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 _____	03/12/2026

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 follow-up survey from 03/10/26 through 03/12/26.	D 000		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations	D 259		

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 _____	03/12/2026

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D 259	Continued From page 1	D 259		

warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents had a care plan that was signed by a physician within 15 days of completion for a change in condition (#3).

The findings are:

Review of Resident #3's current FL2 dated 10/09/25 revealed:
-Diagnoses included dysarthria following cerebral infarction (a speech disorder caused by muscle weakness following a stroke), fall, spinal stenosis, and osteoarthritis.
-Resident #3 was semi-ambulatory.

Review of Resident #3's Resident Register revealed an admission date of 02/22/24.

Review of Resident #3's care plan dated 11/20/25 revealed:
-Resident #3 had a change in condition related to

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 _____	03/12/2026

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 259	Continued From page 2 an increase in falls. -Resident #3 required extensive assistance from staff with toileting, and dressing/undressing. -Resident #3 was independent with eating, ambulation, grooming, and transferring. -Hospice staff assisted Resident #3 with showers. -Resident #3 utilized a walker. -The change in condition care plan was not signed by Resident #3's primary care provider (PCP). Interview with the Health and Wellness Coordinator (HWC) on 03/12/26 at 2:20pm revealed: -She was not aware that Resident #3's change in condition care plan had not been signed. -It was the responsibility of the Health and Wellness Director (HWD) and HWC to make sure the care plans were signed by the PCP. Interview with the HWD on 03/12/26 at 2:52pm revealed: -It was the responsibility of the HWD and HWC to make sure the care plans were signed by the PCP. -She was not aware that a change in condition care plan needed to be signed by the PCP. -She thought the care plan only needed to be signed by the PCP every 6 months. Interview with the Administrator on 03/12/26 at 3:34pm revealed: -She was not aware Resident #3's care plan was not signed. -It was the responsibility of the HWD and HWC to make sure the care plans were signed by the PCP. -She was not aware that a change in condition care plan needed to be signed by the PCP.	D 259		

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 _____	03/12/2026

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 259	Continued From page 3 Attempted telephone interview with the PCP on 03/12/26 at 11:09am was unsuccessful.	D 259		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure supervision for 1 of 5 sampled residents (#3) related to a resident who had 16 falls in 3 months resulting in a head injury and skin tears. The findings are: Review of the facility's Falls Management Policy dated 03/2026 revealed: -A resident who sustained a fall should have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury. -Individualized interventions were considered as a part of the post fall evaluation and the evaluation was a part of the resident record.	D 270		

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 _____	03/12/2026

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 270	Continued From page 4	D 270		

-When a fall occurred, staff were to document the resident's fall/injuries, resident response, and interventions taken in the resident's progress notes.
-The resident's service plan was reviewed for potential fall interventions and updated as necessary.
-The fall(s) were discussed at the next stand-up meeting and discussed at the next collaborative care review (CCR) meeting.

Review of the facility's Fall Intervention Clinical Guidelines dated 02/2024 revealed interventions identified implemented, documented in the resident record and on the personal service plan (care plan).

Review of Resident #3's current FL2 dated 10/09/25 revealed:
-Diagnoses included dysarthria following cerebral infarction, fall, spinal stenosis, and osteoarthritis.
-Resident #3 was semi-ambulatory.

Review of Resident #3's Resident Register revealed an admission date of 02/22/24.

Review of Resident #3's care plan dated 11/20/25 revealed:
-Resident #3 had a change in condition related to an increase in falls.
-Resident #3 required extensive assistance from staff with toileting, and dressing/undressing.
-Resident #3 required supervision from staff with grooming.
-Resident #3 was independent with eating, ambulation, and transferring.
-Hospice staff assisted Resident #3 with showers.
-Resident #3 ambulated with a walker.
-Interventions included encouraging program participation to increase observation of Resident

