Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: ________ B. WING ________	R 09/15/2022

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 and the Wake County Department of Social Services conducted a follow up survey and a complaint investigation on 09/14/22- 09/15/22. The complaint investigation was initiated by the County Department of Social Services on 08/24/22.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the front door in the Assisted Living (AL) unit had an sounding device which activated when the door opened	D 067	Sounding device which is activated door is opened was installed on the front door on September 22, 2022. Sounding device is monitored by concierge and/ designee between 8am and 7:30pm, and by Med Tech and/or designee from 7:30pm and 8am.	September 22, 2022

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Operation Special[i]st — (X6) DATE Revised 11/10/22

Reviewed and Acknowledged [signature] 11/15/22

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while 20 of 32 residents residing in the AL were determined by a physician to be disoriented.

The findings are:

Observations upon entrance to the facility at the Assisted Living door on 09/15/22 at 7:30am and intermittently throughout the day until 4:45pm revealed:
-The exterior and interior sliding glass doors were unlocked.
-There was no audible sounding device heard when the front exterior and interior entrance/exit doors were opened.
-There was no attendant seated at the front entrance desk.
-There was a Medication Aide (MA) standing at a medication cart pushed against the wall in the hallway. The MA was assisting a resident seated in a wheelchair with medications.

Observation of the assisted living unit entrance lobby on 09/15/22 at 8:30am revealed:
-There was no attendant at the lobby entrance desk.
-The entrance/exit doors were unlocked and unalarmed.

Review of FL-2s for current residents residing on the AL unit on 09/15/22 revealed:
-There were 32 resident FL-2s that were reviewed.
-There were 12 resident FL-2s with no indication of disorientation.
-There were 16 resident FL-2s that indicated intermittent disorientation.
-There were 4 resident FL-2s that indicated constant disorientation.

Review of Resident #1's current FL-2 dated

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09/01/22 revealed:
-Diagnoses included dementia, anxiety, hypertension, history of urinary tract infections, and history of falls.
-The resident was semi-ambulatory.
-The resident was intermittently disoriented.

Review of Resident #1's current care plan with an assessment date of 08/31/22 revealed:
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.

Observations of Resident #1 on 09/14/22 at 9:19am revealed:
-The resident was seated in a wheelchair in front of the medication room.
-The resident left the medication room mobilizing the wheelchair independently with foot motion.

Interview with Resident #1 on 09/14/22 at 9:19am revealed:
-She "don't live here as a patient".
-She "generally" worked with the residents.
-She did not want to speak about any concerns because she" don't stay here that much, so wouldn't be fair".

Second interview with Resident #1 on 09/14/22 at 9:37am revealed:
-The resident was in the bedroom watching television.
-The resident's room was "on a campus, a private university (named) accommodated by state funds".
-She was going to work today and keep her room straightened up.
-She came there year after year.

Interview with the front desk attendant on

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09/14/22 at 12:30pm revealed:
-She worked at the front desk daily until 5:00pm.
-Someone else attended the front desk from 5:00pm to 7:30pm.
-She believed the medication aides (MAs) managed the assisted living unit front doors from 7:30pm to 8:00pm.
-The assisted living unit front doors were locked at 8:00pm.

Interview with a housekeeper working on the assisted living unit on 09/15/22 at 9:13am revealed:
-She did not know Resident #1.
-She did not normally work on the assisted living unit and was helping today (09/15/22).

Interview with the Assistant Residential Care Director (ARCD) on 09/15/22 at 9:20am revealed:
-There were confused and wandering residents living on the assisted living unit.
-Resident #1 was "very confused".
-When Resident #1 became confused, she "may be on her way to her room".
-The assisted living unit front entrance and exit doors had never been alarmed with a sounding device.
-The last residents she was aware of that had eloped from the facility through the assisted living unit entrance/exit doors was moved to the secured unit of the facility.
-She did not know if Resident #1 had an elopement assessment completed.
-Nobody managed the assisted living unit front entrance/exit door before the front desk attendant reported to work.

Interview with the Residential Care Director (DRC) on 09/15/22 at 2:07pm revealed:
-She was the person in charge today.

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-The Executive Director was scheduled out of the facility on today (09/15/22).
-There were residents living on the assisted living unit of the facility who were confused and disoriented.
-She would say that at least half of the residents on the assisted living unit had dementia or some confusion.
-She was not sure why there was no audible sounding device on the front entrance/exit doors to the assisted living unit.
-The Executive Director and Maintenance staff were responsible for the physical building.
-There was one resident she would be concerned that he was at risk for unsafe wandering due to his cognitive status, but that resident had additional supervision from a family member.
-She would expect residents to have continuous monitoring and staff to recognize changing risk factors and new behavior and report those to management before there was an event.
-There had not been any residents to leave the assisted living unit unsafely or elope from the assisted living unit since June 2022 when a resident ran out the facility and went up the street.
-She was not aware of the requirement for a sounding device on entrance/exit doors used by residents if there were residents assessed to be disoriented or have wandering behaviors.
-There was not always someone at the front desk of the assisted living unit.
-Entrance/exit doors were locked until 7:00am.
-The MAs and personal care aides were responsible for managing the assisted living front entrance/exit doors until the receptionist reported to work at 8:30am.

