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HARMONY AT GREENSBORO	3420 WHITEHURST ROAD GREENSBORO, NC 27410

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 07/21/26 to 07/23/26.	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: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 7 sampled residents (#4) related to not obtaining a recollection of urine when the initial sample was rejected by the laboratory, which resulted in the resident being sent to the emergency room. The findings are: Review of Resident #4's current FL2 dated 03/12/26 revealed: -Diagnoses included Alzheimer's dementia, overactive bladder, depression and anxiety. -She was constantly disoriented. -She was incontinent of bowel and bladder. Review of Resident #4's care plan dated 04/17/26 revealed she required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring. Review of Resident #4's Primary Care Provider (PCP) note dated 05/07/26 revealed: -Resident #4 had recent onset of increased	D 273		

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confusion and lethargy from her baseline, along with dysuria (painful urination) and worsening urinary incontinence.
-Staff reported foul-smelling urine and increased frequency of incontinence episodes.
-Recent urine molecular testing on 05/02/26 demonstrated polymicrobial (multiple bacterial) infection with Citrobacter loseri (high load), Enterococcus faecalis (medium load) and Mycoplasma hominis (low load) with associated multidrug resistance markers.
-The PCP ordered Levaquin 500mg by mouth once daily X 3 days.

Review of Resident #4's PCP noted dated 06/04/26 revealed:
-Resident #4 completed a course of antibiotics in May 2026, but staff reported progressive generalized weakness, most notable in the lower extremities, with decline in mobility and increased dependence for transfers.
-She was no longer able to safely ambulate even short distances with assistive devices due to instability and poor strength.
-She had recurrent foul-smelling urine with increased urinary incontinence, concerning for persistent or recurrent urinary tract infection (UTI).
-The PCP ordered a catheterized urine specimen for urinalysis and culture to improve diagnostic accuracy due to recurrent foul-smelling urine with history of polymicrobial multidrug resistant infection and functional decline concerning for ongoing infection.
-The PCP ordered empiric antibiotics (prescribed in the likelihood there is bacteria present) to be held pending results unless clinical status worsened and oral fluids three times daily between meals.

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Review of Resident #4's urinalysis report from the facility's contracted laboratory dated 06/10/26 revealed:
-Resident #4's urine sample collected on 06/09/26 was rejected because the collection tube was blank.
-Instructions were to recollect the sample and ensure to include Resident #4's name and date of birth on the collection tube.

Review of Resident #4's progress note dated 06/16/26 at 2:45pm revealed:
-Resident #4 was sent to the hospital for a change in condition.
-The medication aide (MA) stated she was toileting Resident #4, and she wasn't able to stand or wasn't responding to stimulation techniques.
-Resident #4 had a slight temperature but the value was not documented.

Review of Resident #4's progress note dated 06/17/26 at 2:34am revealed:
-Resident #4 returned from the hospital around 1:19am via emergency medical services (EMS) transport.
-She was diagnosed with lower urinary tract infectious disease.
-While in the emergency department (ED), Resident #4 received several lab and imaging tests and received a dose of ceftriaxone (antibiotic).
-Resident #4 received a prescription for cephalexin (antibiotic) 500mg, 1 capsule twice daily for 7 days.

Review of Resident #4's hospital after-visit summary dated 06/16/26 revealed:
-Resident #4 underwent lab tests and imaging tests, including a urinalysis with a sample

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obtained via catheterization.
-She was administered 2gm of ceftriaxone via injection and received a prescription for cephalexin.

Review of Resident #4's PCP note dated 06/19/26 revealed:
-The PCP visited Resident #4 for follow-up after her ED visit on 06/16/26 for altered mental status, shortness of breath and concern for infection.
-The PCP noted that Resident #4's urine sample sent to the lab for evaluation for a UTI following her visit on 06/04/26 was rejected by the laboratory due to a labeling error, delaying diagnostic confirmation.
-Following the PCP visit on 06/04/26, Resident #4 demonstrated continued decline with worsening cognition, lethargy and decreased responsiveness, prompting the ED transfer on 06/16/26.
-Resident #4's urine culture revealed more than 100,000 live, growing clusters of Escherichia coli bacteria in every milliliter of urine. The normal range is less than 10,000 units of bacteria per milliliter, or a negative, "no growth" result.
-PCP noted that Resident #4 had shown steady and clinically meaningful improvement since her ED discharge.
-She was observed sitting in the dining room, feeding herself independently and engaging appropriately with staff.
-She was smiling, conversational, followed commands and denied pain or urinary complaints.
-Staff confirmed progressive improvement in cognition, alertness and overall functional status.

Telephone interview with Resident #4's PCP on 07/22/26 at 10:05am revealed:
-Facility staff did not inform her of Resident #4's

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mislabeled urine received by the laboratory or the instructions to recollect.
-She became aware of the laboratory's report when she checked the online health portal to see results of Resident #4's urine sample ordered on 06/04/26. She could not recall the date she checked the health portal.
-She expected facility staff to notify her of Resident #4's mislabeled urine.
-She expected facility staff to notify her if they had difficulty obtaining urine samples for Resident #4.
-It was the facility's responsibility to recollect a urine sample for Resident #4 as instructed by the laboratory and they did not need a new order from her to do so.
-Resident #4 was unable to communicate her symptoms due to her diagnosis of Alzheimer's dementia.
-If the UTI was left untreated, Resident #4 could have developed sepsis, which is life-threatening organ dysfunction caused by a dysregulated host response to infection..

