STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041077	A. BUILDING: _____ B. WING _____	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HOUSE	5918 NETFIELD RD GREENSBORO, NC 27455

(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-survey on February 17, 2026 and February 18, 2026.	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, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) including a moisture barrier cream used to prevent incontinent dermatitis. The findings are: Review of Resident #2's current FL2 dated 07/14/25 revealed diagnoses included Alzheimer's disease, unspecified urinary incontinence, hypertension, type 2 diabetes, depression, anxiety disorder, vitamin D deficiency and hyperlipidemia. Review of Resident #2's signed Primary Care Provider (PCP) progress note dated 02/10/26 revealed: -Resident #2 was being seen for having a "sore" on her buttocks. -There was an order for moisture barrier cream,	D 358		

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D 358	Continued From page 1	D 358		

apply to buttocks daily and after each incontinence episode.

Review of Resident #2's February 2026 electronic medication administration record (eMAR) (02/01/26-02/17/26) revealed:
-There was no entry for moisture barrier cream.
-There was no documentation that moisture barrier cream had been administered.

Observation of Resident #2's medications on hand on 02/17/26 at 4:20pm revealed there was no moisture barrier cream available.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/26 at 2:14pm revealed:
-Resident #2 had a current order dated 02/17/26 for moisture barrier cream.
-The pharmacy staff entered all medication orders and changes onto the facility's eMARs.
-The pharmacy only profiled Resident #2's medication and did not dispense the moisture barrier cream because Resident #2 had been utilizing another pharmacy since February 2024 .

Telephone interview with a pharmacist from Resident #2's pharmacy revealed the pharmacy had never received an order for moisture barrier cream for Resident #2.

Interview with Resident #2's PCP on 02/18/26 at 2:52pm revealed:
-She ordered moisture barrier cream for Resident #2.
-Resident #2 would likely always need a moisture barrier ointment due to her incontinence and if the cream was not applied as ordered, Resident #2 could experience worsening incontinent dermatitis or skin breakdown.

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D 358	Continued From page 2	D 358		

-Someone from the facility, usually a medication aide (MA), or a manager rounded with the PCP during her visits and was informed of new orders while the PCP was in the building.
- Management staff also received subsequent emails containing new orders.
-She expected her orders to be carried out.

Interview with an MA on 02/18/26 at 3:16pm revealed:
-She was not aware of the order for Resident #2's moisture barrier cream.
-The Memory Care Unit (MCU) manager entered orders into the eMAR system.
-She administered residents' medications based on the eMARs

Interview with the MCU manager on 02/18/26 at 3:20pm revealed:
-She was not aware of the order for Resident #2's moisture barrier cream.
-She and MAs processed orders and sent them to the pharmacy who then generated the eMARs.
-MAs were responsible for making sure orders were implemented following PCP visits.
-Either she or an MA rounded with the PCP during her visits to the facility.
-The PCP would fax new orders and order changes following her visits and would also sign paper orders that were placed in a folder for processing.

Interview with the Administrator on 02/18/26 at 3:26pm revealed:
-She was not aware of the order for Resident #2's moisture barrier cream until 02/17/26.
-The MCU manager was responsible for entering new orders or an MA in the absence of the manager.
-She, along with an MA or manager rounded with

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D 358	Continued From page 3 the PCP during her visits to the facility. -The PCP emailed new orders or order changes to her and her managers within 1-2 days of the PCP visits. -PCP progress notes were usually received within 1-2 days following a visit. -She expected staff to administer residents' medications as ordered by the provider.	D 358		