Attempted interview with the Primary Care Provider for residents on the assisted living unit on 09/15/22 at 2:42pm was unsuccessful.

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Interview with the front desk attendant on 09/15/22 at 9:35am revealed:
-She monitored the doors daily from 8:30am - 5:00pm and another attendant comes in from 5:00pm - 7:30pm.
-She monitored residents who went in and out of the front door and if elopement behaviors were noted, she alerted the staff via walkie talkie.

Interview with the maintenance director on 09/15/22 at 3:00pm revealed:
-The front entrance to the AL unit did not have a sounding device engaged.
-He was not aware that the AL unit needed a sounding device and thought that residents residing on the AL unit were allowed to walk outside as desired.
-The desk attendant monitored the front entrance door from 8:00am - 7:00pm and afterwards, the doors were locked with no sounding device engaged.

___

Twenty of 32 residents living in the Assisted Living (AL) unit of the facility were determined to be disoriented by a physician. The front door to the AL unit did not have a sounding device which activated when the door opened. The failure of the facility to ensure a sounding device activated on the front door when opened was detrimental to the health, safety and welfare of the AL residents who were deemed by a physician to be disoriented.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/22.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2022

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 1 of 6 sampled residents (#5) who resided in the Special Care Unit (SCU) and had wandering behaviors was provided increased supervision while the west exit door on the SCU was malfunctioning. The findings are: Review of Resident #5's current FL-2 dated 06/30/22 revealed: -Diagnoses included Alzheimer's dementia, hypothyroidism, osteoporosis, anxiety and depression. -She was ambulatory without an assistive device. -She had wandering behavior. -She was intermittently disoriented. -She resided in the Special Care Unit (SCU).	D 270	ED/DRC and/or Designee will provide supervision of residents in accordance with each residents' assessed needs, care plan and current symptoms. All residents re-assessed for elopement on 9/23/22 by the DRC. DRC and/or Designee will complete elopement evaluations upon admission, quarterly and at significant change for all residents. These will be monitored daily by the DRC, ED and/or designee through schedules set in Point Click Care, and any significant change in condition. Daily, during stand-up, communication logs and event reports reviewed from previous shifts. Residents evaluated by clinical for injury, interventions and proper communication with the resident's family and physicians. Orders will be requested for the residents with their PCP as indicated.	

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Review of Resident #5's incident and accident report dated 08/21/22 revealed:
-There was a faulty lock and alarm on a door.
-She was wandering and not exit seeking.
-Staff found her in the parking lot.
-There were no injuries.
-The door was being observed until repair was made.
-The date of the incident was 08/21/22.

Review of Resident #5's incident report form dated 08/24/22 revealed:
-The dated of the incident was 08/21/22.
-She had an admitting diagnosis of Alzheimer's.
-She eloped from the facility.
-She exited a rear door in the Special Care Unit (SCU) on the west side.
-The alarm on the door did not sound.
-Staff found her in the employee parking lot.
-She was placed on every 15-minute checks and 1 to 1 observation until repair to the door was made.

Interview with a medication aide (MA) on 09/15/22 at 11:16am revealed:
-Resident #5 eloped between 3:00pm and 4:00pm.
-On 08/21/22, she saw Resident #5 standing with staff outside.
-She informed the Director of Resident Care (DRC), Resident #5 was outside.
-She went outside to get the resident and escorted her back into the facility.
-About 30 minutes later, a family member approached her in the assisted living unit lobby and informed her a possible resident was outside, attempting to enter the facility from the side of the building.
-She informed the DRC before she went outside.

Provider's Plan of Correction:

Weekly, during the interdisciplinary team meeting, the community reviews residents at risk. Residents at risk include but are not limited to the following:
- Move ins for the last 30 days
- Change in cognition from baseline
- Falls, changes in balance and mobility.

Interventions established during IDT and documented in the resident's service plan. Progress notes updated to reflect a summary of discussion and interventions.

Resident's current Care Plan will be printed and placed in front of ADL logs for staff review, reference and documentation.

The DRC, ADRC, BTR Manager or their designee will complete observations of staff implementation of interventions. — Sept. 30, 2022

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D 270	Continued From page 8 -She went to the front door of the facility and walked toward the right. -She saw Resident #5 standing in the driveway that goes to the employee parking lot. Interview with the Director of Resident Care on 09/14/22 between 11:09am and 11:30am revealed: -Resident #5 eloped from the facility on 08/21/22 and 08/27/22. -On 08/21/22, Resident #5 was found by staff in the employee parking lot. -The exit door on the west side of the SCU was unarmed and unlocked. -After, the elopement on 08/21/22, staff was placed at the door until repairs could be made. -The facility did not place Resident #5 on one on one supervision. -Resident #5 was placed on every 15- minute checks. -The Executive Director (ED) took over the investigation. Interview with the DRC on 09/15/22 at 8:13am revealed: -On 08/21/22, she notified the Director of Clinical Operations the doors in the facility were malfunctioning. -On 08/21/22, Resident #5 eloped twice within minutes apart. -She had not completed her incident and accident report for the first elopement therefore she put both elopements into one. -Resident #5 was found in the employee parking lot on both occasions. -She was not aware the exit door was not working when Resident #5 eloped the first time. -Facility Staff (named) provided 1 on 1 observation, at Resident #5's door after she eloped the first time.	D 270		