Interview with a personal care aide (PCA) on 07/22/26 at 2:40pm revealed:
-Resident #4 had UTIs often.
-She was unable to view PCP notes or laboratory reports.
-She assisted with collecting urine samples from residents by using collection pans that fit over toilet seats or by using swabs to obtain samples from incontinent briefs.
-The manager of the secured assisted living (AL) or the lead MA instructed her when to collect urine samples.
-She collected Resident #4's urine sample in June 2026 by using a collection pan but could not recall the date.
-The MA was responsible for labeling the urine sample and putting it in a sealed envelope to be

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D 273	Continued From page 5 sent to the laboratory. Interview with an MA on 07/22/26 at 2:50pm revealed: -She was aware of Resident #4's chronic UTIs. -She was aware of the urine sample collected in June 2026, but could not recall the date. -She was not the MA responsible for labeling the urine sample. -Resident #4 was incontinent and she had obtained past urine samples by using swabs in her incontinent briefs. -She was aware of Resident #4's June 2026 urine sample being rejected by the laboratory because the MA supervisor communicated this information and instructed her to recollect another sample. -She was unable to recollect another sample of Resident #4's urine because there were no swabs in the facility. -Resident #4 was incontinent and did not use the toilet, so she could not use a collection pan. Interview with the MA supervisor on 07/22/26 at 2:58pm revealed: -She was aware of Resident #4's chronic UTIs. -She viewed PCP notes regularly and received them via fax. -She viewed laboratory results and notes via an online health portal that she checked daily. -Resident #4's PCP ordered a urine sample on 06/05/26 which was collected on 06/06/26. -She was aware that Resident #4's urine sample collected on 06/06/26 was rejected by the laboratory due to mislabeling because she contacted the lab by phone on 06/08/26. -She viewed the laboratory report for Resident #4's mislabeled urine via the online health portal on 06/09/26. -A paper copy of the laboratory rejection was received via fax on 06/10/26.	D 273		

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-She was aware that the laboratory instructed the facility to recollect Resident #4's urine on 06/08/26.
-She notified the unit manager about the laboratory rejection on 06/09/26.
-She instructed an MA to recollect Resident #4's urine on 06/09/26 but was told that the facility had no swabs to use in Resident #4's incontinent briefs.
-She contacted a representative from the facility's contracted medical supply company to request more swabs but could not recall the date.
-Only collection pans were available in the facility on 06/09/26 and because Resident #4 did not use the toilet, staff did not attempt to collect the urine by other means.
-No attempts to collect Resident #4's urine were made on 06/10/26, 06/11/26, 06/12/26, 06/13/26, 06/14/26 or 06/15/26 because there were no swabs in the facility and Resident #4 was unable to urinate into a collection pan.
-She did not notify Resident #4's PCP about the rejection of Resident #4's urine sample or the instructions to recollect.
-She was aware that Resident #4 was sent to the ED on 06/16/26 due to a change in condition.

Interview with the facility nurse on 07/23/26 at 2:22pm revealed:
-She was not aware of Resident #4's history of UTIs.
-She was not aware of the PCP's order to collect a urine sample for Resident #4 on 06/04/26.
-She was aware of a urine sample for Resident #4 being rejected by the laboratory on 06/09/26 due to mislabeling after she checked the laboratory's online health portal.
-She could not recall the date she checked the laboratory's online health portal.
-She was able to view the laboratory's

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recommendation for recollection of Resident #4's urine on 06/09/26.
-Resident #4's urine was not recollected due to difficulty obtaining a sample, but staff did not report a specific reason why.
-She did not notify Resident #4's PCP of the rejection or the recommendation to recollect because either the MA supervisor or Unit Coordinator of the secured AL were responsible to do so.
-She was aware that Resident #4 was sent to the ED on 06/16/26 for a change in condition.
-She would expect staff to communicate the inability to collect urine samples and to try alternative methods.

Interview with the Administrator on 07/23/26 at 2:55pm revealed:
-She was not aware of Resident #4's PCP ordering a urine sample on 06/04/26.
-She was not aware that Resident #4's urine was collected on 06/06/26.
-She was not aware that Resident #4's urine was rejected by the laboratory due to mislabeling.
-She was not aware that the laboratory recommended a recollection of Resident #4's urine.
-She was aware that Resident #4 was sent to the ED on 06/16/26 because it was reported in a daily staff meeting on 06/17/26.
-She expected staff to communicate with Resident #4's PCP and follow procedures according to the PCP's orders.

The Unit Coordinator of the secured AL was unavailable for interview.

Attempted telephone interview with Resident #4's responsible party on 07/23/26 at 9:28am was unsuccessful.

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D 273	Continued From page 8 Based on observations, interviews and record reviews, it was determined that Resident #4 was not interviewable. _____ _____ The facility failed to ensure referral and follow-up to meet the acute health care needs of a resident on the secured assisted living (AL) with a history of urinary tract infections. The resident was exhibiting behaviors indicating a possible UTI and the PCP ordered a urine sample. The urine sample was rejected by the laboratory due to not labeling the sample and a recollection was required due to the risk of becoming septic for an untreated UTI. The recollection was not obtained for 7 days while symptoms persisted, including a low grade fever. This resulted in the resident being sent to the emergency room and receiving an injection of antibiotics and oral antibiotics for lower urinary tract infectious disease. This failure resulted in substantial risk for harm or injury, and constitutes a Type A2 Violation. _____ _____ The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 07/22/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 22, 2026.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a	D 280		

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D 280	Continued From page 9 registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure quarterly Licensed Professional Health Support evaluations (LHPS) were completed by an LHPS nurse for 2 of 5 sampled residents (#3, #4) related to evaluating tasks including obtaining finger stick blood sugar (FSBS) (#3), and ambulation using assistive devices and forcing fluids (#4). The findings are: 1. Review of Resident #3's current FL2 dated	D 280		

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04/30/26 revealed:
-Diagnoses included vascular dementia, primary hypertension, loss of appetite, and hyperlipidemia.
-She was non-ambulatory and constantly disoriented.
-She was incontinent of both bowel and bladder.
-There was an order for FSBS checks once weekly.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 07/30/25.

