STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with onsite visits March 18, 2021 and March 19, 2021, and a desk review survey March 22, 2021 and March 23, 2021, and a telephone exit on March 23, 2021.	{D 000}		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure personal care was provided for 2 of 5 sampled residents related to one resident who did not receive the personal care he needed to include repositioning in bed and up in his high back reclining wheelchair (#4); and a second resident who did not receive the personal care he needed to include dressing, transferring and other personal care needs (#5). 1. Review of Resident #4's current FL-2 dated 02/22/21 revealed: -Diagnoses included Parkinson's, dementia with behaviors, atrial fibrillation, hypertension, gout, hyperlipidemia, insomnia, and history of urinary tract infection. -He was constantly disoriented. -He was totally dependent with eating, toileting, bathing, dressing, grooming and transferring. -His communication of needs was non-verbal.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 1	D 269		

-There was an order for "Bunny" boots (used to prevent foot drop, heel cord shortening, and pressure sores).

Review of Resident #4's care plan dated 02/20/21 revealed:
-Resident #4 was totally bed bound/wheelchair bound.
-He was total care for all activities of daily living (ADLs).
-He was resistant to care at times.
-He had a pressure wound to both heels which was being treated by hospice.
-He had limited eye-hand coordination.

Observation on 03/18/21 at 11:48am revealed:
-Resident #4 was lying on his back in a hospital bed on a scoop mattress in his room.
-His feet were on a pillow with his legs crossed right over left.
-There were no "Bunny" boots on his feet.
-There were 2 fall mats present on the floor alongside the resident's bed.
-There was a foam wedge pillow (used to relieve pressure on sensitive areas) on the reclining high back wheelchair in his room.

Interview with personal care aide (PCA) on 03/18/21 at 10:14am revealed:
-The staffing was short at times especially on the weekends.
-There were residents (#4) who required a mechanical lift to get them out of bed so if there were only 2 PCAs they had to work together.
-The 2 PCAs and the MA would all feed residents who required to be fed.

Interview with second PCA on 03/18/21 at 11:48am revealed:
-Resident #4 was "not a morning person".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 269	Continued From page 2	D 269		

-The staff would get him out of bed and up in his reclining high back wheelchair after breakfast.
-He was a two person assist.
-He required to be lifted with a mechanical lift.
-The mechanical lift had to be used with two staff members.

Telephone interview with a third PCA on 03/23/21 at 8:09am revealed:
-There was usually only one PCA assigned to each hall on the special care unit (SCU).
-She usually worked on the hall with Resident #4.
-He was not able to help with turning, repositioning and incontinent care.
-He required 2 staff to get him up in his reclining high back wheelchair with the mechanical lift.

Observation on 03/18/21 at 2:00pm revealed:
-Resident #4 was lying on his back in a hospital bed on a scoop mattress in his room.
-His feet were on a pillow with his legs crossed right over left.
-There were no "Bunny" boots on his feet.
-There were 2 fall mats present on the floor alongside the resident's bed.
-There was a foam wedge pillow on the reclining high back wheelchair in his room..

Observation of Resident #4 on 03/19/21 at 9:31am revealed:
-Resident #4 was lying on his back in a hospital bed on a scoop mattress in his room.
-His feet were on a pillow with his legs crossed right over left.
-There were no "Bunny" boots on his feet.

Observation of Resident #4 on 03/19/21 at 2:20pm revealed:
-Resident #4 was lying on his back in a hospital bed on a scoop mattress in his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 3	D 269		

-His feet were on a pillow with his legs crossed right over left.
-There were no "Bunny" boots on his feet.
-The MA attempted to reposition Resident #4 on his side and he became combative.
-He swung his right arm in a hammering motion towards the MA's arm.
-The MA was able to calm him to allow her to position him on his left side using the turning sheet which allowed a visual inspection of his buttocks and sacral area.
-There was an area the size between a quarter and golf ball of intact pink to pale pink skin on the sacral area.

Interview with the MA on 03/19/21 at 2:20pm revealed:
-Resident #4 was not able to reposition himself in bed.
-He was to be repositioned every two hours.
-If Resident #4 became agitated, he would thrash about violently and hit his legs against the wall.
-The staff used the foam bed wedge as a protector between him and the wall.
-The staff used the scoop mattress and elevation of the head of the bed to help prevent him from falling out of the bed.
-His fall mat was on the floor in case he did fall to keep from being injured.
-His heels had healed; and the "Bunny" boots were not needed.
-The staff tried to reposition him every 2 hours, but it depended on if 2 staff were available since he was a 2 person assist.

