	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
			A. BOILDING		D.C.	
		HAL041052	B. WING		R-C	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	re, zip code		
			LM STREET			
MORNING	VIEW AT IRVING PARK	GREENS	BORO, NC 2740	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	_	sure Section conducted an survey on 11/02/21 through				
D 076	10A NCAC 13F .0306 Furnishings	i(a)(3) Housekeeping And	D 076			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (3) have furniture clear This Rule shall apply facilities.	shall: an and in good repair;				
	failed to ensure 2 cha	is and interviews, the facility irs in the hallway of the CU) and 1 chair in the SCU				
	The findings are:					
	on 11/02/21 at 11:15a -There were two cloth light-colored fabric pri -The fabric on the arm layered with dirt build-					
	11/03/21 at 8:20am re- There was a cloth che the hallway area near -There were unidentifing the fabric on both arm. Attempted interviews	air that matched the chair in Room #200. ied dark colored stains on as of the chair. with 3 residents of the SCU				
	on 11/02/21 between	12:22pm and 12:35pm was				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
			A. BUILDING:			
		HAL041052	B. WING			R-C / 05/2021
						103/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET BORO, NC 27408	,		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES	,		ADECTION .	T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 076	Continued From page	: 1	D 076			
	unsuccessful.					
	Interview with the Mai 11/04/21 at 10:22am in 11/04/21 at 10:22am in 11/04/21 at 10:22am in 11/04/21 at 10:22am in 11/04/21 at	revealed: GCU was cleaned once a way and the television room out a month ago. chased this past summer p clean. ekeeper on 11/04/21 at sure in the television room out 2 months ago. ne chairs had gotten stained urniture as needed. ecial Care Unit Coordinator				
	-If she did not clean th	ne chairs in the SCU, they				
	did not get cleaned.	ry to get the cloth chairs				
		h a wipeable covering.				
	9:09am revealed: -He did not know abo chairs in the SCUThe maintenance an responsible for cleani	ninistrator on 11/05/21 at ut the soiled and stained d housekeeping staff were ng the furniture. uiture in the SCU to be				

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STATE FORM 8ZWU11 If continuation sheet 2 of 173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
MORNING	SVIEW AT IRVING PARK		ELM STREET SBORO, NC 27408	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 076	Continued From page	2	D 076		
	cleaned once a week	and as needed.			
D 137	10A NCAC 13F .0407 Qualifications	(a)(5) Other Staff	D 137		
	(a) Each staff person shall:	Other Staff Qualifications at an adult care home			
		iated findings listed on the Care Personnel Registry E-256;			
	facility failed to ensure	and record reviews, the e 2 of 6 sampled staff (Staff stantiated findings listed on ealth Care Personnel			
	The findings are:				
	personnel record reve -Staff C was hired on	08/24/21. nentation a HCPR check			
	5:05pm revealed: -She was hired in late care aide (PCA)She did not know if a	er August 2021 as a personal anyone at the facility heck on her when she was			
	Refer to interview with Manager (BOM) on 1				

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STATE FORM 8ZWU11 If continuation sheet 3 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D WING		R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
			M STREET		
MORNINGVIEW AT IRVING PARK			ORO, NC 2740	18	
			T T T T T T T T T T T T T T T T T T T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(*)
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
1710		,	1.10	DEFICIENCY)	
5 40=		_	D 407		
D 137	Continued From page	3	D 137		
	Refer to interview with	h the Administrator on			
	11/04/21 at 5:39pm.				
	1170 1721 at 0.00pm.				
	2 Review of Staff F's	, personal care aide (PCA)			
	personnel record reve	· · · · · · · · · · · · · · · · · · ·			
	-Staff E was hired on				
		nentation a HCPR check			
	was completed upon				
	was completed upon	ille.			
	Attempted telephone	interview with Staff E on			
	11/05/21 at 5:07pm w				
	11/05/21 at 5.07 pill w	as unsuccessiui.			
	Refer to interview with	h the Rusiness Office			
	Manager (BOM) on 1				
	Wanager (BOW) on 1	170-721 at 3.33pm.			
	Refer to interview with	h the Administrator on			
	11/04/21 at 5:39pm.	The Administrator on			
	11/04/21 at 0.00pm.				
	Interview with the Rus	 siness Office Manager			
	(BOM) on 11-05-21 a	•			
	, ,	HCPR check in staffs'			
	personnel records.	TIOI IX GILCOX III Stalls			
	· ·	to complete HCPR checks			
	on all new hires.	to complete from it checks			
		the personnel records for			
	HCPR checks.	the personner records for			
	-	y staff did not have HCPR			
	checks when they we				
	Checks when they we	re illieu.			
	Interview with the Adr	ministrator on 11-05-21 at			
	5:39pm revealed:	minoration on 11-00-21 at			
		ving some staff had HCPR			
		ound in their personnel			
	records.	ound in their personner			
		nsible to complete HCPR			
	•	name to complete HCFK			
	checks.	stoff did not hour LICED			
		staff did not have HCPR			
	checks when they we	re nirea.			
			1		

Division of Health Service Regulation

STATE FORM 8ZWU11 If continuation sheet 4 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041052	B. WING			R-C I/ 05/2021
	ROVIDER OR SUPPLIER	3200 N E	DDRESS, CITY, STATE LM STREET BORO, NC 27408	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 162	Continued From page	e 4	D 162			
D 162	10A NCAC 13F .0504 For LHPS Tasks	I(b) Competency Validation	D 162			
		l Competency Validation For essional Support Task				
	the following licensed (1) A registered nurse competency of staff wasks specified in Sub (28) of Rule .0903 of (2) In lieu of a regist care practitioner licen 38, may validate the experform personal care Subparagraphs (a)(6) (19) and (a)(21) of Rule (3) In lieu of a regist pharmacist may valid who perform the personal Subparagraph (a)(8) Subchapter. (4) In lieu of a regist therapist or physical to competency of staff was staff was subparagraph (a)(b) subchapter.	who perform personal care opparagraphs (a)(1) through this Subchapter. ered nurse, a respiratory used under G.S. 90, Article competency of staff who et tasks specified in (a), (a)(11), (a)(16), (a)(18), (a)				
	interviews, the facility sampled staff (Staff C competency validated (RN) to perform Licer	ns record reviews and failed to ensure 4 of 6 c, D, E and F) were d by a Registered Nurse nsed Health Professional s including finger stick blood				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		HAL041052	B. WING		l l	R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
MODNING	SVIEW AT IRVING PARK	3200 N E	LM STREET			
WORNING	VIEW AT IKVING PAKK	GREENS	BORO, NC 27408	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 162	Continued From page	÷ 5	D 162			
	compression stocking	S.				
	The findings are:					
	personnel record reve -She was hired on 08 -There was no docum	/24/21.				
		C on 11/04/21 from 2:00pm he assisted residents with				
	5:05pm revealed: -She started working 2021She did not know wh -She did not know wh complete LHPS check -She helped residents transfer in and out of chairs and applied co residentsThe MA or another P some tasks but she d training her for tasks	klists with staff. s with bathing, toileting, wheel chairs, bed and mpression stockings to CA watched her perform id not remember a nurse				
	on 11/05/21 at 5:35pr	n Business Office Manager n. n Administrator on 11/05/21				
	2. Review of Staff D's personnel record reve	, medication aide (MA) ealed:				

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STATE FORM 8ZWU11 If continuation sheet 6 of 173

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STATE, ZIP CODE 3200 N ELM STREET GREENSBORD, NC 27408 PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY PULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION CONTROL OF PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY PULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY PULL PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY PULL PREFIX TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MORNINGVIEW AT IRVING PARK X4 ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRE			HAL041052	B. WING		1	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 162 Continued From page 6 -She was hired on 07/06/21There was no documentation Staff D had completed the LHPS competency validation checklist. Review of residents' MARs revealed Staff D performed fingerstick blood sugar checks for 6 days in August 2021, 3 days in September 2021 and 6 days in October 2021. Review of residents' MARs revealed Staff D and applied/removed compression stockings for 3 days in August 2021 and 1 day in September 2021. Interview with Staff D on 11/02/21 at 10:54am revealed she assisted residents with applying and removing compression stockings. Refer to interview with Business Office Manager on 11/05/21 at 5:35pm. Refer to interview with Administrator on 11/05/21 at 5:35pm. 3. Review of Staff E's, personal care aide (PCA) personnel record on 11/04/21 revealed: -She was hired on 09/28/21There was no documentation Staff E had completed the LHPS competence validation checklist. Observation of Staff E in the Special Care Unit (SCU) on 11/03/21 at 7:55am revealed she assisted residents with transferring and			STREET ADD	VI STREET		11700	72021
She was hired on 07/06/21. -There was no documentation Staff D had completed the LHPS competency validation checklist. Review of residents' MARs revealed Staff D performed fingerstick blood sugar checks for 6 days in August 2021, 3 days in September 2021 and 6 days in October 2021. Review of residents' MARs revealed Staff D and applied/removed compression stockings for 3 days in August 2021 and 1 day in September 2021. Interview with Staff D on 11/02/21 at 10:54am revealed she assisted residents with applying and removing compression stockings. Refer to interview with Business Office Manager on 11/05/21 at 5:35pm. Refer to interview with Administrator on 11/05/21 at 5:39pm. 3. Review of Staff E's, personal care aide (PCA) personnel record on 11/04/21 revealed: -She was hired on 09/28/21. -There was no documentation Staff E had completed the LHPS competence validation checklist. Observation of Staff E in the Special Care Unit (SCU) on 11/03/21 at 7:55am revealed she assisted residents with transferring and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
Attempted telephone interview with Staff E on 11/05/21 at 5:07pm was unsuccessful.	D 162	-She was hired on 07There was no docum completed the LHPS checklist. Review of residents' In performed fingerstick days in August 2021, and 6 days in Octobe Review of residents' In applied/removed completed fremoved completed she assisted removing compression. Refer to interview with on 11/05/21 at 5:35pm. Refer to interview with at 5:39pm. 3. Review of Staff E's personnel record on an applied she was hired on 09There was no docum completed the LHPS checklist. Observation of Staff E (SCU) on 11/03/21 at assisted residents with ambulating from the context of t	mentation Staff D had competency validation MARs revealed Staff D blood sugar checks for 6 3 days in September 2021 r 2021. MARs revealed Staff D and pression stockings for 3 and 1 day in September on 11/02/21 at 10:54am d residents with applying and in stockings. In Business Office Manager in. In Administrator on 11/05/21 In personal care aide (PCA) 11/04/21 revealed: 1/28/21. Intentation Staff E had competence validation E in the Special Care Unit 7:55am revealed she th transferring and dining room. Interview with Staff E on	D 162			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		, , ,	E SURVEY PLETED	
		HAL041052	B. WING		l l	R-C / 05/2021
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 162	Continued From page	÷ 7	D 162			
	Refer to interview with on 11/05/21 at 5:35pr	n Business Office Manager n.				
	Refer to interview with at 5:39pm.	n Administrator on 11/05/21				
	personnel record on 7- -She was hired on 05- -There was no docum	/04/21.				
	5:05pm revealed: -She started working -She did not know wh -She did not know wh complete LHPS comp with staffShe helped resident wheel chairs, bed and removed compression -She did not remembe tasks such as applyin helping residents tran taught by MAs and ot Refer to interview with on 11/05/21 at 5:35pm	s transfer in and out of dichairs and had applied and in stockings on residents. For a nurse training her for g compression stockings or sfer or ambulate but was her PCAs. In Business Office Manager in.				
	at 5:39pm. Interview with the Bus (BOM) on 11/05/21 at -She could not find do records showing Staff	ocumentation in personnel				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIR CODE	
NAIVIE OF FI	NOVIDER OR SUPPLIER		M STREET	ie, zir cobe	
MORNING	VIEW AT IRVING PARK		W 51KEE1 BORO, NC 2740	18	
	OUR MAN ENVIOR		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 162	Continued From page	e 8	D 162		
	-The nurse was responsible staffs' LHPS checklist	onsible to complete the			
	5:39pm. revealed:	Timistrator on 11/05/21 at			
		ving Staff C, D, E and F			
		competency validation found in their personnel			
	records.	ricana in their personner			
	-All MAs and PCAs should have LHPS competency validationThere was a nurse employed until 10/10/21 who				
	kept track of needed				
	complete staff LHPS				
D 164	10A NCAC 13F .0505 Diabetic Resident	5 Training On Care Of	D 164		
	10A NCAC 13F .0505 Diabetic Residents	5 Training On Care Of			
		hall assure that training on			
		with diabetes is provided to to the administration of			
	(1) Training shall be	provided by a registered rmacist or prescribing			
	practitioner.	•			
		ude at least the following:			
	in the management of	diabetes and care involved f diabetes:			
	(b) insulin action;				
	(c) insulin storage;				
		g and injection techniques			
	for insulin administrat (e) treatment and pre	ion; evention of hypoglycemia			
	and hyperglycemia, ir				
	symptoms;				
	(f) blood glucose mor	nitoring; universal			
	precautions;		1		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	' '	SURVEY PLETED
		HAL041052	B. WING			R-C / 05/2021
					1 11	103/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT L M STREET	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		BORO, NC 2740	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 164	Continued From page (g) universal precauti (h) appropriate admir (i) sliding scale insuli	ions; nistration times; and	D 164			
	facility failed to ensure aides (Staff A and D),	and record reviews, the e 2 of 3 sampled medication who obtained fingerstick for residents, completed				
	The findings are:					
	personnel record reversely -Staff A was hired on	07/07/20. entation she had completed				
	Administration Record checked the residents	' October 2021 Medication d (MAR) revealed Staff A b' fingerstick blood sugar at did not require insulin				
	Attempted telephone 11/05/21 at 5:19pm w	interview with Staff A on as unsuccessful.				
	Refer to interview with Manager (BOM) on 1					
	Refer interview with that 5:39pm.	ne Administrator on 11/05/21				
	Review of Staff D's personnel record reve	, medication aide (MA)				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MODNING	3200 N				
MORNING	VIEW AT IRVING PARK	GREENSBO	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 164	Continued From page	e 10	D 164		
	-Staff D was hired on				
	training on the care of	nentation she had completed			
	training on the care of	i diabelio residents.			
	Review of a residents	s' Medication Administration			
		ed Staff D checked the			
	•	blood sugar (FSBS) on 5			
		on 4 days in September			
	2021 and on 5 days in	n October 2021.			
	Attempted telephone 11/05/21 at 5:22pm w	interview with Staff D on as unsuccessful.			
	Refer to interview with Manager (BOM) on 1				
	Refer interview with that 5:39pm.	he Administrator on 11/05/21			
	(BOM) on 11/05/21 at -She could not find th personnel records she completed the diabeti	e documentation in owing Staff A and D had ic care training. onsible for completing the			
	5:39pm revealed: -Documentation show completed the diabeti found in their personr -All MAs should have diabetic care of reside	completed training in ents. mployed until 10/10/21 who training and helped			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATI	E, ZIP CODE		
MORNING	VIEW AT IRVING PARK		ELM STREET SBORO, NC 27408	2		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
D 269	Continued From page	: 11	D 269			
D 269	10A NCAC 13F .0901 Supervision	(a) Personal Care and	D 269			
	care to residents accorplans and attend to a	Personal Care and staff shall provide personal ording to the residents' care may other personal care be unable to attend to for				
	reviews, the facility fa was for 2 of 6 residen assistance with toileti	as evidenced by: as, interviews, and record iled to ensure personal care ts (#4 and #6) who needed and and bathing (Resident assistance with toileting				
	The findings are:					
	03/17/21 revealed: -Diagnoses include Al unspecified dementia disturbance, essential cardiac murmurHe was ambulatory, constantly disoriented -He was incontinent of -He required assistant Review of Resident #	without behavioral I primary hypertension, and wandered, and was I. If bladder and bowel. I. It is with bathing. It is care plan dated 09/28/21				
	toileting, bathing, and	6's Activities of Daily Living				

Division of Health Service Regulation

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DIVISION	n Health Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			1		l _	_
			D WING		R-	_
		HAL041052	B. WING		11/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE. ZIP CODE		
		3200 N EL		,		
MORNING	VIEW AT IRVING PARK			10		
		GREENSB	ORO, NC 2740	J6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	NEGOLATORT OR L	ESCIDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	27.1.2
				,		
D 269	Continued From page	e 12	D 269			
	Th					
		o document assistance for				
		r each day in August 2021.				
	-There was documen					
	Resident #6 with bath	_				
	-There was document	tation staff assisted				
	Resident #6 with toile	ting on 6 shifts.				
	-There was document	tation Resident #6 was				
	totally dependent upo	n staff for bathing and				
	toileting.					
	-There was no docum	nentation of refusals.				
	Review of Resident #	6's Weekly Skin Check				
	Sheet revealed Resid	lent #6's skin was				
	checked/bath given o	n 08/03/21, 08/12/21,				
	08/17/21, 08/21/21, a					
	, ,					
	Review of Resident #	6's ADL log for September				
	2021 revealed:	3 1				
		o document assistance for				
		r each day in September				
	2021.	. cach aay iii copionisci				
		nentation staff assisted				
	Resident #6 with bath					
		nentation staff assisted				
	Resident #6 with toile					
	-There was no docum	···· · · · · ·				
	-There was no docum	ientation of refusals.				
	Review of Resident #	6's Weekly Skin Check				
	Sheet revealed:	03 Weekly Okill Officek				
		as checked/bath given on				
		•				
		9/21/21, and 09/23/21. tation Resident #6 refused 3				
	a skin check/bath 3 til	mes on 09/21/21.				
	Peview of Posidont #	6's ADL log for October				
		6's ADL log for October				
	2021 revealed:	a decument assistance for				
		o document assistance for				
	ADLs on each shift to	r each day in August 2021.				
	- LUBIE Was Unclimen	rannin elan acciciad	1	Í		

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Resident #6 with bathing on 1 shift.

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	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING: _			
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		LM STREET			
	Т		BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	e 13	D 269			
	totally dependent upo toileting. -There was no docum	eting on 1 shift. tation Resident #6 was on staff for bathing and mentation of refusals.				
	Review of Resident #6's Weekly Skin Check Sheet revealed: -Resident #6's skin was checked/bath was given on 10/12/21, 10/16/21, 10/21/21, 10/26/21, and					
	10/30/21 -There was no docum	nentation of refusals.				
	-There was no documentation of refusals. Observation of Resident #6's suite on 11/02/21 at 10:47am revealed: -He resided in the Special Care Unit (SCU)Resident #6's suite consisted of a bedroom, a living area, and a bathroomThere was dried feces on the light switch in his bathroom and dried feces on the light switch in his living area. Observation of Resident #6 on 11/02/21 at 10:51 revealed he had dried feces on top of and under the fingernails of his middle, ring, and pinky fingers of his left hand.					
	11/02/21 at 10:51am -Resident #6 was supfirst shift, but he had a -Sometimes he receively literal took 3 to 4 and 3 staff to provide -She had not seen the Resident #6's fingern	oposed to receive a bath on not had one yet on 11/02/21. Wed a bath on second shift. staff to assist with a bath incontinence care. The feces on and under ails.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			D 0
		HAL041052	B. WING			R-C I /05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE		
MODNING	SVIEW AT IRVING PARK	3200 N E	LM STREET			
WORNING	GREEN					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 269	-She noticed Residen when she started her -She did not try to wa #6's fingernails becaubreakfastResident #6 was ver from staffIt usually took 3 peop with toileting. Observation of Resident 11:16am revealed: -PCAs were standing observing the feces of speaking with the surrous transfer and the product of the produc	at #6 had feces on his fingers shift a 7:00am on 11/02/21. sh the feces off Resident use she was helping with by strong and tried to run tole to bath him and assist ent #6 on 11/02/21 at near Resident #6 after in his fingernails and	D 269			
	times weekly on first solution. The Weekly Skin Care each time a resident reach time. The solution is a resident reach time time time time time time. The weekly on the solution reach time time time time time time time time	needuled to receive a bath 3 shift. re Sheets were completed received a bath. ull feces from his staff had to watch him and im prior to meals. It to provide baths and bath days if Resident #4 ecial Care Unit Coordinator at 12:47pm revealed: It total care except for attinence care and baths, but				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		UAI 044052	B. WING		l l	R-C / 05/2021
		HAL041052			11	/05/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET	_		
			BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	÷ 15	D 269			
	care. -Resident #6 played i	to provide incontinence n his feces at times so staff				
	had to watch him clos					
		sident #6 had feces on his ning of 11/02/21 and staff				
	•	Resident #6's fingernails.				
	Interview with the Adr	ninistrator on 11/05/21 at				
		expected staff to provide				
	personal care to resid	lent #4 as needed.				
	2. Review of Resident 10/06/21 revealed:	t #4's current FL2 dated				
	-Diagnoses included	dementia, major depressive				
		se, diabetes mellitus, and				
	hypertension.	rmittantly discrimated				
		ermittently disoriented. Continent of bladder, but				
	continent of bowel.	Station of Bladdon, But				
	Review of Resident #	4's care plan dated 05/12/21				
		ed using a rolling walker.				
		asional incontinence of the				
	bladder, less than dai	-				
	-Resident #4 was son					
	-Resident #4 was forg	gettut and needed				
		supervision for toileting.				
		4's Activities of Daily Living				
	(ADL) log for August 2	2021 revealed: o document assistance for				
		r each day in August 2021.				
		nentation staff assisted				
	Resident #4 with toile					
		cumented as independent				
	with toiletingThere was no docum	pentation of refusals				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI	
			A. BUILDING: _		_	_
		HAL041052	B. WING		R-0 11/0	C 5/ 2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELI		30		
			ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	e 16	D 269			
	2021 revealed: -There was an entry to ADLs on each shift for 2021There was no docum Resident #4 with toiledent #4 was docum to with toiletingThere was no docum Review of Resident #2021 revealed: -There was an entry to ADLs on each shift for there was no docum Resident #4 with bath and the resident #4 was docum Resident #4 was docum Resident #4 was no docum Reside	cumented as independent nentation of refusals. 4's ADL log for October o document assistance for or each day in October 2021. nentation staff assisted hing. cumented as independent nentation of refusals. Intrance to the Special Care 21 at 10:00am revealed: bodor of urine immediately was located to the entrance to the SCU. door was closed and locked. Lent #4's room on 11/02/21 at of urine on the floor outside froom. Lurine-soaked underwear on H4's bathroom. Lunderwear soiled with feces				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL041052	B. WING		R-0 11/0	C 5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N EL	.M STREET			
WOKINING	GREENSE			08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	: 17	D 269			
D 269	8:04am revealed: -Resident #4's room of unlocked, and Resider rollator outside his rootResident #4 was cleater was an odor of Resident #4's roomOn the floor outside hor of urine. Interview with Reside revealed: -Staff did not assist his toiletingHe had urine on the state this morning and that outside his roomHe probably put the most know that for sureWhen he saw urine of was usually in the sareHe did not wear inco have accidents in hisHe did not think he not toiletingStaff did not give him bathroom. Interview with a house 11/02/21 at 11:25am in the resident #4's room deresident #4's room deresident #4's floor with resident floor floor floor floor floor floor flo	door was closed, but it was ent #4 was sitting on his om. an and his clothes were dry. If urine coming from this bathroom was a puddle ant #4 on 11/03/21 at 7:52am and with bathing, dressing, or and the floor outside of his bathroom was why he was sitting the was why he was sitting the spot. The spot. The spot. The spot with the did not underwear. The eded assistance with the reminders to use the sekeeper in the SCU on revealed: The strong odor of urine near oor. The on the floor a lot. The mop Resident #4's floors	D 269			
	clean the urine off his					

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floor, but he had never seen any incontinence

