

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/27/2024
NAME OF PROVIDER OR SUPPLIER HARMONY AT GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WHITEHURST ROAD GREENSBORO, NC 27410		
(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 03/26/24 through 03/27/24.	{D 000}			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care follow-up was completed for 1 of 5 sampled residents (#2) related to an order to fax daily blood pressure and heart rate results to the primary care provider (PCP) each week. The findings are: Review of Resident #2's current FL2 dated 02/29/24 revealed: -Diagnoses included chronic cluster headaches, Parkinson's disease and hyperlipidemia. -There was an order for daily blood pressure (BP) checks at 1:00pm. Review of a prescriber medication order form for Resident #2 revealed: -There were instructions to print off 1 week of vital signs and fax every Wednesday to Resident #2's PCP. -The instructions were signed by the previous facility nurse and was undated. Review of Resident #2's physician's orders dated 03/07/24 revealed: -There was an order to check Resident #2's BP and heart rate (HR) every day at 1:00pm for	D 273			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 273	Continued From page 1 monitoring and fax all BP/HR findings for the week to Resident #2's PCP every week; the fax number was documented. -There was an order to print 1 week of Resident #2's vital signs (BP and HR) every Wednesday and fax to her PCP; the fax number was documented. Review of Resident #2's hospital after visit summary dated 01/14/24 revealed she was seen in the emergency room with a diagnosis hypertension. Review of Resident #2's electronic treatment administration record (eTAR) for 03/01/24 through 03/26/24 revealed: -There was an entry for BP and HR check every day at 1:00pm for monitoring; fax all BP/HR findings for the week to Resident #2's PCP and the fax number was documented. -There was documentation of Resident #2's BP and HR results daily from 03/01/24 through 03/26/24. -Resident #2's systolic BP ranged from 98 to 179; diastolic BP ranged from 51 to 95; and her pulse ranged from 57 to 98. -There was an entry for vital signs; check every Wednesday print off 1 week of vital signs (BP and HR) and the fax number was documented. -There was documentation Resident #2's BP and HR results were faxed to her PCP on 03/07/24, 03/13/24, and 03/20/24. Review of Resident #2's record revealed there were no fax confirmations documenting that BP and HR results were faxed to Resident #2's PCP weekly. Interview with Resident #2 on 03/27/24 at 9:37am revealed:	D 273		

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D 273	Continued From page 2 -Staff checked her BP and pulse every day at 1:00pm. -She had to go to the hospital in January 2024 because her BP was really high, but her BP readings were not really high anymore. -She thought her highest systolic BP reading was 135. -She did not know if her PCP received reports of her BP results. -She felt a little off balance most of the time, but she was not falling, and she sometimes had headaches with a stiff neck. Interview with a medication aide (MA) on 03/27/24 at 9:38pm revealed: -She documented Resident #2's BP and HR on 03/07/24, 03/13/24, and 03/20/24. -She documented Resident #2's BP and HR results were faxed to her PCP on 03/07/24, 03/13/24, and 03/20/24, but she did not fax the results on those days. -She read the order on the eTAR incorrectly and thought it just gave instruction to send weekly vital signs to Resident #2's PCP. -She did not know Resident #2's daily BP and HR results were to be faxed to her PCP weekly on Wednesdays. -Today, Wednesday, 03/27/24, was her first time faxing Resident #2's BP and HR results to her PCP. Interview with the Resident Care Coordinator (RCC) on 03/27/24 at 10:10am revealed: -She did not know about the order for Resident #2's daily BP and HR results to be faxed to her PCP weekly on Wednesday. -MAs should have faxed Resident #2's daily BP and HR results to her PCP each week on Wednesdays, placed a copy of the completed fax confirmation in Resident #2's record, and	D 273		

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D 273	Continued From page 3 followed up with a phone call to her PCP to ensure receipt of the daily BP and HR results. Telephone interview with Resident #2's PCP on 03/26/24 at 2:37pm revealed: -She ordered the facility to check Resident #2's BP and HR in January 2024 after a hospital visit for hypertension and a history of variable blood pressures. -She lowered the dose of one of Resident #2's BP medications and she wanted to see how it was working by reviewing the weekly results. -She also needed to keep an eye on Resident #2's BPs and HRs because she was on a medication used to treat Parkinson's disease and the medication sometimes caused a drop in BPs. -The facility was not faxing Resident #2's daily BP and HR results to her weekly as ordered. -She received one week of readings shortly after she wrote the order in January 2024 for the facility to fax Resident #2's daily BP and HR results to her weekly. -She also received a list of BP and HR results for the month of February 2024 when the facility sent her Resident #2's care plan for her to review and sign on 03/07/24. -She expected the facility to send weekly reports of Resident #2's BP and HR. Interview with the Administrator on 03/27/24 at 10:45am revealed: -She knew there was an entry on the eTAR to check Resident #2's BP and HR and send daily results to her PCP every Wednesday, but she did not know the results were not being sent to Resident #2's PCP weekly. -She expected MAs to send Resident #2's daily BP and HR results to her PCP weekly and place a copy of the fax confirmation in Resident #2's record.	D 273			

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