Telephone interview with the Interim Director of Resident Care on 03/22/21 at 1:00pm revealed:
-Resident #4 had Parkinson's and was receiving hospice care.
-He had "violent" tremors at times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 4	D 269		

-He should be turned and repositioned every 2 hours.
-The staff should get him up into his reclining high back wheelchair (to help prevent pressure sores from staying in the same position in bed).

Telephone interview with Resident #4's hospice case manager on 03/22/21 at 5:20pm revealed:
-She was responsible for assessing and caring for Resident #4's wounds to his heels, buttocks and sacrum on a weekly to bi-weekly basis.
-Her last visit to see him was either Thursday or Friday of last week (03/18/21 or 03/19/21).
-She had seen him with his incontinent brief "soaked" at times during the pandemic.
-She expected the facility staff to check Resident #4 every 2 hours and provide incontinent care.

Telephone interview with Resident #4's primary care provider (PCP) on 03/23/21 at 11:40am revealed:
-Resident #4 was bed bound and had decreased level of communication.
-He was a total care.
-He required to be checked frequently and turned and repositioned with incontinent care every 2 hours.

Attempted telephone interview with Resident #4's Power of Attorney (POA) on 03/22/21 at 12:32pm was unsuccessful.

A request for the activities of daily living personal care sheets for Resident #4 was made on 03/23/21 at 10:58am with none being received at the time of survey exit.

2. Review of Resident #5's current FL-2 dated 12/29/20 revealed diagnoses included dehydration, hypertension, hypotension, diarrhea,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 5 clostridium difficile and sepsis. Review of Resident #5's current care plan dated 10/02/20 revealed: -Resident #5 needed intermittent assistance with transfers and ambulation related to Parkinson's disease. -Resident #5 was able to verbalize his needs. -Resident #5 used a walker with ambulation. -Resident #5 was incontinent of bowel and bladder. -Resident #5 was sometimes disoriented. Observations on the special care unit (SCU) on 03/19/21 from 8:32am until 9:59am revealed: -From 8:32am until 8:34am the personal care aide (PCA) working on the hall with resident rooms 126 - 146 was in the dining room. -The second PCA working on the SCU was on the hall with resident rooms 104 - 124. -At 8:34am, the PCA working resident rooms 126 - 146 went to a resident's room on that hall. -At 8:39am, Resident #5 was sitting on the edge of his bed with waist of his sweat pants at his mid to upper thigh area. -Resident #5 had his head own and his wheelchair was in front of him with the seat in touching his knees. -From 8:42am until 8:46am the PCA working resident rooms 126 - 146 remained in another resident's room. -At 8:44am, Resident #5 was lying on his bed with the waist of his sweat pants still at his mid to upper thigh area. -At 8:46am, the PCA exited a resident's room on the hall with resident rooms 126 - 146 pushing a female resident in a wheelchair to the dining room. -At 8:47am, the PCA left the dining room and went directly to another resident's resident room	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 269	Continued From page 6 (137). -The PCA remained in resident room 137 from 8:47am until 8:57am. -The PCA went to Resident #5's room at 8:59am. -The PCA checked Resident #5's incontinence brief; the brief was dry and there was no redness or open areas on the resident's buttocks. -The PCA helped Resident #5 to sit at the edge of the bed from lying down. -The PCA placed Resident #5's walker in front of him and helped the resident to stand and pulled his sweat pants up to his waist. -The PCA helped Resident #5 to turn while standing with his walker and sit down in his wheelchair. -The PCA took Resident #5 to the bathroom in his wheelchair to wash his face and brush his teeth. -At 9:12am, the PCA pushed Resident #5 in his wheelchair to the dining room for the breakfast meal. Interview with Resident #5 on 03/19/21 at 8:39am revealed: -He was "not so good at the moment." -He was not able to transfer from the bed to his wheelchair and needed help. -A staff was helping him but went to get another staff. Interview with the PCA on 03/19/21 at 8:59am revealed: -The Wellness Coordinator might have helped Resident #5 to start getting dressed and she was there to finish helping the resident. -The Wellness Coordinator might have needed a second staff to get Resident #5 into his wheelchair. Interview with the Wellness Coordinator on 03/19/21 at 10:11am revealed:	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 269	Continued From page 7	D 269		

-She helped Resident #5 to change his shirt because it was wet from sweat.
-She helped Resident #5 put his socks on.
-She told Resident #5 another staff would be in to help in and she went to get the PCA.
-She did not remember what time she helped Resident #5 or told the PCA.