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	JE ZIP CODE	,
TO THIS COLUMN	NOVIDEN ON GOL LEEN	3200 N ELI		(12, 2), GGBE	
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 269	Continued From page	e 18	D 269		
	briefs in his trash.				
	bricio in filo traori.				
	11/02/21 at 10:48am -She had noticed odo #4's room since she v -Resident #4 urinated	onal care aide (PCA) on revealed: ors coming from Resident was hired a month ago. I on the floor of his room. nim with toileting because he			
	10:54am revealed: -If Resident #4 wore i not keep them on bedurineResident #4's room a	nd PCA on 11/02/021 at ncontinence briefs, he did cause his room smelled like always smelled like urine. esident #4 with toileting. f go in his room.			
	(SCUC) on 11/04/21 a -She knew about the Resident #4's room a the floorResident #4 sat on h holding his urine until it to his bathroom toile -Staff did not assist R because he did not lik -First shift staff has st #4 to use the bathroo	urine odor coming from nd Resident #4 urinating on is rollator and went to sleep, he had a hard time making			
	revealed: -Resident #4 usually himselfShe had seen urine of	on 11/04/21 at 2:56pm went to the bathroom by on Resident #4's floor a had not seen him soil or			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAI 041052			CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET BORO, NC 2740	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 269	Continued From page	e 19	D 269			
	urinate in his clothesShe had never given or cues to use the ba	Resident #4 any reminders throom.				
	3:18pm revealed: -Resident #4 toileted -She did not provide it toiletHe went to the bathrineeded to goShe had seen urine or roomShe did not know whis room floor. Interview with the Adr 10:13am revealed:	reminders or cues for him to oom by himself when he on the floor of Resident #4's ny Resident #4 urinated on ministrator on 11/05/21 at				
	Resident #4's roomResident #4 urinated times.	dor of urine coming from I on the floor of his room at assist Resident #4 with				
D 270	10A NCAC 13F .0901 Supervision	I(b) Personal Care and	D 270			
		e supervision of residents in n resident's assessed needs,				
	This Rule is not met	as evidenced by:				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED
					l R	-C
		HAL041052	B. WING		I	05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE	•	
NAME OF T	KOVIDEK OK 301 1 EIEK		M STREET	KIE, ZII GODE		
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR	ECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 20	D 270			
		ns, interviews and record				
		iled to provide supervision				
		ampled (#4 and #5) related				
		I multiple falls resulting in				
	injuries (#4), a male r	found undressed and in bed				
		sident (#4) inappropriately				
	~	esident (#5), and the female				
	· ·	alone in the male resident's				
	room (#4) without sup					
	(*)					
	The findings are:					
	1. Review of the facili	ty's Fall Management and				
	Investigation Policy d	ated 09/01/18 revealed:				
		pdated post-fall to address				
		and suggested interventions.				
	-The Morse Fall Risk					
		cident and if the score				
	of a referral for an out	have prompted discussion				
	consultation.	iside renabilitation				
		included evaluating the				
	resident, immediate fi					
	· · · · · · · · · · · · · · · · · · ·	al or urgent care if needed,				
		nd attending physician,				
		esident's treatment and				
	interventions according	ngly if indicated, and fall				
	interventions were rev					
	effectiveness.					
		re communicated to the				
	staff, family, and the resident for safety					
	_	the risks and benefits of fall				
	prevention.					
	-There was no docum					
	increasing supervision	n of residents after a fall.				
	Review of Resident #	4's current FL2 dated				
	10/06/21 revealed:					
	-Diagnoses included	unspecified dementia, major				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
						R-C
		HAL041052	B. WING			/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		LM STREET			
	T		BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	21	D 270			
	depressive disorder, a diabetes mellitus, and -He was intermittently -He was ambulatory a	d essential hypertension. disoriented.				
	revealed: -He required no assis transfersHe used a walker for	propriate behaviors at times				
	dated 06/17/21 revea -Resident #4 was rou diagnosis of dementia -Resident #4 was am deviceResident #4's goal w maintainedInterventions include	tinely disoriented and had a a. bulatory with an assistive				
	Report dated 03/10/2 -Resident #4 had an ufound in the hallwayResident #4's primar responsible party wer	t #4's Incident and Accident 1 at 12:40pm revealed: unwitnessed fall and was y care physician (PCP) and re notified. hentation regarding injuries.				
	03/10/21 revealed: -Resident #4 was fou his left arm under his	st from the floor with one				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL041052	B. WING		11/05/2021
					11/00/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELF		••	
	I	GREENSB	ORO, NC 2740	J8	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page 22		D 270		
D 270	Based on record reviet documentation of intersupervision implement the fall on 03/10/21. Review of Resident #Report dated 04/06/2 -Resident #4 had an usen on the floor by seneral review of Resident #4's PCP anotified. -There was no document review of Resident #4 had an usen of his forehead. -Resident #4 had an usen of his forehead. -Resident #4 got himse the medication aide (I Emergency Medical Senesident #4 was seneral reviews of the resident #4 was seneral reviews of Resident #4 was seneral reviews of Resident #4 got himse the medication aide (I Emergency Medical Senesident #4 was seneral reviews of Resident #4 was seneral reviews o	I he did not fall. family member, and otified. nitored after the fall and ns. ews, there was no erventions or increase in nted for Resident #4 after 4's Incident and Accident 1 at 10:26am revealed: unwitnessed fall and was staff. and responsible party were mentation regarding injuries. 4's progress note dated unwitnessed fall. and a bump on the right side self up from the floor while MA) was on the phone with	D 270		
	Review of a fax docur on 04/06/21 revealed -Resident 4 was foun- -Resident #4 had a sr the right side of his fo -Resident #4 was sen	d on the floor in the hallway. mall abrasion and bump on brehead. In to the ED for evaluation. risited Resident #4 and			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED	
		HAL041052	B. WING			R-C 1/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
		3200 N I	ELM STREET			
MORNING	SVIEW AT IRVING PARK	GREEN:	SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	supervision implement the fall on 04/06/21. Review of Resident #Report dated 06/09/2-Resident #4 had an found on the floorResident #4 compla-Resident #4's response for the rewas no progress. Review of Resident #4 visit summary dated resident #4 was seepainDiagnoses included resident #4 was evaluated resident #4 was evalu	ews, there was no erventions or increase in need for Resident #4 after #4's Incident and Accident #1 at 1:58pm revealed: unwitnessed fall and was ined of chest pain. Insible party was notified. #4's progress notes revealed is note dated 06/09/21. #4's local hospital ED after 106/09/21 revealed: en in the ED due to chest eatypical chest pain. Insible party was notified.	D 270			
	dated 06/17/21 reveal -Resident #4 had fall -Resident #4's gait wrising from chairs, us bounced to riseHe kept his head do watched the groundHe grasped furniture ambulatingResident #4 could new -Resident #4 was a fall have his fall risk mini -Interventions include #4 with a safe environ free; support/assistives.	t4's Fall Risk Evaluation aled: en within the past 6 months. as impaired; he had difficulty ed chair arms to get up, and wn when walking and e, person, or aid when ot walk unassisted. all risk and his goals were to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET	90		
040.15	SHIMMADV ST.	ATEMENT OF DEFICIENCIES	BORO, NC 2740	PROVIDER'S PLAN OF CORRECTION	M (ME)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 24	D 270			
	were within reach.					
		ews, there was no increase in supervision dent #4 after the fall on				
	Review of Resident #4's Incident Report Form dated 07/02/21 at 2:30pm revealed: -Resident #4 had an unwitnessed fallResident #4's PCP was notifiedThere was no documentation regarding injuries. Review of Resident #4's progress note dated 07/02/21 revealed: -Resident #4 had an unwitnessed fall on 07/02/21He did not complain of painThe MA did range of motion and checked for redness, bruising, and knotsThere were no injuries to reportResident #4's family member and the facility nurse were notified.					
		ews, there was no erventions or increase in nted for Resident #4 after				
	Report dated 07/11/2 -Resident #4 had an useatResident #4 injured to forehead.	y care physician (PCP) and				
	Review of Resident #	A's progress note dated				

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07/11/21 revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL041052	B. WING			R-C / /05/2021
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	3200 N E	LM STREET			
		GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 25	D 270			
	-Resident #4 was sitti the hallway when he floorHis head was bleedin-Resident #4 was ser -The facility nurse and notifiedResident #4 returned 4:50pm with his head -He did not have any Review of Resident # visit summary dated (-Resident #4 was see -Resident #4's diagnot the head, and abrasid Based on record revied documentation of inte supervision implement fall on 07/11/21. Review of Resident # Reports revealed the Accident Report for 0 Review of Resident # there was no progres Review of Resident # visit summary dated (-Resident #4 was see -Resident #4's diagnot injury of the backThere was no evider emergency on Reside ED on 09/21/21Resident #4 did not lead to the floor of the second resident #4 did not lead to the floor of the second resident #4 did not lead to the floor of the floor of the second resident #4 did not lead to the floor of the floor	ing on a loveseat asleep in fell face forward onto the ing. Into out to the ED by EMS in the control of the facility on 07/11/21 at its wrapped. It wrapped. It is local hospital ED after of the ED due to a fall. It is included a fall, injury of on of the scalp. It is local hospital ED after on of the scalp. It is local hospital ED after on of the scalp. It is local hospital ED after on of the scalp. It is local hospital ED after of the scalp. It is local hospital ED after of the scale				

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STATE FORM 8ZWU11 If continuation sheet 26 of 173

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		3200 N ELI	M STREET		
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08	
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 26	D 270		
		ews, there was no erventions or increase in nted for Resident #4 after			
	7:51am revealed he	ent #4 on 11/03/21 at was sitting on the seat of his e of his room and the wheels			
	Interview with Resident #4 on 11/03/21 at 7:52am revealed he did not remember having any falls, injuries, or going to the ED.				
	11/04/21 at 2:56pm re-She checked on resi including Resident #4-She found Resident hallway in September -Resident #4 was ser but he did not have a -She was not told to a Resident #4 when he -She was not told to it Resident #4 after his -She was not aware a place for Resident #4-Resident #4 could prof shoes.	dents every 2 hours #4 on his back in the 2021. In to the local hospital ED, Iny injuries. It do anything differently for I returned from the ED. Increase supervision for I falls. I fany interventions put in I after his fall. I robably use a different pair I ear his shoes completely on I feet in the shoes and			
	revealed: -She remembered Re	n 11/04/12 at 9:35am esident #4 having two falls it she did not remember			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	Ξυ
		HAL041052	B. WING		R-C 11/05/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING		3200 N ELI	M STREET			
MORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	falling was when he we hallway; he fell off the did not witness the fare a condition when he we hallway and fell backs the fall. -When Resident #4 fesent out to the hospitate fell on his back. -There were no intervent Resident #4 that she condition was no set length of the condition of the resident whether the resident whether the resident to checks. -There was no docume checks on residents a condition of the condition of th	membered Resident #4 vas sitting in a chair in the e chair and hit his head; she III. e remembered Resident #4 vas sitting on his walker in wards; she did not witness ell backwards, she had him eal for precaution because he rentions put in place for knew of after either fall. check on all residents every II, she checked on the r every 30 minutes, but there ime. determined if the resident was placed on 30 minute mentation of any increased after a fall. ent increased safety checks, pleted the documentation in ot remember how long it had	D 270			
	Interview with the Spe (SCUC) on 11/04/21 a	ecial Care Unit Coordinator				
	-Resident #4 fell aslethis falls occurred whill -She did not think sup Resident #4 after his common area most o	pervision was increased for falls, but he was in the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	1 ' '	SURVEY PLETED
			A. BUILDING: _			
			B. WING			R-C
		HAL041052	B. WING		11	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		M STREET			
	-	GREENSE	BORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	28	D 270			
	-It was hard to have a staff tried to keep resi -She did not think res	a visual on all residents, so idents engaged in activities.				
	Interview with the SC revealed:	UC on 11/05/21 at 11:45am				
	-Anytime a resident had a fall, staff documented in the progress notes for 3 days. -During the 3 days after a fall, staff should have documented if there was any discomfort, bruises, or pain. -After a fall, the resident should have been monitored throughout the day. Interview with Resident #4's primary care provider (PCP) on 11/03/21 at 1:23pm revealed: -The facility notified her of Resident #4's falls. -After Resident #4's falls, she expected staff to notify her, call EMS if he hit his heat, and redirect him. -She would have to refer to the facility's policy regarding supervision of residents after a fall.					
	5:19pm revealed: -The facility had tried unknown, with Reside -Staff discussed Resident rollator and making his locked when he sat of the residents after falls in -Staff should have conhourly checks on the fall.	nentation of discussions of dent #4. creased supervision for				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE	
MORNING	EVIEW AT IRVING PARK		LM STREET BORO, NC 2740	8	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 270	resident's physician, secessary, and conting and conting the party on unsuccessful. b. Review of Residen Report dated 05/04/2 - Resident #4 exhibite found lying in his bed - Resident #4's primar responsible party, the Social Services (DSS were notified There was no additionable the sexual behavior. Review of Resident #4 there was no progres Based on record revied documentation of integration implement the incident on 05/04/2 Review of Resident #4 Reports revealed the Accident Reports date Review of Resident #4 was in a the zipper of his pants - Resident #4 was red female resident and residen	in, the staff were to notify the send out to the ED if hue hourly checks. interview with Resident #4's 11/05/21 at 9:09am was It #4's Incident and Accident 1 at 6:30pm revealed: 1 d sexual behavior and was 1 y care physician (PCP), 1 county Department of 1 onal information regarding 1 onal information regarding 1 onal information regarding 1 onal information or increase in steed for Resident #4 after 1 onal incident and Accident 1 onal incident and 1 onal inci	D 270		

Division of Health Service Regulation

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	PLETED
						R-C
		HAL041052	B. WING	<u>-</u>	11	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3200 N EI	M STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 2740	08		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE DATE
D 270	Continued From page	e 30	D 270			
	Based on record revi	owe there was no				
		erventions or increase in				
		nted for Resident #4 after				
	the incident on 05/03					
	and moradine on do, do,	,				
	Review of Resident #	4's Incident and Accident				
	Reports revealed the	re was no Incident and				
	Accident Report date	d 05/10/21.				
		/Intervention Monitoring				
		dated 05/10/21 at 1:55pm				
		dication if the other resident				
		lirected				
	Troolagilt // Troolagilt	ootou.				
	Review of Resident #	4's PCP's consultation notes				
	dated 05/12/21 revea					
		male resident, were found in				
		amala rasidant wara				
		nave any recommend or and				
		ounty DSS and the female				
		nber, but they were not able				
	to get in contact with	Resident #4's family				
	member.					
	self and roughly to pla					
		ala not remember the				
		ded staff to continue to				
	revealed: -Resident #4 exhibite behavior as he had a lap. (There was no in was female or male.) -Resident #4 was red Review of Resident # dated 05/12/21 revea -Resident #4 had a se-Staff reported to the Resident #4 and a fel bed togetherResident #4 and a fel bed togetherResident #4 did not lincident occurringStaff contacted the cresident's family men to get in contact with memberThe PCP assessed I self and roughly to planes and roughly to planes and said he sexual incidentThe PCP recommen	d sexually inappropriate nother resident sitting in his dication if the other resident lirected. 44's PCP's consultation notes aled: exual arousal disorder. PCP that two residents, male resident, were found in emale resident were aist down. have any recollection of the county DSS and the female aber, but they were not able Resident #4's family Resident #4 to be alert to ace. on a conversation with loose did not remember the ded staff to continue to nitoring, and administer				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET			
	I		BORO, NC 2740		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	O BE COMPLETE	
D 270	Continued From page	÷ 31	D 270			
		rventions or increase in nted for Resident #4 after				
	Report dated 05/16/2 -Resident #4 had a fe (female resident was -Resident #4's PCP a notified.	nd responsible party were				
	-No injuries were identified. Review of Resident #4's progress note dated 05/16/21 revealed: -Resident had a female resident in his room. (female resident was not identified) -Staff redirected them apartStaff left Resident #4 in his room and let him "cool off." -Resident #4's family member, the facility nurse, Administrator, and PCP were notified.					
		rventions or increase in nted for Resident #4 after				
		4's Incident and Accident re was no Incident and d 09/20/21.				
	09/20/21 revealed: -Resident #4 was "ca residentA Personal Care Aide moved him to a difference	4's progress note dated ught" touching on a female e (PCA) told him to stop and ent area. corted to the facility nurse.				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETEL]
		HAL041052	B. WING		R-C 11/05/2	021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	JE. ZIP CODE	•	
			M STREET	,		
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		OMPLETE DATE
D 270	Continued From page	2 32	D 270			
		erventions or increase in nted for Resident #4 after				
	11/04/21 at 3:05pm re -Resident #4 was sea walker in the commor was standing beside	ated on the seat his rollator n area and a female resident him. arm around the female				
	3:44pm and 4:15pm r -Resident #4's room v hall as the female res -At 3:44pm, the femal coming out of Reside -At 3:56pm, the femal #4's roomAt 4:11pm, Resident came out of Resident -At 4:13pm, the femal Resident #4 down the rollator walkerAt 4:14pm, a persona down the hallway whe locatedNo staff came to obs Resident #4 and the femal	was located on the same sident's room. le resident was observed nt #4's room. le resident entered Resident #4 and the female resident #4's room. le resident was pushing e hallway seated in his al care aide (PCA) walked here Resident #4's room was erve the whereabouts of female resident between the lent entered Resident #4's the time they exited				
	Interview with Reside revealed: -He did not have a gir	nt #4 on 11/03/21 at 7:52am				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3		
,	5. GGT125.1161.1	.52	A. BUILDING:	A. BUILDING: COMPLE		
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK		BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Interview with a PCA revealed: -Resident #4 displaye with the female resideHe tried to feel on the and tried to kiss herThe female resident to keep Resident #4 alf she saw Resident behaviors, she tried to with her. Interview with a medicat 4:37pm revealed: -Resident #4 was infaresident, but female resident, but female resident, but female resident #4 and the usually togetherResident #4 was usually together.	Id not be around a certain not remember which one. on 11/02/21 at 10:54am ad inappropriate behaviors ent. a female resident's breasts as family member asked staff away from her. #4 displaying inappropriate or get female resident to walk cation aide (MA) on 11/02/21 attuated with the female esident thought he was her female resident were ally out of his room in the	D 270			
	-Resident #4 and the caught in bed together remember whenResident #4 inappropresident and the femaleShe did not know if the supervision of Reside	or by staff, but she did not coriately touched the female ale resident sat in his lap. There was any increased ont #4 and the female are caught in bed together or				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		M STREET			
	-	GREENSB	ORO, NC 2740	98		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE	
D 270	Continued From page	: 34	D 270			
	-Staff locked Residen out of his room.	t #4's room when he was				
	(SCUC) on 11/04/21 a	ecial Care Unit Coordinator at 12:47pm revealed: y friendly with the female				
		thought Resident #4 was				
	-It was difficult to contact Resident #4's family, but the family was aware of his behaviorsThe female resident's family member was okay					
	with her being around	Resident #4, but he did not e or Resident #4 touching				
	-Staff tried to keep an and the female reside	eye on both Resident #4 nt.				
	-Supervision of all res	idents was hard because of				
	staff tried to keep resi -She did not think res	visual on all residents, so dents engaged in activities. idents were being J according to their needs.				
	11/04/21 at 2:56pm re	onal care aide (PCA) on evealed: thought Resident #4 was				
	her family memberResident #4 played a resident.	-				
		s family member did not und the female resident at				
	-It was difficult to keep from the female residen	o Resident #4 separated ent.				
	revealed:	UC on 11/05/21 at 11:45am sident #4 every 1 to 2 hours.				

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-Staff always had a visual on Resident #4 and the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL041052	B. WING		R-0	C 5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
MORNING	VIEW AT IRVING PARK	3200 N ELI GREENSB	MISTREET ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Resident #4's room u Interview with Reside 1:23pm revealed: -She was aware of Resexual behaviors with -She could not remensaff reported to her widocumentationThe female Resident more so than Resident resident from what she she expected staff to there were incidents of behaviors. Interview with the Adr 5:19pm revealed: -He knew about the she between Resident #4-Resident #4's and the did not mind them betweant them in either of the expected staff to female resident when were observedHe expected staff to on Resident #4 and the and for staff to keep a as much as humanly Attempted telephone Responsible party on unsuccessful. 2. Review of Resident	e female resident was in insupervised for 15 minutes. Int #4's PCP on 11/03/21 at esident #4's inappropriate the female resident. In the details of incidents without looking at her expressed and the female e had seen. In redirect Resident #4 if of inappropriate sexual example the female resident. In the female resident #4 if of inappropriate sexual example the female resident. In the female resident is female resident. In the female resident ongoing in eye on the two residents	D 270			

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with behavioral disturbance.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MODNING		3200 N EL	M STREET		
MORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	2 36	D 270		
	Review of Resident # 08/26/21 revealed: -Her behaviors includ -Her degree of cognit of orientation to time and ambulation. Review of Resident # (PCA) activities of data 2021 revealed: -There was an entry fevery 2 hoursThere was document 2-hour checks on Resident # September 2021 revealed: -There was an entry fevery of Resident # September 2021 revealed: -There was an entry fere was a	ed sadness and wandering. ive impairment included lack and place. In with dressing, transfers, 5's personal care aide ily living (ADL) log for August for staff to check on her tation that staff completed sident #5 two days in the Ind 08/16/21 on the 11:00pm 5's PCA ADL log for staff to check on her but face where it would specify mentation staff completed ent #5.			
	•	or staff to check on her but ace where it would specify			
	checks on Resident#	tation that staff completed t5 for one day, on 10/09/21 00pm shift and the 11:00pm			
	Report dated 05/04/2	5's Incident and Accident 1 revealed: dinner it was reported that			

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A. BUILDING: R-C HAL041052 B. WING 11/05/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	21
HAL041052 B. WING 11/05/202	21
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MORNINGVIEW AT IRVING PARK 3200 N ELM STREET	
GREENSBORO, NC 27408	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) OMPLETE DATE
D 270 Continued From page 37 D 270	
Resident #5 was seen laying in the bed in a male resident's room with no clothing on, under the blankets. Staff assisted Resident #5 out of the room. Resident #5 did not want to leave the male resident, thinking that he was her spouse. The male resident was lying on his side towards Resident #5 with his pants down. -The incident occurred on 05/04/21 at 6:30pm. -It was noted there was no apparent injury to Resident #5 at the time the incident was discovered. -The corporate Director of Clinical Services was notified on 05/06/21 at 4:45pm. -The responsible person of Resident #5 was notified on 05/06/21 at 4:45pm. -The Poporate Director of Services was notified on 05/06/21 at 5:00pm. -The County Department of Social Services was notified on 05/07/21 at 8:20am. -The primary care provider (PCP) was notified on 05/07/21 at 9:20am. -Resident #5 was redirected from the male resident. Full assessment was completed upon notification (05/06/21) that Resident #5 had no pain, redness, bruising, or swelling. No cognition changes, emotional changes noted. Review of Resident #5's progress note dated 05/05/21 revealed: -Resident #5 was found with her clothes off in her room with a male resident. Resident #5 was redirected to dress in her clothes and told male resident was not her spouse. -The action taken was that staff redirected Resident #5 meded constant supervision from staff due to not understanding "the need to leave male resident alone."	

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Review of Resident #5's progress note dated

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	A. BUILDING:		COMPLETED		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF B	ROVIDER OR SUPPLIER	STREET AN	DRESS, CITY, STA	TE ZIR CODE	,,
NAIVIE OF F	ROVIDER OR SUFFLIER		M STREET	KIE, ZIF GODE	
MORNING	VIEW AT IRVING PARK		BORO, NC 2740	08	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 38	D 270		
	05/06/21 revealed:	nitored for behaviors and			
	needed to be redirect				
	admitted to hospice s				
		g and redirecting as needed.			
	-otan were monitoring	g and real county as needed.			
	Review of Resident #	5's progress note dated			
	05/16/21 revealed:				
		another resident's room. She			
	•	away. No clothing had been			
	removed.				
		ent #5's power of attorney			
	(POA), the Executive staff, and PCP.	Director (ED), the nurse on			
		tation to keep redirecting the			
	resident to go other p	laces or to sit down.			
	Interview with a PCA revealed:	on 11/05/21 at 11:35am			
	-Resident #5 liked to	stay in her room.			
		ner every 2 hours if she was			
	not already visible in				
	-Usually she was eas	y to redirect but sometimes			
	if she was in another like to leave.	resident's room she did not			
	-She was not working	the night Resident #5 was			
		ne male resident's room, but			
		ent #5 did like to sit and			
	stand close to him in	the common areas.			
		cation aide (MA) on 11/05/21			
	at 11:40am revealed:				
		rect Resident #5 from the			
		as she thought he was			
	-	nber, or her spouse at			
	various times.	act Decident #E avvey from			
		ect Resident #5 away from			
	the male resident's ro	oom every day. ed in the halls and she would			
		nale resident's room and			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE	-
	10115211 011 001 1 21211		M STREET	, 2 0002	
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08	
0/10/15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CORRECTION	1 0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 270	Continued From page	39	D 270		
	knock or shake his do was locked. Staff wou saw her at the male ru-lif staff did not see Re areas, they would che until staff found her. Interview with Reside 11/05/21 at 12:32pm u-The facility would cal	oor handle when the room ald redirect her when they esident's door. esident #5 in the common eck other resident rooms ant #5's Responsible Party on revealed: I him immediately whenever			
	-The facility would call him immediately whenever there was an incident with Resident #5Every resident in the Special Care Unit (SCU) wandered into other residents' roomsHe visited Resident #5 every day from around 9:00am to noonHe was notified by the facility of the incident with Resident #5 and the male resident being undressed in bed togetherHe did not want Resident #5 and the male resident alone in a room together after he had learned about the incident of them being together				
	in a bed, but was "oka together in the comm	ay" if the two of them were on areas.			
	or in the hallways. -The staff were supported to the residents every two half the residents "all the flaving dementia and -Resident #5 liked to resident but she had none of the resident ro-She was unaware of between Resident #5	ost of her time in her room used to do checks on all the ours, but they watched all time" due to the residents wandering behavior. walk the halls with the male never seen them together in			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IDVING DADK	3200 N ELM	I STREET			
WORNING	VIEW AT IRVING PARK	GREENSBO	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 40	D 270			
D 270	Interview with the Adr 5:20pm revealed: -He expected the PC/documentation every two hours checks on -Resident #5's family family were both "oka together in common a in a roomHe expected staff we as needed if Resident resident's room. The facility failed to presidents including a intermittently disorien dementia which result multiple falls, 4 emerginjuries including abraside of the forehead, the scalp, and an injuresidents in the Special who both had a diagn found unsupervised in and alone in one of the inappropriately touchi was detrimental to the of residents and consumer of the facility provided a accordance with G.S. this violation.	As to complete shift that they performed Resident #5. and the male resident's y" with the residents being areas but not alone together buld supervise and intervene trust #5 went into another	D 270			
D 273	20, 2021. 10A NCAC 13F .0902	2(b) Health Care	D 273			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						R-C
		HAL041052	B. WING			1/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
MORNING	SVIEW AT IRVING PARK		LM STREET			
	Т		BBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 41	D 273			
	` '	P. Health Care assure referral and follow-up nd acute health care needs				
	interviews the facility follow-up with health sampled residents (R	as evidenced by: ews, observations and failed to ensure referral and care providers, for 1 of 5 esident #2) regarding an nedication and a urinalysis				
	The findings are:					
	08/29/21 revealed dia stroke, hyperlipidemia	t #2's current FL2 dated agnoses included ischemic a, urinary tract infection sepsis (a blood infection) fection.				
	summary and medical revealed: -Resident #2's primar stay was ischemic str -There was a physicial medication used to tre	an's order for atorvastatin (a eat high cholesterol and art attack or stroke) 20mg				
	20mg daily, as Reside	(PCP) on 09/02/21 for an order for atorvastatin ent #2 had returned from the r but the hospital had not the pharmacy.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	
TO AME OF THE	NOVIDEN ON OUT FIELD	3200 N ELM		, 2.11 3332	
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	2 42	D 273		
	Response" was blank	.			
	2021 medication adm	2's September and October inistration record (MAR) no entries for atorvastatin			
	11/03/21 at 12:00pm and a property of the process the facily new orders from a property order tracking form." -The medication aided the order request to the then either the MA or would await a response complete the form one addressed and complete a shift was ending received from the PC placed in the WC's morders would not be not be recontracted pharmacy revealed the only orders.	lity used to clarify or request ovider included using an (MA) or nurse who faxed the PCP would start the form, Wellness Coordinator (WC) se from the PCP and the request had been leted. and no response had been P yet, the form was to be ailbox for follow up so nissed.			
	Interview with Reside 1:30pm revealed: -She did not receive a atorvastatin from the -She did not feel there Resident #2 for not ha atorvastatin as ordere -It would have been h facility would try conta	facility. e was any potential harm to aving started the			