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 _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 5 #3. -Resident #3's interventions also included encouraging use of scoop mattress to prompt residents to call for help and to define bed boundaries and reduce risk of sliding from bed. -Resident #3's interventions also included familiarizing the resident with the call system and having her demonstrate use. -There were fall interventions handwritten at the bottom of the care plan pages. Observation of Resident #3 on 03/10/26 at 10:35am revealed: -She was ambulating from the bathroom located in her room towards her bed with her walker. -She had a bandage on her right outer calf. -She had a large dark purple bruise on her back just above her buttocks. -She had a large dark purple bruise on her right side near her ribs. -Both of her legs were discolored and had several bruised areas that covered the entire right and left leg. -Both of her arms were discolored and had several bruised areas that covered her entire right and left arm. Observation of Resident #3's room on 03/10/26 at 10:42am revealed: -The call bell string was located at the foot of the bed and not within reach of Resident #3. -Resident #3 was sitting at the edge of the mattress at the head of the bed. -The telephone cord was laying on the floor in a loop by Resident #3's foot that appeared to be stuck under the bedside table leg. -The carpet had several small areas of red drops from her bed to her apartment door with a larger area in front of the bedside table. -There was a large pile of laundry stacked up	D 270		

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 _____	03/12/2026

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 270	Continued From page 6	D 270		

blocking her closet door.
-There was no scoop mattress on the resident's bed.

a. Review of Resident #3's initial post fall report dated 01/03/26 revealed:
-Resident #3 had an unwitnessed fall in her room near her bed at 5:30am.
-Resident #3 stated she rolled out of bed.
-Her vital signs were not obtained.
-There were no visible signs of injury.
-Resident #3 denied having pain.

Review of Resident #3's post-fall evaluation dated 01/05/26 revealed:
-Resident #3 had some confusion/forgetfulness at baseline.
-Resident #3 had some unsteadiness on feet at baseline and she was not eligible for physical therapy (PT) or occupational therapy (OT) due to being on hospice.
-The fall intervention was for staff and Activities Director to encourage Resident #3 to be more involved in activities to decrease time alone and likelihood of falls.
-Resident #3's care plan was reviewed with no new changes.

Review of Resident #3's record revealed:
-There was no documentation from staff or the Activities Director of when they encouraged Resident #3 to attend activities.
-The intervention for staff and the Activities Director to encourage Resident #3 to attend activities was handwritten at the bottom of Resident #3's paper care plan.

b. Review of Resident #3's initial post fall report dated 01/07/26 revealed:
-Resident #3 had an unwitnessed fall in her room

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 _____	03/12/2026

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 270	Continued From page 7	D 270		

near her bed at 3:00am.
-Resident #3 stated she rolled out of bed.
-Her vital signs were obtained at 6:22am.
-There were no visible signs of skin or head injury.
-Resident #3 denied any pain.

Review of Resident #3's post-fall evaluation dated 01/08/26 revealed:
-The risk factor that appeared to contribute to the fall was that she accidentally rolled out of bed.
-Resident #3 had some confusion/forgetfulness at baseline.
-Resident #3 had some gait instability at baseline and was not eligible for PT.
-The intervention for 01/07/26 fall was for clinical staff to lay a pillow or blanket behind Resident #3 once she goes to bed to help prevent her from rolling out of bed again.
-Resident #3's care plan was reviewed with no new changes.

Review of Resident #3's record revealed:
-There was no documentation when the staff was putting a pillow or blanket behind Resident #3 once she was in bed.
-The intervention for staff to put a pillow or blanket behind Resident #3 once she was in bed was handwritten on the bottom of the 11/20/25 care plan.

c. Review of Resident #3's initial post fall report dated 01/13/26 revealed:
-Resident #3 had an unwitnessed fall in her room at 11:36am.
-Resident #3 did not recall how she fell.
-Resident #3's vital signs were obtained and there were no signs of a head injury.
-A skin tear on Resident #3's right elbow was noted.

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 _____	03/12/2026

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 270	Continued From page 8	D 270		

-Hospice provided wound care to Resident #3's right elbow.
-Resident #3 denied any pain.

Review of Resident #3's post fall evaluation dated 01/14/26 revealed:
-Resident #3 was active with hospice.
-Within the last 30 days Resident #3's pain medicine was increased to address pain.
-Resident had some confusion at baseline.
-Resident was unsteady at baseline.
-It was unsure what contributed to the fall, but Resident #3 moved around a lot in her room.
-A fall mat was ordered by hospice per their suggested intervention.