Second interview with Resident #5 on 03/19/21 at 2:19pm revealed:
-When he needed help, he pulled the red string attached to the call bell on the wall.
-Sometimes he had difficulty getting out of bed and needed staff to help him.
-Some staff were helpful, and some were not.
-Some staff did not want to help him because he was too tall and heavy.
-Sometimes he pulled the string, and no one came to help him for hours if they came at all.
-Sometimes staff came right away but they generally took a long time.
-"These were well known and documented problems;" he was not able to say specifically who he told and when.

Observations of Resident #5 during the interview on 03/19/21 at 2:19pm revealed:
-Resident #5 had continuous tremors of his hands and arms during the conversation and with purposeful movement.
-Resident #5 had tremors of his feet when attempting to sit up in the bed.
-Resident #5 had lengthy pauses in his verbal responses.

Interview with a second PCA on 02/19/21 at 3:25pm revealed:
-He helped Resident #5 to get into and out of his wheelchair.
-He would stay close to Resident #5 during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 269	Continued From page 8	D 269		

transfer and make sure the resident was using his walker.
-Resident #5 was able to feed himself after staff cut up the food.
-Resident #5 needed help with using the bathroom, changing his incontinence brief, bathing, and brushing his teeth after dinner.
-He also helped Resident #5 by keeping his water bottle full of fresh water and with using the phone to talk with family members.

Telephone interview with Resident #5's primary care provider (PCP) on 03/22/21 at 11:45am revealed:
-She started at the facility in July 2020 and had seen Resident #5 several times.
-Resident #5 need full assistance with ADLs due to the severity of the residents Parkinson's disease and tremors.
-Resident #5 had experienced recent falls and spinal compression fractures with lower back and knee pain.
-Resident #5 had some good days cognitively and some not so good days.

Interview with the Administrator on 03/19/21 at 12:30pm revealed:
-He was not aware Resident #5 waited for dressing and transfer assistance before the breakfast meal on 03/19/21 for at least 30 minutes.
-The SCU was staffed according to the census.

Attempted telephone interview with Resident #5's Power of Attorney (POA) on 03/22/21 at 9:40am was unsuccessful.

[Refer to Tag 465, 10A NCAC 1308(a) Special Care Unit Staffing]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 9	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents sampled including medications to treat Parkinson's disease (Resident #2), a medication to treat atrial fibrillation and a medication to treat memory loss (Resident #1). 1. Review of Resident #2's current FL-2 dated 10/21/20 revealed diagnoses of Parkinson's disease, anxiety, gastroesophageal reflux disease, hypothyroidism and atherosclerotic heart disease. a. Review of Resident #2's physician orders dated 10/07/20 revealed: -There was an order for Carbidopa-Levodopa-Entacapone 25-100-200, (a medication used to treat involuntary movements associated with Parkinson's Disease), take one tablet by mouth five times a day at 7:00am, 10:30am, 2:00pm, 5:30pm and 9:00pm and take	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10	D 358		

one tablet by mouth at bedtime as needed for dyskinesia (dyskinesia is the involuntary, erratic, writhing movements of the face, arms, legs or trunk.)
- Carbidopa-Levodopa-Entacapone is a prescription medication used to treat Parkinson's disease.

Review of Resident #2's March 2021 medication administration record (MAR) revealed:
-There was a computer generated entry for Carbidopa-Levodopa-Entacapone 25-100-200, take one tablet by mouth five times a day at 7:00am, 10:30am, 2:00pm, 5:30pm, 9:00pm and take one tablet by mouth at bedtime as needed for dyskinesia.
-Resident #2 did not receive the five scheduled doses or her as needed bedtime dose of Carbidopa-Levodopa-Entacapone medication on 03/01/21.
-A Medication Aide (MA) documented "out of refills" on the MAR on 03/01/21 at 6:30am and "contact pharmacy."
-A second MA documented "not given" on the MAR on 03/01/21 at 5:30pm-9:00pm "awaiting order."