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STATE FORM 8ZWU11 If continuation sheet 43 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74101 2741	A. BUILDING:				
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELM	I STREET		
- INORATIVE	VIEW AT INVINOT AND	GREENSBO	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 43	D 273		
D 213	Interview with the WC revealed: -When a resident was hospital the MA shoul fax any new orders to -If there were new ord clarification, the MA s PCPHer role was to revie paperwork for new or MA transcribed every-If an order request w response was receive shift, the MA should n watch for a faxed response with the Adr 3:00pm revealed: -The WC was responders received from -If a new medication or received, he would expurse or Director of C facility could obtain the resident. Interview with an MA revealed: -The MA staff used the whenever a fax was series.	c on 11/03/21 at 4:45pm s discharged from the dreview the paperwork and o the pharmacy. ders that required should send a fax to the w the hospital discharge ders and to make sure the thing correctly. The fax faxed to the PCP and no red from the PCP during that notify the oncoming MA to ponse back from the PCP. ministrator on 11/04/21 at sible for following up on new the PCP or hospital. was ordered and not expect the WC to notify the clinical Services so that the me medication for the on 11/05/21 at 4:20pm			
	during their shift, the on the desk in the offi see.	ot received by the PCP order tracking form was left ice for the oncoming shift to			
	11/02/21 revealed: -There were two lab of	t #2's physician orders on order request sheets from /21 and 09/29/21 requesting			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		LM STREET			
		GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	out a urinary tract inforthere were no lab re and urine culture (UC 09/29/21. Interview with the Dir 11/03/21 at 12:00pm - The Wellness Coord for following up on ne PCPShe did not know wh results in Resident #2 Interview with Resider revealed: -She got frequent UT - She remembered gir September 2021 whe collection device in h temperature for too ld for the lab testShe remembered gir specimen in Septeml weekend and she ne - She had asked what had been told by staff back from the lab. Interview with Reside 1:30pm revealed: -She was not aware from September 202 - There was no harm completed the ordere	e sample for testing to rule ection (UTI). esults for the urinalysis (UA) c) orders dated 09/22/21 and ector of Clinical Services on revealed: linator (WC) was responsible ew orders received from the ew orders received from the extra the services on 11/03/21 at 12:41 extra the urinated into a er toilet, but it sat at room ong and could not be used eving a second urine extra the the second the extra the extra the urinated into a er toilet, but it was on a extra the extra the urinated into a er toilet, but it was on a extra the extra the urinated into the extra the urinated into the extra the urinated into the used extra the urinated into the urinated into the extra the urinated into the urinate	D 273			
	revealed: -When a new order w	C on 11/03/21 at 4:45pm vas written by the PCP, f would be responsible for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	ITIFICATION NUMBER: A. BUILDING:		COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	-	
NAME OF T	COVIDEIX OIX OOF FEIER	3200 N ELM		12, 211 0002		
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	18		
240.15	CLIMMADV CT		· ·		1 25	—
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	<u>:</u>
D 273	Continued From page	e 45	D 273			
	have results, or if the collected. Interview with a repre	y the UA/UC orders did not specimens had ever been sentative from the facility				
	revealed: -The lab had a reques	on 11/04/21 at 8:45am st from the facility to pick up				
		e facility to pick up the				
	ready or available to I					
	staff obtained the spe	a MA would call the lab once cimen and it was available				
	to be picked up, but the return to the facility.	ney never received a call to				
		10/07/21, but when they o pick it up, again there was				
		UA or UC lab for Resident				
	Interview with the Adr 3:00pm revealed:	ministrator on 11/04/21 at				
	-When a lab specime facility it is the respon	lab to pick up the specimen				
	•	r the lab orders had been s called to pick up a				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	10A NCAC 13F .0902 (c) The facility shall at following in the reside	ssure documentation of the				

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STATE FORM 8ZWU11 If continuation sheet 46 of 173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		· ,	E SURVEY PLETED
	HAL041052	B. WING			R-C / 05/2021
NAME OF PROVIDER OR SUPPLIE	ER STREET A	DDRESS, CITY, STATE	ZIP CODE		
MORNINGVIEW AT IRVING F	PARK	ELM STREET BBORO, NC 27408			
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
a physician or o and (4) implementat orders specified Rule. This Rule is not Based on obser interviews, the forders were impresidents (#1) wasolution every 6. The findings are 1. Review of Re 10/08/21 reveal-Diagnoses inclutract infections a -There was an oalbuterol 0.5-2.5 nebulizer every. Review of Residence and the revealed she was 10/18/21. Review of Residence and the revealed she was 10/18/21. Review of Residence and the revealed she was 10/18/21.	edures, treatments or orders from ther licensed health professional; ion of procedures, treatments or l in Subparagraph (c)(3) of this t met as evidenced by: vation, record reviews, and facility failed to ensure physician's elemented for 1 of 5 sampled with an order for inhaled nebulizer is hours.	D 276			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION (X			
7.1.12 1 27.11	0. 002011011	.52.11	A. BUILDING:	A. BUILDING:		PLETED
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	. ZIP CODE		
			LM STREET			
MORNING	SVIEW AT IRVING PARK		BORO, NC 27408			
040.15	CHMMADV CT				CODDECTION	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	÷ 47	D 276			
	from the facility pharm -She did not know if F machineIf residents needed of Coordinator (WC) wo health companies del -Resident #1's family medications himselfShe had not request lpratropium bromide a 0.5mg(2.5mg)3ml even pharmacy because he would bring in her mis -She had reminded him admission that he need lpratropium bromide a	ele for ordering medication nacy. Resident #1 had a nebulizer equipment the Wellness uld get an order and home ivered it. In member brought in all of her led Resident #1's missing albuterol solution ery 6 hours from the facility er family member said he ssing medications. In multiple times since her leded to bring in the albuterol solution				
	the datesShe last spoke to him he said he would brin medications to the facthim to bring in a nebu-He had not yet delive albuterol solution 0.5r -MAs were responsib medications were not residents had missed -She notified the WC have Ipratropium bror 0.5mg(2.5mg)3ml ever	ered the Ipratropium bromide mg(2.5mg)3ml to the facility. le to inform the WC when in the facility or that				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		HAL041052	B. WING			R-C 1/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET			
	OUNDAMEN OF		SBORO, NC 27408	DD0//DDD0 D1 AV 05 4	000000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	: 48	D 276			
D 276	-She did not know wh not notified the PCP to of ipratropium bromid requested an order for she did not know if Four notified that she did not albuterol solution and administer the solution. Observation room #10 resided on 11/02/21 awas no nebulizer made awas no nebulizer made awas no nebulizer made awas no nebulizer made remember one for bree-she did not had any not had a cough since all the had supplied the medication from their solutions and did not solutions and did not solutions and did not solutions that he could he was not asked if the solutions and asked if the solutions are solutions asked if the solutions and asked if the solutions are solutions asked if th	o her provider was and had hat she had missed doses e albuterol solution or r a nebulizer machine. Resident #1's PCP was ot have ipratropium bromide a nebulizer machine to n. O4 where Resident #1 tt 4:10pm revealed there chine available. Int #1 on 11/02/21 at 4:15pm her medications but did not eathing. For using a machine to inhale trouble breathing and had e she was admitted. Int #1's family on 11/02/21 at facility with Resident #1's family pharmacy. had an order for nebulizer have a prescription for any. nachine for breathing	D 276			
	when she needed me -He spoke to the WC	f at the facility to tell him				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED
	HAL041052	B. WING		R-C 11/05/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MODNING VIEW AT IDVING DADY	3200 N ELI	VI STREET		
MORNINGVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 276 Continued From page	49	D 276		
Interview with the WC revealed: -MAs were responsible residents missed medi-MAs or herself order the facility pharmacy be member had chosen to emergency pharmacy: -The emergency pharmsupply for a residentShe knew Resident # bromide albuterol 0.5-her admission 10/18/2 -She had not requeste albuterol 0.5-2.5mg/3r medications from emethe family member saiting -She spoke to Resider week of 10/25/2021-10 list of needed medicate ipratropium bromide alsolution as solutionShe did not know if she and had not requested provider or the family responsible or the family responsible of the solution. Telephone interview we facility pharmacy on 1 revealed: -There was a profile of they provide emergency for the family of the provide emergency for the facility pharmacy on 1 revealed: -The FL2 on file dated for ipratropium bromid solution every 6 hours	e to report to her the ications and notify the PCP. resident medications from out Resident #1's family o use them as her macy can only fill a 3-day and ipratropium 2.5mg/3ml solution since 1021. It is dipratropium bromide in solution the missing argency pharmacy because id he would bring them in. In the thing that is family member the 10/29/2021 and gave him a ions for her including libuterol 0.5-2.5mg/3ml in the had a nebulizer machine id a machine from the member. In up with him to see if he bromide albuterol in. In the for Resident #1, but the cy pharmacy services for 10/08/2021 had an order e albuterol 0.5-2.5mg/3ml	D 276		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D MANAGE		R-C
		HAL041052	B. WING		11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELI	M STREET		
		GREENSB	ORO, NC 2740	08	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 50	D 276		
	Resident #1 before 1				
	Resident #1 before 1	1/3/2021.			
	primary care provider 8:35am revealed: -The PCP followed Reprevious assisted livin her care to this facility. He expected all med as orderedShe did not see an obut it would stand to needed to administer albuterol 0.5-2.5mg/3. There was no commence was no commenced to a no commence of the provider of the provider of the could not speak.	ications to be administered order for a nebulizer machine reason that one would be for ipratropium bromide ml solution. unication from the facility to a nebulizer machine. unication from the facility to missed doses of ipratropium ution. to the results of not pium bromide albuterol			
	Interview with the Adr 10:15am revealed:	ministrator on 11/04/21 at			
		Coordinator (RCC) or WC			
		mission, including faxing nd writing medication orders			
	on the MAR.	-			
		administer medications as			
	ordered by the PCPHe did not know if Re	esident #1 had a nebulizer			
	machine.				
		pharmacy to refill needed			
	medications.	a him tha MO an BOO if			
		o him, the WC or RCC if ment were not in the facility			
	to give to residents.	Hone were not in the lacility			
	-If a family member d	id not bring in needed tion, the facility would get an			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK		LM STREET BORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 276	Continued From page 51		D 276		
	order from the PCP at medication and work -Resident #1's family own pharmacy and or pharmacy for emerge -He did not know Res	nd obtain the equipment or out payment later. member chose to use their nly use the facility's ncy pharmacy needs. ident #1's family member ratropium bromide albuterol			
D 296	10A NCAC 13F .0904 Service	(c)(7) Nutrition And Food	D 296		
	(c) Menus in Adult Ca (7) The facility shall h	nave a matching therapeutic ician-ordered therapeutic			
	facility failed to have a of 5 sampled resident	and record reviews the a therapeutic diet menu for 1 s with a diet order for a no sistent carbohydrate diet			
	The findings are:				
		nt #1's current FL2 10/08/21 n order for a NAS/CCHO/HH ture.			
		1's Diet Order Form dated order for a NAS/CCHO/HH ture.			
	Review of the Therap	eutic Diet List dated			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MORNING	GVIEW AT IRVING PARK		ELM STREET BBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 296	10/31/21 revealed Rea a CCHO diet. Review of the facility's revealed there was not NAS/CCHO/HH diet. Review of the regular 11/03/21 revealed resolasagna or fried chick zucchini squash, corresouthern green beans yogurt pie. Observation of Reside on 11/03/21 at 12:23g-Resident #1 at ehere-Resident #1 was serchicken, corn on the concolate cake, and tolt could not be deternshould have been send diet menu available for Interview with Reside 12:27pm revealed: -She usually ate herreshe was served what mealsShe thought she was did not know which of Interview with the Dieter 11/04/21 at 8:59am resus 11/04/21 at 8:59a	esident #1 was to be served stherapeutic menus to therapeutic menu for a menu for the lunch meal on sidents had a choice of en, parsley, leeks and non the cob, and/or states, and berry ent #1's lunch meal service om revealed: meal in her room. ved two pieces of fried cob, mixed vegetables, ea. mined what Resident #1 rved due to no combination or staff guidance. Int #1 on 11/03/21 at meals in her room. Intever she requested for her as on a special diet, but she he. Stary Manager (DM) on evealed: #1 had an order for a with a regular texture, but or a NAS/CCHO/HH diet. henus for NAS, CCHO, and ave a menu for a	D 296			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELI	M STREET		
		GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 296	Continued From page	e 53	D 296		
D 290	-She did not know whe she served her a NAS consistencyShe told the Wellnes Resident #1 could no facility's morning meet received any updated. Interview with a cook revealed: -Resident #1 was new with her diet orderHe did not know what supposed to be servedHe had never seen a diet. Interview with the WC revealed: -She completed the dietShe thought Resider diet typeShe did not rememble about not being able in than 1 dietShe did not know the menu for Resident #1 NAS/CCHO/HH diet.	at to serve Resident #1, so a diet with a regular so Coordinator (WC) thave 3 diets during the stings, but she had not diet orders for Resident #1. on 11/03/21 at 9:12am and he was not familiar at Resident #1 was and he menu for NAS/CCHO/HH con 11/04/21 at 11:20am are iet order sheet for Resident at #1 could have more than 1 are if the DM talked to her to serve Resident #1 more are had to be a matching	D 290		
	primary care provider order. Interview with the Adr	O/HH diet. I up with Resident #1's (PCP) to clarify the diet ministrator on 11/04/21 at			
	11:34am revealed: -He did not know Res	ident #1 had an order for a			

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-The facility did not have a menu for a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		D.C.
		HAL041052	B. WING		R-C 11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELI		•	
OVA) ID	SHIMMARY ST	ATEMENT OF DEFICIENCIES	ORO, NC 2740	PROVIDER'S PLAN OF CORRECTION	d (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 296	Continued From page	: 54	D 296		
	NAS/CCHO/HH diet. -He did not know this 11/03/21.	was an issue prior to			
D 306	10A NCAC 13F .0904 Service	(d)(3)(H) Nutrition and Food	D 306		
	(d) Food Requirement(3) Daily menus for refollowing:(H) Water and Other B	Nutrition and Food Service nts in Adult Care Homes: egular diets shall include the Beverages: Water shall be nt at each meal, in addition			
	This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure water was served, in addition to other beverages to each resident in the Special Care Unit (SCU).				
	The findings are:				
	Review of the facility's revealed water was no	s menus for regular diets ot listed on the menu.			
	SCU on 11/03/21 betweevealed: -There were 11 resideroom and 7 residents the breakfast meal setThere were 4 resider had been served water	nts in the dining room who			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COM	-LETED
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MODNING	NUEVAL AT IDVINO DADIC	3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 306	Continued From page	÷ 55	D 306			
	Interview with a SCU 3:41pm revealed: -Staff gave residents -Staff did not automat the tables for resident -Staff gave her water -All residents had 3 g milk, tea, and water. Interview with the Die 11/04/21 at 8:47am re-All residents in the S in addition to other be-She did not know all	resident on 11/04/21 at water if they asked for it. tically offer or place water on ts. at lunch today. lasses at the lunch meal for tary Manager (DM) on				
	at times during meals -All residents should I meal.	rving residents in the SCU have 3 glasses at each hal, residents had three				
	(SCUC) on 11/04/21 a -She assisted during SCU on 11/03/21Water, milk, and resi should have been ser SCU during the break -She did not realize a was not served to all breakfast meal on 11/	the breakfast meal in the dents' choice of beverage ved to all residents in the cfast meal. nd did not know why water residents during the				
	11:34am revealed: -He did not know all r	esidents were not served				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SU COMPLE	
			_		R-(c
		HAL041052	B. WING		1	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELI	W STREET ORO, NC 2740	10		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
D 306	Continued From page	: 56	D 306			
	water in the SCU on 11/02/21He expected for all residents to be served water at each meal.					
D 344	10A NCAC 13F .1002	(a) Medication Orders	D 344			
	the resident's physicial for verification or clari medications and treat (1) if orders for admission admission or readmission admission or readmissions are not the same	ne shall ensure contact with an or prescribing practitioner fication of orders for ments: sion or readmission of the and signed within 24 hours hission to the facility; ear or complete; or on forms are received upon sion and orders on the ne. re that this verification or				
	interviews the facility of medication orders f	as evidenced by: as, record reviews, and failed to ensure clarification for 1 of 5 residents sampled for a pain medication and a				
	The findings are:					
	1. Review of Resident 10/08/21 revealed the tramadol 50mg every					
		1's November 2021 ation record (MAR) revealed: or tramadol 50mg take 1				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING			_
		HAL041052	B. WING		R- 11/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELM				
		GREENSBO	ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page 57		D 344			
	tablet every 8 hours for heel pain with "prn" written beside the entry. -There was no documentation that tramadol 50mg had been administered every 8 hours. Interview with a medication aide (MA) on 11/02/21 at 4:05pm revealed: -She knew Resident #1 had an order for tramadol 50mg but thought it was as needed for painHer family member supplied her medications and had not brought in tramadol and so she had not administered it to the residentThe WC or the nurse were responsible to add orders to the MARs. Interview with Resident #1 on 11/02/21 at 4:15pm revealed:					
	-Her family member fi own pharmacy and br	lled her medications at their ought them to the facility. er family member brought				
		her or how often she was to				
		er taking tramadol 50mg but casionally for a headache				
	Telephone interview v member on 11/02/21 -He filled her medicat pharmacy.	•				
	-He did not bring in th not know she had an prescription for it.	e tramadol 50mg and did order and he did not have a r often she was supposed to				
	· ·					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	I ' '	SURVEY PLETED
			A. BUILDING			
		HAL041052	B. WING			R-C / 05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
	TIEVA IIVIIIO I AIVI	GREENSE	BORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	÷ 58	D 344			
	Continued From page 58 -She added Resident #1's tramadol 50mg every 8 hours as needed to the MARShe did not verify with the provider if the tramadol was scheduled or as needed. Telephone interview with a pharmacist from the facility pharmacy on 11/03/2021 at 12:05pm revealed: -There was a profile on file for Resident #1, but they provide emergency pharmacy services only for herThe FL2 on file dated 10/08/2021 had an order for tramadol 50mg every 8 hours.					
	Resident #1's prmary 11/04/2021 at 8:35am -There was an order f hours. -He expected all med as ordered.	for tramadol 50mg every 8 ications to be administered to the result of missing				
	10:15am revealed: -The Resident Care C processed orders on orders to pharmacy a on the MAR.	coordinator RCC) or WC admission, including faxing and writing medication orders be entered on the MAR and the PCP.				
	10/08/21 revealed the ipratropium bromide a	albuterol 0.5-2.5mg/3ml bulizer every 6 hours for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED	
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N ELF	M STREET			
WORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ξ
D 344	Continued From page	e 59	D 344			
	medication administra-There was an entry falbuterol 0.5-2.5mg/3 nebulizer every 6 hou written beside the entropy of the entrop	ation record(MAR) revealed: for ipratropium bromide ml solution inhale via ars for emphysema with "prn" ary. hentation that ipratropium -2.5mg/3ml solution had avery 6 hours. cation aide (MA) on 11/02/21				
	revealed: -Her family member frown pharmacy and brown pharmacy. -She did not remembrous having breathing preaching preaching preaching preaching pharmacy.	with Resident #1's family at 4:19pm revealed: ions at their family				
	not know she had an prescription for itHe did not know how	ne nebulizer solution and did order and he did not have a orden she was supposed to nide albuterol solution.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING		D.C.
	HAL041052	B. WING		R-C 11/05/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNINGVIEW AT IRVING PARK	3200 N ELM		_	
		ORO, NC 2740		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344 Continued From page	e 60	D 344		
revealed: -She was responsible resident MARsShe added Resident albuterol solution 6 h -She did not verify with nebulizer solution was response interview of facility pharmacy on revealed: -There was a profile of they provided emerging for herThe FL2 on file date for ipratropium broming hours for emphysems. Telephone interview of Resident #1's primary office 11/04/2021 at 8 gradent with the respected all medias orderedShe could not speak scheduled ipratropium every 6 hours. Interview with the Ad 10:15am revealed: -The Resident Care of processed orders on orders to pharmacy as on the MAR.	at #1's ipratropium bromide ours as needed to the MAR. the provider if the secheduled or as needed. With a pharmacist from the 11/03/2021 at 12:05pm In file for Resident #1, but bency pharmacy services only and 10/08/2021 had an order dealbuterol solution every 6 as. With a representative from y care provider's (PCP) 3:35am revealed: for ipratropium bromide bery 6 hours. Silications to be administered at to the result of missing m bromide albuterol solution In the result of missing m bromide albuterol solution ministrator on 11/04/21 at Coordinator(RCC) or WC admission, including faxing and writing medication orders be entered on the MAR and			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			0
		HAL041052	B. WING		R- 11/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELI				
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	: 61	D 358			
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358			
	(a) An adult care hon preparation and admi prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not metal TYPE B VIOLATION Based on observation reviews, the facility farmedications as ordered sampled (Residents at a topical pain medication and thinner (#5); a mild para bronchodilator, a me protein supplement at topical pain medication muscle relaxer, a cho	need prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: as, interviews, and record illed to administer and for 4 of 5 residents at, #2, #4, and #5) related to tion, an antibiotic, an a eye drops (#2); a blood ain reliever, an expectorant, oderate pain reliever, a and a multivitamin (#1); and a an, a pain medication, a				
	The findings are:					
	1. Review of Resident #5's current FL2 dated 03/17/21 revealed diagnoses included paroxysmal atrial fibrillation and dementia with behavioral disturbance.					
	07/02/21 revealed:	5's physician's orders dated o discontinue warfarin (a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (SURVEY PLETED	
			A. BUILDING:			
		HAL041052	B. WING			R-C / 05/2021
NAME OF D				F 7/D 00DF		700/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI LM STREET	E, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		BORO, NC 27408	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
D 358	Continued From page	: 62	D 358			
	clots) 3mg dailyThere was an order t daily on Monday, Tue Thursday and FridayThere was an order t one and a half tablets and Sunday. Review of Resident #	o start warfarin 3mg, take (total 4.5mg) on Saturday 5's August 2021 medication				
	take 1 and a half table Saturday and Sunday date of 06/17/21.	or warfarin 3mg tablets, ets (4.5mg total) every at 5:00pm with an order				
	was administered on documented reason v -There was no docum was administered on					
	take 1 tablet every Mo Wednesday, Thursda an order date of 06/17 -There was no docum administered on the fo	y and Friday at 5:00pm with				
	no documented reaso administered. -There was no docum	on why it was not nentation warfarin 3mg was 6/21 with the reason the				
	09/08/21 revealed:	5's physician order dated o discontinue warfarin Sunday.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			5 11/11/0		R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELI				
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 63	D 358			
	one tablet every Satu continue warfarin 3mg Wednesday, Thursda	g every Monday, Tuesday,				
	revealed: -There was an entry f	for warfarin 3mg tablets, ets (4.5mg total) every				
	Saturday and Sunday	, - , -				
	discontinue date of 09					
	take 1 tablet every Mo Wednesday, Thursda -There was no docum administered on 09/10	y, and Friday at 5:00pm. nentation warfarin 3mg was 0/21, 09/14/21, 09/20/21, or				
	not administered.	mented reason why it was nentation warfarin 3mg was				
	administered on 09/2009/30/21, with the rea					
	order from the pharm					
	-There was an entry f take 1 tablet every Sa 5:00pm, with a start d	or warfarin 5mg tablets, aturday and Sunday at late of 09/08/21.				
		nentation warfarin 5mg was 9/21 with no documented t administered.				
	orders dated 10/06/2 -There was an order take 1 tablet every Sa 5:00pm.	for warfarin 5mg tablets, aturday and Sunday at				
	take 1 tablet every Mo	for warfarin 3mg tablets, onday, Tuesday, y and Friday at 5:00pm.				

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Review of Resident #5's October 2021 MAR

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		D 0	
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
moranic	VIEW AT INVINOT AND	GREENSE	BORO, NC 2740	08	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 64	D 358			
	revealed: -There was an entry fitake 1 tablet every Mowed was an odocument administered on 10/15 reason why it was noted. There was an entry fitake 1 tablet every Satistical tablet every Satistical was administered on documented reason was administered on document administered on 10/05 medication was on or There was document.	for warfarin 3mg tablets, conday, Tuesday, y, and Friday at 5:00pm. Inentation warfarin 3mg was 5:/21 and no documented to administered. For warfarin 5mg tablets, aturday and Sunday at the sentation that warfarin 5mg 10/10/21 with no why it was not administered. Inentation warfarin 5mg was 9:/21 with the reason der from the pharmacy. Itation warfarin 3mg tablet let were both administered.				
	hand on 11/05/21 at 1 -There were warfarin dispensed date of 10/ tablets dispensed wer -There were warfarin dispensed date of 10/ tablets dispensed wer Interview with a medicat 11:40am revealed: -She did not recall a troth have warfarin avar -She always ordered medication supply warthat medication did not recall and the order of the company of the c	3mg tablets with a (26/21, 21 tablets of 22 total re remaining. 5mg tablets with a (10/21, 4 tablets of 8 total re remaining. cation aide (MA) on 11/05/21 time when Resident #5 did (11able in the medication cart. medications when the 1s down to 7-days' worth so ot run out.				