Review of Resident #3's record revealed:
-There was no documentation that a fall mat was put in place.
-The intervention for a fall mat was handwritten at the bottom of Resident #3's care plan dated 11/20/25.

Observation of Resident #3's room on 03/10/26 at 10:42am revealed there was no fall mat present.

d. Review of Resident #3's progress note dated 01/13/26 revealed:
-Resident #3 had a second unwitnessed fall on 01/13/26 at 10:35pm in her room.
-Resident #3 was found sitting on her room floor yelling out for someone to help her.
-Resident #3's vital signs were taken.
-Resident #3 did not state what she was doing before the fall.
-Resident #3 denied any pain.

Review of Resident #3's record revealed on 03/11/26:
-There was no documentation of an initial post fall

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 _____	03/12/2026

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 270	Continued From page 9	D 270		

report for 01/13/26 available for review.
-There was no documentation of a post-fall evaluation completed after her second fall on 01/13/26.
-There was no intervention documented after the fall on 01/13/26.

Attempted telephone interview with the medication aide (MA) that documented the progress note on 03/12/26 at 10:42am was unsuccessful.

e. Review of Resident #3's initial post fall report dated 01/18/26 revealed:
-Resident #3 had an unwitnessed fall in her room at 1:45pm.
-She was observed sitting on the floor by her bed and recliner.
-Resident #3 stated she was trying to get to her bed.
-Her vital signs were not obtained and there were no physical signs of a head injury.
-Resident #3 denied any pain.

Review of Resident #3's record on 03/11/26 revealed:
-There was no documentation of a post-fall evaluation completed after her fall on 01/18/26.
-There was no intervention documented after the fall on 01/18/26.

f. Review of Resident #3's initial post-fall note dated 01/20/26 revealed:
-Resident #3 had an unwitnessed fall in her room at 11:03am.
-Resident #3 stated she was trying to get hangers out of the closet.
-Her vital signs were not taken and there were no physical signs of a head injury.
-Resident #3 received a skin tear on her right

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 _____	03/12/2026

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 270	Continued From page 10 wrist. -Resident #3 denied pain. Review of Resident #3's post fall evaluation dated 01/22/26 revealed: -Resident #3 was active with hospice. -Within the last 30 days Resident #3's pain medicine was increased to address pain. -Resident #3's had a change in her ability to ambulate and ambulated with a rollator walker and a wheelchair. - Resident #3 was educated to ask for assistance when needing to get things out of her closet. -Staff were advised to increase rounding and try to assist Resident #3 with toileting as much as she would allow to prevent her from attempting to do things on her own. -The care plan was not reviewed. Review of Resident #3's record on 03/11/26 revealed: -There was no documentation that increased rounding was being completed for Resident #3. -The intervention for increased rounding on Resident #3 was handwritten on the bottom of her care plan dated 11/20/25. g. Review of Resident #3's initial post-fall note dated 01/27/26 revealed: -Resident #3 had an unwitnessed fall in her room near her bed at 5:35am. -Resident #3 stated she was messing around in her room. -Resident #3's vital signs were obtained and there were no physical signs of skin or head injury. -Resident #3 denied any pain. Review of Resident #3's post fall evaluation form dated 01/28/26 revealed: -Resident #3 was active with hospice.	D 270		

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 _____	03/12/2026

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 270	Continued From page 11	D 270		

-Within the last 30 days Resident #3's pain medicine was increased to address pain.
-Risk factor that contributed to the fall was compliance with safety issues.
-A family member was contacted by the Health and Wellness Director (HWD) and recommended a sitter.
-The HWD encouraged family members to come visit Resident #3 more often to keep her engaged and decrease alone time.
-The care plan was reviewed with no new changes.

Review of Resident #3 record on 03/11/26 revealed there was no documentation that family members were visiting more often.

h. Review of Resident #3's progress note dated 01/29/26 revealed:
-Resident #3 had an unwitnessed fall in her room at 10:24pm.
-Resident #3's vital signs were obtained and no injuries were noted.
-Resident #3 denied any pain.