Review of Resident #3's care plan dated 06/11/26 revealed:
-She required limited staff assistance with transferring and ambulation.
-She required extensive staff assistance for toileting, bathing, dressing, and grooming.
-Resident #3 was ambulatory but she used a wheelchair.
-She was incontinent of bowel and bladder daily.
-She was totally dependent on staff for obtaining FSBS.

Review of Resident #3's LHPS evaluation records revealed:
-There was no current quarterly LHPS evaluation available for review.
-The last quarterly LHPS evaluation available for review was dated 01/27/26 and Resident #3 was marked for no tasks.

Review of Resident #3's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS once weekly before breakfast for every Monday at 7:00am.
-There were FSBS values documented on the

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eMAR from 05/01/26 through 05/31/26.

Review of Resident #3's June 2026 eMAR revealed:
-There was an entry to check FSBS once weekly before breakfast for every Monday at 7:00am.
-There were FSBS values documented on the eMAR from 06/01/26 through 06/30/26.

Review of Resident #3's July 2026 eMAR from 07/01/26 to 07/20/26 revealed:
-There was an entry to check FSBS once weekly before breakfast for every Monday at 7:00am.
-There were FSBS values documented on the eMAR from 07/01/26 through 07/20/26.

Interview with a medication aide (MA) on 07/22/26 at 11:50am revealed:
-Resident #3 required FSBS checks from the MAs.
-She checked Resident #3's FSBS on 1st shift most of the time.

Interview with a medication aide (MA) on 06/10/26 at 9:40am revealed:
-Resident #3 required FSBS checks from the MAs.
-She checked Resident #3's FSBS when she had worked on 1st shift.

Interview with the MA supervisor in the secured assisted living (AL) on 07/22/26 at 3:25pm revealed:
-Resident #3 required weekly FSBS checks from the MAs.
-She was not aware a quarterly LHPS evaluation had not been completed for FSBS checks related to Resident #3.

Interview with the facility nurse on 07/23/26 at

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D 280	Continued From page 12 2:22pm revealed: -She was aware Resident #3 required weekly FSBS checks. -She was not aware an LHPS had not been completed for Resident #3 related to FSBS checks and it must have been overlooked. Interview with the Administrator on 07/23/26 at 2:55pm revealed she was not aware an LHPS was not completed for Resident #3's weekly FSBS checks. Refer to the interview with the MA supervisor in the secured AL on 07/22/26 at 3:25pm. Refer to the interview with the facility nurse on 07/23/26 at 2:22pm. Refer to the interview with the Administrator on 07/23/26 at 2:55pm. Based on observations, interviews and record review, it was determined Resident #3 was not interviewable. Attempted interview with the Unit Coordinator of the secured AL on 7/23/26 at 11:28am was unsuccessful. 2. Review of Resident #4's FL2 dated 03/02/26 revealed: -Diagnoses included Alzheimer's dementia, overactive bladder, vertigo and arthritis. -She was constantly confused. -She was incontinent of bowel and bladder. -She required assistance with bathing and dressing. Review of Resident #4's Resident Register revealed she was admitted to the facility on 05/29/25.	D 280		

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D 280	Continued From page 13 Review of Resident #4's initial care plan (CP) completed on 06/18/25 revealed she required limited assistance with bathing only. Review of Resident #4's initial licensed health professional support (LHPS) assessment dated 06/13/25 revealed no LHPS tasks noted. Review of a significant change CP completed on 04/06/26 for Resident #4 revealed she required extensive assistance with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and transfers. Review of a signed physician's order for Resident #4 dated 06/05/26 revealed staff were to encourage fluids three times a day between meals. Review of Resident #4's LHPS assessment completed on 06/25/26 revealed a recent decline in status requiring extensive assistance with transfers. Interview with a personal care aide (PCA) on 07/23/26 at 9:00am revealed that the director of the secured assisted living (AL) interviewed staff to determine what assistance was needed for each resident on the unit. Interview with the facility nurse on 07/23/26 at 2:22pm revealed: -She could not recall Resident #4's CP completed in April 2026 and did not receive a report from the unit manager. -She was aware of Resident #4's change in condition but was unaware that she required assistance in more than one task. -She was not aware of the physician's order to	D 280		

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D 280	Continued From page 14 encourage fluids for Resident #4. Refer to the interview with the medication aide (MA) supervisor in the secured AL on 07/22/26 at 3:25pm. Refer to the interview with the facility nurse on 07/23/26 at 2:22pm. Refer to the interview with the Administrator on 07/23/26 at 2:55pm. Attempted interview with the Unit Coordinator of the secured AL on 7/23/26 at 11:28am was unsuccessful. _____ Interview with the medication aide (MA) supervisor in the secured assisted living (AL) on 07/22/26 at 3:25pm revealed: -She did not complete LHPS assessments. -She was unaware that a new LHPS was supposed to be completed within 30 days of an identified task. -The Unit Coordinator of the secured AL was responsible for completing resident care plans and for communicating care needs that related to LHPS tasks to the facility nurse. -The facility nurse was responsible for completing resident LHPS evaluations. Interview with the facility nurse on 07/23/26 at 2:22pm revealed: -She was responsible for ensuring resident LHPS reviews were completed quarterly. -She was aware LHPS evaluations should be completed within 30 days of a resident's identified task. -The unit manager of the secured AL would let her know when a CP had been completed and dates would be coordinated to complete an LHPS	D 280		