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Sunday.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			
		HAL041052	B. WING			R-C / /05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N E	LM STREET			
MORITING	WIEW AT INVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 65	D 358			
	-She never left blank Resident #5 refused a the MAR with a circle documented the expla MARResident #5 sometim but she could not rem medication refusals. Interview with a pharr contracted pharmacy revealed: -They did not automa facility either needed or a new orderThey dispensed warf Monday through Frida quantity of 22 tabletsThey dispensed warf Monday through Frida quantity of 25 tabletsThey dispensed warf Monday through Frida daily on Saturday and quantity of 35 tabletsThey dispensed warf Monday through Frida daily on Saturday and quantity of 35 tabletsThey dispensed warf Monday through Frida daily on Saturday and quantity of 35 tabletsThey dispensed warf on Saturday and Sun- quantity of 8 tabletsThey dispensed warf on Saturday and Sun- quantity of 8 tablets.	spaces on the MAR; if a medication she initialed around her initials, then anation on the back of the mes did refuse medications member specific dates of macist from the facility's on 11/05/21 at 12:20pm tically refill medications; the to fax them a refill request farin 3mg (take 1 tablet daily ay) on 10/26/21 for a farin 3mg (take 1 tablet daily ay) on 09/30/21 for a farin 3mg (take 1 tablet daily ay and 1 and a half tablets at Sunday) on 08/16/21 for a farin 3mg (take 1 tablet daily ay and 1 and a half tablets at Sunday) on 06/17/21 for a				
	(PCP) on 11/05/21 at -Resident #5's goal in	nt #5's primary care provider 3:30pm revealed: iternational normalized ratio odwork used to check the				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MORNINGVIEW AT IRVING PARK (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) R-C 11/05/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 3200 N ELM STREET GREENSBORO, NC 27408 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED ATTENDATE) COMPLETED ATTENDATE CROSS-REFERENCED TO THE APPROPRIATE DATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 N ELM STREET GREENSBORO, NC 27408 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE		HAL041052		B. WING			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE		,					
	PREFIX (EACH DEF	CIENCY MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPL	ETE
effectiveness of a blood thinner) used to be 2.0-3.0 (the normal range for a person taking a blood thinner due to atrial fibrillation) but since she was admitted to hospice the INR was expected to be subtherapeuticResident #5 had her INR lab drawn once a month and she would adjust the warfarin dose based on the INR resultIt was her expectation that staff requested refills from the pharmacy one week prior to the medication running outShe expected MAs to document if Resident #5 refused her warfarin and then notify herShe had not been notified that Resident #5 had missed doses of her warfarin in the last three monthsThe potential harm to Resident #5 from missing warfarin doses was that her INR could decrease and cause a blood clot in her leg or chest. Interview with the Special Care Unit Coordinator (SCUC) on 11/05/21 at 4-50pm revealed: -She expected staff to reorder medications when they were down to 7 doses or by the "refill by" date on the sticker from the pharmacyIf there was no initial on the MAR it would indicate that the medication had not been administeredIt was their process to notify the PCP if a resident went without/refused a medication for a week or more, and to notify the nurse if there were more than two missed doses. Interview with the Wellness Coordinator (WC) on 11/05/21 at 4-40pm revealed: -She had never known Resident #5 to not have her warfarin available on the medication cartShe felt the blank spaces on the MAR were from the MAR storgetting to document their initials.	effectiveness of 2.0-3.0 (the non blood thinner dushe was admitted expected to be a Resident #5 had month and she based on the IN-lt was her expected Interview with the same and cause a blood Interview with the same administered. It was their processing were more than Interview with the same administered were warfarin available. Interview with the same administered. It was their processing the same and the stick of the same and the stick of the same and	a blood thinner) used to be nal range for a person taking a se to atrial fibrillation) but since d to hospice the INR was subtherapeutic. In the INR lab drawn once a would adjust the warfarin dose R result. It is to a to a trial frequested refills to a to a would adjust the warfarin dose R result. It is to a to a would adjust the warfarin dose R result. It is to a to a would adjust the warfarin dose R result. It is to a to a would adjust the warfarin dose R result. It is to a to a would adjust the warfarin to the ing out. If is to a would adjust the warfarin in the last three warfarin dose wa	effectiveness of a blo 2.0-3.0 (the normal rablood thinner due to a she was admitted to hexpected to be subthered. Resident #5 had her month and she would based on the INR result was her expectation from the pharmacy or medication running of the expected MAs to refused her warfarin a she had not been not missed doses of her warfarin doses was the and cause a blood closs. The potential harm to warfarin doses was the and cause a blood closs. The expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to they were down to 7 of date on the sticker frou of the expected staff to the expected staff to they were down to 7 of date on the sticker frou of the expected staff to the expected sta	D 358			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D MANAGO		R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK		M STREET		
		GREENSE	BORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 67	D 358		
D 330	Interview with the Adr 5:20pm revealed: -He was not aware of her warfarin as ordered the was his expectation medications as ordered administrations or refulf a space on the MA indicate that the medical administered. Based on observation attempted interview, i #5 was not interview attempted interview at 2. Review of Residen 08/29/21 revealed diapain, back pain, urinated of sepsis due to urinate a. Review of Residen orders dated 10/06/20 order for Diclofenaction pain-relief medication. Review of Resident # administration recorded.	Resident #5 not receiving ed. In that MAs would administer ed and would document usals on the MAR. R was left blank it would cation was not In, record review and the was determined Resident able. It #2's current FL2 dated agnoses included chronic ry tract infection, and history ry tract infection (UTI). It #2's signed physician's applied to the skin). It was a determined Resident able. It #2's current FL2 dated agnoses included chronic ry tract infection (UTI). It #2's signed physician's applied to the skin). It was a determined Resident able. It #2's signed physician's applied to the skin).			
	transdermal at 8:00ar 8:00pm.	m, 12:00pm, 4:00pm and			
	a:00pm. -There was documentation Diclofenac was applied 48 out of 124 opportunities. -There was no documented reason why Diclofenac was not applied the remaining 76 opportunities.				
	revealed:	2's September 2021 TAR or Diclofenac sodium 1%			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MORNING	GVIEW AT IRVING PARK		ELM STREET SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	gel, apply 2 grams to transdermal at 8:00a 8:00pm. -There was no docur was applied from 09/ Review of Resident # revealed: -There was an entry gel, apply 2 grams to transdermal at 8:00a 8:00pm. -There was documer applied 1 out of 124 -There was no docur Diclofenac was not a opportunities. Observation of medic #2 revealed there was labeled for Resident remaining. Interview with Resident 10:40am revealed: -She was able to ask treatment when she can she did not know who were scheduled to be scheduled times verse. -The staff did apply as	low back four times a day m, 12:00pm, 4:00pm and mentation that Diclofenac 01/21 to 09.30/21. #2's October 2021 TAR for Diclofenac sodium 1% low back four times a day m, 12:00pm, 4:00pm and station that Diclofenac was opportunities. mented reason why pplied the remaining 123 cations on hand for Resident is 1 tube of Diclofenac gel #2 with half of a tube ent #2 on 11/04/21 at for a medication or meeded to. mat medications she had that a administered or applied at sus as needed.	D 358			
	cream applied but if apply it for her. Interview with Reside (PCP) on 11/05/21 at	vas ordered to help alleviate				

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1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	R-C (05/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 N ELM STREET GREENSBORO, NC 27408	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
She had not been notified that Resident #2 had not been receiving the Diclofenac gel four times daily as ordered. -It was her expectation that staff would document the Diclofenac gel as either administered, or not administered along with the reason why. Interview with a medication aide (MA) on 11/05/21 at 4:20pm revealed: -She could not remember whether she ever applied Diclofenac gel to Resident #2. -She reviewed the TAR and the blank spaces indicated a medication or treatment was not administered. Interview with the Wellness Coordinator (WC) on 11/05/21 at 4:40pm revealed: -The Diclofenac gel should be administered four times daily as scheduled because it was ordered that way. -The MAs were probably administering it as ordered but had forgotten to sign their initials on the TAR afterward. Interview with the Administrator on 11/05/21 at 5:20pm revealed: -The facility had been working to improve their documentation. -If the MA staff did not document each administration, they could not prove the MAs applied the medication as ordered. -It was his expectation that staff document every medication/treatment administered or that the medication was offered and was refused. b. Review of Resident #2's hospital discharge papervork dated 08/29/21 revealed there was an order for Fosfomycin tromethamine (an antibiotic medication use to treat bladder infections) 3	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL041052	B. WING			R-C 1/ 05/2021
	ROVIDER OR SUPPLIER	3200 N E	ADDRESS, CITY, STATE ELM STREET SBORO, NC 27408	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	order for Fosfomycin take 1 packet every 3 Review of Resident # administration record - There was a hand-w 3gm pack, take 3gm eto start 08/31/21. Review of Resident # revealed there was no packet. Review of Resident # 10/13/21 revealed the one-time administration packet. Review of Resident # revealed: -There was a hand-w for Fosfomycin 3gm pounces (oz) water, on -Fosfomycin was doconce on 10/14/21, timentake 3gm every three Observation of Resident # 10/103/21 at 11 no Fosfomycin availal Review of Resident # dated 10/20/21 revealed the side of Resident # dated 10/20/21 revealed th	2's signed physician's revealed there was an tromethamine 3gm packet, days. 2's August 2021 medication (MAR) revealed: ritten entry for Fosfomycin every three days at 8:00am 2's September 2021 MAR entry for Fosfomycin 3gm 2's physician order dated are was an order for a con of Fosfomycin 3gm 2's October 2021 MAR ritten entry dated 10/14/21 acket, mix 3 gm in 8 etime dose. Immented as administered e unspecified. For Fosfomycin 3gm pack, days at 8:00am ent #2's medications on 1:20am revealed there was ole for administration. 2's physician's order sheet led Resident #2's PCP had r for Fosfomycin, dose to be	D 358			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MODNING	VIEW AT IDVING DADE	3200 N ELI	VI STREET		
WORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	2 71	D 358		
	contracted pharmacy revealed: -Fosfomycin had been a hospital physician, the pharmacy received order of Fosfomycin of dispensed. Interview with Reside 12:41pm revealed shows the second of the second order orde	on 10/13/21 and it was on #2 on 11/03/21 at e did not remember taking a			
	days.	iquid or water every three nt #2's PCP on 11/03/21 at			
	was usually prescribed -It was not typical to t	an ongoing medication, it ed for one dose. ake Fosfomycin every three prophylactic (preventative)			
	11/03/21 at 4:45pm re-When a resident was hospital the MA shoul fax any new orders to learn there were new orders clarification, the MA section PCP. It was her responsible discharge paperwork	s discharged from the ld review the paperwork and o the pharmacy.			
	3:00pm revealed:				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1	_		
		HAL041052	B. WING		R-C 11/05/2021	
					11/00/2021	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		M STREET			
	ı	GREENSB	ORO, NC 2740	08		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 72	D 358			
	received, he would expect the WC to notify the nurse or Director of Clinical Services so that the facility could obtain the medication for the resident. c. Review of Resident #2's signed physician's orders dated 10/06/21 revealed there was an order for acetic acid irrigation 0.25% solution (used to help prevent bacteria growth or infection from the urethra to the bladder), use 200 mL to wash perineum area thoroughly once weekly with a start date of 05/10/21.					
	Review of Resident #2's August 2021 MAR revealed: -There was an entry for acetic acid irrigation 0.25% irrigation solution, use 200 mL to wash perineum area thoroughly once weekly. -There were no documented applications from 08/01/21 to 08/31/21.					
	revealed: -There was an entry f 0.25% irrigation soluti perineum area thorou -There were no docur 09/01/21 to 09/30/21.	mented applications from				
	revealed: -There was an entry firrigation solution, use area thoroughly once -There were no docur 10/01/21 to 10/31/21.	for acetic acid 0.25% e 200mL to wash perineum weekly. mented applications from				
		am revealed there was one				

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full container of acetic acid irrigation solution

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
MORNING	VIEW AT IRVING PARK		_M STREET		
		GREENS	BORO, NC 27408	В	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	73	D 358		
	labeled with Resident date of 05/10/21.	#2's name with a dispensed			
	contracted pharmacy revealed: -The last time they dis irrigation solution for I for an order to use on -To obtain refills, staff	Resident #2 was 05/10/21			
	ever offering the acetishe experienced frequivariant (UTI), she would be in Interview with Reside 3:30pm revealed: -The acetic acid irriga as a prophylactic for Use -She would expect state applications or refusariant -There would be no proportion for not having receive with the acetic acid so	e did not remember staff c acid solution, but since uent urinary tract infections nterested in trying it. nt #2's PCP on 11/05/21 at tion solution was prescribed JTIs. aff to document either			
	it would indicate that the administeredShe did not know if Facetic acid perineal in	documentation on the MAR the medication was not desident #2 had received the rigation as she usually shift and it was ordered for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2)			
			A. Boilebino.	A. BOILDING.		
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
MODNING	NUEVA AT IDVINO DADIC	3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408	(
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	2 74	D 358			
	5:20pm revealed: -The facility had been documentationHe was not aware of the ordered acetic aci-lt was his expectation medications and treat-lt was his expectation administrations or refulf the MA did not documedication as ordered	n that MAs would administer timents as ordered. In that MAs would document usals on the MAR. It will be the many timent each administration, the MAs administered the d.				
	d. Review of Resident #2's current FL2 dated 08/29/21 revealed: -There was an order for Dorzolamide-timolol 2%-0.5% eye drops, instill 1 drop into both eyes twice daily (used to lower high pressure in the eye to prevent blindness)There was an order for Lumigan 0.01% eye drops, instill 1 drop into both eyes at bedtime (used to lower high pressure in the eye to prevent blindness).					
	orders dated 10/06/2' -There was an order to 2%-0.5% eye drops, it wice daily, with an order to drops, instill 1 drop in with an order start da	for Dorzolamide-timolol nstill 1 drop into both eyes der start date of 07/01/20. for Lumigan 0.01% eye to both eyes at bedtime,				
	revealed: -There was an entry f	or Dorzolamide-timolol nstill 1 drop into both eyes				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					R-C	
	HAL041052 B. WING		11/05/2021			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IDVING DADIC	3200 N ELI	M STREET			
WORNING	SVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 75	D 358			
D 358	out of 62 opportunitie -There was no docum Dorzolamide-timolol of administered on 08/2: -There was an entry f drops, instill 1 drop in -There was documen out of 31 opportunitie -There was no docum eye drops were not an Review of Resident # revealed: -There was an entry f 2%-0.5% eye drops, if twice daily at 8:00am -There was documen out of 60 opportunitie -There was no docum Dorzolamide-timolol of administered on 09/02 09/21/21There was an entry f drops, instill 1 drop in -There was documen out of 30 opportunitie -There was no docum Lumigan eye drops w 09/02/21, 09/05/21, 0 09/26/21. Review of Resident # revealed: -There was an entry f 2%-0.5% eye drops, in	tation of administration 61 s. hented reason why eye drops were not 3/21. For Lumigan 0.01% eye to both eyes at bedtime. Itation of administration 30 s for the month. Hented reason why Lumigan diministered on 08/24/21. The september 2021 MAR for Dorzolamide-timolol finstill 1 drop into both eyes and 8:00pm. Itation of administration 56 s. Hented reason why eye drops were not 2/21, 09/05/21, 09/06/21, or for Lumigan 0.01% eye to both eyes at bedtime. Itation of administration 25 s. Hented reason why the rere not administered on 9/06/21, 09/21/21, or 2's October 2021 MAR for Dorzolamide-timolol finstill 1 drop into both eyes instill 1 drop into both eyes in the first part of th	D 358			
	twice daily at 8:00am -There was documen out of 62 opportunitie -There was no docum	tation of administration 59 s.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
	HAL041052 B. WING			R-0 11/0	5/ 2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELF	M STREET			
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	-There was an entry f drops, instill 1 drop in -There was document out of 31 opportunities -There was no docum Lumigan eye drops w 10/08/21. Observation of Reside hand on 11/03/21 at 1-There was one bottle 2%-0.5% eye drops laname and a dispense than half of the bottle -There was one full be drops labeled with Redispensed date of 11/1 Interview with Reside	eye drops were not 8/21, 10/16/21 or 10/26/21. For Lumigan 0.01% eye to both eyes at bedtime. Itation of administration 30 s. In the series of Lumigan 0.01% eye are not administered on 11:20am revealed: Italian of Lumigan 0.01% eye esident #2's name and a 10/1/21.				
	she was completely of reordering more, cause she did not know specusive. She was concerned a because her eye doct reason why she shout the shear with a MA of revealed: -She could not rement missing a dose of her "maybe one time." -She always ordered	about missing doses tor told her there was no ld ever miss a dose. In 11/04/21 at 9:15am Inber Resident #2 ever The eye drops more than Index and the edications of days ahead edications did not run out.				

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STATE FORM 8ZWU11 If continuation sheet 77 of 173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	HAL041052	B. WING		R-C 11/05/2021	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
	3200 N ELI	M STREET			
MORNINGVIEW AT IRVING PARK		ORO, NC 2740	08		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 358 Continued From page	e 77	D 358			
-She could only think #2 did not have eye of medication cartShe ordered medicat to a 7-day supply so a left a medication was pharmacy for a refill at the medications were alf a space on the Mathat the medication will have the facility have the facility have the medication refill it would arrive with the delivery, but if it was would be delivered the lateral have the medication revealed: -Resident #2 was predoctored the model of the medication of the phanal have the open angle and the ophthalmost the model.	of one time when Resident drops available in the tions once they were down that they would not run out. In a vailable, she faxed the and then call to follow up if the not received within a day. AR was left blank, it indicated was not administered. Sesentative with the facility on 11/04/21 at 10:06am eye drops were dispensed 14/21, and one bottle was not 30 days. Were dispensed on 11/01/21 are bottle was expected to last attically refill medications; the ad either a refill request or a rmacy to get refills. In the instock, the pharmacy of the pharmacy of another local pharmacy. Was requested prior to noon, at evening's medication requested after noon, it is following day. Cal technician at Resident office on 11/05/21 at 1:32pm escribed the and Lumigan eye drops to	D 358			

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STATE FORM 8ZWU11 If continuation sheet 78 of 173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		HAL041052	B. WING			R-C I/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		ELM STREET			
	I		SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	an increase in the procause vision loss; she vision in her left eye, the vision she had leteral eye pain from the incomplete pain from the Ad 5:20pm revealed: The facility had been documentation. He was not aware on her two eye drops dated and the incomplete pain from the provents of the province pain from the province	essure in her eyes and e already had very limited so the goal was to preserve ft. her eye drops could cause creased pressure. ministrator on 11/05/21 at n working to improve their ff Resident #2 not receiving filly as ordered. In that MAs would administer fed and would document fusals on the MAR. Cument each administration, the MAs administered the fill. In #4's current FL2 dated agnoses included dementia, order, alcohol abuse, d hypertension. In #4's FL2 dated 10/06/21 In order for baclofen 5mg 1 fied to treat muscle spasms). #4's physician's orders dated in order for baclofen 5mg	D 358			
	administration record revealed: -There was an entry twice daily scheduled 9:00am and 9:00pm.	I (MAR) for August 2021 for baclofen 5mg 1 tablet I for administration at				

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STATE FORM 8ZWU11 If continuation sheet 79 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	A. BUILDING:					
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELI	M STREET			
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	2 79	D 358			
	administered for 3 out of 31 opportunities at 9:00pm on 08/13/21, 08/16/21, and 08/20/21There was no documentation on the back of the MAR why baclofen was not administered.					
	2021 revealed: -There was an entry f twice daily scheduled	4's MAR for September or baclofen 5mg 1 tablet for administration at				
	9:00am and 9:00pmThere was no documentation baclofen 5mg was administered for 4 out of 30 opportunities at 9:00am on 09/13/21, 09/14/21, 09/15/21, and 09/29/21 and 7 out of 30 opportunities at 9:00pm					
	on 09/13/21, 09/14/21 09/21/21, 09/23/21, a -There was no docum MAR why baclofen wa	nd 09/26/21. nentation on the back of the				
	revealed:	4's MAR for October 2021 or baclofen 5mg 1 tablet				
	twice daily scheduled 9:00am and 9:00pm.					
	administered for 2 out 9:00pm on 10/08/21 a	t of 31 opportunities at and 10/13/21.				
	-There was no docum MAR why baclofen wa	nentation on the back of the as not administered.				
	revealed:	4's MAR for November 2021				
	twice daily scheduled 9:00am and 9:00pm.	or baclofen 5mg 1 tablet for administration at nentation baclofen 5mg was				
	administered for 2 out	t of 4 opportunities at and 11/04/21 and 2 of 3				

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STATE FORM 8ZWU11 If continuation sheet 80 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
		3200 N EL	M STREET			
MORNING	IVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 80	D 358			
	-There was documen	tation on the back of the				
	MAR baclofen had be					
	Observation of Resid	ent #4's medications on				
		9:20am revealed baclofen				
	was not available for	administration.				
	Interview with a repre	esentative from Resident #4's				
		1 at 8:48am revealed:				
	-Resident #4 had an	order for baclofen 5mg 1				
	tablet daily.					
		sed by the pharmacy on				
		tity of 14 tablets, on 10/25/21				
		ablets, and on 11/03/21 with				
	a quantity of 14 table -Baclofen should hav					
	administered daily as					
	· ·	ests to refill baclofen in				
	September 2021.					
		lly refilled upon request.				
	Interview with Reside revealed:	nt #4 on 11/03/21 at 7:52am				
	-He did not know any	thing about his medications.				
	-He did not know if th	e facility ever ran out of any				
	of his medications.					
		ny current pain, but he had				
	pain in his back occa	sionally.				
		cation aide (MA) on 11/04/21				
	at 9:21am revealed:					
	_	ed medication within 7 days				
	of the medication run	•				
		ordered from the pharmacy				
	before 12:00pm, the i delivered to the facilit					
		ordered from the pharmacy				
		edication would not be				
	delivered to the facilit					
		ny there were blank spaces				

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STATE FORM 8ZWU11 If continuation sheet 81 of 173

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED		
			D MANAGE		R-C	
	HAL041052 B. WING		11/05/2021			
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
	VIEW AT IRVINOT ARR	GREENSE	BORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 81	D 358			
	for administration on l					
	ioi administration on i	Resident #4 S MAR.				
	count on the bubble p -Sometimes Resident but there should have medication was refuse -If there was a blank s that the medication w -She did not specificate being out of baclofen, arrived at work, Resident medication and she corefillsSometimes there we	cations when the medication back was down to 7 tablets. If #4 refused medications, is been documentation the ed. space on the MAR, it meant as not administered. If the second in the second in the ed. If the second in the second in the ed. If the second in the second				
	Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -MAs were expected to reorder medication 7 days in advance of the medication running outThere should not have been a lapse in Resident #4 being administered his medication.					
	-Resident #4 had an or spasmsShe did not know state baclofen to Resident -If Resident #4 misser muscle spasms could -Sometimes Resident insurance covering his sometimes covered the spasms covered the	1/03/21 at 1:23pm revealed: order for baclofen for muscle aff had not administered #4 as ordered twice daily. d doses of baclofen his have increased. #4 had issues with his s medication, but the facility he cost. ent #4's medications to be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		R-C
		HAL041052	B. Wiite		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		3200 N EL	M STREET		
MORNING	SVIEW AT IRVING PARK	GREENSI	3ORO, NC 2740	08	
040.15	STIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
D 358	Continued From page	. 92	D 358		
D 336	Continued From page	8 82	D 336		
	Interview with the Adr	ministrator on 11/04/21 at			
	11:34am revealed:				
		sident #4 missed doses of			
	baclofen.				
		reorder medication prior to			
	the medication running				
		not have gone without any			
	doses of his medication	•			
	doses of fils friedloativ	on.			
	Attempted interviews	with Resident #4's family			
		at 9:09am and at 3:38pm			
	were unsuccessful.	at 3.03am and at 3.30pm			
	were unsuccessiui.				
	h Review of Residen	it #4's FL2 dated 10/06/21			
		n order for gabapentin			
		ee times daily (used to treat			
		ee times daily (used to treat			
	nerve pain).				
	Review of Resident #	4's physician's orders dated			
		order for gabapentin 300mg			
	1 capsule 3 times dai				
	l capsuic o unics dai	ıy.			
	Review of Resident #	4's medication			
		(MAR) for August 2021			
	revealed:	(IVIAIT) IOI August 2021			
		for gabapentin 300mg 1			
	_	scheduled for administration			
	at 8:00am, 2:00pm, a				
		nentation gabapentin was			
		t of 31 opportunities at			
		08/19/21, 08/20/21, and			
	*	opportunities at 2:00pm			
		08/18/21, 08/19/21, 08/20/21,			
		out of 31 opportunities at			
		08/16/21, 08/18/21, and			
	08/19/21.				
		tation on the back of the			
	MAR medication not a	available.			

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STATE FORM 8ZWU11 If continuation sheet 83 of 173

		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A.		A. BUILDING:		COMPLETED		
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELM				
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 83	D 358			
	Review of Resident # 2021 revealed: -There was an entry f capsule 3 times daily at 8:00am, 2:00pm, a -There was no docum administered for 2 ou 2:00pm on 09/06/21 a opportunities at 8:00p 09/23/21, 09/26/21, a -There was no docum MAR why gabapentin Review of Resident # revealed: -There was an entry f capsule 3 times daily at 8:00am, 2:00pm, a -There was no docum administered for 2 ou 2:00pm on 10/04/21 a opportunities at 8:00p and 10/13/21There was no docum MAR why gabapentin Observation of Residhand on 11/04/21 at 9 -There was a bubble capsule three times of administrationGabapentin 300mg with pharmacy on 10/22/2 tablets (3 bubble pace)	4's MAR for September for gabapentin 300mg 1 scheduled for administration and 8:00pm. hentation gabapentin was at of 30 opportunities at and 09/20/21 and 5 out of 30 om on 09/19/21, 09/21/21, and 09/29/21. hentation on the back of the awas not administered. 4's MAR for October 2021 for gabapentin 300mg 1 scheduled for administration and 8:00pm. hentation gabapentin was at of 31 opportunities at and 10/14/21 and 3 out of 31 om on 10/04/21, 10/08/21, hentation on the back of the awas not administered. ent #4's medications on 0:20am revealed: pack of gabapentin 300mg 1 aily available for				
	pharmacy on 11/05/2	sentative from Resident #4's 1 at 8:48am revealed: order for gabapentin 300mg				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MODNING	VIEW AT IDVING DADK	3200 N EL	M STREET		
WORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 358	58 Continued From page 84		D 358		
D 358	1 capsule 3 times dail-Gabapentin was disp 08/20/21 with a quant 10/22/21 with a quant -Gabapentin should hadministered 3 times -There were no requeseptember 2021Medications were on Interview with Reside revealed: -He did not know any -He did not know if the of his medicationsHe was not having a pain in his back on or Interview with a MA or revealed: -She usually reordered of the medication runder -If a medication was obefore 12:00pm, the redelivered to the facility -If a medication was dafter 12:00pm, the medication was of after 12:00pm, the medication was of a medication was of the medication was obefore 12:00pm, the medicatio	ly. Densed by the pharmacy on city of 90 capsules and on city of 90 tablets. Lave lasted 30 days if daily as ordered. Dests to refill gabapentin in clyrefilled upon request. Int #4 on 11/03/21 at 7:52am Ithing about his medications. De facility ever ran out of any current pain, but he had coasion. In 11/04/21 at 9:21am Ind medication within 7 days ning out. Dedered from the pharmacy medication would be yon third shift. Dedered from the pharmacy medication would not be yountil the next day. Dedered from the pharmacy medication would not be yountil the next day. Destruction of initials on the lation was not administered. Ind MA on 11/04/21 at cations when the medication was down to 7 tablets. Destruction of tablet	D 358		
	count on the bubble p -Sometimes Resident	eack was down to 7 tablets. #4 refused medications, be been documentation the			

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STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	SI GORREGHOW	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		HAL041052	B. WING		R- 11/0	C 5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELN				
			ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	2 85	D 358			
	-If there was a blank sethat the medication weshed did not specifical being out of gabapent arrived at work, Residemedication and she corefillsSometimes there weshed did not a west of the medication and she corefillsSometimes there weshed did not the second former facility nurse west of the medication advance of the medication advance of the medication to Reside 1:23pm revealed: -Resident #4 had an of the nerve painShe did not know state gabapentin to Reside dailyIf Resident #4 missed nerve pain could have she expected Reside administered as order literative with the Adrit:34am revealed: -He did not know ResigabapentinHe expected staff to the medication running the state of the medication running the state of	space on the MAR, it meant as not administered. Illy remember Resident #4 tin, but sometimes when she lent #4 was out of alled the pharmacy for re issues with billing for tions and she would let the now. UC on 11/04/21 at 12:47pm to reorder medication 7 days dication running out. It is been a lapse in Resident in this medication. Int #4's PCP on 11/03/21 at it is produced for gabapentin for fifthad not administered in the action of gabapentin his increased. It is increased. It is medications to be red. Int #4's medications to be red. Int #4's medication prior to gout. Interest on the gone without any interest in t				

