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-C 01/04/2023

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 on 01/03/23 - 01/04/23.	{D 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or concluding set forth in the statement of deficiencies. The POC is prepared solely as a matter of compliance with the law.	
{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 B VIOLATION Based on these findings, the previous Type B Violation was unabated. 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 a working sounding device which activated when the door opened while 25 of 36 residents residing in the AL were determined by a physician to be disoriented.	{D 067}	Front entrance door chime was corrected by Maintenance Director 1/5/23 by replacing the batteries. Maintenance Director will check weekly. Additionally, entrance door chime was hardwired into a permanent power supply on 2/15/23. All staff that enters and exits the front entrance on a daily basis will ensure the door chime is functioning properly. If not, staff is to immediately notify a supervisor. A resident sign out book was established for residents who exit the front entrance that go on daily walks or sits on the front porch. This is monitored by the front receptionist and reviewed by the managers daily.	1/5/23

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Executive Director (X6) DATE 3/28/23

RECEIVED AND ACKNOWLEDGED ON 04/06/23 BY

Tina B Nielsen

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-C 01/04/2023

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 067}	Continued From page 1 The findings are: Observation upon approaching the front doors of the facility on 01/03/23 at 9:00am revealed a sign that denoted "These doors are secured during the hours of 7:30pm -8:30am Monday - Friday and 8:00pm -8:00am on Saturday and Sunday. Please ring the doorbell or call 'the facility number listed'. Thank you." Observations upon entrance to the facility at the Assisted Living door on 01/03/23 at 9:00am and intermittently throughout the day until 5:15pm 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 at the receptionist's desk. -There was one female resident seated in a wheelchair with a private sitter with her in the living room area next to the receptionist's desk. -There was another female resident seated in a wheelchair near the first resident and her sitter. -The sitter was unable to identify the second resident. -There were no facility staff seen upon entering the facility. Observations on 01/03/23 from 9:00am to 1:30pm and from 2:30pm to 5:00pm of the receptionist's desk revealed there was no receptionist seen at the desk during that day. Observation of the assisted living unit entrance lobby on 01/04/23 at 7:45am revealed: -There was no attendant at the receptionist's desk.	{D 067}	Continued from page 1 A receptionist will be at the front desk daily during normal business hours to monitor the front entrance. The Executive Director and Maintenance Director will discuss maintenance issues weekly and immediately correct any deficiencies.	

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-C 01/04/2023

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 067}	Continued From page 2	{D 067}		

-The entrance/exit doors were unlocked and unalarmed.
-There were 4 residents seated in the lobby/living room area in their wheelchairs near the dining room door and entrance.
-There were no staff seen in the lobby/living room area.

Review of FL-2s for current residents residing on the AL unit on 01/04/23 revealed:
-There were 37 resident FL-2s that were reviewed.
-There were 26 resident FL-2s that indicated a diagnosis of dementia, Alzheimer's, or indicated intermittent disorientation.

a. Review of Resident #1's current FL-2 dated 10/03/22 revealed:
-Diagnoses included osteoporosis, congestive heart failure, acquired absence of left breast, history of breast cancer, dermatitis, and rosacea.
-The resident's admission date was 02/05/19.
-The resident was semi-ambulatory.
-The resident was intermittently disoriented.

Review of Resident #1's current care plan with an assessment date of 07/14/22 revealed the resident was forgetful and needed reminders.

Observations of Resident #1 on 01/03/23 at 9:30am revealed:
-The resident was in her room making her bed.
-She was oriented to self and place.

Interview with Resident #1 on 01/03/23 at 9:30am revealed:
-She referenced the previous facility in which she had resided as having lived there last month.
-She did not remember the last time she had seen her doctor.

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-C 01/04/2023

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 067}	Continued From page 3	{D 067}		

-She planned to get her son to move her back to the other facility.
-"It was nicer there; I had more room in my apartment."

b. Review of Resident #3's current FL-2 dated 10/13/22 revealed:
-His diagnosis was dementia.
-The resident was ambulatory.
-The resident was intermittently disoriented.