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D 280	Continued From page 15 assessment. Interview with the Administrator on 07/23/26 at 2:55pm revealed: -It was the responsibility of the facility nurse to complete the LHPS. -She was aware that LHPS assessments were to be completed within 30 days of an identified task, but was unaware that an LHPS for Resident #4 was not completed. -She expected the LHPS to be completed in a timely manner and as required. -She expected resident CPs and LHPS assessments to contain matching information regarding the resident's level of functioning and required assistance with tasks. -She expected the unit manager of the secured AL to communicate with the facility nurse.	D 280		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.	D 283		

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D 283	Continued From page 16	D 283		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure residents' ice supply was served under sanitary conditions as evidenced by the inside and outside of the ice machine in the kitchen being visibly dirty.

The findings are:

Initial observation of the kitchen on 07/22/26 at 10:39am revealed:
-Brown and black residue inside the ice machine along the left and right walls.
-Yellow and white residue around the outside walls and trim of the door of the ice machine.

Interview with a server on 07/23/26 at 9:20am revealed:
-She was unaware that the ice machine in the kitchen was dirty.
-Servers were supposed to clean the ice machine monthly by removing all the ice and using soap and water to wipe down the inside and outside.
-The ice machine was last cleaned on 06/07/26.
-Clinical staff used the ice machine in the kitchen despite there being another machine on the secured assisted living unit of the facility.

Interview with a cook on 07/23/26 at 9:30am revealed:
-He was unaware that the ice machine in the kitchen was dirty.
-All facility staff used the ice machine daily.

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D 283	Continued From page 17 -Servers were responsible to clean the machine every two months by using soap, water and rags to wipe it down. Interview with the assistant dietary manager on 07/23/26 at 111:26am revealed: -The facility did not have a dietary manager. -The ice machine in the kitchen serviced the entire facility and all staff had access to it. -He was unaware that the ice machine was dirty. -The ice machine was last cleaned on 07/15/26 by a server. -He expected an assigned server to clean the ice machine weekly by either spraying out or scooping out the ice, spraying the machine with disinfectant and then rinsing. Interview with the Administrator on 07/23/26 at 10:18am revealed: -She was unaware the ice machine in the kitchen was dirty. -She was aware that clinical staff obtained ice from the machine but was unaware if dietary staff scooped it for them. -Dining staff were responsible for cleaning the machine monthly and as needed. -She expected the ice machine to be observed more closely by herself and dining staff for visible signs of residue.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 18	D 310		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a nutritional supplement was served as ordered for 1 of 7 sampled residents (#5).

The findings are:

Review of Resident #5's current FL2 dated 07/16/26 revealed:
-Diagnoses included type 2 diabetes mellitus, encephalopathy, and hyperlipidemia.
-There was an order for a nutritional supplement 1 can twice daily between meals.

Review of Resident #5's previous signed provider order dated 05/21/26 revealed there was an order for a nutritional supplement 1 can twice daily between meals.

Observation of the medication room on 07/23/26 at 12:00pm revealed there were no nutritional supplements for Resident #5 available for administration.

Review of Resident #5's May 2026 electronic medication administration record (eMAR) from 05/21/26 to 05/31/26 revealed:
-There was an entry for a nutritional supplement drink 1 can/bottle two times a day between meals with a scheduled administration time of 10:00am and 2:00pm.
-There was documentation a nutritional supplement was administered as ordered.

Review of Resident #5's June 2026 eMAR revealed:
-There was an entry for a nutritional supplement

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drink 1 can/bottle two times a day between meals with a scheduled administration time of 10:00am and 2:00pm.
-There was documentation a nutritional supplement was administered as ordered.

Review of Resident #5's July 2026 eMAR from 07/01/26 to 07/21/26 revealed:
-There was an entry for a nutritional supplement drink 1 can/bottle two times a day between meals with a scheduled administration time of 10:00am and 2:00pm.
-There was documentation a nutritional supplement was administered as ordered.

Interview with Resident #5 on 07/23/26 at 11:48am revealed:
-She did not receive nutritional supplements between meals.
-She would drink the nutritional supplement if it was administered to her and the nutritional supplement was only administered to her once.

Telephone interview with a representative from the facility's contracted pharmacy on 07/23/26 at 1:33pm revealed:
-Resident #5 had an active order for a nutritional supplement twice daily between meals.
-The pharmacy filled Resident #5's nutritional supplement on 07/23/26.
-The pharmacy had never filled Resident #5's nutritional supplement prior to 07/23/26.

Telephone interview with Resident #5's primary care provider (PCP) on 07/23/26 at 2:00pm revealed:
-She did not know Resident #5 was not being administered the nutritional supplement.
-She expected the facility to administer supplements as ordered for Resident #5.

