Received via electronic mail on 04/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041086	A. BUILDING: _____ B. WING _____	R 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT GREENSBORO	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}	The following is a Plan of Correction (POC) for Harmony at Greensboro Assisted Living. This POC is in regard to the Follow-Up Survey, completed March 27th, 2024.	
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	This POC is not to be constructed as an admission of or an 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 statuatory and regulatory requirements. In this document, we have outlined a specific response to identified issues. We have not provided a detailed response to each allegation, or identified mitigating factors. 10 NCAC 13F .0902 (b) Healthcare Executive Director provided immediate education to the medication aides that blood pressure results are to be faxed as ordered. Completed 3/27/2024. Audit of orders requesting follow up with additional documentation to the primary care provider ("PCP") to be conducted by 4/1/2024. Audit will be completed by SIC and orders requiring fax/follow up will be documented on the MAR to require additional signature to affirm fax was sent with vitals to the PCP as requested.	

Reviewed and Acknowledged Keisha Banks 04/26/24

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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	Monthly audit of the fax will be completed by the Healthcare Director ("HCD") or Designee and documented in communication log at nursing station. Initiated 4/1/2024. Standard will be ongoing and monitored by HCD/Designee. Education and training will be completed by HCD/Designee to Care Staff on the process for faxing vital results to PCP to clinical staff by 5/1/2024 and will be monitored by the Business Office Manager or Designee to ensure team members have notified all clinical team members. Completion date 5/1/2024.	

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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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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Electronic Mail

March 28, 2024

Mr. Hunter D. Smith, Executive Officer
Greensboro Operations, LLC, Licensee
Harmony at Greensboro
3420 Whitehurst Road
Greensboro, NC 27410

Email Address: hsmith@smithpackett.com
lrumley@harmonyatgreensboro.com

Re: Follow-up Survey completed March 27, 2024 (ASPEN Event ID: 4RUX12)

Facility:	**Harmony at Greensboro**
Licensure Number:	**HAL-041-086**
County:	**Guilford**

Dear Mr. Smith:

Thank you for the cooperation and courtesy extended during the survey completed March 27, 2024 by staff with the Adult Care Licensure Section.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

The Type A1 violations in the rule areas of **10A NCAC 13F .0901(c) Personl Care and Supervision and 10A NCAC 13F .1221(b) Written Policies and Procedures** were abated as of the correction date, March 1, 2024. Information regarding the penalty impositions(s) for the violations(s) identified during the survey completed January 31, 2024 will be mailed to you separately.

The Type B Violation in the rule areas of **10A NCAC 13F .0311(a) Other Requirements** was abated as of the correction date, March 16, 2024. Therefore a penalty will not be recommended.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. The plan of correction can be faxed, mailed to our office, or e-mailed to the survey team leader directly. Please make sure the copy you fax, mail, or e-mail to us is **SIGNED AND DATED** or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to dispute cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **April 19, 2024**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **April 19, 2024**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at **704-774-0124**. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Keisha Banks, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Ms. Laura Rumley, Administrator w/Enclosures
Ms. Jessika Blue, Supervisor, Guilford County Department of Social Services
Ms. Bridget Rackley, Branch Manager, Central Region, Adult Care Licensure Section
Ms. Carolyn Harrison, Team Supervisor, Cemtra; Region, Adult Care Licensure Section
Victor Orija, State LTC Ombudsman, Division of Aging and Adult Services
Star Rating, Adult Care Licensure Section
Quality and Compliance Unit, Adult Care Licensure Section
Facility File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL041086 Y1	A. Building B. Wing Y2	3/27/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT GREENSBORO	3420 WHITEHURST ROAD GREENSBORO, NC 27410

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0105	Correction	ID Prefix D0271	Correction	ID Prefix D0276	Correction
Reg. # 10A NCAC 13F .0311(a)	Completed	Reg. # 10A NCAC 13F .0901(c)	Completed	Reg. # 10A NCAC 13F .0902(c) (3-4)	Completed
LSC	03/16/2024	LSC	03/01/2024	LSC	03/08/2024
ID Prefix D0449	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 10A NCAC 13F .1211 (b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/01/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Keisha Banks	03/28/24
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/31/2024	