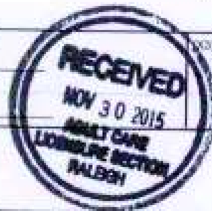
PRINTED: 11/03/2015
FORM APPROVED

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
	HAL041052	A. BUILDING: ______ B. WING ______	10/20/2015



NAME OF PROVIDER OR SUPPLIER: MORNINGVIEW AT IRVING PARK

STREET ADDRESS, CITY, STATE, ZIP CODE: 3200 N ELM STREET, GREENSBORO, NC 27408

(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 conduted an annual survey and complaint investigation on 10/15/15, 10/16/15, and 10/19/15 with an exit conference via telephone on 10/20/15.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a Dietary Aide on 03/08/13. -His responsibilities were serving meals in the dining room. -There was no documentation of a HCPR check. Interview on 10/20/15 at 8:15 am with Staff A revealed: -He worked at the facility since March 2013. -He previously worked at a group home as a Medication Aide and Personal Care Aide.	D 137	Please see attached Plan of Correction KJones 11/23/15 Approved with Addendum (pg 2) - 12/01/15 BMoore	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: KJones TITLE: Executive Director (X6) DATE: 11/23/15

Addendum

Moore, Bonnie

From: Jones, Kyle <KJONES@5SSL.COM>
Sent: Tuesday, December 01, 2015 3:36 PM
To: Moore, Bonnie
Subject: Completion days

Hi Bonnie,
Per our conversation the corrected days for violations are as follows:
A1 & A2 will be corrected by 11/19/15
B violation will be corrected by 12/3/15
Standard deficiencies will be corrected by 12/19/15.

Thank you and feel free to call or email with any others questions or concerns.

Kyle Jones
Executive Director
Morningview at Irving Park
3200 N. Elm St.
Greensboro, N.C. 27408
p: (336) 545-3444, c: (336) 543-8762 f: (336) 545-3424

Preparation and/or execution of this plan of corrections does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Morningview at Irving Park
Plan of Correction
Facility License # HAL-041-052

1) 13F 0407(a)(5) Other Staff Qualifications – (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; Based on observation, interview, and record review, the facility failed to ensure 3 of 6 staff had no substantiated findings listed on the NC HCPR prior to hire according to G.S. 131E-256.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

- Staff A - a HCPR check was completed on 10/16/15 with no substantiated findings listed.
- Staff B - a HCPR check was completed on 10/16/15 with no substantiated findings listed.
- Staff C - a HCPR check was completed on 10/16/15 with no substantiated findings listed.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could be affected by the alleged deficient practice. A HCPR audit was completed on all staff on 10/24/15 to ensure compliance with this regulation.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Business Office Manager or designee will complete a HCPR check for all new staff as part of the pre-hire process.

D) The facility will monitor the corrective actions as follows:

The Executive Director or designee will complete random staff file audits to ensure compliance with this regulation.

2) 13F .0901(b) Personal Care and Supervision – (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs; care plans and current symptoms. Based on observation, interview, and record review, the facility failed to provide adequate supervision for 2 of 2 sampled residents (resident #4 and #5) with repeated falls which result in injury.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

- Resident #4 – On 10/22/15 facility increased supervision to 1-2 hours for observation and updated care plan reflecting changes made.
- Resident #6 – On 10/15/15 facility updated the care plan, increased supervision and new interventions were added during At Risk meetings deemed appropriately.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could be affected by the alleged deficient practice. A full audit of residents with history of falls was completed on 10/16/15 to ensure effective supervision and/or measures were in place.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Resident Service Director (RSD) or designee will update care plans and the Personal Care Sheet Log to reflect the accurate supervision and/or measures implemented for each resident.

On 10/16/15 facility initiated staff in-services on the guidelines and protocol of the community's falls management program, the Butterfly Program. (See attached Attendance Log).

Facility will continually assess residents on the Butterfly Program to ensure resident needs are met. If a resident exceeds the Butterfly Program guidelines the facility will assess resident needs to determine if alternative measures are warranted up to and including discharge.

