STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041030	A. BUILDING: _____ B. WING _____	R 01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT	201 WEST HARTLEY DRIVE HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on January 5, 2023.	{D 000}		
{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, interview, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents (#4) for record review including errors with a medication used to regulate heart rate. The findings are: Review of Resident #4's current FL-2 dated 06/14/22 revealed: -There was a diagnosis of atrial fibrillation. -There was an order for diltiazem 180mg daily. Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for diltiazem 180mg daily with an administration time of 8:00am. -There was documentation that diltiazem was administered daily at 8:00am from 11/01/22 to 11/30/22. -There were daily blood pressure readings	{D 358}		

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{D 358}	Continued From page 1 ranging from 106/64 to 151/87 from 11/01/22 to 11/30/22. There were daily heart rate readings ranging from 60 to 92 beats per minute from 11/01/22 to 11/30/22. Review of Resident #4's December 2022 eMAR revealed: -There was an entry for diltiazem 180mg daily with an administration time of 8:00am. -There was documentation that diltiazem was administered daily at 8:00am from 12/01/22 to 12/31/22. -There were daily blood pressure readings ranging from 113/76 to 157/86 from 12/01/22 to 12/31/22. There were daily heart rate readings ranging from 63 to 80 beats per minute from 12/01/22 to 12/31/22. Review of Resident #4's January 2022 eMAR from 01/01/23 to 01/04/23 revealed: -There was an entry for diltiazem 180mg daily with an administration time of 8:00am. -There was documentation that diltiazem was administered daily at 8:00am from 01/01/23 to 01/04/23. -There were daily blood pressure readings ranging from 124/78 to 140/80 from 01/01/23 to 01/04/23. There were daily heart rate readings ranging from 73 to 78 beats per minute from 01/01/23 to 01/04/23. Observation of medications on hand for Resident #4 on 01/04/22 at 3:20pm revealed: -There was a bottle of diltiazem 240mg available for administration. -There was no diltiazem 180mg available for administration.	{D 358}		

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{D 358}	Continued From page 2 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 01/04/22 at 2:58pm revealed: -The facility's contracted pharmacy was not Resident #4's primary pharmacy. -The pharmacy would profile the new orders faxed to them and send a week of medications to the facility until Resident #4 received her mail order medications. -The pharmacy received an order on 11/17/22 for diltiazem 180mg daily. The pharmacy dispensed 10 tablets of diltiazem 180mg on 11/18/22. Telephone interview with the Pharmacist at Resident's #4's mail order pharmacy on 01/04/22 at 3:15pm revealed: -The pharmacy has an order for diltiazem 240mg daily. -They did not receive an order for diltiazem 180mg daily. -The pharmacy dispensed 90 tablets of diltiazem 240mg, a 90 supply, on 11/17/22. -The pharmacy accepts prescriptions; they do not accept FL-2's or hospital discharge summaries as orders. Interview with Resident #4 on 01/05/22 at 10:33am revealed: -She took diltiazem daily but did not know what dose should took. -She knew diltiazem helped with her heart rate. -The facility staff checked her blood pressure and heart rate daily. -She did not have any episode of a low blood pressure or low heart rate. Interview with a Medication Aide (MA) on 01/05/23 at 8:03am revealed:	{D 358}		

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{D 358}	Continued From page 3 -She compared the medications to Resident #4's eMAR. -She prepared and administered the medication to Resident #4. -She documented on the eMAR after the medications was administered. -She administered diltiazem to Resident #4. -She had not noticed diltiazem 240mg was on the medication cart instead of diltiazem 180mg. -She should have noticed Resident #4 did not have the correct dosage of medication. Interview with another MA on 01/05/22 at 10:09am revealed: -When administering medication, she compared the medication to the eMAR for accuracy. -She prepared the medication for administration and then administered the medication to the resident. -She would document on the eMAR the medication was administered. -She had not noticed Resident #4 had diltiazem 240 medication on the medication cart and diltiazem 180 was entered on the eMAR. -She needed to be more careful when administering medication. -Resident #4 did not use the facility's contracting pharmacy. -The order for diltiazem should have been faxed to Resident #4's personal mail order pharmacy. Interview with Resident #4's Primary Care Provider (PCP) on 01/05/23 at 12:58am revealed: -She managed medications for Resident #4. -Resident #4 had an order for diltiazem 180mg daily. -Diltiazem was administered to control heart rate. -Resident #4 could experience a low blood pressure reading or a low heart rate reading if she received too much diltiazem.	{D 358}		

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{D 358}	Continued From page 4 -She had not been notified of any low blood pressure readings or a low heart rate reading in the past several months.- Interview with the nurse from Resident #4's cardiologist on 01/05/23 at 4:30pm revealed: -Resident #4 had an order for diltiazem 180mg daily. -Diltiazem was used to maintain Resident #4's heart rate. -The facility staff had not notified the office of issues with Resident #4's blood pressure or heart rate being too low. Interview with the Health Wellness Director (HWD) on 01/05/23 at 10:33am revealed: -The facility has a tracking order form that should be used with each new order. -The Health Wellness Coordinator (HWC) was responsible for faxing orders to Resident #4's primary pharmacy. -She expected new and changed medication orders to be faxed to the pharmacy the same day the order was received. -The HWC audited a medication cart every week. -The HWC should have compared Resident #4's orders with her medications on hand. -She expected the HWC to compare medications on hand with Resident #4's current orders during the medication cart audit. Interview with the Associate Executive Director on 01/05/22 at 3:02pm revealed: -Resident #4's mail order pharmacy only took prescriptions for medication orders; they did not take FL-2's, hospital discharge summaries. -She expected the MAs, HWC, and the HWD to fax orders to the pharmacy in order to receive the medications for administration. -The MAs should have compared the medications	{D 358}		

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{D 358}	Continued From page 5 with the eMAR prior to administration of the medication. -The MAs should have notified the HWD the wrong dosage of diltiazem was on the medication cart. -She expected the MAs to administer medications as ordered, and if the correct medication was not on the medication cart, she expected the MA to notify the HWC or HWD. -The HWC audited the medication carts weekly. -She would have expected the HWC to have noticed the wrong dosage of diltiazem was on the medication cart. Attempted telephone interview with the HWC on 01/05/23 at 9:35am was unsuccessful.	{D 358}		