Review of Resident #3's record revealed:
-There was no documentation of an initial post-fall completed for the fall on 01/29/26.
-There was no documentation of a post-fall evaluation completed after her fall on 01/29/26.
-There was no intervention documented after the fall on 01/29/26.

i. Review of Resident #3's progress note dated 01/30/26 revealed:
-Resident #3 had an unwitnessed fall in her room at 3:50pm.
-Resident #3 was found on her knees by her bed.
-Resident #3 was attempting to grab her lipstick.
-Resident #3's vital signs were obtained and 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 _____	03/12/2026

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 270	Continued From page 12	D 270		

were no physical signs of skin or head injury.
-Resident #3 denied any pain.

Review of Resident #3's record on 03/11/26 revealed:
-There was no documentation of a post-fall evaluation completed after her fall on 01/30/26.
-There was no intervention documented after the fall on 01/30/26.

j. Review of Resident #3's initial post-fall note dated 02/03/26 revealed:
-Resident #3 had an unwitnessed fall in her room near her bed at 2:45pm.
-Resident #3 stated that she was walking back to her bed.
-Resident #3's vital signs were obtained.
-Skin tears to Resident #3's right knee, right arm and right wrist were noted.
-Resident #3 denied any pain.

Review of Resident #3's record revealed:
-There was no post-fall evaluation documentation completed after the fall on 02/03/26.
-There was no intervention documented for the fall on 02/03/26.

k. Review of Resident #3's progress note dated 02/03/26 revealed:
-Resident #3 had a second fall at 3:37pm resulting in an injury to her head.
-Resident #3 had swelling and bruising above her left eye.
-There were no vital signs documented.
-The HWD and hospice were notified.
-The hospice nurse completed a visit at 5:20pm.

Review of Resident #3's record revealed:
-There was no post-fall evaluation documented after her second fall on 02/03/26.

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 _____	03/12/2026

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 270	Continued From page 13 -There was no intervention documented after her second fall on 02/03/26. Review of Resident #3's hospice note dated 02/03/26 revealed: -Resident #3 had 2 falls on 02/03/26. -Resident obtained skin tears to the right arm and a hematoma (a collection of blood under the skin) over her left eye. -The hospice case manager would follow up on 02/04/26. Review of Resident #3's progress note dated 02/03/26 revealed: -A post fall follow up note was documented at 10:54pm. -Resident #3 complained of a lot of pain. -Resident #3's left eye, was "very swollen and lots of discoloration". -There was no documentation of an intervention or notification to the HWD or hospice. Attempted telephone interview with the MA on 03/11/26 at 4:24pm was unsuccessful. Attempted telephone interview with the hospice case manager on 03/12/26 at 10:30am was unsuccessful. I. Review of Resident #3's initial post-fall note dated 02/04/26 revealed: -Resident #3 had an unwitnessed fall by her room door at 1:45am. -Resident #3 stated she was messing around in her room. -Resident #3's vital signs were obtained and there were no physical signs of skin or head injury. -Resident #3 denied any pain. Review of Resident #3's record on 03/11/26	D 270		

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 _____	03/12/2026

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 270	Continued From page 14	D 270		

revealed there was no documentation of a post-fall evaluation completed after Resident #3's fall on 02/04/26.

Review of Resident #3's care plan dated 11/20/25 revealed:
-There was handwritten documentation the HWD recommended a sitter for Resident #3.
-Several companies and prices were sent to Resident #3's family.
-The family declined to obtain a sitter for Resident #3.
-No other intervention was documented for Resident #3's fall on 02/04/26.

m. Review of Resident #3's initial post fall note dated 02/05/26 revealed:
-Resident #3 had an unwitnessed fall in her bathroom at 5:40pm.
-Resident #3 stated that she saw something black on her bathroom floor, when she tried to pick it up, she lost her balance and fell on her bottom.
-Resident #3's vital signs were obtained and there were no physical signs of a head injury.
-A skin tear to Resident #3 left elbow was noted.
-A hospice nurse arrived at 8:00pm to assess Resident #3.