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Attempted interviews with Resident #4's family

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
			B. WING		R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N E	LM STREET		
WIORNING	IVIEW AT IRVING PARK	GREENS	SBORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	÷ 86	D 358		
	member on 11/05/21 were unsuccessful.	at 9:09am and at 3:38pm			
	revealed there was ar	t #4's FL2 dated 10/06/21 n order for biofreeze 4% gel (used on the skin to treat			
		4's physician's orders dated order for biofreeze 4% gel			
	revealed:	4's MAR for August 2021			
	four times daily sched 8:00am, 1:00pm, 6:00	or biofreeze 4% gel apply luled for administration at lpm, and 10:00pm. lentation biofreeze was			
	administered for 1 out 8:00am on 08/18/21,	t of 31 opportunities at 2 out of 31 opportunities at			
	opportunities at 6:00p	and 08/17/21, 10 out of 31 m on 08/11/21, 08/12/21, 8/18/21, 08/19/21, 08/20/21,			
		nd 08/25/21, and 3 out of 31 pm on 08/13/21, 08/20/21,			
	-There was no docum MAR why biofreeze w	entation on the back of the as not administered.			
	2021 revealed:	4's MAR for September			
	four times daily sched 8:00am, 1:00pm, 6:00 -There was no docum	entation biofreeze was			
	1:00pm on 09/06/21,	t of 30 opportunities at 09/20/21, and 09/29/21, 3 s at 6:00pm on 09/06/21, 21, and 2 out of 30			
	opportunities at 10:00	pm on 09/19/21, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 1244	or Contraction	ibertii io, tiioit itombetti	A. BUILDING: _		J COMIT EL	
		HAL041052	B. WING	B. WING		C 5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N ELI	M STREET			
WIORNING	IVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	. 87	D 358			
	09/21/21. -There was no docum	nentation on the back of the				
	MAR why biofreeze w	as not administered.				
	Review of Resident # revealed:	4's MAR for October 2021				
	-There was an entry f	or biofreeze 4% gel apply				
	four times daily sched 8:00am, 1:00pm, 6:00	luled for administration at				
	•	nentation biofreeze was				
		t of 31 opportunities at				
		10/14/21, 10/18/21, and opportunities at 6:00pm				
		0/14/21, and 10/27/21, and				
	3 out of 31 opportunit	ies at 10:00pm on 10/08/21				
	and 10/15/21.					
	-There was no docum MAR why biofreeze w	nentation on the back of the vas not administered.				
	Observation of Reside	ent #4's medications on				
	-	9:20am revealed a tube of				
	biofreeze was availab	le for administration.				
	Interview with a repre	sentative from Resident #4's				
	pharmacy on 11/05/2					
	apply 4 times daily.	order for biofreeze 4% gel				
		nsed by the pharmacy on				
	04/28/21 with a quant	ity of 89mL and there had				
	been no other dispens					
		nsed on 04/28/21 should ately 15 days depending on				
	the amount used whe					
		er the counter medication				
		by Resident #4's insurance.				
		ly refilled upon request.				
	Interview with Reside	nt #4 on 11/03/21 at 7:52am				

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-He did not know anything about his medications.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL041052	B. WING		R-C 11/05/202	:1
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
MODNING		3200 N E	LM STREET			
WORNING	VIEW AT IRVING PARK	GREENS	BORO, NC 2740	98		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLETE DATE
D 358	Continued From page	88	D 358			
	of his medications. -He was not having a pain in his back occase. Interview with a MA or revealed: -She usually reordered of the medication runder. -If a medication was obefore 12:00pm, the redelivered to the facilities.	n 11/04/21 at 9:21am and medication within 7 days ning out. ordered from the pharmacy medication would be y on third shift. ordered from the pharmacy				
	delivered to the facilit -She did not know wh for administration on -If there was no docu	y there were blank spaces Resident #4's MAR. mentation of initials on the				
	Interview with a second 9:35am revealed: -She reordered medic count on the bubble properties of there should have been medication was refusely there was a blank of the them to the medication well and the medication well arrived at work, Resident work, Resident work arrived at work work medication and she controlled the medication and she contro	cations when the medication back was down to 7 tablets. #4 refused medications, but en documentation the ed. space on the MAR, it meant as not administered. Illy remember Resident #4 e, but sometimes when she dent #4 was out of alled the pharmacy for re issues with billing for tions and she let the former				
	Interview with the SC	UC on 11/04/21 at 12:47pm				

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revealed:

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		СОМ	E SURVEY PLETED
		HAL041052	B. WING			R-C I /05/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MORNIN	GVIEW AT IRVING PARK		LM STREET BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	-MAs were expected in advance of the me -There should not ha #4 being administere Interview with Reside 1:23pm revealed: -Resident #4 had an -She did not know stabiofreeze to Resident dailyIf Resident #4 misses could have increased -She expected Reside administered as order Interview with the Ad 11:34am revealed: -He did not know Resident #4 should doses of his medication running -Resident #4 should doses of his medicat. Attempted interviews member on 11/05/21 were unsuccessful. d. Review of Resident #4 should doses doses for Resident #4 should doses for Resident #4 should doses doses for Resident #4 should doses for	to reorder medication 7 days dication running out. ve been a lapse in Resident dhis medication. ent #4's PCP on 11/03/21 at order for biofreeze for pain. aff had not administered that as ordered four times and doses of biofreeze, he dimuscle or joint pain. The lent #4's medications to be ered. ministrator on 11/04/21 at sident #4 missed doses of reorder medication prior to ang out. The lent was a large of the large	D 358			

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STATE FORM 8ZWU11 If continuation sheet 90 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				, , ,	E SURVEY PLETED	
			A. BUILDING:	A. BUILDING:		
		HAL041052	B. WING		I	R-C I /05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	3200 N E	LM STREET			
MORNING	VIEW AT IIIVING PAIK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	90	D 358			
	-There was an entry f bedtime scheduled for there was no docume administered for 5 our 08/11/21, 08/12/21, 0 08/21/21. -There was no docume MAR why Lipitor was Review of Resident #2021 revealed: -There was an entry for the bedtime scheduled for there was no docume administered for 1 our 09/19/21. -There was no docume MAR why Lipitor was Review of Resident #1 revealed: -There was an entry for the bedtime scheduled for the there was no docume administered for 2 our 10/04/21 and 10/08/2. -There was no docume MAR why Lipitor was Observation of Reside hand on 11/04/21 at 9-Lipitor 40mg 1 tablet administration. -Lipitor was dispense 10/09/21 with a quantitablets were remaining the service was no docume was dispense 10/09/21 with a quantitablets were remaining the service was dispense 10/09/21 with a quantitablets were remaining the service was no docume was dispense 10/09/21 with a quantitablets were remaining the service was dispense 10/09/21 with a quantitablets were remaining the service was no docume was	for Lipitor 40mg 1 tablet at a administration at 8:00pm. Inentation Lipitor was at of 30 opportunities on 8/13/21, 08/20/21, and Inentation on the back of the not administered. 4's MAR for September for Lipitor 40mg 1 tablet at a radministration at 8:00pm. Inentation Lipitor was at of 30 opportunities on the not administered. 4's MAR for October 2021 for Lipitor 40mg 1 tablet at a radministration at 8:00pm. Inentation on the back of the not administered. 4's MAR for October 2021 for Lipitor 40mg 1 tablet at a radministration at 8:00pm. Inentation Lipitor was at of 30 opportunities on 1. Inentation on the back of the not administered. Bent #4's medications on 0:20am revealed: at bedtime was available for did by the pharmacy on tity of 30 tablets and 29 g.				
	pharmacy on 11/05/2	sentative from Resident #4's 1 at 8:48am revealed: order for Lipitor 40mg 1				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		PLETED
			D WING		l l	₹-C
		HAL041052	B. WING		11	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET			
		GREENS	BORO, NC 2740	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 91	D 358			
	tablet at bedtime.	d by the pharmacy on				
		tity of 30 tablets, on 09/15/21				
		tablets, and on 10/09/21 with				
	a quantity of 30 table					
		have lasted for 30 days if				
	administered daily as					
		ily refilled upon request.				
		nt #4 on 11/03/21 at 7:52am				
	revealed:					
	_	thing about his medications.				
		e facility ever ran out of any				
	of his medications.					
	Interview with a MA c	on 11/04/21 at 9:21am				
	revealed:					
	-She usually reordere	ed medication within 7 days				
	of the medication run					
		ordered from the pharmacy				
	before 12:00pm, the					
	delivered to the facilit					
		ordered from the pharmacy edication would not be				
	delivered to the facilit					
		ny there were blank spaces				
	for administration on					
		mentation of initials on the				
	MAR, then the medic	ation was not administered.				
	Intonvious with a case	nd MA on 11/04/21 at				
	9:35am revealed:	nu wa on 11/04/21 at				
		cations when the medication				
		pack was down to 7 tablets.				
		#4 refused medications, but				
		en documentation the				
	medication was refus	ed.				
		space on the MAR, it meant				
	that the medication w					
	-She did not specification	ally remember Resident #4				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL041052	B. WING		11/05/2021
		11/1041032			11/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET		
mortime	VIEW AT INVINOTATIO	GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	92	D 358		
	arrived at work, Resid	ut sometimes when she dent #4 was out of alled the pharmacy for			
	Interview with the SCUC on 11/04/21 at 12:47pm revealed: -MAs were expected to reorder medication 7 days in advance of the medication running out. -There should not have been a lapse in Resident				
	#4 being administered his medication. Interview with Resident #4's PCP on 11/03/21 at 1:23pm revealed: -Resident #4 had an order for Lipitor for cholesterolShe did not know staff had not administered Lipitor to Resident #4 as ordered dailyIf Resident #4 missed doses of Lipitor he could have increased cholesterol levelsShe did not have any current concerns with Resident #4's cholesterol levelsShe expected Resident #4's medications to be administered as ordered.				
	11:34am revealed: -He did not know Res LipitorHe expected staff to the medication runnin -Resident #4 should r doses of his medication Attempted interviews	not have gone without any			
	e. Review of Residen	t #4's FL2 dated 10/06/21			

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revealed there was an order for Seroquel 25mg 1

STATE FORM 8ZWU11 If continuation sheet 93 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3)			
			A. BUILDING:	A. BUILDING:		
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
MODNING	NATIONAL DE DE DE	3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	93	D 358			
	tablet at bedtime with dose of 125mg (used	100mg dose for a total to treat agitation).				
	08/11/21 revealed an	4's physician's orders dated order for Seroquel 25mg 1 100mg for a total dose of				
	revealed: -There was an entry f bedtime with 100mg t 125mg scheduled for -There was no docum administered for 1 ou 08/20/21.	or Seroquel 25mg 1 tablet at tablet for a total dose of administration at 8:00pm. Inentation Seroquel was at of 31 opportunities on the back of the tas not administered.				
	2021 revealed: -There was an entry f bedtime with 100mg t 125mg scheduled for -There was no docum administered for 6 ou 09/04/21, 09/05/21, 0 09/20/21, and 09/25/2 -There was documen	4's MAR for September for Seroquel 25mg 1 tablet at lablet for a total dose of administration at 8:00pm. In the seroquel was to 6 30 opportunities on 9/17/21, 09/18/21, 09/19/21, 21 tation on the back of the not available and on order.				
	revealed: -There was an entry f bedtime with 100mg t 125mg scheduled for -There was no docum administered for 1 ou 10/08/21.	4's MAR for October 2021 for Seroquel 25mg 1 tablet at ablet for a total dose of administration at 8:00pm. hentation Seroquel was tof 30 opportunities on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK		LM STREET	_	
	CLIMMADY CT		BORO, NC 2740		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page 94		D 358		
	MAR why Seroquel w	as not administered.			
	hand on 11/04/21 at 9 -Seroquel 25mg 1 tab for a total dose of 125 administrationSeroquel was dispen 10/31/21 with a quant tablets were remainin Interview with a repre pharmacy on 11/05/2 -Resident #4 had an of tablet at bedtime with dose of 125mgSeroquel was dispen 07/26/21 with a quant 10/31/21 with a quant -Seroquel 25mg table days if administered of -There had been no re 25mg tablets in Augus -Medications were on	seed by the pharmacy on ity of 30 tablets and 23 g. sentative from Resident #4's 1 at 8:48am revealed: order for Seroquel 25mg 1 100mg dose for a total seed by the pharmacy on ity of 30 tablets and on ity of 30 tablets. Its should have lasted for 30 taily as ordered. equests to refill Seroquel st or September 2021. Ity refilled upon request.			
	Seroquel 25mg.	an order to discontinue nt #4 on 11/03/21 at 7:52am			
	revealed: -He did not know any	nt #4 on 11/03/21 at 7:52am thing about his medications. e facility ever ran out of any			
	of the medication runi	d medication within 7 days ning out. ordered from the pharmacy			

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delivered to the facility on third shift.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,
		3200 N ELI	VI STREET		
MORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	95	D 358		
	-If a medication was cafter 12:00pm, the medivered to the facilitished in the faciliti	ordered from the pharmacy edication would not be y until the next day. The property of the pro			
	revealed:	UC on 11/04/21 at 12:47pm			
		reorder medication 7 days			
	in advance of the med -There should not have	dication running out. /e been a lapse in Resident			
	#4 being administered	•			
	1:23pm revealed: -Resident #4 had an oragitationShe did not know sta	off had not administered #4 as ordered daily at			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILDING.			D 0
		HAL041052	B. WING		l	R-C / /05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N E	LM STREET			
WORNING	IVIEW AT IRVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	358 Continued From page 96		D 358			
	-If Resident #4 missed doses of Seroquel he could have an increase in aggressive behaviorsShe expected Resident #4's medications to be administered as ordered.					
	11:34am revealed: -He did not know Res SeroquelHe expected staff to the medication runnin -Resident #4's family medications at timesResident #4 should r doses of his medication Attempted interviews	has not paid for his not have gone without any				
	4. Review of Resident #1's current FL2 dated 10/08/21 revealed diagnoses included generalized weakness, history of falling, unsteadiness of feet and urinary tract infection due to Klebsiella pneumoniae.					
	10/08/21 revealed the	g 1 tablet every 6 hours				
	Review of Resident #1 revealed Resident #1	1's Resident Register was admitted on 10/18/21.				
	revealed: -There was an entry f	(MAR) for October 2021 or acetaminophen 500mg 1 cheduled for administration				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			7 56.25(6.			D 0
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		ELM STREET			
			SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	97	D 358			
	administered (initials 10/18/21 and 10/19/2 blankThere were no reaso of the MAR as to why was not administered Observation of Resident 11/02/21 at 4:00 p	ng documented as not circled) and 2 spaces on 1 for 8:00am which were left ons documented on the back the acetaminophen 500mg				
	at 4:05pm revealed: -MAs were responsib from the pharmacyResident #1's family medications himselfShe had not request acetaminophen 500m because her family medications himself hadmission that he need acetaminophen 500m remember the datesShe last spoke to him he said he would bring to the facilityHe had not yet delives 500mg to the facilityMAs were responsib Coordinator (WC) which the facility or that resimedications.	ng from the pharmacy ember told the MA he edications. im multiple times since her eded to bring in the				
	have acetaminophen	that Resident #1 did not 500mg, but she could not she informed the WC of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	_
		HAL041052	B. WING		R- 11/0	C 5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
MODNING	VIEW AT IDVING DADIC	3200 N ELI	M STREET			
WORNING	SVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 98		D 358			
	care provider (PCP) we PCP that she had mis acetaminophen 500m. She did not know if Footified that she did not 500mg available for a linterview with Reside revealed: Her family member foown pharmacy and bushe was unable to not know if her far acetaminophen 500m. She did not remember 500mg, but needed sheadache.	Resident #1's PCP was ot have acetaminophen idministration. Int #1 on 11/02/21 at 4:15pm illed her medications at their rought them to the facility. ame all her medications and mily member brought in				
	member on 11/02/21 -Resident #1's provid followed her and order the filled her medicate pharmacyHe asked the MAs of medication prescription needed to be filledHe last spoke to a Mand 11/01/21 but was medicationsHe did not bring in account of the medication of the medicatio	er from the previous facility ered her medications. ions at their family T WC to give him the on numbers when they A and the WC on 10/29/21 not asked to bring in any cetaminophen 500mg irin (used to treat fever and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (
	A. BUILDING:			PLETED		
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATI	E, ZIP CODE		
MODNING	N/IEW AT IDVINO DADIC	3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	99	D 358			
D 358	-MAs were responsible the residents missed PCPMAs or herself orders from the pharmacy, be member had chosen apharmacy as her emergency pharmacy as her emergency pharmacy are residentShe knew Resident acetaminophen 500m 10/18/2021She had not requeste from the emergency pfamily member said head noweld acetaminophen 500m	le to report concerns to her medications and notify the ed resident medications ut Resident #1's family to use the contracted ergency pharmacy. If was not administered ag since her admission ed acetaminophen 500mg obarmacy because the e would bring them in. ent #1's family member the 29/21 and gave him a list of for her including ag tablets. If up with the family member in acetaminophen 500mg. With a pharmacist from the entity of the for Resident #1, and covided emergency in her.	D 358			
		for Resident #1 before				
	Resident #1's PCP's orevealed: -He followed her care orders at the previous	with a representative from office on 11/04/21 at 8:35am and wrote medication a facility where Resident #1 admission to the current				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		· ,	E SURVEY PLETED
		HAL041052	B. WING		II	R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MORNING	EVIEW AT IRVING PARK		ELM STREET SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	facility. -The PCP expected a available and adminis -He had not had a fac admission on 10/18/2 -There was no record facility of missed dose 500mg. -He did not know she acetaminophen 500m -The representative of not taking acetamin hours. Telephone interview of not taking acetamin hours. Interview as no FL2 for lorders on file for acetal -If the resident had not mild pain, she could be pain. Interview with the Administration of the pharmacorders on the MAR. -He expected MAs to ordered by the PCP. -MAs were to fax the medications. -MAs were to report to medications were not to residents. -If a family member dimedications from the back-up pharmacy.	all medications to be stered as ordered. See to face visit since her 1. of communication from the es of acetaminophen had not been administered ag since she was admitted. Ould not speak to the result nophen 500mg every 6 with Resident #1's family 1 at 9:05am revealed: Resident #1 or medication	D 358			

Division of Health Service Regulation

STATE FORM 8ZWU11 If continuation sheet 101 of 173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041052	B. WING		R- 11/0	C 5/2021
	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOKINING	IVIEW AT INVING PARK	GREENSB(ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	did not bring in her act in the facility. b. Review of Resident 10/08/21 revealed the ER 600mg 1 tablet 2 to treat cough and cook Review of Resident # revealed Resident #1 Review of Resident # revealed: -There was an entry for tablet 2 times a day so at 8am and 8:00pm. -There were 25 out of 50mg documented as circled) and 2 spaces at 8:00am which were 1-there were no reason of the MAR as to why not administered. Observation of Resident 11/02/21 at 4:00 pm Mucinex ER 50mg table administration. Telephone interview we pharmacy on 11/04/2	nly used the facility's ncy pharmacy needs. ident #1's family member retaminophen to administer at #1's current FL2 dated for ewas an order for Mucinex times a day for cough (used ingestion). 1's Resident Register was admitted on 10/18/21 1's MAR for October 2021 or Mucinex ER 50mg 1 cheduled for administration 27 doses of Mucinex ER ont administered (initials on 10/19/21 and 10/21/21 eleft blank. In the Mucinex ER 50mg was sent #1's medication on hand on revealed there were no olets available for with Resident #1's family 1 at 9:05am revealed: medication orders on file	D 358	DEFICIENCY		
		ot taken Mucinex ER 50mg experience cough and				

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STATE FORM 8ZWU11 If continuation sheet 102 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION			
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COIVI	PLETED
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 102	D 358			
		n 11/02/21 at 4:05pm				
	revealed:					
		le for ordering medication				
	from the pharmacy.					
	medications himself.	member brought in all of her				
		ed Resident #1's Mucinex				
	· ·	cility pharmacy because her				
		ne would bring in her missing				
	medications.					
		-She had reminded him multiple times since her				
		eded to bring in the Mucinex				
		uld not remember the dates.				
	_ ·	n in person on 11/01/21 and g the rest of her missing				
	medications to the fac	-				
		ered the Mucinex ER 50mg				
	to the facility.	· ·				
	-MAs were responsib	le to inform the WC when				
	medications were not	<u> </u>				
	residents had missed	•				
		that Resident #1 did not				
		mg 2 times a day, but she the dates she informed her				
	of the missing medica					
		no her PCP was and had not				
		she had missed doses of				
	Mucinex ER 50mg.					
		Resident #1's PCP was				
		ot have Mucinex ER 50mg 2				
	to administer.					
	Interview with Reside	nt #1 on 11/02/21 at 4:15pm				
	revealed:					
	1	illed her medications at their				
		rought them to the facility.				
		ame all her medications and				
	Mucinex ER 50mg for	mily member brought in				
		per taking Mucinex but did				

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STATE FORM 8ZWU11 If continuation sheet 103 of 173

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R-C
		HAL041052	B. W. C		11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		3200 N E	LM STREET		
MORNING	VIEW AT IRVING PARK	GREENS	BORO, NC 2740	08	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-/
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE DATE
				DEFICIENCY)	
D 358	Continued From page	103	D 358		
	not have any congest				
	-She had never refuse	ed any medication at the			
	facility.				
	•	with Resident #1's family			
	member on 11/02/21	•			
	•	e previous facility followed			
	her and ordered her r				
	-He filled her medicat	ions at their family			
	pharmacy.				
	-He asked the MAs o				
		on numbers when they			
	needed to be filled.				
	-He last spoke to a M				
		1/21 but was not asked to			
	bring in any medication				
		ome but did not bring it			
	because she did not h	have a cough.			
	Intorvious with the MC	C on 11/02/21 at 4:45pm			
	revealed:	2 OII 11/02/21 at 4.43piii			
	-MAs were responsib	le to report to her			
	· · · · · · · · · · · · · · · · · · ·	missed medications and			
	notify the PCP.	missed medications and			
	•	ed resident medications			
		nacy but Resident #1's			
	• •	hosen to use the facility's			
	contracted pharmacy	_			
	pharmacy.	3 - <i>y</i>			
		rmacy could only fill a 3-day			
	supply for a resident.	,			
		#1 was missing Mucinex ER			
	50mg 2 times a day s	<u>~</u>			
	10/18/21.				
	-She had not request	ed Mucinex ER 50mg 2			
	•	emergency pharmacy			
		ember said he would bring			
	them in.	Ŭ			
		ent #1's family member the			

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week of 10/25/21-10/29/21 and gave him a list of

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL041052	B. WING		R-C 11/05/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELN				
		GREENSBO	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE 0	(X5) COMPLETE DATE
D 358	8 Continued From page 104		D 358			
	ER.	for her including Mucinex If up with the family member In Mucinex ER 50mg.				
	facility's contracted pl 12:05pm revealed: -There was a profile of the pharmacy only propharmacy services fo -The FL2 on file dated for acetaminophen 50 -There was no reques	r her. d 10/08/21 included an order				
	Resident #1's PCP's revealed: -He followed her care orders at the previous resided and since her -The PCP expected a available and adminis -He had not had a fact admission on 10/18/2 -There was no record facility of missed dose times a dayHe did not know Resident administered Mucines administered Mucines administered Mucines at taking any of the R 50mg 2 times a day.	stered as ordered. the to face visit since her the to face visit since her the to face visit since her the the to face visit since her the so of Mucinex ER 50mg 2 sident #1 had not been the since she was admitted. the missing doses of Mucinex the missing doses of Mucinex the to face the result had not speak to the result had not speak t				
	pharmacy on 11/04/2 -The was no FL2 for I orders on file for Muc	vith Resident #1's family 1 at 9:05am revealed: Resident #1 or medication inex 50mg. ot taken Mucinex ER 50mg,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			
			A. BOILDING			7.0
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N E	LM STREET			
MORNING	WIEW AT INVING PARK	GREENS	BORO, NC 2740	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
D 358	Continued From page 105		D 358			
	she could have cough	n and congestion.				
	10:15am revealed: -The Resident Care Coprocess orders on adorders to pharmacy a on the MARHe expected MAs to ordered by the provid-MAs were to fax the medicationsMAs were to report to medications were not to residentsIf a family member domedications, the facili medications from the back-up pharmacyResident #1's family own pharmacy and or pharmacy for emerger-He did not know Residents.	pharmacy to refill needed o him, the WC or RCC if in the facility to administer id not bring in needed ity would order and pay for facility's pharmacy or the member chose to use their				
	10/08/21 revealed the Ipratropium bromide a 0.5mg(2.5mg)3ml inh					
	Review of Resident # revealed Resident #1	1's Resident Register was admitted on 10/18/21.				
	revealed:	1's MAR for October 2021 or Ipratropium bromide ng (2.5mg) 3ml via				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		1141 044050	B. WING		R-C	
		HAL041052	3: ******		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		M STREET			
		GREENSB	ORO, NC 2740	08	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
D 358	Continued From page 106		D 358			
D 358	nebulizer every 6 hou needed (prn) hand wr-There was no docum bromide albuterol solunebulizer was adminisopportunities from 10. There were no reaso of the MAR as to why albuterol solution 0.5r administered. Observation of Residon 11/02/21 at 4:00 p Ipratropium bromide a (2.5mg) 3ml vials available.	irs for emphysema with as ritten beside the order. In the the order in t	D 358			
	from the pharmacy.	le for ordering medication member brought in all of her				
	(2.5mg) 3ml from the family member said h medicationsShe had reminded hi admission that he need pratropium bromide at (2.5mg) 3ml, but she datesShe last spoke to him he said he would brim medications to the factureHe had not yet deliver albuterol solution 0.5m facility.	albuterol solution 0.5mg pharmacy because her e would bring in her missing im multiple times since her eded to bring in the albuterol solution 0.5mg could not remember the in in person on 11/01/21 and ig the rest of her missing cility. ered the Ipratropium bromide ing (2.5mg) 3ml to the le to inform the WC when				