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D 310	Continued From page 20 Interview with a medication aide (MA) on 07/23/26 at 12:00pm revealed: -Resident #5's nutritional supplement was stored in the medication room. -Resident #5 was out of the nutritional supplement and she had ordered it from the pharmacy today. Interview with the facility nurse on 07/23/26 at 2:40pm revealed: -She did not know Resident #5's nutritional supplement was not available for administration nor dispensed until 07/23/26. -She did not know Resident #5 had not been administered the nutritional supplement. Interview with the Administrator on 07/23/26 at 3:07pm revealed: -She did not know Resident #5 had an order for a nutritional supplement twice daily between meals. -She did not know Resident #5's nutritional supplement was not available to administer and Resident #5 had not been administered the nutritional supplement. -She expected the MAs to administer supplements as ordered.	D 310		
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	D 358		

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D 358	Continued From page 21 and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents observed during the morning medication pass including errors with eyedrops (#8); and for 2 of 7 sampled residents for record review including errors with a combination inhaler (#5), a beta blocker and an angiotensin-converting enzyme (ACE) inhibitor (#2). The findings are: 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 8:00am medication pass on 07/22/26. Review of Resident #8's current FL2 dated 10/27/25 revealed diagnoses included rheumatoid arthritis and hypertension. a. Review of Resident #8's FL2 dated 10/27/25 revealed there was an order for olopatadine HCL 0.2% eyedrops (used to treat itchy eyes) instill 1 drop into both eyes daily. Observation of the morning medication pass on 07/22/26 at 8:25am revealed: -The medication aide (MA) removed Resident #8's medication cards from the medication cart. -The MA administered 8 and a half oral medications to Resident #8. -The MA administered a subcutaneous injection, a combination inhaler, and eyedrops to Resident #8. Review of Resident #8's July 2026 electronic	D 358		

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medication administration record (eMAR) for 07/22/26 revealed:
There was an entry for olopatadine HCL 0.2% eyedrops instill 1 drop into both eyes daily scheduled for administration at 8:00am.
-There was documentation olopatadine was administered at 8:00am on 07/22/26.

Telephone interview with a representative from Resident #8's pharmacy on 07/22/26 at 11:14am revealed:
-Resident #8 had an active order on file for olopatadine HCL 0.2% eyedrops instill one drop into both eyes daily.
-The olopatadine order was dated 12/06/25 but the medication was never filled and never dispensed.
-She did not know why Resident #8's olopatadine had never been filled.

Observation of the medications on hand for Resident #8 on 07/22/26 at 8:26am revealed:
-There was not any olopatadine available for administration on the medication cart.
-There was a bottle of over-the-counter (OTC) lubricating eyedrops available for administration.

Attempted interviews with Resident #8 on 07/22/26 at 11:45am, 07/22/26 at 2:06pm, 07/23/26 at 12:06pm were unsuccessful.

Telephone interview with Resident #8's primary care provider (PCP) on 07/22/26 at 10:18am revealed:
-Resident #8 used to self-administer her medications and ordered her medications from a different pharmacy than the facility's contracted pharmacy.
-Olopatadine eyedrops were an antihistamine prescribed for itchy eyes.

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D 358	Continued From page 23 -She expected the facility to have Resident #8's olopatadine eyedrops available for administration. Interview with the MA observed during the medication pass on 07/22/26 at 2:38pm revealed: -Resident #8 and her family member reordered her medications from a different pharmacy. -She had never seen Resident #8's olopatadine in the facility. -She always administered Resident #8's lubricating eyedrops instead of olopatadine. -She had not tried to call Resident #8's pharmacy about Resident #8's olopatadine. Interview with the facility nurse on 07/23/26 at 2:40pm revealed: -She did not know Resident #8 had an order for olopatadine eyedrops that were not available for administration during the morning medication pass on 07/22/26. -Resident #8 reordered her medications from a different pharmacy. Interview with the Administrator on 07/23/26 at 3:07pm revealed she did not know Resident #8 had an order for olopatadine eyedrops that were not available for administration during the morning medication pass on 07/22/26. Refer to the interview with the facility nurse on 07/23/26 at 2:22pm. Refer to the interview with the Administrator on 07/23/26 at 2:55pm. b. Review of Resident #8's signed physician orders dated 07/16/26 revealed there was not an order for carboxymethylcellulose sodium 0.5% eyedrops (used to lubricate the eyes).	D 358		

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D 358	Continued From page 24 Observation of the morning medication pass on 07/22/26 at 8:25am revealed: -The medication aide (MA) removed Resident #8's medication cards from the medication cart. -The MA administered 8 and a half oral medications to Resident #8. -The MA administered a subcutaneous injection, a combination inhaler, and eyedrops to Resident #8. Review of Resident #8's July 2026 electronic medication administration record (eMAR) for 07/22/26 revealed there was not an entry for carboxymethylcellulose sodium 0.5% eyedrops. Telephone interview with a representative from Resident #8's pharmacy on 07/22/26 at 11:14am revealed: -Resident #8 did not have an order on file for carboxymethylcellulose sodium 0.5% eyedrops. -Carboxymethylcellulose sodium 0.5% eyedrops were never dispensed for Resident #8 because there was no provider order. Observation of the medications on hand for Resident #8 on 07/22/26 at 8:26am for Resident #8 revealed there was a bottle of over-the-counter (OTC) carboxymethylcellulose sodium 0.5% eyedrops on the medication cart. Interview with the MA observed during the medication pass on 07/22/26 at 2:38pm revealed: -She thought carboxymethylcellulose sodium 0.5% eyedrops were the same type of eyedrops as Resident #8's antihistamine eyedrops. -She thought Resident #8 used to have an order for carboxymethylcellulose sodium eyedrops. -Resident #8 did not currently have an order for carboxymethylcellulose sodium eyedrops but Resident #8 was still administered the	D 358		