Review of Resident #3's record revealed there was no hospice note from 02/05/26 to review.

Review of Resident #3's post fall evaluation dated 02/06/26 revealed:
-It was documented that Resident #3 had a change in medication in the past 30 days, but it was not documented which medication.
-Resident #3 had unsteadiness at baseline.
-Resident #3 could not receive PT due to being active with hospice.

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 _____	03/12/2026

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 270	Continued From page 15	D 270		

-Resident #3 was not compliant with safety interventions.
-A sitter was recommended to the family.
-The care plan was not reviewed.

Review of Resident #3's care plan dated 11/20/25 revealed:
-There was handwritten documentation the HWD recommended a sitter for Resident #3.
-Several companies and prices were sent to Resident #3's family.
-The family declined to obtain a sitter for Resident #3.
-No other intervention was documented for Resident #3's fall on 02/05/26.

n. Review of Resident #3's initial post fall note dated 02/28/26 revealed:
-Resident #3 had an unwitnessed fall in her room by the bed at 5:15am.
-Resident #3 stated she was trying to pick up a hanger.
-Resident #3 vitals signs were obtained and no physical signs of a head injury were noted.
-A skin tear above Resident #3's right elbow was noted.
-Resident #3 denied any pain.

Review of Resident #3's post fall evaluation dated 03/03/26 revealed:
-Compliance with safety issues appeared to contribute to the fall.
-The intervention for Resident #3's fall on 02/28/26 was to remind her to use her assistive device.
-It was not specified which assistive device to remind Resident #3 to use.
-Resident #3's care plan was not reviewed.

Review of Resident #3 record on 03/11/26

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 _____	03/12/2026

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 270	Continued From page 16	D 270		

revealed:
-There was no documentation that staff reminded Resident #3 to use her assistive device.
-There was no documentation that Resident #3's fall on 03/03/26 was discussed during the stand-up meeting.

o. Review of Resident #3's progress notes dated 03/03/26 revealed:
-Resident had a fall in front of the dining room at 2:24pm.
-It was not documented if the fall was witnessed or not.
-Resident #3 tripped over her walker.
-Resident #3 denied any pain.
-There was documentation that hospice was notified at 2:45pm of both Resident #3's falls on 03/06/26 and she may have hit her head on the second fall.
-There was no documentation that Resident #3 had a second fall on 03/03/26.
-Hospice stated to not send Resident #3 out to the hospital and a hospice visit would be made on 03/04/26.

Review of Resident #3's record on 03/11/26 revealed:
-There was no documentation of a post-fall evaluation completed after Resident #3's falls on 03/03/26.
-There were no documented interventions for Resident #3's falls on 03/03/26.

p. Review of Resident #3's initial post fall note dated 03/06/26 revealed:
-Resident #3 had an unwitnessed fall in her room by her bed at 1:46pm.
-Resident #3 stated she was going to see if her son was at the front.
-Resident #3's vital signs were obtained and there

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	HAL041039	A. BUILDING: _____ B. WING _____	03/12/2026

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 270	Continued From page 17	D 270		

were no physical signs of a head injury.
-A skin tear on Resident #3's outer right calf was noted.

Review of Resident #3's post fall evaluation dated 03/09/26 revealed:
-Compliance with safety issues appeared to contribute to the fall.
-Resident #3's safety devices were in good working order and applied correctly.
-It did not state which safety devices were in good working order or applied correctly.
-The hospice nurse verified Resident #3 had appropriate shoes and that her clothing was appropriately fitting.
-Pain management was addressed and Resident #3 denied pain.
-Resident #3's care plan was reviewed with no new changes.

Interview with Resident #3 on 03/10/26 at 10:43am revealed:
-She had falls but could not recall how many.
-She did not recall what caused any of the falls.
-She did not hear well.
-She had trouble seeing sometimes.
-She did not complain of any pain.

