for multivitamin take 1 tablet daily scheduled for administration at 9:00am. -There was documentation multivitamin was administered from 06/01/26 to 06/12/26, from 06/17/26 to 06/23/26 and from 06/28/26 to 06/30/26. -There was documentation Resident #4 was out of the facility from 06/13/26 to 06/16/26 and from 06/25/26 to 06/27/26. Review of Resident #4's July 2026 eMAR from 07/01/26 to 07/08/26 revealed: -There was an entry for multivitamin take 1 tablet daily scheduled for administration at 9:00am. -There was documentation multivitamin was administered from 07/01/26 to 07/08/26. Observation of the medications on hand for Resident #4 on 07/09/26 at 4:15pm revealed: -There was a full multivitamin medication card available for administration on the medication cart. -The multivitamin medication card had 28 of 28 tablets remaining with a dispensed date of 06/19/26. -There were two other medications with a dispensed date of 06/19/26 with 16 of 28 tablets	D 358		

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D 358	Continued From page 10 and 15 of 28 tablets remaining on the medication cart. -There were 7 doses of multivitamin administration that were unaccounted for including the days that Resident #4 was out of the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/10/26 at 8:50am revealed: -Resident #4 had a current order on file for multivitamin take 1 tablet daily. -Multivitamin was dispensed on 06/12/26, 05/15/26 and 04/17/26 for a quantity of 28 tablets each which was a 28-day supply. Attempted interview with Resident #4 on 07/10/26 at 9:25am was unsuccessful. Attempted telephone interview with a medication aide (MA) on 07/10/26 at 11:11am was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 07/10/26 at 10:50am revealed: -She administered medications to Resident #4. -She did not know when Resident #4's multivitamin order was started. Interview with the Administrator on 07/10/26 at 12:30pm revealed: -She did not know Resident #4's multivitamin medication card was full on the medication cart. -She did not know there were 7 doses of Resident #4's multivitamin that were unaccounted for in the last 3 months. Attempted telephone interview with Resident #4's primary care provider (PCP) on 07/10/26 at 10:11am was unsuccessful.	D 358		

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D 358	Continued From page 11 Refer to the interview with the Health and Wellness Coordinator (HWC) on 07/10/26 at 11:22am. Refer to the interview with the Health and Wellness Director (HWD) on 07/10/26 at 11:36am. Refer to the interview with the Administrator on 07/10/26 at 12:30pm. Interview with the Health and Wellness Coordinator (HWC) on 07/10/26 at 11:22am revealed: -Resident #4 had been out of the facility several times in the last few months. -The facility administered medication from older medication cards before using new medication cards. -She completed medication cart audits and tried to complete audits weekly. -She last completed an audit on 07/05/26 for one medication cart and two or three weeks ago for the other medication cart. -When she audited the medications carts, she was looking to ensure the medication orders matched the medications on the carts and that there were no expired medications on the medication carts. Interview with the Health and Wellness Director (HWD) on 07/10/26 at 11:36am revealed: -She administered medications to Resident #4 sometimes. -Resident #4's medications were not administered when he was out of the facility. -Resident #4 was in the hospital 12 days over the last 3 months. -She had pulled some empty medications cards	D 358		

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D 358	Continued From page 12 off the medication cart and disposed of them in a recyclable bin. -Resident #4's medications were on a cycle fill from the pharmacy. -The facility administered medications from older cycle fills first if there were medications left over. Interview with the Administrator on 07/10/26 at 12:30pm revealed: -The medication carts were audited weekly and an audit consisted of looking for outdated medications and ensuring the ordered medications matched the medications on the medication cart. -MAs or whoever was assigned to the medication cart were responsible to administer medications as ordered.	D 358		

The following is a summary of the Plan of Correction for Brookdale Skeet Club. This Plan of Correction is in regards to the Corrective Action Report dated July 10, 2026. 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 .0909 Resident Rights

An adult care home shall assure that the rights of all residents guaranteed under G.S, 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

The Executive Director/Health and Wellness Director/Nurse or designee will lead a diverse committee in developing dietary/dining guidelines for all disciplines involved to ensure the rights of residents are maintained, including being treated with dignity and respect related to being served food within the scheduled meal service times. These guidelines will be reviewed, revised (if necessary), communicated and implemented. The Executive Director/Health and Wellness Director/Nurse or designee will audit for compliance twice weekly for two months. To ensure ongoing compliance, unannounced audits will be conducted routinely thereafter. Plan of correction to be completed by August 24, 2026.

10A NCAC 13F. 1004 (a) 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.

The Health and Wellness Director/Nurse/Executive Director or designee will re-in-service medication aids and LPNs on the 7 rights of medication administration; along with an eMAR to medication cart audit to ensure that physician orders and eMAR match. The Health and Wellness Director/Nurse/Executive Director will also ensure the process for cycle fill is being followed especially as it relates to removing the old medication cards, once the new ones are inserted. To assist with ongoing compliance, the Health and 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 and then randomly thereafter. Plan of correction to be completed by August 24, 2026.

Elizabeth Newton, RN, MSN Executive Director

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