Interview with Resident #2 on 03/18/21 at 10:46am revealed:
-She had Parkinson's disease and needed five doses a day of her Parkinson's medication.
-She did not receive her Parkinson's medication in early March.
-She had a difficult time getting to the bathroom the day she did not have her Parkinson's medication.
-She was unable to move or turn her feet when she attempted to go to the restroom.
-A MA assisted her to the restroom.
-She hoped the facility did not run out of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11	D 358		

medication again.

Telephone interview with a MA on 03/22/21 at 11:08am revealed:
-She followed the facility's medication refill policy.
-She removed the sticker from the medication bubble card and placed the sticker on the medication refill order form that was sent by facsimile to the facility's contracted pharmacy.
-The medication order would be faxed to the pharmacy before 12:00pm to ensure delivery of the medication by the pharmacy to the facility by 12:00am.
-If a medication did not have a refill sticker to place on the pharmacy request form, they were expected to check the overstock, notify the pharmacy and the Primary Care Physician (PCP).
-On 03/01/21, Resident #2 did not have her five scheduled doses of Carbidopa-Levodopa-Entacapone.
-Resident #2 was irritable and frustrated because she knew she did not have her Carbidopa-Levodopa-Entacapone medication on 03/01/21.
-Resident #2 asked the MA if the facility had contacted the pharmacy or her Primary Care Physician (PCP) to inform them that the medication was not available.
-Resident #2 had more difficulty walking the day she missed her Parkinson's medication.
-Resident #2 was able to pivot her feet and legs independently to use the restroom when she took her medication as prescribed.
-When Resident #2 did not have her Parkinson's medication she was unable to use her feet and legs to pivot her body.
-She assisted her to the restroom.
-She remembered Resident #2 was tearful and upset because she was not able to make her feet and legs move.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 Telephone interview with the Interim Director of Resident Care on 03/22/21 at 1:08pm revealed: -Medication refills were faxed to the facility's contracted pharmacy when there were only 7 days remaining of a medication. -The MAs were expected to complete the refill order form and fax to the facility's contracted pharmacy once there were only 7 days left of a medication. -If there were not any refills on a medication, the MA was expected to contact the PCP and request a refill. -Refill orders were placed in each residents' record and the facsimile confirmation that a medication refill request had been sent to the facility's contracted pharmacy were filed in a tracking log. -She had completed audits of the medication carts to ensure residents did not miss any medications. -She had completed the last medication cart audit the assisted living (AL) hall on 03/12/21. -She was not aware Resident #2 had missed five doses of her Carbidopa-Levodopa-Entacapone. -The facility did have a back up pharmacy to contact if they needed a medication quickly. -She did not know why the MAs had not contacted the backup pharmacy. -The MAs should have faxed her refill order to the pharmacy earlier so that Resident #2 did not run out of her medication. Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 03/22/21 at 2:38pm revealed: -The pharmacy delivered 180 tablets of Carbidopa-Levodopa-Entacapone to the facility for Resident #2 on 01/24/21 and 03/01/21 at 11:19pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 358	Continued From page 13 -The facility missed the deadline for the medication to be delivered prior to 03/01/21. Telephone interview with a pharmacist with the facility's contracted pharmacy on 03/23/21 at 1:28pm revealed: -Based on the pharmacy records, Resident #2 had been taking Carbidopa-Levodopa-Entacapone to help with her Parkinson's disease symptoms since 2018. -Resident #2 would have experienced an increase in her tremors, which would have decreased her mobility. -Resident #2 would have experienced difficulties transferring from a seated position to a standing position due to increased stiffness. -She was at an increased fall risk due to not received her scheduled doses of Carbidopa-Levodopa-Entacapone. Telephone interview with Resident #2's PCP on 03/23/21 at 1:34pm revealed: -She was not notified by the facility that Resident #2 had not received her 5 scheduled doses of Carbidopa-Levodopa-Entacapone on 03/01/21. -Resident #2 would have experienced an increase in dyskinesia symptoms such as tremors. -Resident #2 was at an increased fall risk due to increase rigidity of her muscles. -She expected the facility to notify her that Resident #2 missed 5 doses of her Carbidopa-Levodopa-Entacapone. Telephone interview with a family member of Resident #2 on 03/23/21 at 2:26pm revealed: -Resident #2 informed her by telephone that she did not have her Carbidopa-Levodopa-Entacapone medication on 03/01/21.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14	D 358		