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D 358	Continued From page 25 medication. Attempted interviews with Resident #8 on 07/22/26 at 11:45am, 07/22/26 at 2:06pm, 07/23/26 at 12:06pm were unsuccessful. Telephone interview with Resident #8's primary care provider (PCP) on 07/22/26 at 10:18am revealed: -Carboxymethylcellulose sodium eyedrops were lubricating eyedrops and were not the same medication as Resident #8's antihistamine eyedrops. -Resident #8 did not currently have an order for carboxymethylcellulose sodium eyedrops. Interview with the facility nurse on 07/23/26 at 2:40pm revealed: -She did not know Resident #8 did not have an order for carboxymethylcellulose sodium eyedrops that were administered during the morning medication pass on 07/22/26. -Resident #8 reordered her medications from a different pharmacy. Interview with the Administrator on 07/23/26 at 3:07pm revealed she did not know Resident #8 did not have a physician's order for carboxymethylcellulose sodium eyedrops that were administered during the morning medication pass on 07/22/26. Refer to the interview with the facility nurse on 07/23/26 at 2:22pm. Refer to the interview with the Administrator on 07/23/26 at 2:55pm. 2. Review of Resident #5's FL2 dated 07/16/26 revealed:	D 358		

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-Diagnoses included type 2 diabetes and chronic obstructive pulmonary disease (COPD).
-There was an order for fluticasone-salmeterol 250-50 combination inhaler (used to treat wheezing or shortness of breath) inhale 1 puff every 12 hours.

Review of Resident #5's previous signed physician orders dated 01/03/26 revealed there was an order for fluticasone-salmeterol 250-50 combination inhaler inhale 1 puff every 12 hours for wheezing or shortness of breath.

Review of Resident #5's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone-salmeterol 250-50mcg inhalation aerosol powder inhale 1 puff every 12 hours for wheezing or shortness of breath scheduled for administration at 8:00am and 8:00pm.
-There was documentation fluticasone-salmeterol 250-50mcg was administered except for one blank entry on 05/10/26 at 8:00pm.

Review of Resident #5's June 2026 eMAR revealed:
-There was an entry for fluticasone-salmeterol 250-50mcg inhalation aerosol powder inhale 1 puff every 12 hours for wheezing or shortness of breath scheduled for administration at 8:00am and 8:00pm.
-There was documentation fluticasone-salmeterol 250-50mcg was administered except for one blank entry on 06/11/26 at 8:00pm.

Review of Resident #5's July 2026 eMAR revealed:
-There was an entry for fluticasone-salmeterol 250-50mcg inhalation aerosol powder inhale 1

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HARMONY AT GREENSBORO	3420 WHITEHURST ROAD GREENSBORO, NC 27410

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puff every 12 hours for wheezing or shortness of breath scheduled for administration at 8:00am and 8:00pm.
-There was documentation fluticasone-salmeterol 250-50mcg was administered from 07/01/26 to 07/21/26.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/26 at 1:33pm revealed:
-Resident #5 had an active order on file for fluticasone-salmeterol 250-50mcg inhalation aerosol powder inhale 1 puff every 12 hours for wheezing or shortness of breath.
-The three most recent dispense dates for Resident #5's fluticasone-salmeterol were 07/23/26, 11/10/25 and 10/08/25 for one inhaler with a quantity of 60 inhalations each.
-60 inhalations per one inhaler was a 30-day supply.

Observation of the medications on hand for Resident #5 on 07/23/26 at 11:24am revealed there was no fluticasone-salmeterol combination inhaler available for administration on the medication cart.

Interview with Resident #5 on 12/03/25 at 3:50pm revealed she did not think she was administered fluticasone-salmeterol and thought fluticasone-salmeterol was only for emergencies.

Telephone interview with Resident #5's PCP on 07/23/26 at 2:00pm revealed:
-She did not know Resident #5 did not have any fluticasone-salmeterol available for administration on the medication cart.
-She expected the facility to administer Resident #5's fluticasone-salmeterol.

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D 358	Continued From page 28 Interview with a medication aide (MA) on 07/23/26 at 12:00pm revealed: -Resident #5's fluticasone-salmeterol was not available on the medication cart. -She thought Resident #5 was only out of her fluticasone-salmeterol medication for one day. Interview with the facility nurse on 07/23/26 at 2:40pm revealed: -She knew Resident #5 had an order for fluticasone-salmeterol every 12 hours. -She thought she administered fluticasone-salmeterol to Resident #5 a month or two ago. -She thought there may have been a request to fill Resident #5's fluticasone-salmeterol at a different pharmacy. Interview with the Administrator on 12/03/25 at 3:00pm revealed: -She did not know Resident #5 had an order for fluticasone-salmeterol that was not available for administration on the medication cart. -She did not know Resident #5's fluticasone-salmeterol was not dispensed from the facility's contracted pharmacy since November 2025 prior to 07/23/26. Refer to the interview with the facility nurse on 07/23/26 at 2:22pm. Refer to the interview with the Administrator on 07/23/26 at 2:55pm. 3. Review of Resident #2's current FL2 dated 12/23/25 revealed: -Diagnoses included hypertensive chronic kidney disease, fracture of facial bones, dysphagia, atherosclerotic heart disease, anxiety, and mild cognitive impairment.	D 358		

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-There was an order for metoprolol (used to treat hypertension) 100mg take one tablet once daily, hold for systolic blood pressure (SBP) less than 100 and for heart rate (HR) less than 55.
-There was an order for lisinopril (used to treat hypertension) 40mg take one table once daily, hold for SBP less than 100 and for HR less than 55.

a. Review of Resident #2's signed physician's order dated 05/14/26 revealed an order for metoprolol 100mg 1 tablet once daily, hold for SBP less than 100 and for HR less than 55.