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STATE FORM 8ZWU11 If continuation sheet 107 of 173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 ti Boilebiitoi _		R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
MORRING	WIEW AT INVINOTANT	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP	PLETE
D 358	Continued From page	e 107	D 358			
	have Ipratropium brom 0.5mg (2.5mg) 3ml, be the dates she informed medications. -She did not know whoo notified the PCP that ipratropium bromide a (2.5mg) 3ml. -She did not know if Footified that she did not albuterol solution 0.5- Interview with Reside revealed: -Her family member foown pharmacy and be she was unable to not did not know if her far ipratropium bromide a -She did not remember bromide albuterol solution of the shortness of breath of the dates and the shortness of breath of the shortness of the shortn	that Resident #1 did not mide albuterol solution ut she could not remember ad her of the missing to her PCP was and had not she had missed doses of albuterol solution 0.5mg Resident #1's PCP was ot have ipratropium bromide 1.2.5mg/3ml to administer. Int #1 on 11/02/21 at 4:15pm tilled her medications at their rought them to the facility. It is ame all her medications and mily member brought in albuterol solution for her. It is retained to the facility of the solution but did not have				
	member on 11/02/21 -Her provider from the her and ordered her r -He filled her medicat pharmacy.	e previous facility followed nedications. ions at their family				
	needed to be filledHe last spoke to a M	r WC to give him the on numbers when they A and the WC on 10/29/21 onot asked to bring in any				

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-He did not fill ipratropium bromide albuterol

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILBING.		D.C.
HAL041052		B. WING		R-C 11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MODNING	WEW AT IDVINO DADIC	3200 N EL	M STREET		
WORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 108	D 358		
	nebulizer solutions because he did not have a prescription for them and did not know she had an order for them.				
	revealed:	c on 11/02/21 at 4:45pm			
	-MAs were responsib				
	concerning residents' notify the PCP.	missed medications and			
		resident medications from			
		but Resident #1's family			
	member had chosen to emergency pharmacy				
		macy could only fill a 3-day			
	-She knew Resident #	#1 was missing ipratropium -2.5mg/3ml solution since			
	her admission 10/18/2	21.			
		ed ipratropium bromide			
		ml solution the missing emergency pharmacy			
		ember said he would bring			
	-She spoke to Reside week of 10/25/2021-1	ent #1's family member the 0/29/2021 and gave him a			
		tions for her including albuterol 0.5-2.5mg/3ml			
	solutionShe had not followed	l up with the family member			
	to see if he brought in				
	albuterol 0.5-2.5mg/3	ml solution.			
	facility's contracted ph 12:05pm revealed:	vith a pharmacist from the narmacy on 11/03/2021 at on file for Resident #1, but			
	•	nergency pharmacy services			
	-The FI 2 on file dated	1 10/08/2021 had an order			

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for ipratropium bromide albuterol 0.5-2.5mg/3ml

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE SI		
			A. BUILDING: _				
		HAL041052	B. WING		R-0	C 5/ 2021	
NAME OF D			DEGG OITY OTA	TE 710 000E	1 11/0	5/2021	
NAME OF P	ROVIDER OR SUPPLIER	3200 N ELI	RESS, CITY, STA MISTREET	ILE, ZIP CODE			
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE	
D 358	Continued From page	÷ 109	D 358				
	solution every 6 hours -There was no reques albuterol 0.5-2.5mg/3 Resident #1 before 1	s. st to fill ipratropium bromide ml solution every 6 hours for 1/03/21.					
	Resident #1's PCP's revealed: -He followed her care facilityThe PCP expected a available and adminis-He had not had a fac admission on 10/18/2-There was no record facility of missed dose	stered as ordered. Se to face visit since her 1. of communication from the se of ipratropium bromide					
	albuterol 0.5-2.5mg/3ml solution every 6 hoursHe did not know she had not been administered ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours since she was admittedThe representative could not speak to the result of not taking ipratropium bromide albuterol 0.5-2.5mg/3ml solution.						
	pharmacy on 11/04/2 -The was no FL2 or n Ipratropium bromide a 0.5mg(2.5mg)3ml via -If the resident had no	nedication orders on file for albuterol solution Is for Resident #1. ot taken Ipratropium bromide ng(2.5mg)3ml vials she					
	10:15am revealed: -The Resident Care C processed orders on orders to pharmacy a on the MAR.	ninistrator on 11/04/21 at Coordinator(RCC) or WC admission, including faxing nd writing medication orders administer medications as					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELM	/I STREET			
ortituite	VIEW AT IRVINO I ARR	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 110	D 358			
	ordered by the PCPMAs were to fax the medicationsMAs were to report to medications were not to residentsIf a family member d medications, the facili medications from the back-up pharmacyResident #1's family own pharmacy and or pharmacy for emerge-He did not know Residing in her ipp solution to administer d. Review of Residen 10/08/21 revealed the tramadol HCL 50mg heel pain (used to tree.	pharmacy to refill needed o him, the WC or RCC if in the facility to administer id not bring in needed ity would order and pay for facility's pharmacy or the member chose to use their nly use the facility's ency pharmacy needs. sident #1's family member ratropium bromide albuterol in the facility. t #1's current FL2 dated ere was an order for 1 tablet every 8 hours for at pain).				
	Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21. Review of Resident #1's MAR for October 2021 revealed: -There was an entry for tramadol HCL 50mg 1 tablet every 8 hours for (L) heel pain (used to treat pain) with "prn" hand written beside the order. -There was no documentation tramadol HCL 50mg was administered for 40 of 40 opportunities from 10/18/21 to 10/31/21. -There were no reasons documented on the back of the MAR as to why the tramadol 50mg was not administered.					
	-	ent #1's medication on hand m revealed there were no				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
HAL041052		B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET		
		GREENSE	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 111	D 358		
	tramadol HCL 50mg administration.	tablets available for			
	Interview with a MA o revealed:	n 11/02/21 at 4:05pm			
		le for ordering medication			
	-Resident #1's family	member brought in all of her			
	medications himself. -She had not request	ed Resident #1's tramadol			
		acility pharmacy because			
	her family member sa	•			
	Resident #1's missing				
		im multiple times since her eded to bring in the tramadol			
		ould not remember the			
	dates.				
	-She last spoke to him	n in person 11/01/21 and he			
	said he would bring the medications to the factors	cility.			
	to the facility.	ered the tramadol HCL 50mg			
	 -MAs were responsib medications were not 	le to inform the WC when in the facility or that			
	residents had missed	<u> </u>			
		that Resident #1 did not			
	remember the dates	0mg , but she could not she informed her of the			
	missing medicationsShe did not know wh	o her PCP was and had not			
		she had missed doses of			
	tramadol HCL 50mg.				
		Resident #1's PCP was			
	notified that she did n 50mg available for ad	ot have tramadol HCL Iministration.			
	Interview with Reside revealed:	nt #1 on 11/02/21 at 4:15pm			
		illed her medications at their rought them to the facility.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
			D WING		R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING	VIEW AT IDVING DADE	3200 N ELI	M STREET			
WORNING	SVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	÷ 112	D 358			
	-She was unable to n did not know if her far tramadol for herShe did not rememble heel pain but did not in pain.	ame all her medications and mily member brought in er taking tramadol 50mg for need medication for heel ed any medication at the				
	Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her PCP from the previous facility followed her and ordered her medicationsHe filled her medications at their family pharmacyHe asked the MAs or WC to give him the medication prescription numbers when they needed to be filledHe last spoke to a MA and the WC on 10/29/21 and 11/01/21 but was not asked to bring in any medicationsHe did not bring in tramadol 50mg because he					
	did not know she had an order for it. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerning residents' missed medications and notify the PCP. -MAs or herself order resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew she was missing tramadol 50mg since her admission on 10/18/21. -She had not requested tramadol 50mg from the emergency pharmacy because the family					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041052		(X2) MULTIPLE CO			E SURVEY PLETED	
		B. WING		I	R-C I/ 05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		ELM STREET			
		GREENS	SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 113	D 358			
	week of 10/25/21-10/ needed medications to 50mg.	ent #1's family member the 29/21 and gave him a list of for her including tramadol d up with the family member in her tramadol 50mg.				
	Telephone interview v facility pharmacy on revealed:	with a pharmacist from the 11/03/21 at 12:05pm				
	-There was a profile on file for Resident #1, but the pharmacy only provided emergency pharmacy services for herThe FL2 on file dated 10/08/21 had an order tramadol 50mg take 1 every 8 hours.					
	-There was no reques	st to fill tramadol 50mg take esident #1 before 11/03/21.				
		with a representative from office 11/04/21 at 8:35am				
	orders at the previous resided and since her	e and wrote medication s facility where Resident #1 r admission to this facility. lications to be available and				
	-He had not had a fac admission on 10/18/2 -There was no record	ce to face visit since her 2021. I of communication from the				
	facility of missed dose -He did not know that administered tramade admitted.	G				
	-The representative of not taking tramado	ould not speak to the result I 50mg.				
	pharmacy on 11/04/2	with Resident #1's family 1 at 9:05am revealed: r medication orders on file mg for Resident #1.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELI GREENSB	/ISTREET ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page -If the resident had no 50mg she could have pain. Interview with the Adr 10:15am revealed: -The Resident Care O processed orders on orders to pharmacy a on the MARHe expected MAs to ordered by the PCPMAs were to fax the medicationsMAs were to report to medications were not to residentsIf a family member d medications from the back-up pharmacyResident #1's family own pharmacy and or pharmacy for emerge -He did not know Residen 10/08/21 revealed the 30ml 2 times a day to to help with wound he Review of Resident #	e 114 of taken tramadol HCL increased or prolonged ministrator on 11/04/21 at Coordinator (RCC) or WC admission, including faxing and writing medication orders administer medications as pharmacy to refill needed of him, the WC or RCC if in the facility to administer iid not bring in needed ity would order and pay for facility's pharmacy or the member chose to used their analy use the facility's ancy pharmacy needs. iident #1's family member amadol to administer in the t #1's current FL2 dated are was an order for Prostat and in wound healing (used ealing).	D 358	DEFICIENCY)	
	Review of Resident # revealed:	1's MAR for October 2021 for Prostat 30ml 2 times a			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	1 ' '	SURVEY PLETED
			A. BUILDING: _			
		HAL041052	B. WING			R-C / 05/2021
NAME OF R	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIR CODE		103/2021
NAIVIE OF F	ROVIDER OR SUFFLIER		, ,	TE, ZIF GODE		
MORNING	VIEW AT IRVING PARK		M STREET	10		
			BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 115	D 358			
	documented as not a 2 spaces on 10/19/21 which were left blank -There were no reaso	doses of Prostat 30ml dministered (initials circled) and 10/20/21 at 8:00am ons documented on the back the Prostat 30ml was not				
	-	ent #1's medication on hand m revealed there was no e for administration.				
	Interview with a MA on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication from the pharmacyResident #1's family member brought in all of her medications himselfShe had not requested Resident #1's Prostat 30ml 2 times a day from the facility pharmacy because her family member said he would bring in her missing medicationsShe had reminded him multiple times since her admission that he needed to bring in the Prostat 30ml 2 times a day, but she could not remember the datesShe last spoke to him in person 11/01/21 and he said he would bring the rest of her missing medications to the facilityHe had not yet delivered the Prostat 30ml 2 times a day to the facilityMAs were responsible to inform the WC when					
	have Prostat 30ml 2 t not remember the dat missing medication. -She did not know wh					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			_		R-C	
		HAL041052	B. WING		1	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELM				
			ORO, NC 2740		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 116	D 358			
	notified that she did n	Resident #1's PCP was ot have Prostat 30ml				
	notified that she did not have Prostat 30ml available for administration. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facilityShe was unable to name all her medications and was unsure if her family member brought in Prosat for to takeShe did not remember drinking any syrup medication to help her wounds to healShe had never refused any medication at the facilityShe had a wound on her heel that the home health nurse was coming in to treat. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her PCP from the previous facility followed her and ordered her medicationsHe filled her medications at their family pharmacyHe asked the MAs or WC to give him the medication prescription numbers when they needed to be filledHe last spoke to an MA and the WC on 10/29/2021 and 11/01/21 but was not asked to bring in any medicationsHe did not fill Prostat because he did not have a prescription for it and did not know she had an order for it. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerning residents' missed medications and					

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STATE FORM 8ZWU11 If continuation sheet 117 of 173

	LETED	
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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 117 -MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew was missing Prostat 30ml since her admission on 10/18/21. -She had not requested Prostat 30ml from the emergency pharmacy because the family member said he would bring it in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for her. -She had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed:	R-C	
MORNINGVIEW AT IRVING PARK (A4) ID PREFIX TAG (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 117 -MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew was missing Prostat 30ml since her admission on 10/18/21. -She had not requested Prostat 30ml from the emergency pharmacy because the family member said he would bring it in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for her. -She had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed:	05/2021	
CX4 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 117 D 358 D 358 D 358 D 358 Continued From page 117 D 358 D 35		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 117 -MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew was missing Prostat 30ml from the emergency pharmacy because the family member said he would bring it in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for her. -She had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed:		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 117 -MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacyThe emergency pharmacy could only fill a 3-day supply for a residentShe knew was missing Prostat 30ml since her admission on 10/18/21She had not requested Prostat 30ml from the emergency pharmacy because the family member said he would bring it inShe spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for herShe had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed:		
-MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew was missing Prostat 30ml since her admission on 10/18/21. -She had not requested Prostat 30ml from the emergency pharmacy because the family member said he would bring it in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for her. -She had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed:	(X5) COMPLETE DATE	
from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew was missing Prostat 30ml since her admission on 10/18/21. -She had not requested Prostat 30ml from the emergency pharmacy because the family member said he would bring it in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for her. -She had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed:		
the pharmacy only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/2021 had an order Prostat 30ml 2 times a day. -There was no request to fill Prostat 30ml for Resident #1 before 11/03/21. -The facility pharmacy did not provide Prostat, it would have to be requested by a medical equipment provider or a home health provider. Telephone interview with a representative from Resident #1's PCP's office 11/04/21 at 8:35am revealed: -He followed her care since her admission to this facility.		
-The PCP expected all medications to be available and administered as orderedHe had not had a face to face visit since her admission on 10/18/21.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-C	
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK		LM STREET		
		GREENS	BORO, NC 2740	08	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page -There was no record facility of missed dose	of communication from the	D 358		
	-He did not know that administered Prostat she was admitted.	she had not been 30ml 2 times a day since			
	of not taking Prostat 3				
	pharmacy on 11/04/2	vith Resident #1's family 1 at 9:05am revealed: nedication orders on file for			
	Prostat 30ml for Resid				
	-If the resident had no could have delayed w	ot taken Prostat 30ml she round healing.			
	Telephone interview with Resident #1's home health nurse on 11/04/21 at 9:19am revealed: -They provided medication or supplement recommendations for clients with non-healing wounds.				
		el was almost healed and medication or supplement her			
	-If the PCP ordered P would expect it to be a -They did not supply I	rostat for her client, she administered as ordered. Prostat for clients, but it			
		ht at local pharmacies.			
	10:15am revealed:	ninistrator on 11/04/21 at cess orders on admission,			
	medication orders on	s to pharmacy and writing the MAR. administer medications as			
	-MAs were to fax the medications.	pharmacy to refill needed			
		o him, the WC or RCC if in the facility to administer			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		71. BOILDING.		R-0	C	
		HAL041052	B. WING		1	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		LM STREET			
040.45	CHIMMADV CT.		BORO, NC 2740			0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 119	D 358			
D 330	-If a family member dimedications, the facilis medications from the back-up pharmacyResident #1's family own pharmacy and or contracted pharmacy needsHe did not know Resident did not bring in her Prifacility. f. Review of Resident 10/08/21 revealed the multivit-minerals take promote wound healing healing). Review of Resident #1 revealed: -There was an entry fitablet every day to pro-There were 12 out of multivit-minerals docu (initials circled) and 1 was left blankReasons documente 10/21/21 and 10/25/2 multivit-minerals was	id not bring in needed ty would order and pay for facility's pharmacy or the member chose to use their nly used the facility's for emergency pharmacy ident #1's family member rostat to administer in the #1's current FL2 dated ere was an order for 1 tablet every day to ng. (used to help with wound 1's Resident Register was admitted on 10/18/21. 1's MAR for October 2021 or multivit-minerals take 1 comote wound healing. 13 doses of mented as not administered space on 10/19/21 which d on back of the MAR on 1 was "on order" as why not administered. ent #1's medication on hand m revealed there was no				
	Interview with a MA o	n 11/02/21 at 4:05pm				

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revealed:

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DIVISION	n Health Service Negu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
					_	_
	P. WING			R-		
		HAL041052	B. WING		11/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
0. 11			M STREET	,		
MORNING	VIEW AT IRVING PARK			20		
		GREENSE	BORO, NC 2740	J8		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR E	SO DENTI TING INI ONWATION)	TAG	DEFICIENCY)	II/II	5,2
				,		
D 358	Continued From page	e 120	D 358			
	-MAs were responsible	le for ordering medication				
	from the pharmacy.	is is ordering modication				
	-	member brought in all of her				
	medications himself.	member brought in all of fiel				
		ad Pasidant #1's				
	-She had not requeste					
		the pharmacy because her				
	•	e would bring in her missing				
	medications.					
		m multiple times since her				
	admission that he nee	eded to bring in the				
	multivit-minerals table	et, but she could not				
	remember the dates.					
	-She last spoke to him	n in person 11/01/21 and he				
	said he would bring th	ne rest of her missing				
	medications to the fac	cility.				
		ered the multivit-minerals				
	tablet to the facility.					
	_	le to inform the WC when				
	medications were not					
	residents had missed	-				
		that Resident #1 did not				
	have multivit-minerals					
		she informed her of the				
	missing medication.	o her DCD was said had ast				
		o her PCP was and had not				
	_	she had missed doses of				
	multivit-minerals.					
		Resident #1's PCP was				
		ot have multivit-minerals				
	available for administ	ration.				
	Interview with Reside	nt #1 on 11/02/21 at 4:15pm				
	revealed:					
	-Her family member fi	lled all her medications at				
		nd brought them to the				
	facility.	-				
	•	ame all her medications and				
		ily member brought in a				
	multivit mineral tablet					

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-She did not remember taking a vitamin or

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,			A. BUILDING: _		00 22.25	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ITE, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
WORNING	IVIEW AT IRVING PARK	GREENSE	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPLETE	
D 358	Continued From page	e 121	D 358			
	mineral tablet for her					
		ny medication at the facility.				
		her heel that the home				
	health nurse was com	ning in to take care of.				
		=				
		vith Resident #1's family				
	member on 11/02/21					
	and ordered her med	evious facility followed her				
	-He filled her medicat					
	pharmacy.	ions at their family				
	-He asked the MAs o	r WC to give him the				
		on numbers when they				
	needed to be filled.	on name of when they				
	-He last spoke to a M	A and the WC on				
	•	1/21 but was not asked to				
	bring in any medication	ons.				
	-He did not fill multivit	mineral tablet because he				
	did not have a prescri	iption for them and did not				
	know she had an orde	er for it.				
	Interview with the WC revealed:	C on 11/02/21 at 4:45pm				
	-MAs were responsib	le to report to her concerns				
		dications and notify the				
	PCP.					
		ed resident medications				
		nacy but Resident #1's				
	-	hosen to use them as her				
	emergency pharmacy					
		macy could only fill a 3-day				
	supply for a resident.	W4a main ain a marakkada				
		#1 was missing multivit				
		her admission on 10/18/21.				
	emergency pharmacy	ed multivit minerals from the				
	member said he woul					
		ent #1's family member the				
		29/21 and gave him a list of				
		ncluding multivit minerals				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MODNING	\//=\4/ 4T ID\//\0 D4 D/	3200 N EL	M STREET			
MORNING	VIEW AT IRVING PARK	GREENSE	BORO, NC 2740	08		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE	
D 358	Continued From page	e 122	D 358			
	tablet.					
		d up with the family member				
		her multivit minerals tablet.				
	· ·					
		vith a representative from				
	**	office 11/04/21 at 8:35am				
	revealed:					
		since her admission to this				
	facilityThe PCP expected a	all medications to be				
	available and adminis					
		ce to face visit since her				
	admission on 10/18/2					
	-There was no record	of communication from the				
	facility of missed dose	es of multivit minerals.				
	-He did not know that					
		minerals since she was				
	admitted.					
		ould not speak to the result				
	of not taking multivit-r	ninerais.				
	Interview with a MA o	n 11/02/21 at 4:05pm				
	revealed:					
	from the pharmacy.	le for ordering medication				
	-Resident #1's family medications himself.	member brought in all of her				
	-She had not request	ed Resident #1's				
	multivit-minerals table					
		ember said he would bring				
	in her missing medica					
		im multiple times since her				
		eded to bring in the missing				
	medications, but she	could not remember the				
	dates.					
		n in person on 11/01/21 and				
		g the rest of her missing				
	medications to the fac					
	 -He had not yet delive tablets to the facility. 	ered the multivit-minerals				

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STATE FORM 8ZWU11 If continuation sheet 123 of 173

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
					100/2021
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK		M STREET	•	
	Г		ORO, NC 2740	J8	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 123	D 358		
	-MAs were responsib medications were not residents had missed -She notified the WC have some medication remember the dates a missing medicationsShe did not notify Rehad missed medication her PCP wasShe did not know if Footified that she did not medications available. Interview with Reside revealed: -Her family member foown pharmacyShe could not name -She did not remember heel wound to her	le to inform the WC when in the facility or that taking medications. that Resident #1 did not ns, but she could not she informed her of the esident #1's PCP that she ons and did not know who Resident #1's PCP was not have all of her at the facility. Int #1 on 11/02/21 at 4:15pm tilled her medications at their all her medications. er taking a vitamin tablet for			
	facility's contracted pl 12:05pm revealed: -There was a profile of they only provided en for her. -The FL2 on file dated multivit-minerals table	st to fill multivit-minerals for			
	pharmacy on 11/04/2	vith Resident #1's family 1 at 9:05am revealed: nedication orders on file for ets for Resident #1.			

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-If the resident had not taken multivit-minerals

STATE FORM 8ZWU11 If continuation sheet 124 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAI 044052	B. WING		R-C
		HAL041052			11/05/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELI	VISTREET ORO, NC 2740	18	
	CLIMMA DV CT		1		u
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	358 Continued From page 124		D 358		
	she could have vitam	in/mineral deficiencies.			
	health nurse on 11/04 -They provided medic recommendations for woundsResident #1's left he she did not make any recommendations for left the PCP ordered medication to be administration to the expected MAs to ordered by the PCPMAs were to fax the medicationsMAs were to report to medications were not to residentsIf a family member didications from the back-up pharmacyResident #1's family own pharmacy and of pharmacy for emergenent did not know Residin the facility.	el was almost healed and medication or supplement her. nultivit-minerals for Resident she would expect inistered as ordered. ministrator on 11/04/21 at cessed orders on faxing orders to pharmacy norders on the MAR. administer medications as pharmacy to refill needed to him, the WC or RCC if in the facility to administer id not bring in needed ty would order and pay for facility's pharmacy or the member chose to use their nly used the facility's ncy pharmacy needs. sident #1's family member ultivit-minerals to administer			
		_ nsure medications were red for 4 of 5 sampled resident who was not			

Division of Health Service Regulation

STATE FORM 8ZWU11 If continuation sheet 125 of 173

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETI	
					R-C	
		HAL041052	B. WING		1	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		3200 N EL				
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08		
(VA) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 125	D 358			
	administered her eye which could result in i eyes, pain, and vision a blood thinner which in the leg(s) or chest administered an oral a medication which coumuscle relaxer which muscle spasms, a chamedication which could cholesterol levels, and which could result in i behaviors (#4). This finealth, safety, and we constitutes a Type B. The facility provided a accordance with G.S.	drops twice daily as ordered increased pressure in the la loss (#2); multiple doses of could result in a blood clot (#5); a resident who was not and a topical pain ald result in increased pain, a could result in increased olesterol lowering ald result in increased da behavior medication increased aggression and cailure was detrimental to the elfare of the residents which Violation.				
	this violation. CORRECTION DATE VIOLATION SHALL N 20, 2021.	FOR THE TYPE B NOT EXCEED DECEMBER				
D 367	10A NCAC 13F .1004 Administration	I(j) Medication	D 367			
	(j) The resident's mer record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ador treatment; (5) reason or justifications	Medication Administration dication administration e accurate and include the cation or treatment order; ge or quantity of medication ministering the medication tion for the administration of ments as needed (PRN) and				

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STATE FORM 8ZWU11 If continuation sheet 126 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		3200 N EL	M STREET			
MORNING	IVIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE	
				,		
D 367	Continued From page	2 126	D 367			
	documenting the resu	ılting effect on the resident;				
	(6) date and time of a					
	(7) documentation of					
	medications or treatm	ents and the reason for the				
	omission, including re					
		the person administering				
		atment. If initials are used, a				
	•	o those initials is to be				
		ntained with the medication				
	administration record	(MAR).				
	This Rule is not met	as evidenced by:				
		ns, record reviews, and				
	interviews, the facility					
	accuracy of the electr					
	-	ds (MAR) for 3 of 5 sampled				
	residents (#1, #4, and	l #7) regarding a pain				
		#1), documentation of				
		ars (FSBS) (Residents #4				
	*	ntation of blood pressure				
	(BP) readings (Reside	ent #4).				
	The findings are:					
	1 Review of Resident	#1's current FL2 dated				
	10/08/21 revealed:	o barrone i LL datou				
		es of muscle weakness and				
	urinary tract infections					
	_	for acetaminophen 500mg				
	take one every 6 hour	rs.				
	Review of Resident #	±1's November 2021				
		ation record(MAR) revealed:				
		or acetaminophen 500mg				
	take 1 tablet every 6 h					
	•	o document administration				
	-	nd 8:00pm but there was not				
	a fourth space for doo	cumentation every 6 hours,				
	there was no 2:00am	space to document.				