Review of Resident #3's current care plan with an assessment date of 09/16/22 revealed the resident was always disoriented, forgetful, and needed reminders.

Review of Resident #3's Elopement Assessment dated 09/23/22 revealed Resident #3 had a history of elopement.

Based on observations, record reviews and interviews, Resident #3 was not interviewable.

c. Observation of a female resident on 01/04/23 at 12:50pm - 12:55pm revealed:
-She was ambulating with a walker on the AL hall near the elevator.
-The resident was heard to say to herself 'I can't find my room'.
-She was redirected by a housekeeper to the other hall where her room was located.
-She turned around and started walking down the other hall to her room.
-She looked at each name plate on each door with the room number until she came upon her name plate for her room.

Interview with a housekeeper working on the assisted living unit on 01/04/23 at 12:50pm revealed:

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-C 01/04/2023

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 067}	Continued From page 4	{D 067}		

-She knew when she saw this resident on that hall that the resident was confused and looking for her room.
-She would redirect the resident to the other hall where her room was located.

d. Observation of a second female resident on 01/04/23 at 3:00pm revealed:
-She was ambulating with her walker and asked where to go for dinner.
-Surveyor explained it was 3:00pm and dinner was not served until 5:00pm and offered BINGO being played in dining room.
-Resident refused activities and snack and stated, "I wanted dinner".

Review of the second female resident's Elopement Assessment dated 09/23/22 revealed:
-The resident had significant dementia.
-She ambulated with a walker.
-She had wandering and/or elopement behaviors.

Interview with the front desk attendant on 01/04/23 at 10:55am and 2:55pm revealed:
-She normally worked at the front desk afternoons and evenings.
-She had been called in to work today (01/04/23).
-The facility had a new employee who was scheduled to start this Friday (01/06/23) to be the day receptionist.
-She was not sure how long the door chime had not been working.
-She liked having it working as it helped her know when someone was coming in or going out of the doors.
-She normally sat at the receptionist desk and could see the door, but there were times when she would go to the copier room behind the desk or to the room with the television to change the TV channels for the residents and she would not

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-C 01/04/2023

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 067}	Continued From page 5	{D 067}		

be able to see the front door.
-The assisted living unit front doors were locked around 7:30pm.

Interview with the Resident Care Director (RCD) on 01/04/23 at 8:40am revealed:
-The previous Executive Director had placed a sounding device on the front door.
-There were residents living on the assisted living unit of the facility who were confused and disoriented.
-The front entrance/exit doors to the assisted living unit had a "chime" that sounded when the door opened.
-There was not always someone at the front desk of the assisted living unit.
-Entrance/exit doors were locked until 7:00am.
-She was not sure when the device had been placed on the front door and thought it worked.

Interview with the maintenance director on 01/04/23 at 9:30am and 10:45am revealed:
-The front entrance to the AL unit had a sounding device installed before the previous ED was left in November 2022.
-He was not aware of how long the sounding device had not worked by making an audible sound when the front doors opened and closed.
-There was not a system in place for him to check the front door to ensure it was working.
-He was trying to get an audible alert on the door since he was not sure from where the former ED had purchased the current device.
-The desk attendant monitored the front entrance door from 8:00am - 7:00pm and afterwards, the doors were locked with no sounding device engaged.
-He had determined that the battery in the contact sensor on the door had died and he replaced it.
-The sounding device worked, and an audible

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-C 01/04/2023

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 067}	Continued From page 6 sound was noted when the front door opened. Telephone interview with the Primary Care Provider for residents on the assisted living unit on 01/05/23 at 2:10pm revealed: -There were several residents on AL who were confused or had diagnoses of dementia. -The residents who were confused could elope since the doors were not locked. Twenty six of 37 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 working sounding device which activated when the door opened, or a designated staff to monitor the door. The failure of the facility to ensure a working sounding device activated on the front door when opened or a designated staff, was detrimental to the health, safety and welfare of the AL residents who were deemed by a physician to be disoriented and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/23.	{D 067}		
{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:	{D 270}		