Review of Resident #2's June 2026 electronic medication administration record (eMAR) from 06/01/26 to 06/30/26 revealed:
-There was an entry for metoprolol 100mg tablet take one tablet once daily at 9:00am from 06/01/26 through 06/30/26, hold for SBP less than 100 and for HR less than 55.
-There was documentation metoprolol was administered when it should have been held, with the example as follows on 06/28/26 Resident #2's SBP value was documented as 99 at 9:00am.
-There was no additional documentation as to why metoprolol was administered when it should have been held for 06/28/26.

Review of Resident #2's July 2026 eMAR from 07/01/26 to 07/20/26 revealed:
-There was an entry for metoprolol 100mg tablet take one tablet once daily at 9:00am from 07/01/26 through 07/20/26, hold for SBP less than 100 and for HR less than 55.
-There was documentation metoprolol was administered when it should have been held, with the example as follows on 07/13/26 Resident #2's HR value was documented as 41 at 9:00am.
-There was no additional documentation as to

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why metoprolol was administered when it should have been held for 07/13/26.

Review of Resident #2's SBP and HR values revealed the facility documented a SBP value of 139 and a HR value of 69 on 07/21/26 at 9:00am.

Observation of the medications on hand for Resident #2 on 07/22/26 at 11:11am revealed there were 31 tablets remaining of 31 tablets dispensed on 07/23/26 in a bubble pack labeled as metoprolol 100mg one tablet once daily, hold for SBP less than 100 and for HR less than 55.

Interview with Resident #2's responsible party on 07/23/26 at 10:22am revealed:
-She was not sure if Resident #2 had ever gone without any of her medications.
-Resident #2 had not experienced any lightheadedness or dizziness related to her blood pressure..

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/22/26 at 2:40pm revealed:
-Resident #2 had a current order on file for metoprolol 100mg take one tablet once daily at 9:00am, hold for SBP less than 100 and hold for HR less than 55.
-Metoprolol 100mg was dispensed for Resident #2 on 07/10/26 for 31 tablets.

Interview with Resident #2's primary care provider (PCP) on 07/23/26 at 10:28am revealed:
-He did not know there were errors with Resident #2's metoprolol administration in June 2026 and in July 2026.
-He had no concerns related to low blood pressure or low heart rates for Resident #2 but he expected the facility staff to administer Resident

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D 358	Continued From page 31 #2's metoprolol as he had ordered according to the SBP and HR values. Interview with a medication aide (MA) on 07/22/26 at 11:50am revealed: -She administered medications to Resident #2 and she followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #2's metoprolol if her HR was lower than "some" number but she was not sure of the exact parameter number. -She was not aware Resident #2's metoprolol had been documented as administered when it should have been held according to Resident #2's ordered parameters in June 2026 and July 2026. -The Unit Coordinator of the secured assisted living (AL) was responsible for reviewing the eMAR audits but she had not been informed of any medication errors. Interview with a second MA on 07/22/26 at 3:20pm revealed: -She administered medications to Resident #2 and she followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #2's metoprolol if her SBP was below 100 and if her HR was below 55. -She was not aware Resident #2's metoprolol had been documented as administered when it should have been held according to Resident #2's ordered parameters in June 2026 and July 2026. -The Unit Coordinator of the secured AL and the MA supervisor were responsible for reviewing the eMAR audits but she had not been informed of any medication errors.	D 358		

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D 358	Continued From page 32 Interview with the MA supervisor in the secured AL on 07/22/26 at 12:05pm revealed: -She did not know Resident #2's metoprolol was administered when it should have been held in June 2026 and in July 2026 until yesterday (07/21/26). -The MA administering medications would be responsible to hold Resident #2's metoprolol if it should be held. -She was not sure why Resident #2's metoprolol was documented as administered when the MAs should have held the medication. Interview with the facility nurse on 07/23/26 at 2:22pm revealed: -She was not aware Resident #2's metoprolol was administered when it should have been held in June 2026 and in July 2026 until 07/21/26. -The occurrences with Resident #2's metoprolol in June 2026 and July were overlooked. -She expected the MAs to follow provider orders and MAs were responsible to hold Resident #2's metoprolol if it should be held. Interview with the Administrator on 04/01/26 at 2:26pm revealed she did not know Resident #2's metoprolol was administered when it should have been held in June 2026 and in July 2026. Refer to the interview with the MA supervisor in the secured AL on 07/22/26 at 12:05pm. Refer to the interview with the facility nurse on 07/23/26 at 2:22pm. Refer to the interview with the Administrator on 07/23/26 at 2:55pm. Based on observations and interviews it was determined Resident #2 was not interviewable.	D 358		