-Resident #2 was anxious and worried that she did not have her medication.
-Resident #2 reported that she was feeling better by 03/03/21.

b. Review of Resident #2's physician orders dated 10/07/20 revealed:
-There was an order for Gabapentin 100mg take one capsule at 8:00am and take two 100mg capsules at 5:00pm. (Gabapentin is an anticonvulsant medication used to treat the rigidity and tremors in patients with Parkinson's disease and to treat pain).

Review of Resident #2's February 2021 medication administration record (MAR) revealed:
-There was a computer generated entry for Gabapentin, take one tablet at 8:00am and take two tablets by at 5:00pm.
-Resident #2 did not receive her 8:00am Gabapentin medication on 02/13/21, 02/14/21, 02/15/21, 02/16/21 or 02/17/21.
-Five doses of Gabapentin were not documented administered as prescribed to Resident #2.
-Resident #2 did not receive her 5:00pm Gabapentin medication on 02/12/21, 02/13/21, 02/14/21, 02/15/21, 02/16/21 or 02/17/21.
-Six doses of Gabapentin were not administered as prescribed to Resident #2.
-A MA documented inadequate supply, medication not given from 02/12/21-02/17/21.
-Resident #2 did not receive 11 doses of Gabapentin from 02/12/21-02/17/21 as prescribed.

Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 03/22/21 at 2:38pm revealed:
-The pharmacy delivered a 30-day supply of Gabapentin to the facility for Resident #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15	D 358		

01/24/21.
-The pharmacy delivered another 30- day supply of Gabapentin to the facility for Resident #2 on 02/15/21 at 12:33am.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 03/23/21 at 1:28pm revealed Resident #2 would have experienced difficulties with walking and her overall condition could decline due to her inability to walk.

Telephone interview with Resident #2's PCP on 03/23/21 at 1:34pm revealed:
-She was not notified by the facility that Resident #2 had not received Gabapentin from 02/12/21 to 02/17/21.
-Resident #2 would have experienced an increase pain which could increase her difficulty with her Parkinson disease symptoms.
-The facility did not notify her that Resident #2 had missed her Gabapentin medication.
-She expected the facility to notify her of the missed Gabapentin medication.
2. Review of Resident #1's current FL-2 dated 02/22/21 revealed diagnoses included atrial fibrillation, dementia, muscle weakness, and pneumonia.

a. Review of Resident #1's current FL-2 dated 02/22/21 revealed an order for Digoxin 125mcg, 1 tablet daily, hold for heart rate (HR) less than 50 (Digoxin is used to treat fast heart rate and atrial fibrillation).

Review of Resident #1's February 2021 medication administration record (MAR) revealed:
-There was an entry for Digoxin 125mcg tablet, take one by mouth every day with instructions to hold if HR less than 50.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 16	D 358		

-On 02/05/21, Digoxin was documented as administered but no HR was documented.
-On 02/27/21, Digoxin was documented as administered but no HR was documented.
-A HR was documented for 26 of 28 doses in February 2021.

Review of Resident #1's March 2021 MAR, from 03/01/21 to 03/18/21 revealed:
-There was an entry for Digoxin 125mcg tablet, take one every day with instructions to hold if HR less than 50.
-On 03/05/21, Digoxin was documented as administered but no HR was documented.
-On 03/09/21, Digoxin was documented as administered but no HR was documented.
-On 03/14/21, Digoxin was documented as administered but no HR was documented.
-A HR was documented for 15 of 18 doses in March 2021.

Telephone interview with a medication aide (MA) on 03/22/21 at 3:10pm revealed:
-Resident #1 had parameters on her Digoxin.
-He would take her HR before he administered the Digoxin and document it on the MAR.
-He was not sure why the HR was not documented on the MAR.