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-C 01/04/2023

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 270}	Continued From page 7 FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was abated. Noncompliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents (#2) who had a change in ambulation ability and experienced 9 falls from 10/31/22 through 01/01/23. The findings are: Review of Resident #2's current FL-2 revealed diagnoses included acute metabolic encephalopathy, latent syphilis, chronic anticoagulation, hypertension, acquired immunodeficiency syndrome and glioblastoma. Review of Resident #2's current care plan dated 09/01/22 revealed: -He was sometimes disoriented, forgetful and needed reminders. -He was ambulatory without devices and continent of bowel and bladder. -He required extensive assistance from staff with toileting, bathing, dressing and grooming. -He was independent with transfers, ambulation and eating. Observations during the tour of the special care unit (SCU) on 01/03/2023 from 9:30am until 10:05am revealed: -Resident #2 was sitting in a wheelchair in the day room. -There was one medication aide (MA) and 3 personal care aides (PCAs) in and out of the day room.	{D 270}	DRC instructed all care staff to monitor all residents who were high risk for falls at least every two hours. DRC/ADRC will audit weekly ADL and 24 reports. An intervention will be put in place for any resident with multiple falls. PT will be notified of frequent falls for re-evaluation. All resident encouraged to participate in all activities and exercise activities to maintain strength, agility and endurance.	1/31/23

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-C 01/04/2023

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 270}	Continued From page 8	{D 270}		

-The resident's room was at the end of the hall (approximately 100 steps from the recreational room door).
-There was a fall mat on the floor next to the resident's bed.

Review of Resident #2's acute charting note dated 10/31/22 revealed at 12:50pm the resident was attempting to sit in a dining room, missed the chair and fell in the dining room without injury.

Review of Resident #2's electronic incident report dated 10/31/22 revealed:
-At 12:10pm, the resident was attempting to sit in a chair in the dining room, missed the chair and fell to the floor.
-The fall was witnessed by staff and there were no injuries.

Review of Resident #2's acute charting note dated 11/04/22 revealed:
-The resident was found lying on his back on the floor next to his bed.
-He had an injury with dried blood on his left temple area.
-The primary care provider (PCP) was notified, and staff were instructed to send the resident to the emergency room (ER) for severe headache, vomiting or changes in mental status or level of consciousness.

Review of Resident #2's handwritten incident report dated 11/20/22 revealed:
-At 11:30am, the resident was found on the floor in his room.
-He told staff he lost his balance while walking.
-He did not have any injury and the PCP was notified.

Review of Resident #2's handwritten incident

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-C 01/04/2023

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 270}	Continued From page 9	{D 270}		

report dated 12/04/22 revealed:
-At 10:30am, the resident was found lying on his back on the floor in his room.
-He sustained a small laceration to his left temple.
-The Resident Care Director (RCD) treated the laceration.
-The PCP was notified.

Review of Resident #2's physician's order dated 12/05/22 revealed an order to wash, pat dry and leave paper tape sutures to the resident's left temple in place until they came off on their own.

Review of Resident #2's acute charting notes dated 12/22/22 revealed:
-Documentation at 2:15pm that the resident was found lying on the floor in his room with his head leaning on the side drawer.
-He did not have any injury and the PCP was notified.
-At 4:30pm, the PCP found the resident on the floor next to his bed without injury.
-A fall mat and wheelchair were provided by the resident's family member.
-A third note documented the resident being unsteady on his feet that evening and was on the floor after the dinner meal.
-The resident was being watched closely for falls.

Review of Resident #2's acute charting note dated 12/24/22 revealed:
-At 1:00am, the resident was found on the floor between his bed and the air conditioning unit with his mattress on top of him.
-He complained about head and lower back pain and sent to the ER.

