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	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	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	Per telephone Conversation with Ms. Cole on 4/21/16 at 11:45 AM, Dates of correction will be as previously submitted on 12/1/15 + approved and as noted below -	
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	Type A - Corrected by 11/19/15 Type B - Corrected by 12/3/15 Standard deficiencies - Corrected by 12/19/15 — Bonnie Moore	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Cole — TITLE: Executive Director — (X6) DATE: 4/26/16

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

Complete Date: 10/24/15

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.

Complete Date: 10/30/15

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 #6) 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 10/20/15 facility increased supervision to 1-2 hours for observation and updated care plan reflecting changes made.
- Resident #6 – On 10/30/15 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.

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.

Complete Date: 10/19/15

3) 13F .0904 Nutrition and Food Service (e) 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.

Complete Date: 11/30/15

***4) 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 10/19/15.
- Resident #8 – now receiving the correct dosage of Folic Acid effective 10/19/15.
- 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.

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.

Complete Date: 10/19/15

5) 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.

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,

Mary Cole
Executive Director