Telephone interview with the interim Director of Resident Care (DRC) on 03/22/21 at 1:06pm revealed:
-She expected staff to follow the order and check Resident #1's HR prior to administering the Digoxin.
-She expected staff to document the HR on the MAR.
-She was not aware that staff administered Resident #1's Digoxin 5 times out of 46 opportunities without documenting a HR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17 Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/23/21 at 12:27pm revealed: -HR should be taken prior to administration of Digoxin. -Digoxin may cause dizziness, low heart rate, and fainting. Telephone interview with Resident #1's primary care provider (PCP) on 03/23/21 at 11:45am revealed: -She expected staff to take Resident #1's HR prior to administering her daily Digoxin medication. -If staff did not check Resident #1's HR prior to administering the Digoxin, the resident could experience dizziness or decrease in heart rate. -She was not aware that Resident #1 received Digoxin 5 times over the previous 45 days without having a documented HR. b. Review of Resident #1's current FL-2 dated 02/22/21 revealed an order for Donepezil 10mg, 1 tablet daily (Donepezil is used to treat memory loss). Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry for Donepezil 10 mg, take 1 tablet once a day. -On 02/15/21, the medication aide circled their initials. -On the back of the MAR, there was no reason listed for Donepezil 02/15/21 missed dose. -On 02/16/21, the medication aide circled their initials on the Donepezil entry and the reason documented for it not being given was 'not available'. -On 02/17/21, the medication aide circled their	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18	D 358		

initials on the Donepezil entry and the reason documented for it not being given was 'not available'.
-On 02/18/21, the medication aide circled their initials on the Donepezil entry and the reason documented for it not being given was 'not available'.

Observation of medications on hand for Resident #1 revealed the resident had Donepezil medication available for administration.

Telephone interview with the interim Director of Resident Care (DRC) on 03/22/21 at 1:06pm revealed:
-If a medication was circled on the MAR, that indicates that medication was not given, and a reason was required to be documented on the back on the MAR.
-The MA was responsible for documenting a reason on the back of the MAR.
-She was not aware that Resident #1 missed 4 consecutive doses of Donepezil in February 2021.

Telephone interview with a MA on 03/22/21 at 11:08am revealed:
-When a medication needed refilled she removed the sticker from the medication bubble card.
-She placed the sticker on the medication refill order form that was faxed to the provider's contracted pharmacy.
-The medication order would be faxed to the pharmacy before 12:00pm to ensure delivery of the medication by the pharmacy to the facility by 12:00am.
-If a medication did not have a refill sticker to place on the pharmacy request form, they were expected to check the overstock, notify the pharmacy and the Primary Care Physician (PCP).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19 Telephone interview with the facility's contracted pharmacy on 03/22/21 at 2:38pm revealed: -Resident #1's Donepezil 10 mg was filled on 01/25/21 with a 30-day supply. -Resident #1's Donepezil refill on 01/25/21 would have lasted her until 02/24/21. -On 02/18/21, the facility faxed sent a refill request to the pharmacy for Resident #1's Donepezil. Telephone interview with Resident #1's primary care provider (PCP) on 03/23/21 at 11:45am revealed: -She would expect to be notified of 3 or 4 consistently missed doses. -She was not aware of Resident #1's 4 missed doses of Donepezil in February 2021. -Donepezil was not a high-risk medication but she would expect to be notified of the 4 consecutive missed doses in February 2021. _____ The facility failed to ensure medications were administered as ordered by not having medications available for administration for a resident who did not receive a medication for Parkinson's Disease which resulted in the resident experiencing anxiety related to not being able to move or turn her feet, increasing her risk for falls (Resident #2). This failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/19/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 05/07/21.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the required staffing hours for the special care unit (SCU) with a census of 27 residents were met for 4 of 18 shifts sampled from 02/24/21 to 03/07/21. The findings are: Review of the facility's current license effective January 1, 2021 revealed the facility was licensed for a capacity of 110 beds including a special care unit (SCU) with a capacity of 53 beds. Review of the facility's resident census reports dated 02/24/21 to 03/07/21 revealed there was a SCU census of 27 residents on each of those dates, which required 32 staff hours on first and second shift and 21.6 staff hours on third shift. Review of the employee time cards dated 02/27/21 revealed there was a total of 15 staff hours provided on third shift in the SCU with a	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 21	D 465		

shortage of 6.6 hours.