Interview with a family member of Resident #3 on 03/12/26 at 9:10am revealed:
-She was aware Resident #3 had multiple falls.
-The HWD did contact her and suggested for her and family members to visit more often.
-She could not visit more often due to her work schedule, and she did not live close.
-There were no other family members that lived close.
-The HWD did suggest a sitter service for Resident #3.
-She could not afford a sitter service.

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 _____	03/12/2026

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 270	Continued From page 18 Interview with a personal care aide (PCA) on 03/11/26 at 3:40pm revealed: -She was aware that Resident #3 had several falls. -She did not put a pillow or blanket behind Resident #3 once she was in bed. -PCA's used a tablet to document Resident #3's care. -There were no interventions for Resident #3 on the tablet. -She did not review Resident #3's care plan with the interventions written on it. -She only reviewed the care plan that was available in the tablet. Interview with a second PCA on 03/12/26 at 10:09am revealed: -She was aware that Resident #3 had several falls. -She did encourage Resident #3 to attend activities but did not document her attempts. -PCA's used a tablet to document Resident #3's care. -There were no interventions for Resident #3 on the tablet to document. -She did not review Resident #3's care plan with the interventions on it. -She tried to do 1-hour rounds on Resident #3 as often as possible. -There was no set time of when to do rounds on Resident #3. -She was not told to document when she did rounds on Resident #3. Interview with a MA on 03/12/26 at 10:43am revealed: -She was aware that Resident #3 had multiple falls. -The only intervention that she was aware of was	D 270		

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 _____	03/12/2026

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 270	Continued From page 19	D 270		

to increase rounding on Resident #3.
-She could not recall a place to document the increased rounding.
-She was never told to document when she rounded on Resident #3.
-She was not sure if Resident #3 was discussed during the stand-up meetings.
-She did not attend any meetings to discuss Resident #3's falls.

Interview with the Activities Director on 03/12/26 at 11:39am revealed:
-She was aware that Resident #3 had multiple falls.
-She was not aware there was an intervention to encourage Resident #3 to attend activities.
-She did ask Resident #3 to attend activities, but Resident #3 would sometimes refuse.
-She had not asked Resident #3 to attend an activity in about 2 weeks.
-She did not document when Resident #3 attended an activity.
-She did not review Resident #3's care plan.

Interview with the Health and Wellness Coordinator (HWC) on 03/12/26 at 2:20pm revealed:
-She was aware that Resident #3 had multiple falls.
-The initial post fall report and post fall evaluation should be completed after each fall.
-It was the responsibility of the MA on duty to complete the initial post fall report.
-It was the responsibility of the HWD and HWC to complete the post fall evaluation.
-She hand wrote some of the post-fall interventions on Resident #3's current care plan dated 11/20/25.
-Other interventions that were in place for Resident #3 was clearing clutter and leaving 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 _____	03/12/2026

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 270	Continued From page 20	D 270		

bathroom light on.
-She could not recall why all the interventions were not written on the paper care plan.
-The HWD and HWC were responsible for initiating an intervention after each fall.
-Clinical staff were not instructed by her to read Resident #3's care plan.
-She thought the staff already knew to read Resident #3's care plan.
-Resident #3's interventions were discussed at the morning meetings.
-Increased rounding was defined by rounding at least every hour.
-There was no documentation of when the increased rounding was completed for Resident #3.
-There was no documentation of when each intervention was completed for Resident #3.

Interview with the HWD on 03/12/26 at 2:52pm revealed:
-The HWC was still new in her position, so it was mostly her responsibility to complete the post fall evaluation and ensure the initial post fall form was completed after each fall.
-If Resident #3 had more than one fall on the same day or next day she would complete one post fall evaluation.
-She was not sure why some falls did not have an initial post fall report completed.
-If there was no initial post fall report then a post fall evaluation was not completed.
-The MA who cared for Resident #3 when the fall happened would fill out the initial post fall form.
-She took Resident #3's fall mat away because she was worried Resident #3 would fall more.
-The clinical staff did not document when interventions were completed on Resident #3.
-She was not aware of a way to put the interventions in the tablet for the PCA's to

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	HAL041039	A. BUILDING: _____ B. WING _____	03/12/2026

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 270	Continued From page 21	D 270		

document.
-She did not make a form to document when interventions were completed on Resident #3.