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STATE FORM 8ZWU11 If continuation sheet 127 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MODNING	NUEW AT IDVINO DADIC	3200 N EL	.M STREET			
WORNING	SVIEW AT IRVING PARK	GREENSE	BORO, NC 2740	98		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 127	D 367			
	at 4:05pm revealed: -She knew Resident; acetaminophen 500m -Her family member s and had not brought i had not administered -She circled her initia administer acetamino attention to if it was ti Interview with Reside revealed: -Her family member f own pharmacy and be -She was did not kno brought in acetamino often she was to take -She did not remember	supplied her medications in acetaminophen, so she it to the resident. Its to show that she did not uphen but did not pay med correctly. Int #1 on 11/02/21 at 4:15pm illed her medications at their rought them to the facility. It will her family member phen 500mg for her or how				
	member on 11/02/21 -He filled her medicat pharmacyHe did not bring in the she had aspirin for parameters and the did not know how take acetaminophen structured with the We 11/02/2021 at 4:45pm -She was responsible residents' MARsShe added Resident every 6 hours but miss for documenting administration.	ne acetaminophen because ain. If often she was supposed to 500mg. Illness Coordinator (WC) on a revealed:				

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STATE FORM 8ZWU11 If continuation sheet 128 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041052	B. WING		R-C 11/05/2021
	ROVIDER OR SUPPLIER	3200 N E	DDRESS, CITY, STATE LM STREET BBORO, NC 27408	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	facility's contracted ph 12:05pm revealed: -There was a profile of they provided emerge for herThe FL2 on file dated for acetaminophen 50. Telephone interview was resident #1's primary office 11/04/2021 at 8There was an order fevery 6 hoursHe expected all medias orderedShe could not speak scheduled dose of ace 6 hours. Interview with the Adr 10:15am revealed: -The Resident Care Coprocessed orders on a orders to pharmacy a orders on the MARHe expected orders is ordered by the PCP. 2. Review of Resident 10/13/21 revealed: -Diagnoses included of hypertension and den -There was an order to dailyThere was an order for acting insulin used to	with a pharmacist from the harmacy on 11/03/2021 at an file for Resident #1, but ency pharmacy services only if 10/08/2021 had an order form every 6 hours. with a representative from every 6 care provider's (PCP): 35am revealed: for acetaminophen 500mg every in acetaminophen	D 367		

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STATE FORM 8ZWU11 If continuation sheet 129 of 173

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETE	בט
		HAL041052	B. WING		R-C 11/05 /2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MODNING	WEW AT IDWING DADK	3200 N ELM	I STREET			
WORNING	VIEW AT IRVING PARK	GREENSBO	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page		D 367			
	revealed: -There was an entry to daily at 8:00am and 8There were 1 entry to entries left blank for 8There were no docur omissionsThe FSBS ranged from the remaining of the entry for the entr	eft blank for 8:00am and 15 8:00pm. mented reasons for the om 91 to 189. for humalog insulin inject 6 nd after supper as needed				
	revealed: -There was an entry to daily at 8:00am and 8There were 10 entriedThere were no documomissionsThe FSBS ranged from the remaining and after supper as no greater than 300. Review of Resident # revealed: -There was an entry to the revealed:	es left blank for 8:00pm. mented reasons for the om 77 to 169. for humalog insulin inject 6 nd after supper as needed er than 300 mentation of administration ect 6 units with breakfast eeded for blood sugar E7's October 2021 MAR				
	daily at 8:00am and 8 -There were 17 entrie					

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STATE FORM 8ZWU11 If continuation sheet 130 of 173

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED
			A. BUILDING: _		
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE ZIP CODE	
TVAINE OF T	NOVIDEN ON OUT FIEN		LM STREET		
MORNING	SVIEW AT IRVING PARK		BORO, NC 2740	18	
			DONO, NO 2740		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 367	Continued From page	120	D 367		
D 301	Continued From page	: 130	D 307		
	-The FSBS ranged from	om 91 to 159.			
	-There was an entry f	or humalog insulin inject 6			
	units with breakfast a	nd after supper as needed			
	for blood sugar greate				
		nentation of administration of			
	humalog insulin inject	t 6 units with breakfast and			
		ed for blood sugar greater			
	than 300.	ou ioi biood ougui gioddoi			
	Interview with a medi	cation aide (MA) on 11/04/21			
		at 3:50pm revealed:			
		d the FSBS they recorded			
		l sugar monitoring (BS) log			
	that was with the MAI	0 , ,			
		ed to document their initials			
	1	AR after obtaining the FSBS.			
		#7 had a FSBS order for 2			
		alog insulin if her FSBS was			
	over 300.	g			
		nted the FSBS but had			
		were not documented on the			
	MAR.				
	-Resident #7's FSBS	had not been over 300 for			
	several months.				
	Interview with the Spe	ecial Care Unit Coordinator			
	(SCUC) on 11/04/21	at 1:05pm revealed:			
	-She did not add orde	ers to or audit MARs, the			
	WC and nurse were r	responsible to audit.			
	-She knew Resident	#7 had an order for FSBS 2			
	times a day and huma	alog insulin order for FSBS			
	over 300.	-			
		nt FSBS on the MAR or the			
	FSBS sheet so that in				
	appropriately.	3 ···-··			
	' ' '				
	Interview with the We	ellness Coordinator (WC) on			
	11/04/21 at 4:00pm re	evealed:			
		ome shifts on the SCU.			
	-She added orders to	the MAR and knew			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		· ,	E SURVEY IPLETED
		HAL041052	B. WING			R-C 1/05/2021
	PROVIDER OR SUPPLIER	3200 N E	ADDRESS, CITY, STATE ELM STREET SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Resident #7 had a FS order for FSBS over 3-She did not rememb recentlyShe had not been at like she wanted toMAs should docume FSBS sheet so that so needed for that document and the warm revealed: -The WC and facility audit MAR document and the warm of the FSBS sheet after che administering insulinIf the FSBS was not done and it was not known in the resident should be warm order morning at 6:30 am and blood sugar greater the warm of the w	SBS and Humalog insulin 300. er a FSBS over 300 ble to audit the MARs weekly and FSBS on the MAR or the he could tell if Humalog was mented FSBS. ministrator on 11//21 at 11:30 nurse were responsible to ation. nt and initial the MAR or the ecking a FSBS and documented, then it was not known if and how much mould have. It #4's current FL2 dated type 2 diabetes mellitus. for FSBS check every and notify the physician if than 400 or less than 70. It #4's physician's orders led an order for FSBS g at 6:30 and record. Notify gar greater than 400 or less E4's medication (MAR) for August 2021 For FSBS checks every	D 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			_			С
		HAL041052	B. WING		1	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNINGVIEW AT IRVING PARK			M STREET			
	OLIMAN DV OT		ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 132	D 367			
D 367	than 70. -There were 2 medical documented on the free documentation of FSE 08/16/21 -There were 4 spaces the MAR on 08/18/21 08/21/21. -There were no FSBS back of the MAR. -There was no reason of the MAR why FSBS ranged from 1 Review of Resident # 2021 revealed: -The log was dated from 12 revealed: -There were 3 FSBS were MAR. Review of Resident # 2021 revealed: -There were 3 FSBS were MAR. Review of Resident # 2021 revealed: -There was an entry from from from from from from from from	ation aide (MA) initials ont of the MAR with no BS checks on 08/13/21 and at left blank on the front of , 08/19/21, 08/20/21, and a checks documented on the notation documented on the back schecks were omitted. 19 to 165. 4's FSBS log for August om 08/15/21 through documented on the FSBS duplicate entries from the at left blank on the front ocumentation of FSBS and 09/11/21. It is left blank on the front of services on 08/11/21.	D 367			
	-There was no reasor	n documented on the back S checks were omitted. 17 to 210.				

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Review of Resident #4's MAR for October 2021

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		3200 N EL	M STREET		
MORNING	SVIEW AT IRVING PARK	GREENSE	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 133	D 367		
D 367	revealed: -There was an entry f morning at 6:30am ar physician if blood sugthan 70There was 1 MA initi of the MAR with no dechecksThere were 2 spaces the MAR on 09/07/21 -There were no FSBS back of the MARThere was no reason of the MAR why FSB-FSBS ranged from 1 Interview with a MA or revealed: -Resident #4 had an edailyFSBSs should have MAR and on a FSBS-She did not know whad not been docume on the FSBS logShe did not know if Maccuracy or who review (SCUC) on 11/04/21 and MAR and on a FSBS-She did not know the missing from Resider	for FSBS checks every and record. Notify the par greater than 400 or less all documented on the front ocumentation of FSBS as left blank on the front of and 09/18/21. So checks documented on the and documented on the back of schecks were omitted. To 168. In 11/04/21 at 9:35am order for to check FSBS been documented on the log. By all Resident #4's FSBS ented on the MAR daily and MARs were reviewed for ewed them. Decial Care Unit Coordinator at 12:47pm revealed: cumented FSBS on the log. By ere were FSBS readings	D 367		
	former facility nurse rale. In the past, the MAs	es Coordinator (WC) or eviewed them. on each shift conducted a			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. Boilbillo.			D C
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		3200 N E	LM STREET			
MORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 134	D 367			
	revealed: -She filled in as a MA -She assisted with au	on 11/04/21 at 4:00pm some shifts in the SCU. diting the MAR, but she had t the MARs weekly like she				
	10:13am revealed: -FSBS readings shoulon the MARHe did not know ther missing from Resider -The WC checked the how oftenHe expected for MAs documentation and to completed prior to the b. Review of Residen dated 08/11/21 reveal every day and call the	at #4's MAR. MARs, but he did not know s to check for missing make sure the MARs were e end of their shifts. t #4's physician's orders led an order to check BP				
	Review of Resident # administration record revealed: -There was an entry f Call the physician wit greater than 160 and -There were 26 media documented on the fr documentation of BP 08/04/21 through 08/13/21, 08/15/21 th 08/27/21 through 08/3	or BP checks every day. In blood pressure systolic diastolic greater than 100. Cation aide (MA) initials ont of the MAR with no checks on 08/02/21, 08/21, 08/10/21 through rough 08/25/21, and 31/21 Is left blank on the front of , 08/03/21, 08/09/21,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MODNING	VIEW AT IRVING PARK	3200 N EI	_M STREET		
WORNING	TVIEW AT IKVING PAKK	GREENS	BORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	e 135	D 367		
	-There were no BP ch back of the MAR.	necks documented on the			
	revealed: -The log was dated fr 08/31/21.	documented on the BP log. from 100 to 160 and			
	2021 revealed: -There was an entry f Call the physician wit greater than 160 and -There were 9 MA init front of the MAR with checks on 09/02/21, 0 09/11/21, 09/22/21, a -There were 6 spaces the MAR on 09/14/21 09/24/21, 09/28/21, a -There were 8 BP che back of the MAR.	s left blank on the front of , 09/21/21, 09/23/21, and 09/29/21. ecks documented on the n documented on the back shecks were omitted. from 109 to 140 and			
	revealed: -There was an entry f Call the physician wit greater than 160 and -There were 12 MA ir front of the MAR with	for BP checks every day. The blood pressure systolic diastolic greater than 100. Initials documented on the no documentation of BP on 0/05/21 through 10/07/21,			

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DIVISION	n riedilli Service Negu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE ZIR CODE	
TWANE OF T	NOVIDER OR OUT FIER		, ,	(I, Zii GOBE	
MORNING	VIEW AT IRVING PARK		M STREET	••	
		GREENSE	ORO, NC 2740	J8	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY OR E	SO DENTI TING IN ONWATION)	TAG	DEFICIENCY)	IAIL 5/112
				,	
D 367	Continued From page	e 136	D 367		
	40/00/04 40/40/04 4	0/4/4/04 40/00/04 40/00/04			
		0/14/21, 10/20/21, 10/23/21,			
	10/24/21, and 10/28/2				
		left blank on the front of			
	the MAR on 010/04/2				
	10/12/21, 10/15/21, 1	0/19/21, 10/26/21, 10/29/21,			
	and 10/31/21.				
	-There was 1 MA initia	als circled on the front of the			
	MAR on 10/03/21.				
	-There were 10 BP ch	necks documented on the			
	back of the MAR.				
	-There was no reasor	n documented on the back			
	of the MAR why BP c	hecks were omitted.			
	-Systolic BPs ranged	from 102 to 143 and			
	diastolic BPs ranged t				
	Interview with a MA o	n 11/04/21 at 9:35am			
	revealed:				
	-Resident #4 had an	order for to check BP daily.			
		en documented on the MAR			
	and on a BP log.				
	•	y all Resident #4's BP's had			
		I on the MAR daily and on			
	the BP log.				
	9	MARs were reviewed for			
	accuracy or who revie				
	accuracy of microvic	med alem.			
	Interview with the Sne	ecial Care Unit Coordinator			
	(SCUC) on 11/04/21 a				
		cumented BP on the MAR			
	and on a BP log.	Cameniea Di on the MAR			
	-She did not know the	are were RD readings			
	missing from Residen				
	~	ny of the residents' MARs,			
		ss Coordinator or former			
	facility nurse did.	2 2 3 amater of formor			
	-	on each shift conducted a			
		as not being done now.			
	www. audit, but that w	as not being done now.			
	Interview with the We	liness Coordinator (WC) on			

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11/04/21 at 4:00pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			74. 501251140		R-C
		HAL041052	B. WING		11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELM			
	OLUMBA DV OT		ORO, NC 2740		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 137	D 367		
	-She assisted with au	some shifts in the SCU. diting the MAR, but she had the MARs weekly like she			
	Interview with the Administrator on 11/05/21 at 10:13am revealed: -BP checks should have been documented on the MAR.				
	checks missing from	e MARs, but he did not know			
	documentation and to completed prior to the	make sure the MARs were end of their shifts.			
D 392	10A NCAC 13F .1008	(a) Controlled Substances	D 392		
	(a) An adult care hon retrievable record of or documenting the recedisposition of controller records shall be main	S Controlled Substances ne shall assure a readily controlled substances by cipt, administration and ed substances. These tained with the resident's corder that there can be n.			
	facility failed to ensure that accurately recond administration, and di	and record reviews, the e a readily retrievable record ciled the receipt, sposition of controlled sampled residents (#2) who			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	PLETED
		1141 044050	B. WING		II	R-C
		HAL041052	B. 111110		11	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	3200 N E	LM STREET			
		GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 138	D 392			
	The findings are:					
	Review of Resident # 08/29/21 revealed dia pain, back pain, osted anxiety.	agnoses included chronic				
	orders dated 10/06/2 order for fentanyl 25n	t #2's signed physician's 1 revealed there was an ncg/hr patch (a narcotic pain ace 1 patch onto the skin				
	administration record -There was an entry f apply 1 patch to skin at 8:00pmThere was documen been applied 6 out of 08/05/21 and 08/08/2 completing a prior au #2's insurance compa Resident #2 was in th There was one missin	2's August 2021 medication (MAR) revealed: for fentanyl 25mcg/hr patch, and change every 72 hours tation the fentanyl patch had 10 opportunities except on 1 when the facility was thorization with Resident any, and on 08/26/21 when the Emergency Department. The application on 08/17/21 explanation for why the patch				
	count sheet (CSCS) r on 08/17/21 for 4 pate #2's August 2021 MA -On 08/17/21, a patch removed on the MAR signed out on the CS documented. -On 08/29/21, a patch applied on the MAR b -On 08/30/21, there w	n was documented as but no new patch was CS; there was no reason n was documented as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		3200 N ELI	M STREET		
MORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 139	D 392		
	revealed: -There was an entry fapply 1 patch to skin 8:00pmThere was documen been applied 4 out of 09/02/21, 09/11/21, 0-One application was it on 09/23/21 indicati had documented the administered, but the reason why the patch -There were 5 doses MAR on 09/05/21, 09 and 09/29/21. Review of Resident #	9/14/21. and 09/26/21. initialed with a circle around ng the medication aide (MA)			
		•			
	-On 09/21/21, there we the CSCS but not doo MAR.	vas a patch signed out on cumented as applied on the			
	administered on the N	tch was documented as not MAR, but there was no why. It was also not signed on the CSCS.			
	revealed: -There was an entry f apply 1 patch to skin at 8:00pm.	2's October 2021 MAR for fentanyl 25mcg/hr patch, and change every 72 hours tation the fentanyl patch had			
	been applied 4 out of				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL041052	B. WING			R-C 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
WORMING	VIEW AT IKVING PAKK	GREENSE	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 392	Continued From page	e 140	D 392			
	-Six missed doses we with no explanation for	ere left blank on the MAR or why they were not applied 1, 10/14/21, 10/17/21,				
	pharmacy on 09/24/2 to Resident #2's Octoron 10/01/21, there we the CSCS but not doo MAR. -On 10/02/21, there we applied on the MAR & CSCS. -On 10/08/21, there we the CSCS but not doo MAR. -On 10/30/21, there we consider the CSCS but not doo MAR. -On 10/30/21, there we	2's CSCS received from the 11 for 10 patches compared ober 2021 MARs revealed: vas 1 patch signed out on cumented as applied on the vas 1 patch documented as out not signed out on the vas 1 patch signed out on cumented as applied on the vas 1 patch signed out on cumented as applied on the vas 1 patch signed out on cumented as applied on the cumented as applied on the				
	_	•				
	contracted pharmacy revealed the pharmacy 25mcg/hr patches to -On 09/24/21, a quandispensedOn 08/29/21, a quandispensedOn 08/15/21, a quandispensed.	esentative from the facility's on 11/04/21 at 10:06am by dispensed fentanyl the facility as follows: titly of 10 patches were stitly of 3 patches were stitly of 4 patches were				
	Interview with Reside	ent #2's primary care provider				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041052	B. WING			R-C I/ 05/2021
	ROVIDER OR SUPPLIER	3200 N I	ADDRESS, CITY, STATE ELM STREET SBORO, NC 27408	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	(PCP) on 11/03/21 at -She was aware the falways applied every had been some issue insurance covering the -She did not know Repatches for the month patches for the month -She had last assess prior and Resident #2 complaints of pain at -It was her expectation medications as order medication was not a linterview with the We 11/03/21 at 4:45pm re -Insurance had some delivery of Resident # patches while the star Authorization request -Prior Authorization prompleted 08/02/21 transurance approved it following dates: 07/10 -She also worked in thad fentanyl patches Resident #2She thought the blan from the MAs forgettin not actually applying linterview with Reside revealed: -She used the fentany -She was unsure who of her patchesShe was unsure if her	1:30pm revealed: entanyl patch was not three days becuse there is with Resident #2's ie patches. esident #2 had missed four in of October 2021 and five in of September 2021. ed Resident #2 two weeks is had no increased that time. In that staff administered all ied and documented why a dministered. Illness Coordinator (WC) on evealed: times caused a delay in the is fentanyl 25mcg/hr iff completed Prior is. apperwork was being hrough 08/11/21 and the is on 08/11/21 for the in 08/11/21 for the in on 08/11/22. The role of MA and had never is unavailable to apply for ink spaces on the MAR were ing to document, rather than	D 392			

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SU COMPLE	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		J COWII EE	ILD
		1141 044050	B. WING		R-C	
		HAL041052]		11/05	5/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELI	VISTREET ORO, NC 2740	ne.		
0(0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	N	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 142	D 392			
	a pain medication and	in, she would ask the MA for d they would give it to her. on 11/05/21 at 4:20pm				
	revealed: -Resident #2 had new from her that was not cartShe could not remen #2 did not have fental cart or where Resider fentanyl patchBlank spaces on the medication was not a the blank spaces for I were from the MAs for She worked evening Resident #2 without a linterview with the Adr 5:20pm revealed:	rer requested a medication available on the medication available on the medication where a time where Resident myl patches available in the nt #2 had refused her MAR indicated that a dministered, but she thought Resident #2's fentanyl patch regetting to document. shift and had never seen a fentanyl patch on her.				
	documentation. -If the MA staff did no administration, they capplied the medication of the state of the stat	ould not prove that they				
	Orders dated 10/06/2 order for alprazolam (used to help treat and and an order for alpradaily as needed.	t #2's signed Physician's 1 revealed there was an (a controlled medication (iety) 1mg tablet at bedtime, (azolam 0.25mg tablet twice				
	revealed:	2's August 2021 MAR or alprazolam 1mg tablet,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
		A. BUILDING				
	HAL041052	B. WING		l l	R-C /05/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
MORNINGVIEW AT IRVING PARK		M STREET	••			
		BORO, NC 2740				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
D 392 Continued From page	2 143	D 392				
take 1 tablet once a darbere was an entry fitablet, take 1 tablet two the scheduled alpraza administered 08/10/2 and one day that it do administered (08/27/2 and one day that it do administered alprazalement was an entry fitablet and an entry fitablet once a darbere was an entry fitablet, take 1 tablet two there were five days scheduled alprazolament administered (on 09/09/15/21, and 09/21/2 and 09/26/21 through was documented as madeciation was on or a there were no document and the "as needed" alprazolament was an entry fitablet once and a tablet once and a tablet once and a tablet, take 1 tablet two scheduled alprazolament administered thre 10/19/21 and 10/20/2 10/10/21 stating the made and administered thre 10/19/21 and 10/20/2 10/10/21 stating the made and administered thre 10/19/21 stating the made and 11/19/21 st	lay at bedtime (8:00pm). or alprazolam 0.25mg vice a day as needed. ys without documentation olam 1mg tablet was 1, 08/22/21, and 08/27/21), ocumented as not 21). mented administrations for izolam. 2's September 2021 MAR for alprazolam 1mg tablet, lay at bedtime (8:00pm). or alprazolam 0.25mg vice a day as needed. s without documentation that 1 mg tablet was 102/21, 09/05/21, 09/06/21, 21). 109/30/21 alprazolam 1mg not administered, with 1/26/21 stating the der from the pharmacy. mented administrations for izolam. 2's October 2021 MAR for alprazolam 1mg tablet, lay at bedtime (8:00pm). or alprazolam 0.25mg vice a day as needed. m 1mg was documented as	D 392				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
					R-C	
		HAL041052	B. WING		11/05	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3200 N EL	M STREET			
MORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETE DATE
D 392	Continued From page	e 144	D 392			
	contracted pharmacy -There was a CSCS of alprazolam 1mg table at bedtime with a qua by the facility on 07/1 -There was a CSCS of alprazolam 1mg table at bedtime with a qua by the facility on 08/1 -There was a CSCS of alprazolam 1mg table at bedtime with a qua the facility on 09/18/2 -There was a CSCS of alprazolam 1mg table at bedtime with a qua the facility on 09/18/2 -There was a CSCS of alprazolam 1mg table at bedtime with a qua by the facility on 10/2 -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC alprazolam 0.25mg ta day at as needed with total received by the filter -There were two CSC al	dated 07/18/21 for et, take 1 tablet once a day untity of 30 tablets received 9/21. dated 08/11/21 for et, take 1 tablet once a day untity of 30 tablets received 1/21. dated 09/17/21 for et, take 1 tablet once a day untity of 5 tablets received by et, take 1 tablet once a day untity of 5 tablets received by et, take 1 tablet once a day untity of 30 tablets received by et, take 1 tablet once a day untity of 30 tablets received 0/21. CS dated 08/12/20 for et, take 1 tablet twice a et a quantity of 60 tablets facility on 08/13/20. CS dated 10/13/21 for etblet, take 1 tablet twice a et a quantity of 60 tablets facility on 10/13/21. ES CSCS received from the 1 for 30 tablets compared to 2021 MAR revealed: Iam 1mg was documented the CSCS but not the MAR. Iam 1mg was documented the CSCS two times, at The 8:00am dose was not MAR for the scheduled dose ose.				
	or the "as needed" do -On 08/22/21 alprazo	ose.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL041052	B. WING		R-0	5/ 2021
NAME OF D	ROVIDER OR SUPPLIER			TE 7/D CODE	11/0:	0/2021
		3200 N ELM	RESS, CITY, STA /I STREET	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 145	D 392			
	was written on the CS	SCS and then crossed out.				
	pharmacy on 08/11/2 Resident #2's August revealed: -Scheduled alprazola the CSCS as adminis and 8:00pm for the fo 08/24/21, 08/26/21, 0 09/02/21, and 09/10/2 administrations were MAROn 08/25/21 schedul documented as admin 8:00am instead of the and not documented -Alprazolam 1mg was administered on the 0 MAR for the following 09/06/21, 09/15/21On 09/17/21 alprazolas administered on the 0 market of the control of the c	not documented on the led alprazolam 1mg was nistered on the CSCS at e scheduled time of 8:00pm, on the MAR. documented as CSCS but left blank on the dates: 09/02/21, 09/05/21, lam 1mg was documented e MAR but not the CSCS.				
	pharmacy on 09/18/2 Resident #2's Septem -On 09/21/21 alprazo	2's CSCS received from the 1 for 5 tablets compared to ber 2021 MAR revealed: lam 1mg was documented e CSCS but left blank on				
	•	e to provide the CSCS tes between 09/23/21 and				
	pharmacy on 10/20/2	2's CSCS received from the 1 for 30 tablets compared to r 2021 MAR revealed: blam 1mg tablet was				

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documented as administered on the MAR but not

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		, , ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL041052	B. WING		I	R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MODNING	CVIEW AT IDVING DADK	3200 N E	LM STREET			
WORNING	SVIEW AT IRVING PARK	GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 146	D 392			
	the CSCS.					
	pharmacy on 08/13/2 alprazolam 0.25mg to needed, compared to September and Octol-The only dose of "as 0.25mg that was admand 10/31/21 was on Observation of medic #2's scheduled alpraz-The count on the CS pills available in the nools of the count on the CS pills available in the nools of the count on the CS pills available in the nools of 30 tablets remaining remaining. -Two of the cards were pharmacy on 08/13/2 08/07/21.	take twice a day as Resident #2's August, per 2021 MARs revealed: needed" alprazolam sinistered between 08/01/21 10/14/21 at 8:00pm. ation on hand for Resident colam 1mg tablets revealed: CS matched the quantity of nedication cart. ation on hand for Resident zolam 0.25mg tablets CS matched the quantity of nedication cart. Is of alprazolam 0.25mg I; three were full with 30 out ng and one with 14 tablets Te received from the				
	pharmacy on 11/04/2 -They had dispensed take every night at be following dates: 07/18 for 30 tablets, 09/17/2 10/20/21 for 30 tablet					
	1	1 1mg twice a day at 8:00am				

Division of Health Service Regulation

STATE FORM 8ZWU11 If continuation sheet 147 of 173

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					D 0
			B. WING		R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF T	TO VIDER OR OUT LIER			(i, zii 00b)	
MORNING	VIEW AT IRVING PARK		M STREET		
		GREENSI	BORO, NC 2740	08	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEI IOIENOT)	
D 392	Continued From page	e 147	D 392		
	and 8:00pm.				
	-They had dispensed	"as needed" alprazolam			
	0.25mg tablets on the	following dates: 08/12/20			
	for 60 tablets, and 10	/13/21 for 60 tablets.			
	,				
	Interview with an MA	on 11/04/21 at 1:20pm			
	revealed:				
		SCS sheet for scheduled			
		y night at bedtime that was			
		armacy on 08/11/21 and			
		nistered the 8:00am doses			
	7 out of the total 9 tim				
		y she had administered the			
	alprazolam at 8:00am				
		to twice daily or she had			
	been administering th	e medication "as needed"			
	and documenting on t	the wrong sheet.			
	-Interview with Reside	ent #2's PCP on 11/05/21 at			
	3:30pm revealed:				
	-Resident #2 had bee	n prescribed alprazolam to			
	help with her anxiety	and insomnia.			
	-It was her expectatio	n that staff administer this			
	medication as she ha	d ordered it.			
	-It was her expectatio	n that staff document every			
	time they administer t	•			
	-	rhy this medication was not			
	administered.	Try and medication was not			
		tified that Resident #2 had			
		Img twice daily instead of			
	•	-			
	once daily nine times				
		e facility, she did not look at			
		noticed the 8:00am dose			
	administrations.				
		extra dosages would have			
		lent #2 as a 2mg daily dose			
	would be within the no	ormal dose range for this			
	medication.				
			1		

