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 _____	10/25/2017

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 conducted an annual survey on October 23, 24 and 25, 2017.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure 3 of 47 residents in the Assisted Living Unit were treated with respect and dignity related to non-disposable place settings used for 2 residents (Residents #7 and #8) who received beverages in Styrofoam cups, and 1 resident (#6) who received meals in Styrofoam plate-ware. The findings are: 1. Review of Resident #6's current FL2 dated 03/08/17 revealed: -Diagnoses of muscle weakness, cerebral infarction, hypertension, heart disease, hyperlipidemia and hearing loss. -Intermittently disoriented and semi-ambulatory. Review of Resident #6's Resident Register revealed an admission date of 02/02/17. Observation on 10/23/17 from 11:30 am to 12:50 pm revealed: -A Personal Care Aide (PCA) was carrying a meal	D 338		

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tray.
-On top of the tray was a Styrofoam plate with lid, two Styrofoam bowls with lids, two Styrofoam cups with lids and plastic spoon and fork.
-The PCA took the meal tray to Resident #6's room.
-The resident received feeding assistance from facility staff.

Observation on 10/24/17 from 8:00 am to 9:50 am of the breakfast meal service revealed:
-A PCA carrying a meal tray, and on top of the tray was a Styrofoam plate with lid, two Styrofoam cups.
-The PCA took the meal tray to Resident #6's room.
-The resident received feeding assistance from facility staff.

Interview on 10/25/17 at 8:10 am with the PCA revealed:
-Resident #6 was the only resident at the facility that received all meals in his room.
-The meal and beverages were delivered to the resident's room in Styrofoam containers.

Interview on 10/25/17 at 8:25 am with a second PCA revealed:
-She worked the hall were Resident #6 lived.
-She usually assisted the resident with feeding the breakfast meal.
-Resident #6 had a caregiver that assisted the resident with the lunch and dinner meals.
-All the meals delivered to Resident #6's room were in Styrofoam.

Interview on 10/24/17 at 4:24 pm with Resident #6's sitter revealed:
-Resident #6 came to the facility around February or March 2017.

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-The resident did go to the dining room for meals when he was first admitted to the facility, but his health began to decline and the resident was no longer able to feed himself.
-Resident #6 had started receiving meals in his room and getting feeding assistance from a private sitter (her) and facility staff around April or May 2017.
-Resident #6's meals and beverages were all served in Styrofoam containers.
-She was concerned about the resident meals served in Styrofoam and it being harmful to the resident.
-When she heated the meal using a microwave the Styrofoam melted a little and that caused her to fear for the resident's health.
-The sitter had not mentioned her concern regarding the Styrofoam to the facility or her not wanting non-disposable plateware because the facility charged for "everything" and she was afraid non-disposable flatware would be an extra charge.
-No one at the facility had informed her the resident was allowed meals on non-disposable plateware or beverages in non-disposable containers.

Interview on 10/25/17 at 8:38 am with the Food Service Manager (FSM) revealed:
-Resident #6 did not come to the dining room for meals.
-The resident received all meals in his room.
-All the resident's meals were served in Styrofoam containers with lids, with beverages served in Styrofoam cups, and plastic spoon and fork.
-She did not know why, but it was the facility's protocol.
-He had not considered serving the resident's meal on non-disposable plateware.

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D 338	Continued From page 3 Based on observation, record review, and attempt interview on 10/25/17 at 11:01 am, it was determined Resident #6 was not interviewable. Refer to interview on 10/25/17 at 8:40 am with the Food Service Manager (FSM). 2. Review of Resident #7's current FL2 dated 06/05/17 revealed: -Diagnoses of dementia with Lewy body. Observation on 10/23/17 from 11:30 am to 12:50 pm of the lunch meal service revealed: -At various times there were 40 residents present for the meal. -The residents' beverages were served in tulip shaped glasses and glass coffee cups. -Resident #7 was also present for the meal. -Resident #7's beverage, tea, was served in a Styrofoam cup. Observation on 10/24/17 from 8:00 am to 9:50 am of the breakfast meal service revealed: -At various times there were 38 residents present for the meal. -The residents' beverages were served in tulip shaped glasses and glass coffee cups. -Resident #7 was present for the meal. -Resident #7's beverage was orange juice that was served in a clear plastic cup. Interview on 10/23/17 at 12:10 pm with a Dietary Aide reveled: -Resident #7's beverages were always served in Styrofoam. -The Styrofoam was a request from the resident's family member because she said a glass was too heavy.	D 338		

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Interview on 10/23/17 at 12:48 pm with the FSM revealed:
-Resident #7's family member requested Styrofoam because it would be easier for the resident to pick the cup up to drink beverages.
-He thought the resident received physical therapy, but was not sure if it was related to her inability to hold glasses.

Interview on 10/23/17 at 1:10 pm with the Physical Therapist revealed:
-Resident #7 did physical therapy, but she was unaware the resident used Styrofoam cups.
-No one had ever mentioned to her the resident had weakness in her hands.
-She felt Resident #7's issue was more a cognitive process and the resident had to mentally process picking up the glass and drinking.