Interview with the Administrator on 03/12/26 at 3:34pm revealed:
-She was aware Resident #3 had multiple falls.
-The initial post fall form and post-fall evaluation should be completed after each fall.
-She was not aware that not every fall had an initial post-fall form or post-fall evaluation completed.
-She expected for the initial post fall form and post-fall evaluation to be completed after each fall.
-She discussed Resident #3's falls in the stand-up meeting and in the CCR meeting.
-There was no documentation when Resident #3 was discussed in the stand-up meetings.
-The January 2026, February 2026 and March 2026 CCR meeting notes were documented Resident #3 was active with hospice and had multiple falls due to noncompliance.
-No other notes were documented for Resident #3 related to her multiple falls.
-Interventions were not documented by the staff when they were completed.

Attempted telephone interview with the hospice case manager on 03/12/26 at 10:30am was unsuccessful.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 03/12/26 at 11:09am was unsuccessful.

_____
The facility failed to ensure supervision was provided according to the resident's assessed needs, for a resident (#3) who had multiple falls with interventions that were not documented as

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 _____	03/12/2026

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 270	Continued From page 22 being completed and falls with no interventions considered to reduce the potential for future falls and injury. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 03/12/26. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 26TH, 2026.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (Resident #5) related to a referral to an ophthalmologist for an eye exam. The findings are: Review of Resident #5's current FL2 dated 11/13/25 revealed diagnoses included anxiety, depression and hypertension. Review of Resident #5's signed physician order dated 01/30/26 revealed there was an order to refer Resident #5 to a local ophthalmologist for an eye exam.	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 _____	03/12/2026

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 273	Continued From page 23 Interview with Resident #5 on 03/11/26 at 3:55pm revealed: -She still had blurry vision and needed to see an ophthalmologist. -Her primary care provider (PCP) knew she had blurry vision. -She had not been seen by an eye doctor while at the facility and the staff had not mentioned anything to her about an eye doctor appointment. Interview with a personal care aide (PCA) on 03/12/26 at 2:13pm revealed Resident #5 never said anything to her about having blurry vision. Interview with the medication aide (MA) on 03/12/26 at 1:57pm revealed: -Resident #5 had not told her about having blurry vision. -The Health and Wellness Coordinator (HWC) and the Health and Wellness Director (HWD) both scheduled appointments for residents and set up transportation to those appointments. Interview with the HWC on 03/12/26 at 10:59am revealed: -Resident #5 had an appointment scheduled with an eye doctor on 03/23/26 at 3:30pm with a local eye doctor. -The facility had scheduled Resident #5's eye doctor appointment. Telephone interview with a representative from a local eye doctor's office on 03/12/26 at 11:35am revealed: -Resident #5 had an appointment scheduled for 03/23/26 at 3:30pm. -Resident #5's eye doctor appointment was not scheduled until today, on 03/12/26. Second interview with the HWC on 03/12/26 at	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 _____	03/12/2026

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 24 2:18pm revealed: -She did not know Resident #5 had an order from 01/30/26 to schedule an eye exam prior to 03/12/26. -The HWD normally made appointments for residents and ensured referrals were completed. -Resident #5 had not said anything to her about having blurry vision. Interview with the HWD on 03/12/26 at 3:33pm revealed: -Resident #5's appointment to see an eye doctor for an eye exam was not scheduled until 03/12/26. -She and the HWC scheduled appointments and referrals for the residents. -Resident #5 had not said anything to her about having blurry vision. Interview with the Administrator on 03/12/26 at 3:00pm revealed: -She did not know Resident #5 had a referral to schedule an eye exam. -The HWD normally ensured appointments and referrals were completed. -Resident #5 had told the Administrator that her vision was "different" a few weeks ago. Attempted telephone interview with Resident #5's PCP on 03/12/26 at 11:10am was unsuccessful.	D 273		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.	D 377		

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 _____	03/12/2026

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 377	Continued From page 25	D 377		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure self-administered medications stored in a resident's room were stored in a safe and secure manner for 1 of 5 sampled residents (#1).

