Division of Health Service Regulation

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 ______	09/07/2023

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 survey from 09/06/23 to 09/07/23.	D 000	Responses to the cited deficiencies do not constitute admission of the agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with State Law.	
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, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#3) who had an order for a calcium channel blocker to control heart rate. The findings are: Review of Resident #3's current FL2 dated 07/12/23 revealed: -Diagnoses included spinal stenosis, dementia, atrial fibrillation, and hypertension. -There was an order for diltiazem (a calcium channel blocker used to treat high blood pressure, heart rate and chest pain) 120mg daily. Review of Resident #3's physician's order dated 07/25/23 revealed an order to check blood pressure and heart rate three times daily. Review of Resident #3's hospital discharge summary dated 08/29/23 revealed there was an	D 358	Medication Administration training will be conducted by facility Area Clinical Director to include: Order processing, clarification/verification of orders, ordering medications from pharmacy, and proper cart audit process to ensure order accuracy. Care Coordinator will monitor and initial all new orders from discharge summaries, with Executive Director/Care Coordinator reviewing in daily stand up meetings with staff. ACD to retrain all Medication Technicians on documentation/PCP notification for any issues with receiving medication. Training conducted by ACD on med administration, proper implementation and verification fof orders on 9/21/23 for all med techs.	10/6/23 10/6/23 9/21/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara N. Blake (signature) TITLE: Director (X6) DATE: 10/3/23

Reviewed and Acknowledged K.M. 10/13/23

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D 358	Continued From page 1	D 358		

order to increase diltiazem to 240mg daily.

Review of Resident #3's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for diltiazem 120mg take 1 capsule daily scheduled at 8:00am, with a discontinue date of 08/30/23.
-There was documentation diltiazem 120mg was administered daily at 8:00am from 08/01/23 through 08/24/23.
-There was documentation Resident #3 was in the hospital from 08/25/23 through 08/29/23.
-There was an entry for diltiazem 240mg take 1 capsule daily scheduled at 8:00am, with a start date of 08/29/23.
-Diltiazem 240mg was documented as not administered on 08/30/23 at 8:00am and the reason documented was "other."
-There was no documentation diltiazem 240mg was administered on 08/31/23 at 8:00am; the documentation space had an "x" in it.
-There was an entry to check blood pressure and heart rate three times daily scheduled at 9:00am, 1:00pm and 9:00pm.
-Resident #3's heart rate from 08/01/23 through 08/31/23 ranged from 67 beats per minute (bpm) to 114 bpm.

Review of Resident #3's September 2023 eMAR from 09/01/23 to 09/07/23 revealed:
-There was an entry for diltiazem 240mg take 1 capsule daily scheduled at 8:00am.
-There was no documentation diltiazem was administered from 09/01/23 through 09/06/23; the documentation spaces had an "x" in it.
-There was documentation diltiazem 240mg was not administered at 8:00am on 09/07/23, but the documented reason was that the diltiazem had been given in the morning.

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D 358	Continued From page 2	D 358		

-There was an entry to check blood pressure and heart rate three times daily scheduled at 9:00am, 1:00pm and 9:00pm, with a discontinue date of 09/07/23.
-Resident #3's heart rate from 09/01/23 through 09/06/23 ranged from 65 bpm to 135 bpm.

Observation of medication on hand for Resident #3 on 09/07/23 at 11:45am revealed:
-There was one bottle of diltiazem 240mg capsules with a dispensed date of 08/29/23 and a dispensed quantity of 30 capsules.
-There were 29 capsules remaining in the bottle.
-The label on the prescription was printed from the hospital where Resident #3 had been discharged from on 08/29/23.

Interview with a medication aide (MA) on 09/07/23 at 11:47am revealed:
-She had worked the day shift on Resident #3's hall for the previous week.
-She had not administered diltiazem 240mg, or diltiazem 120mg to Resident #3 since her return from the hospital on 08/29/23, because diltiazem had not been popping up on the eMAR as a medication that was due for administration.
-Two days prior, on 09/05/23, she had noticed the full bottle of diltiazem 240mg capsules in the medication cart and realized the medication had not been administered because it was not on the eMAR.
-She had forgotten to follow up on Resident #3's diltiazem until that morning on 09/07/23.
-Earlier that morning on 09/07/23, she had called the pharmacy and Resident #3's hospice nurse to ask if Resident #3 was supposed to be receiving diltiazem 240mg daily or not because she knew Resident #3 had previously been taking a lower dose of the medication.
-She had reviewed Resident #3's hospital