Interview on 10/25/17 at 10:07 am with Resident #7's family member revealed:
-Resident #7 tended to dehydrate if she did not drink a lot of liquids.
-The resident had a lot of hand weakness and the resident would drink more if she was able to pick-up beverages and drink them.
-The facility served beverages in glasses that were heavy weight.
-She did not want the heavy glass to hinder Resident #7 from drinking her beverages.
-She basically wanted a cup that was light-weight and thought Styrofoam was the only option.
-She was unaware the resident's beverages could be served in non-disposable plastic cups.

Based on observation, attempt interview on 10/25/17 at 9:50 am, and record review, it was determined Resident #7 was not interviewable.

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D 338	Continued From page 5 Refer to interview on 10/25/17 at 8:40 am with the Food Service Manager (FSM). 3. Review of Resident #8's current FL2 dated 09/29/17 revealed: -Diagnoses of hand weakness, hypertension, hypothyroidism, and osteoarthritis. -The resident was intermittently disoriented and non-ambulatory. Observation on 10/23/17 from 11:30 am to 12:50 pm of the lunch meal service revealed: -At various times there were 40 residents present for the meal. -The residents' beverages were in served in tulip shaped glasses and glass coffee cups. -Resident #8 was also present for the meal. -Resident #8's beverage were tea and orange juice served in Styrofoam cups with lids and straw. Observation on 10/24/17 from 8:00 am to 9:50 am of the breakfast meal service revealed: -At various times there were 38 residents present for the meal. -The residents' beverages were served in tulip shaped glasses and glass coffee cups. -Resident #8 was present for the meal. -Resident #8's beverage were orange juice and coffee served in Styrofoam cups with lids and straw. Interview on 10/25/17 at 9:55 am with Resident #8 revealed: -She had received beverages in Styrofoam cups since she moved into the facility. -She did not mind the Styrofoam cups because it was lighter in weight than the glasses. -She also got a straw when she used Styrofoam cups.	D 338		

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D 338	Continued From page 6 -When beverages were served in glasses she did not get a straw. -She would not mind non-disposable cups if it was lighter in weight than the facility's current glasses, and she could have a straw, she would be happy. Interview on 10/23/17 at 12:10 pm with a Dietary Aide revealed: -Resident #8 always got two beverages with each meal. -The resident's beverages were always served in Styrofoam cups with lids and straw. -She was not sure why the resident's beverages were served in Styrofoam cups. Interview on 10/23/17 at 12:48 pm with the FSM revealed: -Resident #8 had been getting beverages in Styrofoam cups at the family's request. -The resident was getting physical therapy due to weakness in her hands. -He believed that was why Resident #8 got beverages in Styrofoam cups. Interview on 10/23/17 at 1:10 pm with the Physical Therapist revealed: -Resident #8 was getting physical therapy due to weakness in her hands. -She was unaware that Styrofoam was not allowed. -She had not considered or fitted the resident for non-disposable plastic cups. -She would have the resident fitted for a cup molded to the resident's hand. Refer to interview on 10/25/17 at 8:40 am with the Food Service Manager (FSM). Interview on 10/25/17 at 8:40 am with the FSM	D 338		

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D 338	Continued From page 7 revealed: -All residents that received meals in their rooms had their meals served in Styrofoam containers/plateware and beverages served in Styrofoam cups. -One reason Styrofoam was used was to eliminate residents possibly not returning the dishes after the meal. -The Styrofoam containers had lids and made it easier to cover the food when transporting to the residents's rooms. -He also thought Styrofoam was safer because if a resident heated up a glass plate in the microwave it could get hot and if not handled properly a resident could get burned. -He had not considered the breakdown of Styrofoam in the microwave and he had not considered using non-disposable plastic for the residents that ate meals in their rooms.	D 338		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the	D 367		

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omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 1 of 5 (#1) sampled residents related to documenting scheduled administration of dustasteride 0.5 mg, fluoxetine hcl 20 mg, latanoprost 0.005% drops, mirtazapine 15 mg, seroquel 50 mg, and tamsulosin hcl 0.4 mg.

The findings are:

Review of Resident #1's current FL2 dated 08/28/17 revealed:
-Diagnoses included nonrheumatic aortic stenosis, unspecified glaucoma, enlarged prostate with lower urinary tract symptoms, hearing loss, rhinitis, chronic constipation, and depression.
-A physician's order for dustasteride (medication used to treat urinary retention) 0.5 mg at bedtime, fluoxetine hcl (medication used to treat depression) 20 mg at bedtime, latanoprost 0.005% (medication used to treat glaucoma) eye drops instill one drop into each eye at bedtime, mirtazapine (medication used to treat depression) 15 mg at bedtime, seroquel (medication used to treat schizophrenia, bipolar, depression) 50 mg at bedtime, and tamsulosin hcl (medication used to treat an enlarged prostate) 0.4 mg at bedtime.