Telephone interview on 03/23/21 at 8:10am with the personal care aide (PCA) who was documented as working on 02/27/21 for third shift revealed:
-She could not remember more than one to two weekends ago "let alone" the night of 02/27/21.
-There had been occasions where there were just two staff working third shift on the SCU.
-It had been more than one month since she worked with just one other staff for third shift on the SCU.

Telephone interview with the Interim Director of Resident Care (DRC) on 03/23/21 at 11:01am revealed:
-The medication aide (MA) scheduled for upstairs in assisted living (AL) area would have gone down and assisted on the SCU.
-The scheduled indicated the MA had a room assignment on the staff assignment sheet, but there were four total staff in the facility on third shift on 02/27/21.
-The MA would have split her time between the AL area and the SCU, so there would have been two and half staff on the SCU.

Attempted telephone interview on 03/22/21 at 4:02pm with the MA assigned to work on the SCU for third shift in 02/27/21 was unsuccessful.

Attempted telephone interview on 03/23/21 at 1:02pm with the MA assigned to work on the AL area for third shift in 02/27/21 was unsuccessful.

Review of the employee time cards dated 02/28/21 revealed there was a total of 17.58 staff hours provided on third shift in the SCU with a shortage of 4.02 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 22 Review of the employee time cards dated 03/03/21 revealed there was a total of 18.54 staff hours provided on third shift in the SCU with a shortage of 3.06 hours. Review of the employee time cards dated 03/07/21 revealed there was a total of 19.25 staff hours provided on third shift in the SCU with a shortage of 2.35 hours. Interview with a personal care aide (PCA) on 03/18/21 at 10:24am revealed: -There were normally 5 total staff on the SCU for first and second shifts. -The 5 staff usually consisted of two PCAs on each side (four total) with one MA for the SCU. -Rooms 104 through 124 only had one resident who needed assistance with activities of daily living (ADLs) such as toileting, bathing and ambulating. -There were more residents in rooms 126 through 146 who needed assistance with ADLs and required a hydraulic lift to transfer in and out of bed. -She did not know the exact numbers of residents who needed assistance and had hydraulic lifts. Confidential interview with a staff revealed: -Sometimes there was just one PCA for each side with one MA for the unit on first shift. -One PCA for each side usually happened on the weekend and sometimes during the week. -The staffing shortage was scheduled that way. -The supervisors tried to get staff to sign up to work the short shifts unsuccessfully. -Staff from the hall with less dependent residents would help the staff on the hall with more dependent residents who had hydraulic lifts and/or needed two staff for transfer in and out of	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 23	D 465		

bed.
-There were five residents who needed help in the dining room on the heavier care hall (resident room 126 - 146).
-The PCA from the hall with resident rooms 104 - 124 and the MA would help on the heavier care hall (resident rooms 126 - 146) during meals.

Review of the facility's resident roster for 03/19/21 revealed there were 26 residents on the SCU.

Observations on the SCU on 03/19/21 from 8:32am until 9:27am revealed:
-At 8:32am there were 9 residents in the dining room on the heavier care hall and the MA was administering medications on the other hall.
-A PCA brought a resident to the dining room and encouraged a female resident already seated in a wheelchair at the table to eat.
-There were two female residents seated in geriatric chairs with breakfast meal plates wrapped in clear plastic on the table in front of them.
-At 8:34am the PCA left the dining room and went down the hall on the hall to a resident room between 126 - 146.
-There were three plates on separate tables wrapped in clear plastic with no resident seated.
-At 8:35am a dietary aide was encouraging a male resident seated in a wheelchair at the table to eat breakfast.
-From 8:34am until 8:46am, there was no PCA or MA in the dining room with residents.
-At 8:45am, the Wellness Coordinator and SCU Activities Director entered the SCU and went into the dining room.
-At 8:46am, the PCA exited a resident's room on the heavier care hall pushing a female resident in a wheelchair to the dining room.
-The dietary aide told the PCA the female

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 24	D 465		

resident in the wheelchair did not eat her breakfast.
-At 8:47am, the PCA left the dining room and went directly to resident room 137.
-The Wellness Director and SCU Activities Director were assisting the two female residents in geriatric chairs with their breakfast meals.

Interview with a PCA on 03/19/21 at 8:32am revealed:
-She was working on the heavier care hall and a second PCA was working on the other hall for first shift on 03/19/21.
-There was one MA working on the SCU for first shift on 03/19/21.