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D 358	Continued From page 33 Attempted interview with the Unit Coordinator of the secured AL on 7/23/26 at 11:28am was unsuccessful. b. Review of Resident #2's signed physician's order dated 05/14/26 revealed an order for lisinopril 40mg take one table once daily, hold for SBP less than 100 and for HR less than 55. Review of Resident #2's June 2026 eMAR from 06/01/26 to 06/30/26 revealed: -There was an entry for lisinopril 40mg tablet take one tablet once daily at 9:00am from 06/01/26 through 06/30/26, hold for SBP less than 100 and for HR less than 55. -There was documentation lisinopril was administered when it should have been held, with the example as follows on 06/28/26 Resident #2's SBP value was documented as 99 at 9:00am. -There was no additional documentation available for the reasoning Resident #2 was administered lisinopril when it should have been held for 06/28/26. Review of Resident #2's July 2026 eMAR from 07/01/26 to 07/20/26 revealed: -There was an entry for lisinopril 40mg tablet take one tablet once daily at 9:00am from 07/01/26 through 07/20/26, hold for SBP less than 100 and for HR less than 55. -There was documentation lisinopril was administered when it should have been held, with the example as follows on 07/13/26 Resident #2's HR value was documented as 41 at 9:00am. -There was no additional documentation available for the reasoning Resident #2 was administered lisinopril when it should have been held for 07/13/26.	D 358		

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D 358	Continued From page 34 Review of Resident #2's SBP and HR values revealed the facility documented a SBP value of 139 and a HR value of 69 on 07/21/26 at 9:00am. Observation of the medications on hand for Resident #2 on 07/22/26 at 11:11am revealed there were 31 tablets remaining of 31 tablets dispensed on 07/23/26 in a bubble pack labeled as lisinopril 40mg one tablet once daily, hold for SBP less than 100 and for HR less than 55. Interview with Resident #2's responsible party on 07/23/26 at 10:22am revealed: -She was not sure if Resident #2 had ever gone without any of her medications. -Resident #2 had not experienced any lightheadedness or dizziness related to her blood pressure.. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/22/26 at 2:40pm revealed: -Resident #2 had a current order on file for lisinopril 40mg take one tablet once daily at 9:00am, hold for SBP less than 100 and hold for HR less than 55. -Lisinopril was dispensed for Resident #2 on 07/10/26 for 31 tablets. Interview with Resident #2's PCP on 07/23/26 at 10:28am revealed: -He did not know there were errors with Resident #2's lisinopril administration in June 2026 and in July 2026. -He had no concerns related to low blood pressure or low heart rates for Resident #2 but he expected the facility staff to administer Resident #2's lisinopril as he had ordered according to the SBP and HR values.	D 358		

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D 358	Continued From page 35 Interview with a MA on 07/22/26 at 11:50am revealed: -She administered medications to Resident #2 and she followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #2's lisinopril if her HR was lower than "some" number but she was not sure of the exact parameter number. -She was not aware Resident #2's lisinopril had been documented as administered when it should have been held according to Resident #2's ordered parameters in June 2026 and July 2026. -The Unit Coordinator of the secured AL was responsible for reviewing the eMAR audits but she had not been informed of any medication errors. Interview with another MA on 07/22/26 at 3:20pm revealed: -She administered medications to Resident #2 and she followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #2's lisinopril if her SBP was below 100 and if her HR was below 55. -She was not aware Resident #2's lisinopril had been documented as administered when it should have been held according to Resident #2's ordered parameters in June 2026 and July 2026. -The Unit Coordinator of the secured AL and the MA supervisor were responsible for reviewing the eMAR audits but she had not been informed of any medication errors. Interview with the MA supervisor in the secured AL on 07/22/26 at 12:05pm revealed: -She did not know Resident #2's lisinopril was	D 358		

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administered when it should have been held in June 2026 and in July 2026 until yesterday (07/21/26).
-The MA administering medications would be responsible to hold Resident #2's lisinopril if it should be held.
-She was not sure why Resident #2's lisinopril was documented as administered when the MAs should have held the medication.

Interview with the facility nurse on 07/23/26 at 2:22pm revealed:
-She was not aware Resident #2's lisinopril was administered when it should have been held in June 2026 and in July 2026 until 07/21/26.
-The occurrences with Resident #2's lisinopril in June 2026 and July were overlooked.
-She expected the MAs to follow provider orders and MAs were responsible to hold Resident #2's lisinopril if it should be held.

Interview with the Administrator on 04/01/26 at 2:26pm revealed she did not know Resident #2's lisinopril was administered when it should have been held in June 2026 and in July 2026.

Refer to the interview with the MA supervisor in the secured AL on 07/22/26 at 12:05pm.

Refer to the interview with the facility nurse on 07/23/26 at 2:22pm.

Refer to the interview with the Administrator on 07/23/26 at 2:55pm.

Based on observations and interviews it was determined Resident #2 was not interviewable.

Attempted interview with the Unit Coordinator of the secured AL on 7/23/26 at 11:28am was

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D 358	Continued From page 37 unsuccessful. _____ Interview with the medication aide (MA) supervisor in the secured assisted living (AL) on revealed: -The MA administering medications would be responsible for administering medications as ordered by the provider. -She and the Unit Coordinator of the secured AL were responsible for reviewing the electronic medication administration records (eMAR).monthly. Interview with the facility nurse on 07/23/26 at 2:22pm revealed: -She and the Unit Coordinator of the secured AL were responsible for completing eMAR audits monthly. -She expected the MAs to administer resident's medications as ordered by the provider. Interview with the Administrator on 07/23/26 at 2:55pm revealed: -The Unit Coordinator of the secured AL and the facility nurse were responsible for completing eMAR audits but she was not aware of how often the eMAR audits were completed. -She expected the MAs to follow provider orders and MAs were responsible for administering medications as ordered by the provider. -She expected the Unit Coordinator and the facility nurse to review the eMAR audits to identify medication errors.	D 358		