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Interview with the Administrator on 11/05/21 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK		M STREET ORO, NC 2740	10	
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 148	D 392		
	received alprazolam r August.				
D 465	10A NCAC 13F .1308	8(a) Special Care Unit Staff	D 465		
	(a) Staff shall be pressufficient number to me residents; but at no time one staff person, who training requirements Section, for up to eight second shifts and 1 hadditional resident; and 10 residents on third time for each addition. This Rule is not met a Based on record reviet facility failed to ensure staff were present at a of residents residing in	me shall there be less than a meets the orientation and in Rule .1309 of this not residents on first and our of staff time for each and one staff person for up to shift and .8 hours of staff tal resident. as evidenced by: ews and interviews, the extending the meets to meet the needs on the Special Care Unit tes sampled for 14 days from			
	Division of Health Ser	s 2021 license from the rvice Regulation revealed ed for a Special Care Unit of 30 beds.			
	-	resident census dated ere was a SCU census of 24			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL041052	B. WING			R-C I/ 05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
MORNING	SVIEW AT IRVING PARK		LM STREET			
		GREENS	BORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 465	Continued From page	e 149	D 465			
	residents, which requ shift.	ired 19.2 staff hours on third				
		ual time sheets dated staff hours were provided in i, leaving the shift short 7.2				
	10/23/21 revealed the	resident census dated ere was a SCU census of 24 ired 19.2 staff hours on third				
		ual time sheets dated staff hours were provided in the shift short 7.2				
	10/24/21 revealed: -There was a SCU ce required 24 staff hour -There should have b	resident census dated ensus of 24 residents, which es on second shift. een a total of 48 hours d AL unit on second shift.				
	on second shift, leavi	nours provided in the SCU ng the shift short 8 hours.				
	10/24/21 revealed the	resident census dated ere was a SCU census of 24 ired 19.2 staff hours on third				
	Review of the individu 10/24/21 revealed 12	ual time sheets dated staff hours were provided in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	A. BOLLOIN		A. BUILDING		D 0
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	VIEW AT IRVING PARK	3200 N ELI	WI STREET ORO, NC 2740	18	
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 465	Continued From page	: 150	D 465		
	the SCU on third shift hours.	, leaving the shift short 7.2			
	10/26/21 revealed the	resident census dated Fre was a SCU census of 24 Fred 24 staff hours on first			
		al time sheets dated 5 staff hours were provided ift, leaving the shift short 7.5			
	10/30/21 revealed the	resident census dated ere was a SCU census of 24 ired 19.2 staff hours on third			
		nal time sheets dated staff hours were provided in , leaving the shift short 7.2			
	11/01/21 revealed:	resident census dated nsus of 24 residents, which urs on third shift.			
	-There should have between the SCU and	een a total of 35.2 hours d AL unit on third shift.			
	Review of the individu				
	SCU on third shift, lead hours.	aff hours provided in the aving the shift short 6.95			
		nined how many of 6.75 were worked in the SCU.			
		resident census dated are was a SCU census of 24			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED	
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 465	Continued From page	2 151	D 465			
	residents, which requ shift.	ired 19.2 staff hours on third				
		ual time sheets dated 5 staff hours were provided nift, leaving the shift short				
	care aide (PCA) on 1 -She worked both the Living(AL) units on th -Staff worked short st sometimes, if they ha be 2 PCAs in the faci -She could not remen staffing was short on -She did not feel the t meet the needs of the	ird shift. affed on third shift d call outs there would only lity, 1 in AL and 1 in SCU. nber a specific date that				
	aide (PCA) on 11/05/2 -She usually worked and AL units and wou and third shifts when	with a first shift personal care 21 at 5:05pm revealed: first shift on both the SCU Id sometimes work second needed. y staffed with 2 PCAs and a				
	-The Administrator an (WC) would make cal staff to come in if their the time office staff filight. The WC filled in severand AL, but she was adates.	eral shifts a week on SCU unable to remember the Manager (BOM) filled in				
	Interview with the WC	C on 11/05/21 at 4:00pm				

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STATEMEN [*]	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		HAL041052	B. WING		R- 11/0	C 5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	3200 N ELM	I STREET			
- Inorthine	THE WAT INVINCE TAKE	GREENSBO	ORO, NC 2740	98		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 465	Continued From page	: 152	D 465			
	revealed: -She was responsible -She kept a record of on SCU or AL as MAS occurredShe kept a record on worked and which unit -There were frequent the SCUS would fill in -She worked the floor times when staffing w -She worked every of filled in some shifts du Interview with the Bus (BOM) on 11/05/21 at -The WC was responsible would help do a shiftShe never worked as Attempted telephone MA on 11/05/21 at 5:2 Interview with Adminis 5:39pm revealed: -The WC was responsible worked as RCC and SCUS filled when staffing was not outsThere was no other was staff working on SCU	for the staff schedule. office staff working the floor or PCAs when she knew it changes to when staff it they worked. staff call outs when she and as PCA or MA. as a MA on the SCU at as short. her weekend as well as and uring the week. siness Office Manager 5:35pm revealed: sible for staff scheduling. bath occasionally on first a PCA or MA on third shift. interview with a third shift 19pm was unsuccessful. interview with a second shift 25pm was unsuccessful. strator on 11/05/21 at sible for staff scheduling. ort staffed because the WC, in shifts as MAs and PCAs a covered, or they had call verifiable record of office or AL as MAs or PCAs d late out punches on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING			R-C
		HAL041052	B. WING			/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MODNING	VIEW AT IDVING DADY	3200 N E	ELM STREET			
MORNING	VIEW AT IRVING PARK	GREENS	SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 468	Continued From page	e 153	D 468			
D 468	10A NCAC 13F .1309 Orientation And Train	Special Care Unit Staff	D 468			
	10A NCAC 13F .1309 Orientation And Train	Special Care Unit Staff ing				
	receive at least the fortraining: (1) Prior to establish administrator shall do 20 hours of training s be served for each spoperated. The administration of the statement of the served for each spoperated. The administration of the statement of the served for each spoperated. The administration of the statement of the served for each special care unit shall orientation on the nat residents. (3) Within six month responsible for persowithin the unit shall cospecific to the popular	distrator shall have in place a strator shall have in place a strator				
	Rule .0501 of this Su of orientation required (4) Staff responsible supervision within the 12 hours of continuing	for personal care and unit shall complete at least g education annually, of				
	This Rule is not met Based on interviews a facility failed to ensur A and B) who worked (SCU) had completed	be dementia specific. as evidenced by: and record reviews, the e 2 of 6 sampled staff (Staff in the Special Care Unit d 6 hours of training within oyment had completed 20				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		,	A. BUILDING: _			
		HAL041052	B. WING		R-C 11/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	,	
		3200 N E	LM STREET			
MORNING	VIEW AT IRVING PARK	GREENS	BORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 468	Continued From page	: 154	D 468			
	hours of training withi employment.	n the first six months of				
	The findings are:					
	personnel record reverses and a was hired on a completed 6 hours of training within her firs. There was no document completed 20 hours of first six months of emails and the completed 20 hours of the complete 20 ho	07/07/20. nentation Staff A had special care unit (SCU) t week of employment. nentation Staff A had of SCU training within her ployment. tation for 1 hour on ur on 05/31/2021 SCU care for Staff A. interview with Staff A on				
	Refer to interview with 11-05-21 at 5:39pm.	n the Administrator on				
	personnel record reversity -Staff A was hired on -There was no docume completed 6 hours of training within her firs -There was no docume completed 20 hours of first six months of em -There was document.	02/21/11. nentation Staff B had special care unit (SCU) t week of employment. nentation Staff B had of SCU training within her ployment. tation for 17 hours of care of er's residents and SCU				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		3200 N ELM	A STREET			
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 468	Continued From page	e 155	D 468			
	Attempted telephone 11/05/21 at 5:25pm w	interview with Staff B on as unsuccessful.				
		h the Special Care Unit on 11/05/21 at 4:45pm.				
	Refer to interview with 11-05-21 at 5:39pm.	h the Administrator on				
	(SCUC) on 11-05-21 -She recently took the -She was responsible completed SCU traini residents in the SCU.	e position as the SCUC. to make sure all staff ng before working with ny staff in the SCU had				
	5:39pm revealed: -He could not find the where Staff A and B of 20 hours of SCU train-He did not know if St initial 6 hours and 20 SCU trainingAll staff were require SCU training before whours of SCU training-The SCUC was resp training and ensure the	taff A and B completed the hours within 6 months of d to have the initial 6 hours working in the SCU and 20				
D 611	10A NCAC 13F .1801 Control Program (terr	(b) Infection Prevention & np)	D 611			
	10A NCAC 13F .1801	INFECTION				

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Division of Fleatin Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
			1		1 11/00/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
MODNING	VIEW AT IRVING PARK	3200 N EL	.M STREET			
WORMING	VILW AT INVINO PARK	GREENSI	BORO, NC 2740	08		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	l l	
TAG	REGULATORT OR E	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MATE 57.112	
			+			
D 611	Continued From page	e 156	D 611			
	PREVENTION AND (CONTROL PROGRAM				
	(b) The facility shall a	ssure the following policies				
	and procedures are e	stablished and implemented				
	consistent with					
	the federal CDC publi	ished guidelines, which are				
	hereby incorporated b	by reference including				
	subsequent					
		tions, on infection control				
	that are accessible at					
	https://www.cdc.gov/i					
	addresses the following	•				
	(1) Standard and tran					
	=	n guidance can be found on				
	the CDC					
	website at					
	including:	nfectioncontrol/basics,				
		ie and cough etiquette;				
		aning and disinfection;				
		disinfection of reusable				
	resident medical equi	pment;				
	(D) hand hygiene;					
	(E) accessibility and protective equipment	oroper use of personal (PPE); and				
		sion-based precautions and				
	when each type is ind					
	contact precautions, o	droplet precautions, and				
	airborne precautions;					
		report to the local health				
	department when the	re is a suspected or				
	confirmed					
	reportable communication					
		icable disease outbreak in				
		e .1802 of this Section;				
	` '	en there is suspected or				
		able disease in the facility,				
	_	ated, isolation of infected				
		stopping group activities and				
	communal dining, and	d based on the mode of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		3200 N ELM	I STREET		
MORNING	VIEW AT IRVING PARK	GREENSBO	ORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 611	Continued From page	e 157	D 611		
	by the residents. Source face coverings for res transmission is throug (4) Procedures for so and criteria for restric signs	cource control as tolerated control includes the use of sidents when the mode of gh a respiratory pathogen; reening visitors to the facility ting visitors who exhibit posting signage for visitors			
	regarding screening a (5) Procedures for sc	and restriction procedures; reening facility staff and staff who exhibit signs of			
	(6) Procedures and si staffing issues and er needs of the residents during	trategies for addressing nsuring staffing to meet the g a communicable disease			
	IPCP to be consistent guidance	•			
	on infection control; a (8) a process for update procedures to reflect recommendations by	ating policies and guidelines and the			
	Services	partment, and North of Health and Human oublic health emergency as			
	declared by the Unite	d States and that applies to ublic health emergency			
	interviews, the facility recommendations and the Centers for Disea	ns, record reviews, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL041052	B. WING			/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	3200 N E	LM STREET			
	, , , , , , , , , , , , , , , , , , ,	GREENS	BORO, NC 2740	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 611	Continued From page	e 158	D 611			
	II =	onavirus (COVID-19) to appropriate screening of rsonal protective equipment				
	Review of the CDC g and spread of COVID facilities, updated on -Personnel and visito facemask in the faciliti- -All visitors should be	rs should always wear a				
	recommendations to nursing homes and lo updated on 09/10/21 -Residents should be -Staff should ask resi feverish or have sym	evaluated at least daily. dents to report if they feel				
	11/02/21 between 9:2 -There was a reception front hallwayThere was a separat staff and for healthcat deskThe sign-in books for providers had entries reading, COVID-19 visymptoms of COVID-19 and exposure risk witester the sign-in book for	to document temperature accination, signs and 19 within the past 14 days,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.12510.		R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N EL	M STREET			
MORANIC	VIEW AT IKVINOT AKK	GREENSB	ORO, NC 2740	08	F	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 611	Continued From page	e 159	D 611			
	reading, signs and sy exposure risk. -There was a wall-more thermometer on the wall-more temperature upon entitle visitor log. -Surveyors were not a questions or asked to screening questions. -The receptionist look temperatures as she not document them a labeled to the compensation of the compensation	vall to the right. asked to self-screen for trance and to sign-in using asked any screening document using a ire. ted at each of the surveyors' sat at the desk, but she did nywhere.				
	9:27am revealed: -Visitors were require sign-in book and take wall-mounted thermore -Visitors were not ask asked to document all questions anywhereStaff and healthcare answers to screening in.	ed screening questions or				
	revealed: -The Administrator wadid not sign-in and as exposure in the staffs-The Administrator tol	alked in the facility and he sess for symptoms and sign-in book.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		D 0
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MORNING	SVIEW AT IRVING PARK	3200 N ELM GREENSBO	/I STREET DRO, NC 2740	98	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 611	Continued From page	e 160	D 611		
	revealed: -A visitor entered the visitor log, and self-so onlyStaff did not ask the questionsThe visitor was wear Interview with the visit revealed: -Staff made the visito for temperatureStaff used to ask visit the beginning of the panymoreVisitors were not requestion of the factors were not the factors of the factors were not the factors of the factor	ing a mask. tor on 11/02/21 at 2:23pm r wear a mask and screen itors screening questions at bandemic, but they did not uired to document answers is on the sign-in book. cility on 11/03/21 at 11:57am beened for temperature, or sign-in book and then			
	11:58am revealed: -She visited the facilit -When she visited, sh temperatureFor a while, visitors of temperatures to be ta agoStaff used to ask scr stopped, and she did Interview with anothe 5:19pm revealed:	did not have to take their ff started requiring visitors' ken again about 3 weeks eening questions, but they not remember when. r receptionist on 11/02/21 at d the facility, she made sure			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			_
		HAL041052	B. WING		R- 11/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELM	/ISTREET DRO, NC 2740	18		
	CHMMADY CT		1		\1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 611	Continued From page	e 161	D 611			
D 611	temperature, and they -The visitors only doc the resident whom the visitor's logShe looked to see wh temperatures were, b temperatures anywhe -She sometimes aske she did not go into de Interview with the Adr 8:22am revealed: -He did not screen for of COVID-19 when he 11/02/21 because he facility before entering -The other facility was -All residents except f -All staff were vaccina -Staff and healthcare temperature and docuscreening questions w facilityHe did not know why for signs and symptor COVID-19. b. Review of 5 sample 11/02/21 through 11/0 documentation of dail COVID-19. Review of August, Se medication administra sampled residents fro 11/05/21 revealed the	y signed in on the visitor log. umented the date, time, and ey were visiting in the hat the visitors' ut she did not document the ere. ed screening questions, but stails. ministrator on 11/04/21 at r temperature or symptoms e entered the facility on was screened at another g the facility. s in his car. for 2 were vaccinated. ated. providers took their umented answers to when they came into the r visitors were not screened ms and exposure risk to ed resident records from 05/21 revealed there was no y screening of residents for eptember, and October 2021 ation records (MARs) for 5 em 11/02/21 through ere was no documentation of ecks or daily screening of	D 611			
	Interview with a reside	ent on 11/03/21 at 12:23pm				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MODNING	SVIEW AT IRVING PARK	3200 N EL	M STREET		
WORMING	WIEW AT INVINO PARK	GREENSE	BORO, NC 2740	08	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 611	Continued From page	162	D 611		
		take her temperature daily 0-19 screening questions.			
	3:41pm revealed staff	nd resident on 11/04/21 at did not take her ask her any COVID-19			
	(SCUC) on 11/04/21 a -Staff used to screen about a couple month -Daily screenings stop received their vaccina -There were still 1 or were not vaccinated a visitors in the facilityResidents' vitals, incl taken between the firs month, but temperatu -If a resident had a ru looked clammy, staff	residents for COVID-19 s ago. oped after the residents titions. 2 residents in the SCU who and 1 of those residents had uding temperature, were			
	Interview with a medic at 11:00am revealed: -Personal care aides residents' temperature shifts, but they stoppe	es daily on first and second ed. er why staff stopped taking			
	revealed: -She did not remember temperaturesShe had not been installed.	on 11/05/21 at 11:36am er ever taking residents' structed as to when she ints' temperatures or screen			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
HAL041052 B. WING			R-C 11/05/2021		
NAME OF D			DESC CITY STA	TE 710 CODE	11/03/2021
NAME OF P	ROVIDER OR SUPPLIER	3200 N ELN	RESS, CITY, STA A STDEET	TE, ZIP CODE	
MORNING	SVIEW AT IRVING PARK		ORO, NC 2740	08	
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 611	Continued From page	e 163	D 611		
	revealed: -MA's or PCA's were temperatures daily ar -Staff was told in Aug facility nurse that resi had to be takenShe screened reside observing if they had Interview with the Adr 8:22pm revealed: -The former Resident charge of the infection regarding COVID-19All residents except to	and documenting on a form. ust 2021 by the former dent temperatures no longer ents for COVID-19 by a cough or did not feel well. ministrator on 11/04/21 at a Care Director (RCD) was in an control and prevention for 2 were vaccinated. as a requirement to screen			
	4:45pm and 5:00pm r -There was a visitor s speaking to the recep a mask onThe visitor left the fro	standing at the front desk stionist and she did not have ont desk, went outside to her d and proceeded into the K.			
	revealed: -She did not wear a n she was just dashing dashing back outShe did not screen w temperature when sh-Staff normally reques	•			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL041052	B. WING		l l	R-C 1/05/2021
	ROVIDER OR SUPPLIER	3200 N	ADDRESS, CITY, STATE ELM STREET SBORO, NC 27408	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
D 611	Continued From page	e 164	D 611			
D912	5:02pm revealed: -She asked the visitor sometimes visitors we sometimes they did not ask the vortice have her take here. The visitor had been to take a resident out. She did not think she questions or recheck the visitor had previor. Interview with the Add 10:13am revealed: -He did not realize the without a mask onThe visitor should have G.S. 131D-21(2) Dec. G.S. 131D-21 Declar Every resident shall have a controlled to the controlled to	visitor screening questions temperature. in the facility earlier and left to eat. e needed to ask screening the visitor's temperature if usly been in the facility. ministrator on 11/05/21 at e visitor was in the facility ave had a mask on. laration of Residents' Rights ration of Residents' Rights have the following rights:	D912			
	reviews, the facility fareceived care and se appropriate, and in confederal and stat laws related to personal care.	ns, interviews, and record willed to ensure residents rvices which were adequate, compliance with relevant and rules and regulations are and supervision, tion and adult care home				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL041052	B. WING		11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORNING	VIEW AT IRVING PARK	3200 N ELM				
		GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D912	Continued From page	e 165	D912			
	evaluation requiremen	nts.				
	•					
	The findings are:					
	reviews, the facility fa for 2 of 5 residents sa to a resident who had injuries (#4), a male re- resident (#4 and #5) f together, the male re- touching the female re- resident (#5) visiting a room (#4) without sup	found undressed and in bed sident (#4) inappropriately esident (#5), and the female alone in the male resident's pervision. [Refer to Tag F .0901(b) Personal Care				
	reviews, the facility fa medications as ordere sampled (Residents # a topical pain medicar irrigation solution and thinner (#5); a mild pa a bronchodilator, a me protein supplement at topical pain medication muscle relaxer, a cho medication, and a bel [Refer to Tag D0358 of Medication Administration of the control of th	ed for 4 of 5 residents #1, #2, #4, and #5) related to tion, an antibiotic, an 2 eye drops (#2); a blood ain reliever, an expectorant, oderate pain reliever, a and a multivitamin (#1); and a on, a pain medication, a				
	A and D) who administresidents had complete medication aide trainitiverification and the wexamination. [Refer to	stered medications to ted the 5, 10, or 15-hour ng or employment ritten medication aide				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL041052	B. WING			R-C / 05/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
MORNING	SVIEW AT IRVING PARK	3200 N	ELM STREET			
MORNING	THE THE TANK	GREEN	SBORO, NC 27408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D912	Continued From page	: 166	D912			
	aides; training and co requirements. (Type I					
D934	G.S. 131D-4.5B. (a) A Requirements	ACH Infection Prevention	D934			
	G.S. 131D-4.5B Adult Prevention Requirem	Care Home Infection ents				
	Service Regulation shannual in-service train home medication aide practices for injection during which bleeding glucose monitoring. E successfully complete program shall receive determined by the De	each medication aide who es the in-service training partial credit, in an amount partment, toward the requirements for adult care es established by the				
	reviews, the facility fa mandatory annual sta	ns, interviews, and record iled to ensure the te approved infection of 3 sampled medication				
	The findings are:					
	personnel record reversely -Staff A was hired on -There was no docum	07/07/20. nentation Staff A had ntory annual state approved				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		HAL041052	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
MORNING	VIEW AT IRVING PARK		ELM STREET BORO, NC 2740	0	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D934	Continued From page	2 167	D934		
	Attempted telephone 11/05/21 at 5:19pm w	interview with Staff A on as unsuccessful.			
	Refer to interview with Manager (BOM) on 1				
	Refer interview with that 5:39pm.	he Administrator on 11/05/21			
	personnel record reversely personnel record reversely personnel record r	07/06/21. nentation Staff D had atory annual state approved			
	Attempted telephone 11/05/21 at 5:22pm w	interview with Staff D on vas unsuccessful.			
	Refer to interview with Manager (BOM) on 1	_			
	Refer interview with that 5:39pm.	he Administrator on 11/05/21			
	(BOM) on 11/05/21 at -She could not find th personnel records of mandatory annual state control trainingThe nurse was response.	e documentation in completion of the			
	5:39pm revealed: -He could not find doo	ministrator on 11/05/21 at cumentation in the personnel ad completed the mandatory			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING: _			
					R-C	
HAL041052		B. WING		11/05/2021		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	IE, ZIP CODE		
MORNING	VIEW AT IRVING PARK		.M STREET			
			BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D934	Continued From page	e 168	D934			
	annual state approvedude -He did not know if state annual state control trainingAll MAs were require annual state approvedude -There was a nurse except track of needed	d infection control training. aff had completed the ate approved infection at to have the mandatory d infection control training. mployed until 10/10/21 that training and helped atory annual state approved				
D935	Training and Competer G.S. § 131D-4.5B (b)	•	D935			
	(b) Beginning Octobe home is prohibited from any unsupervised methat individual has premedication aide during an adult care home of the following: (1) A five-hour training Department that incluing all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and	ents. r 1, 2013, an adult care om allowing staff to perform edication aide duties unless eviously worked as a g the previous 24 months in r successfully completed all g program developed by the ides training and instruction of medication s for Disease Control and infection control and, if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
HAL041052		B. WING		R-C 11/05/2021		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1	
NAME OF T	KOVIDEK OK 301 1 EIEK		M STREET	II., ZII GODE		
MORNING	VIEW AT IRVING PARK		ORO, NC 2740	08		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D935	Continued From page	e 169	D935			
D935	individual must have a. An additional 10-ho developed by the Deptraining and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. b. An examination deby the Division of Heactordance with substitute In the Rule is not metally assed on interviews as	completed the following: our training program partment that includes in in all of the following: of medication s of Disease Control and on infection control and, if tion practices and oring or testing in which e potential for bleeding veloped and administered alth Service Regulation in section (c) of this section. as evidenced by: and record reviews, the e 2 of 3 sampled staff (Staff	D935			
	residents had comple medication aide traini verification and the we examination.					
	The findings are:					
	personnel record reversely extended to the control of the control	was on 07/07/20. tation Staff A passed the on aide examination on hentation Staff A completed 10 or 15 hour medication hentation of employment for				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL041052	B. WING		R-C 11/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
MORNING	SVIEW AT IRVING PARK		LM STREET		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	BORO, NC 27408	PROVIDER'S PLAN OF CORRECTI	ON (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D935	Continued From page 170		D935		
	record (MAR) reveale medication for 14 day September 2021 and Attempted telephone 11/05/21 at 5:19pm w Interview with the Bus (BOM) on 11/05/21 at -She was responsible when staff were hired -The previously emploto ensure staff complemedication aide traini -Staff A's documentat state approved 5, 10 center of the previous of the previ	siness Office Manager 5:35pm revealed: to obtain documentation . byed nurse was responsible eted 5, 10 or 15 hour ng. ion of completion of the			
	Refer to interview with 11/05/21 at 5:39pm.	n the Administrator on			
	personnel record reversity -Staff D's date of hire -There was no document the state written media -There was no document completed the state a medication aide traini	was on 07/06/21. nentation Staff D had passed cation aide examination. nentation Staff B had pproved 5, 10 or 15 hour ng. ation of employment as a			
	administered medicat	s MAR revealed Staff D ion on 7 days in August tember 2021 and 9 days in			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
HAL041052		B. WING		R-C 11/05/2021		
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	,	
		3200 N ELF	M STREET			
MORNING	VIEW AT IRVING PARK	GREENSB	ORO, NC 2740	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D935	Interview with the Bus (BOM) on 11/05/21 at -She was responsible when staff were hired -The previously emplot to ensure staff complemedication aide traini -Staff D told her on 17 taken or scheduled thaide examStaff D's 5, 10 or 15 could not be found in Refer to interview with 11/05/21 at 5:39pm. [Refer to Tag 358 10/Medication Administration aide traini -There was a nurse ewas responsible to ke and helped train staff medication aide traini -Completion of trainin training or employment found in Staff A and D-Staff were responsible written medication aide-Staff A and D's medication aide-Staff A an	interview with Staff D on ras unsuccessful. siness Office Manager is 5:35pm revealed: to obtain documentation opyed nurse was responsible eted 5, 10 or 15 hour ng. 1/05/2021 that she had not be state written medication medication aide training the personnel record. In the Administrator on A NCAC 13F .1004(a) ation (Type B Violation)]. In this training the personnel record is a ministrator on 11/05/2021 at medication aide of training for 5, 10 or 15 hour ng. In the medication aide of the medication aide of the medication could not be on the personnel records. It is to schedule their own	D935			
	5, 10, or 15-hour med	nsure the completion of the lication aide training or on for 2 of 3 sampled staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
HAL041052		B. WING			R-C 11/05/2021			
NAME OF P	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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
D935	and the written medic staff prior to administer residents, placing the medication administrate detrimental to the heat residents which constant The facility provided a accordance with G.S. for this violation.	ation aide examination for 1 ering medications to the residents at risk for ation errors. This failure was alth, safety and welfare of itutes a Type B Violation. a plan of protection in 131D-34(2)(b) on 11/04/21	D935					

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