Second interview with the PCA on 03/19/21 at 8:59am revealed:
-She did not know how one PCA was able to help the residents who needed help on the heavier care hall.
-When she worked on the heavier care hall by herself, she got all the residents who could eat independently up and to the dining room first.
-Then she would get the residents who needed more help with meals up and fed one by one.
-For residents on the heavier care hall who needed two staff to get up and dressed, she would get the PCA from the other hall or the MA to help.
-There was one PCA for each side of the SCU for first shift most weekends.

Interview with the Wellness Coordinator on 03/19/21 at 10:11am revealed:
-She was floating as a PCA for first shift on 03/19/21 between the SCU and the AL area.
-She was helping residents with the breakfast meal on the SCU and was currently helping in the AL area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 25	D 465		

-There were two staff call outs for first shift on 03/19/21.
-There were two PCAs and one MA working on the SCU for first shift on 03/19/21.
-She was not usually a floater PCA, she only worked as a floater PCA for first shift on 03/19/21.

Interview with a MA on 02/19/21 at 2:07pm revealed:
-There was usually enough staff working on the SCU for third shift.
-Third shift staff were responsible for getting seven residents up and dressed.

Second interview with the Wellness Coordinator at 2:28pm revealed:
-She was responsible for making the schedule for the SCU.
-Shifts were 8 hours long, with a 30-minute lunch break.
-Staff clocked out for their lunch breaks.
-When a MA "floated" between units their time was split in half between the AL and SCU units.
-When there was a call out for a shift, she was responsible for finding staffing coverage.

Interview with a second PCA on 02/19/21 at 3:25pm revealed:
-Since March 2020, the facility had lost many staff and staffing numbers varied.
-Ever since March 2020 staffing had been up and down.
-The facility would hire new staff; the new staff would leave after two days or sometimes two weeks.

Interview with the Wellness Coordinator on 03/19/21 at 3:40pm revealed:
-She was working as a MA the evening of 03/19/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

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D 465	Continued From page 26	D 465		

-She worked as a MA two to three times per week depending on staffing.
-The last time she worked as a MA was approximately one and half weeks ago.

Telephone interview with the Interim Director of Resident Care (DRC) on 03/22/21 at 1:10pm revealed:
-She had discussed staffing concerns on the SCU in January 2021 within management meetings.
-The needs of the 25 residents on the SCU ideally would have five total staff for first shift because there were showers, two meals and therapy sessions; four staff minimum for second shift because there was one meal and additional showers; and three staff for third shift.
-When there were short shifts, the Assistant Director of Resident Care (ADRC) would help with direct care assignments.
-The ADRC was no longer working at the facility effective 03/05/21.

Telephone interview with the former ADRC on 03/22/21 at 3:50pm revealed:
-She had not worked at the facility since 03/04/21.
-She was responsible for scheduling, resident care and ensuring the "building was running right."
-She mostly worked Monday through Friday, but covered evenings, nights and weekends if there were staff call outs.
-Due to the number of residents who needed two staff for assistance, there were usually four staff on the SCU.

Interview with the Administrator on 03/19/21 at 12:30pm revealed:
-The facility staffed the SCU according to the required hours.

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	HAL092217	A. BUILDING: _____ B. WING _____	R 03/23/2021

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D 465	Continued From page 27 -He was not aware there was not enough staff to meet the transfer, ambulation, bathing, toileting and eating assistance needs of the residents on the SCU as observed the morning of 03/19/21. _____ The facility failed to ensure there was enough staff to cover the staffing hours required for 4 of 15 shifts sampled on the Special Care Unit (SCU). The facility's failure resulted in a delay in resident care and services, including feeding assistance and toileting needs. The facility's failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/23/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 05/07/21.	D 465		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure Resident #1 and Resident #2 were free of neglect as related to medication administration and Special Care Unit (SCU) residents were free of neglect as related to staffing.	D912		

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D912	Continued From page 28 The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents sampled including medications to treat Parkinson's disease (Resident #2), a medication to treat atrial fibrillation and a medication to treat memory loss (Resident #1) [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. Based on observations, interviews, and record reviews, the facility failed to ensure the required staffing hours for the special care unit (SCU) with a census of 27 residents were met for 4 of 18 shifts sampled from 02/24/21 to 03/07/21 [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing.	D912		