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D 358	Continued From page 3	D 358		

discharge paperwork and saw that Resident #3 was supposed to receive diltiazem 240mg daily so she requested for the pharmacy to re-enter diltiazem on Resident #3's eMAR.
-She administered diltiazem 240mg to Resident #3 during that morning's medication pass on 09/07/23, but documented it late because she was waiting on the pharmacy to enter the medication order on the eMAR.
-She had texted Resident #3's primary care provider (PCP) on 09/07/23, to let her know Resident #3 had not received diltiazem 240mg daily since she returned from the hospital on 08/29/23; she did not receive a response from the PCP.
-The night shift MAs completed medication cart audits for each resident once per week by auditing five resident's medications per night.
-She did not know if an audit had been completed on Resident #3's medications since she returned from the hospital on 08/29/23.
-It was the responsibility of either herself or the Resident Care Coordinator (RCC) to ensure all new medication orders were correct and active on the eMAR after a resident returned from the hospital.

Telephone interview with a representative from the facility's contracted pharmacy on 09/07/23 at 12:15pm revealed:
-Resident #3 had a current order for diltiazem 240mg daily with an order start date of 08/30/23.
-The pharmacy entered medication orders on the facility's eMAR, then someone at the facility had to approve the medication order entry to make it active on the eMAR for documentation.
-The pharmacy staff had entered Resident #3's diltiazem order on the eMAR on 08/30/23 and it showed as being an active order since 08/30/23.

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D 358	Continued From page 4	D 358		

Telephone interview with Resident #3's PCP on 09/07/23 at 1:45pm revealed:
-Resident #3 was prescribed diltiazem due to her diagnoses of atrial fibrillation and pulmonary embolism causing her to have a rapid heart rate, and diltiazem helped to control heart rate.
-She was not aware Resident #3 had not received diltiazem from 08/30/23 through 09/06/23.
-She expected the MAs to administer diltiazem daily as it was ordered, but she was not concerned about Resident #3's heart rates from not receiving diltiazem for one week.

Telephone interview with a representative from Resident #3's hospice service on 09/07/23 at 2:20pm revealed:
-Resident #3 admitted to hospice services on 09/02/23.
-The MA at the facility contacted them on 09/05/23 due to Resident #3's heart rate of 135 bpm.
-The hospice nurse went to the facility on 09/05/23 and was able to get Resident #3 to take her blood pressure medication which resulted in her heart rate also returning to baseline upon recheck a couple of hours later.
-The hospice nurse discontinued Resident #3's order for blood pressure and heart rate checks on 09/05/23.
-There were no notes from the hospice nurse about Resident #3 not receiving diltiazem as ordered.

Interview with the RCC on 09/07/23 at 3:00pm revealed:
-Whichever MA had been working when Resident #3 returned from the hospital would have been responsible for ensuring the medication order changes were faxed to the pharmacy and would have put the bottle of diltiazem 240mg capsules

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D 358	Continued From page 5	D 358		

on the medication cart.
-She was responsible for following up on all new medication order changes and ensuring they were correct and active on the eMAR, but she had overlooked Resident #3's diltiazem order.
-The "x" on the eMAR indicated that the medication had not populated on the eMAR as a medication that was due.
-The facility had been having technical issues with their eMAR system, so since the pharmacy had entered the order on the eMAR but it was not popping up as a medication that was due, it might have been an error with the eMAR system.
-She completed audits of the eMAR and she thought her last audit had been on Friday, 09/01/23, but she did not catch that Resident #3's diltiazem was not active on the eMAR.
-If a medication entry was pending approval to become active on the eMAR, there was a notification that would be triggered each time someone logged into the eMAR, but she had not seen a notification for Resident #3's diltiazem.
-Resident #3 had not experienced any new symptoms of rapid heart rate since her hospital return; she had been having fluctuating heart rates since she was diagnosed with atrial fibrillation and a pulmonary embolism at the beginning of August 2023.

Interview with the Administrator on 09/07/23 at 2:45pm revealed:
-When a resident returned from the hospital, the discharge paperwork with medication order changes was given to her to process, and then to the RCC as a second staff to review.
-She was not aware Resident #3's diltiazem was not showing up as a medication due for administration on the eMAR.
-She was not aware Resident #3 had not received diltiazem as ordered from 08/30/23 through

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D 358	Continued From page 6 09/06/23. -The RCC would have been responsible for ensuring Resident #3's diltiazem had been entered in the eMAR and then approving the entry to activate it. -The MAs were supposed to complete weekly audits on the medication cart on third shift, but she did not know when the last medication cart audit had been completed. -The MAs should have noticed the new bottle of diltiazem 240mg capsules on the medication cart and verified with her if they should be administering the medication or not. -Resident #3's diltiazem entry on the eMAR should have flagged a notification each time a MA logged into the eMAR if it had been pending approval, but she had not seen a notification for any pending medication entries. -She was not aware of Resident #3 experiencing any symptoms of elevated heart rate in the previous week.	D 358		