The findings are:

Review of the facility's Medication and Treatment Self-Administration of Medication Policy dated 03/01/06 revealed:
-The resident should be able to properly store medication.
-Residents who self-administer their own medications should store their own medications so they are not accessible to others.

Review of Resident #1's current FL2 dated 02/14/25 revealed diagnoses included essential hypertension, prediabetes, other specified hearing loss, age-related osteoporosis without current pathological fracture.

Review of Resident #1's physician's orders dated 02/19/26 revealed there was an order to self-administer all medications.

Observation of Resident #1's room on 03/10/26 at 9:24am revealed:
-There were 16 medications inside a broken lock box in Resident #1's room.
-The door to the room where Resident #1 resided was not locked and she was in the room.
-Resident #1's lock box lid was on the floor and a cloth handkerchief covered the 16 medications located in the lock box.

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 _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 377	Continued From page 26 Interview with Resident #1 on 03/10/26 at 9:24am revealed: -She had orders to self-administer all her medications and she was aware her medications should be stored in a secured storage area. -She had told the personal care aides (PCA), medication aides (MA) and the Health and Wellness Director (HWD) several times her lock box lid had broken over the last year but no one had replaced the lock box. -She usually locked her main door when she left her room but not all the time. Observation of Resident #1's room on 03/10/26 at 1:10pm revealed Resident #1's room door was locked and she was not in the room. Observation of the Resident #1's room on 03/11/26 at 9:28am revealed: -Resident #1's room door was not locked and she was in the room. -Resident #1's medications were secured in a new lock box but the lid of the old lock box was on the floor in front of the lock box. Interview with a housekeeper on 03/11/26 at 10:50am revealed: -She cleaned Resident #1's room at least twice a week. -She had not noticed any medications not secured in Resident #1's room or that her medication lock box lid had not been secured while in her room. -Resident #1 had not made the housekeeper aware of her lock box lid being damaged while she cleaned her room. Interview with a PCA on 03/11/26 at 10:05am revealed: -She was aware Resident #1 had	D 377		

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 _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 377	Continued From page 27	D 377		

self-administered medication in her room.
-She was not aware the resident medications were not stored securely and the lid was not secured on the lock box.
-She was not aware self-administered medications should be stored in a safe lockable storage space.

Interview with a medication aide (MA) on 03/11/26 at 9:40am revealed:
-She was aware of Resident #1 had self-administered medication in her room.
-She was not aware Resident #1 medications were not stored securely and the lid was not secured on the lock box.
-She was aware that self-administered medications should be stored in a safe, secure storage area.

Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 9:35am revealed:
-She was aware Resident #1 had self-administered medications in her room but was not aware Resident #1's medications were not stored securely.
-She was not aware Resident #1's lid on the medication lock box was not secured in her room.
-She would have told the Health and Wellness Coordinator (HWC) and the HWD to replace Resident #1's lock box if she had known Resident #1's medications were not stored securely.
-She was aware that self-administered medications should be stored in a safe, secure storage area.

Interview with the HWC on 03/11/26 at 10:10am revealed:
-She was aware self-administered medications should be stored in a safe storage area or lockable storage space.

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 377	Continued From page 28 -She knew Resident #1's medications were covered by a cloth handkerchief but thought Resident #1's medications were stored secured if Resident #1 locked her door. Interview with the HWD on 03/11/26 at 10:15am revealed: -She knew residents who self-administered their medications needed a secured place to store their medications but she was not aware this responsibility also fell on the facility staff. -She was not aware Resident #1's medications were not stored securely and the lid was not secured on her medication lock box until yesterday afternoon (03/10/26). Interview with the Administrator on 03/11/26 at 10:22am revealed: -She was aware residents' self-administered medications should be in a safe and secure place. -She was aware the self-administered medications were not secured in Resident #1's room and had ordered a new lock box previously. -She was not aware the new lock box was not in Resident #1's room until she noticed the lock box in the HWD's office yesterday afternoon (03/10/26) and advised the HWD to put it in Resident #1's room. -She expected the clinical staff to ensure that residents who self-administered medications have a secured place to store the medication.	D 377		