D) The facility will monitor the corrective actions as follows:

The RSD or designee will review residents that have experienced falls weekly to ensure effective supervision and/or measures are in place.

3) 13F .0902 Health Care – (b) the facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Based on observation, interview, and record review, the facility failed to assure referral and follow up for 1 of 5 sampled residents with hypoxic respiratory failure, (resident # 2) by not sending the resident out for medical evaluation.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

Resident #2 – Resident received mobile x-ray at community on 10/16/15 showing "no acute disease" and RSD received order to increase nebulizer treatments. Within 12 hours, resident's condition deteriorated which warranted community RN to seek further treatment at the hospital.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could be affected by the alleged deficient practice. On 10/19/15 the RSD and ED assessed all residents to assure compliance with this regulation as described in the Plan of Protection dated 10/19/15.

C) The following systemic changes will be made to ensure compliance with this regulation:

On 11/23/15 Medication Aides will be in-serviced on identifying signs of distress, protocols for administering PRN medication, MAR documentation procedures, and general medication administration refresher.

An in-service on Hot Box protocol for care staff is scheduled for 11/23/15. Hot Box is the facility's protocol for increased documentation for continuity of care.

D) The facility will monitor the corrective actions as follows:

The RSD or designee will monitor on a daily basis that healthcare is provided according to resident assessed needs.

4) 13F .0904 Nutrition and Food Service (c) Therapeutic diets in Adult Care homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. Based on observation, interview, and record review, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for 3 of 5 sampled residents prescribed a therapeutic diet for the guidance of food service staff.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

Residents #1, 2 & 10 – Residents' diets were audited and clarified as appropriate.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could be affected by the alleged deficient practice. A diet audit was completed on 10/19/15 to ensure compliance with this regulation.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Wellness Secretary or designee will update diets on a spreadsheet and post in designated areas. The community will maintain a diet roster at the service line in Assisted Living dining room, community kitchen, and in the memory care dining rooms.

D) The facility will monitor the corrective actions as follows:

The RSD and/or Food & Beverage Director will audit diets monthly and as needed with updates/new orders to ensure compliance with this regulation.

5) 10A NCAC 13F .1004 Medication Administration – Adult care homes 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. Based on observation, interview, and record review, the facility failed to assure the medication administration records (MARs) were accurate for 3 of 5 sampled residents.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

- Resident #7 – order was discontinued on 10/16/15.
- Resident #8 – now receiving the correct dosage of Folic Acid effective 10/20/15.
- Resident #9 – medication was received and resumed by 10/19/15.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could be affected by the alleged deficient practice. The facility's contracted pharmacy will be conducting a medication audit on 11/30/15 to ensure compliance with this regulation.

C) The following systemic changes will be made to ensure compliance with this regulation:

The RSD or designee will conduct routine audits of medications and MARs to ensure compliance with this regulation. On 11/23/15, Medication Aides will also be in-serviced on the 5 rights of Med Administration as well as when appropriate to notify RSD. (See Attached Attendance Log).

D) The facility will monitor the corrective actions as follows:

The RSD or designee will conduct routine audits of medications and MARs to ensure compliance with this regulation.

6) 13F .1308 (b) Special Care Unit Staffing – There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in paragraph (a) of this rule for units 15 or fewer residents. Based on observation, interview, and record review, the facility failed to ensure a care coordinator was on duty in the special care unit at least eight hours a day, five days a week.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

On 10/19/15 a schedule was implemented to identify the acting care coordinator while the Memory Care Director position is vacant.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could be affected by the alleged deficient practice.

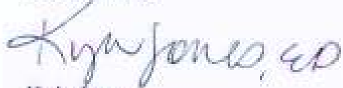
C) The following systemic changes will be made to ensure compliance with this regulation:

On 10/19/15 a schedule was implemented to identify the acting care coordinator while the Memory Care Director position is vacant. (See Attached Calendar).

D) The facility will monitor the corrective actions as follows:

The ED will ensure a care coordinator is on duty eight hours a day, five days a week by hiring a Memory Care Director. ED will implement a scheduled to identify the acting coordinator in the event the Memory Care Director position is vacant.

Respectfully,



Kyle Jones
Executive Director