Review of the October 2017 MAR for Resident #1

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D 367	Continued From page 9 revealed: -An entry for dustasteride 0.5 mg at bedtime and documented as administered for 19 doses on the MAR from 10/01/17 to 10/23/17. Dustasteride 0.5 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -An entry for fluoxetine hcl 20 mg at bedtime and documented as administered for 19 doses on the MAR from 10/01/17 to 10/23/17. Fluoxetine hcl 20 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -An entry for latanoprost 0.005% eye drops instill one drop into each eye at bedtime and documented as administered for 20 doses on the MAR from 10/01/17 to 10/23/17. Latanoprost 0.005% drops was not documented as administered at 8:00 pm on 10/19/17, 10/21/17, and 10/22/17. -An entry for mirtazapine 15 mg at bedtime and documented as administered for 19 doses on the MAR from 10/01/17 to 10/23/17. Mirtazapine 15 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -An entry for seroquel 50 mg at bedtime and documented as administered for 19 doses on the MAR from 10/01/17 to 10/23/17. Seroquel 50 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -An entry for tamsulosin hcl 0.4 mg at bedtime and documented as administered for 19 doses on the MAR from 10/01/17 to 10/23/17. Tamsulosin hcl 0.4 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. Interview on 10/25/17 at 10:35 am with the facility Licensed Practical Nurse (LPN) revealed:	D 367		

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D 367	Continued From page 10 -She was not aware dustasteride 0.5 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware fluoxetine hcl 20 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware latanoprost 0.005% drops was not documented as administered at 8:00 pm on 10/19/17, 10/21/17, and 10/22/17. -She was not aware mirtazapine 15 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware seroquel 50 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware tamsulosin hcl 0.4 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware the MA did not document an explanation for why the medication was not given. -If a medication aide cannot give medication for any reason they were to circle initials on the corresponding area on the MAR and write an explanation on the back of the MAR. -Staff had a 24 hour report sheet but nothing was documented as to why medications were not given on the October 2017 MAR. -The days the medications were not documented were by the same medication aide and he always worked second shift. -The medication aide had been employed with the facility a couple of years. Interview on 10/25/17 at 10:55 am with the Executive Director (ED) revealed: -She was not aware dustasteride 0.5 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware fluoxetine hcl 20 mg was not documented as administered at 8:00 pm on	D 367		

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10/18/17, 10/19/17, 10/21/17, and 10/22/17.
-She was not aware latanoprost 0.005% drops was not documented as administered at 8:00 pm on 10/19/17, 10/21/17, and 10/22/17.
-She was not aware mirtazapine 15 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17.
-She was not aware seroquel 50 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17.
-She was not aware tamsulosin hcl 0.4 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17.
-She was not aware the MA did not document an explanation for why the medication was not given.
-The medication aide (MA) that did not document the October medications were administered always worked second shift and had been with the facility a couple of years. He had worked as a MA for about 9 months at the facility.
-If a MA did not give medications to a resident, the medication aide was expected to try again at a later time, then write R for refused and circle it in the corresponding area, then write an explanation as to why the medication was not given on the back of the MAR.
-The facility's Registered Nurse (RN) performed random MAR audits daily.

Interview on 10/25/17 at 10:58 am with the second shift MA revealed:
-He was not aware dustasteride 0.5 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17.
-He was not aware fluoxetine hcl 20 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17.
-He was not aware latanoprost 0.005% drops was not documented as administered at 8:00 pm on 10/19/17, 10/21/17, and 10/22/17.

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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 367	Continued From page 12 -He was not aware mirtazapine 15 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -He was not aware seroquel 50 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -He was not aware tamsulosin hcl 0.4 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -The MA was positive he had administered the medications and believed he forgot to write his initials on the MAR when he administered the above medications. Interview on 10/25/17 at 11:05 am with the facility's RN revealed: -She was not aware dustasteride 0.5 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware fluoxetine hcl 20 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware latanoprost 0.005% drops was not documented as administered at 8:00 pm on 10/19/17, 10/21/17, and 10/22/17. -She was not aware mirtazapine 15 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware seroquel 50 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware tamsulosin hcl 0.4 mg was not documented as administered at 8:00 pm on 10/18/17, 10/19/17, 10/21/17, and 10/22/17. -She was not aware the MA did not document an explanation for why the medication was not given. -The Wellness Nurse performed weekly MAR audits and she (the RN) performed random daily MAR audits. -When there were days without initials on the	D 367		

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 _____	10/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 13 MARs, they would contact that MA and give the MA until midnight to document the medication if they were positive they had given the medications. Interview on 10/25/17 at 1:18 pm with Resident #1's physician revealed: -The facility had not made him aware of the missed doses of dustasteride 0.5 mg, fluoxetine hcl 20 mg, latanoprost 0.005% drops, mirtazapine 15 mg, seroquel 50 mg, and tamsulosin hcl 0.4 mg. -He did not feel the resident was in danger by not receiving the missed doses of dustasteride 0.5 mg, fluoxetine hcl 20 mg, latanoprost 0.005% drops, mirtazapine 15 mg, seroquel 50 mg, and tamsulosin hcl 0.4 mg. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 367		