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D 270	Continued From page 9 -The staff went to the bathroom and Resident #5 eloped a second time. Interview with the named PCA, who the DRC reported sat outside of Resident #5's door, on 09/15/22 at 10:25am revealed: -She was not aware she was given the responsibility to sit outside Resident #5's door after she eloped. -She was not aware Resident #5 eloped. Attempted telephone interview on 09/15/22 at 10:06am with staff who witnessed Resident #5's elopement on 08/21/22 was unsuccessful. b. Review of Resident #5's county incident and accident report dated 08/27/22 revealed: -She eloped from the facility. -She left the SCU on the west side using the stairwell to the outside of the facility. -There were no injuries. -The primary care provider (PCP) was not notified. -The dated of the incident was 08/27/22. Observation of the exit door on the west side of the SCU on 09/15/22 at 11:35am revealed: -After exiting out the door, the right was not accessible. -There were black steel side rails attached to the stairs. -There were black steel side rails ended on the left side at the last step. -The black steel side rails continued to the right along the sidewalk, separating a wooded area, leading to the highway. -At the end of the sidewalk, the black steel side rails ended and there was no separation from the facility between the wooded area. -There were large chips of rocks on the left used	D 270		

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for landscaping.
-The steps lead to a parking lot and dumpster area.
-There were cars parked in the parking lot.
-There was a sidewalk to the left at the end of the steps.
-The sidewalk to the left lead to the employees' smoking area.

Interview with a personal care aide (PCA) on 09/15/22 at 11:31am revealed:
-On 08/27/22, she and another staff were outside in the employee smoking area.
-They saw Resident #5 walking from the stairs toward them.
-The other staff escorted Resident #5 inside the facility.

Second interview with a PCA on 09/15/22 revealed:
-On 08/27/22, she and another staff were outside in the employee smoking area.
-A third staff was sitting in their car and yelled "look."
-They saw Resident #5 walking toward them.
-She notified the medication aide (MA) on duty in the SCU, Resident #5 eloped.

Interview with the Director of Resident Care on 09/14/22 between 11:09am and 11:30am revealed:
-On 08/27/22, Resident #5 left the facility through the exit door on the west side of the SCU.
-Resident #5 walked up the stairs to enter the employee parking lot.
-There were staff in the employee parking lot, and they escorted her inside the facility.
-The exit door was not locked, and the alarm did not sound.
-Resident #5 was placed on increased

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supervision and every 15-minute checks.

Second interview with the DRC on 09/15/22 at 8:45am revealed when Resident #5 eloped from the facility she was at risk for injury due to her diagnosis dementia.

Interview with the Primary Care Provider (PCP) on 09/15/22 at 10:28am revealed:
-On 08/21/22, she was notified by the facility Resident #5 eloped.
-She was not aware Resident #5 eloped from the facility on 08/27/22.
-She was concerned the SCU was not secured on the dates Resident #5 eloped.
-The elopements placed the resident at risk for injury.
-The resident could have fallen or gotten hit by a car.

Attempted telephone interview on 09/15/22 at 10:08am with a PCA who witnessed Resident #5's elopement on 08/27/22 was unsuccessful.

Attempted telephone interview on 09/15/22 at 10:08am with staff who witnessed Resident #5's elopement on 08/27/22 was unsuccessful.

The facility failed to provide supervision for 1 resident (#5) when the sounding device on the west exit door in the SCU would not sound when activated, which resulted in the resident eloping from the facility twice on 08/21/22 and once on 08/27/22. This failure resulted in substantial risk of serious injury and constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/14/22.

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D 270	Continued From page 12 CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2022.	D 270		
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 residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment and personal care and supervision. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure the front door in the Assisted Living (AL) unit had an sounding device which activated when the door opened while 20 of 32 residents residing in the AL were determined by a physician to be disoriented. [Refer to Tag 067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure 1 of 6 sampled residents (#5) who resided in the Special Care Unit (SCU) and had wandering behaviors was provided increased supervision	D912	ED, DRC and/or Designee will verify residents receive adequate and appropriate care in compliance with relevant federal and state laws, rules and regulations through oversight, supervision, accurate/timely assessments/evaluations, and training of staff where applicable. DRC and/or Designee will complete elopement evaluations as well as assessments upon admission, quarterly and at significant change for all residents to ensure all care needs of resident are identified. These will be monitored daily by the DRC, ED and/or designee through schedules set in Point Click Care, and any significant change in condition.	October 15, 2022

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 09/15/2022

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
D912	Continued From page 13 while the west exit door on the SCU was malfunctioning. [Refer to Tag 270 NCAC 13F .0902 (b) Personal Care and Supervision (Type A2 Violation)].	D912		