Review of Resident #2's electronic incident report dated 12/25/22 revealed:

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-C 01/04/2023

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 270}	Continued From page 10 -At 1:00am, the resident was found on the floor between his bed and the air conditioning unit with the mattress lying on top of him. -The resident stated he fell out of his bed and the mattress flipped over on top of him. -He complained of a headache and was sent to the ER. Review of Resident #2's acute charting note dated 12/26/22 revealed: -The resident was found lying on his back on the floor in his room without injury. -The resident's PCP was notified. Review of Resident #2's electronic incident report dated 12/26/22 revealed: -At 8:55am, the resident was found on the floor next to his bed. -He was unable to tell staff what happened and did not have any visible injury. Review of Resident #2's acute charting note dated 01/01/23 revealed the resident had an unwitnessed fall without injury. Review of Resident #2's handwritten incident report dated 01/01/23 revealed: -At 2:30pm, the resident was found on the floor in the recreational room. -He fell from his wheelchair and did not have any visible injury. -The PCP was notified. Telephone interview with a MA on 01/04/23 at 10:55am revealed: -He documented Resident #2's acute charting note dated 11/04/22. -Other than finding the resident on the floor, he did not remember details about the fall. -After a resident had a fall, the MA was	{D 270}		

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-C 01/04/2023

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 270}	Continued From page 11	{D 270}		

responsible for checking the resident for pain and injuries.
-The MA was responsible for instructing PCAs on duty to check the resident every hour and generally keeping an eye on the resident for any changes.

Interview with a second MA on 01/04/23 at 3:15pm revealed:
-She was working on 12/22/22 on the SCU.
-After the first and second fall on 12/22/22, staff tried to get Resident #2 out of his room more.
-The resident was private and preferred to be in his room.
-A fall mat and wheelchair were put in place due to the falls on 12/22/22.
-He continued to fall so staff tried to keep him in the common areas with staff to keep an eye on him.

Interview with a PCA on 01/03/23 at 10:00am revealed:
-There were no residents on the SCU who had recent falls.
-There were no residents on the SCU who needed increased supervision and/or increased safety checks due to a high risk for falling.

Interview with a second PCA on 01/04/23 at 2:37pm revealed:
-Resident #2 tried to stand up on his own and then would fall sometimes.
-When she saw him trying to stand, she redirected him, took him to the bathroom or took him for a walk.
-Many times Resident #2 insisted on lying down in his bed which was a concern because his room was all the way down the hall.
-After a fall, the resident was placed in one of the common areas for staff to keep an eye on them.

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-C 01/04/2023

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 270}	Continued From page 12	{D 270}		

-Every 15 minute checks were done for 24 hours after a fall.
-The resident was checked for safety and changes in their condition.

Interview with a third PCA on 01/04/23 at 3:21pm revealed:
-Resident #2 was able to get up and walk around his room but he staggered at times.
-He did not seem to have the cognitive ability to call for assistance; she had never seen him call for help.
-Sometimes he had difficulty communicating verbally.
-He was at high risk for falls because he staggered when walking.
-Residents were supposed to be checked every hour on the SCU.

Telephone interview with Resident #2's PCP on 01/05/23 at 2:09pm revealed:
-She had been Resident #2's PCP since November 2022.
-The resident was dependent on staff for activities of daily living (ADLs); he was able to stand but she had never seen him walk.
-She saw him on 12/05/22 which was the day after he fell.
-He had one small barely visible abrasion and a second larger abrasion with paper tape sutures on his left temple.
-The staff were discussing moving him closer to the front desk to keep a closer eye on him.

Interview with the SCU Director on 01/04/23 at 4:04pm revealed:
-Over the last 6 weeks Resident #2 was increasingly unsteady with ambulation and tended to walk fast with a forward lean which increased his risk of falling.

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-C 01/04/2023

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 270)	Continued From page 13	(D 270)		

-Resident #2 had worked with physical therapy (PT) since his admission to the facility (08/31/22), but she was not sure when and how long.
-She had found him twice in his room after a fall but could not remember the dates.
-Since the 3 falls on 12/22/22, a fall mat was put in place, a wheelchair was obtained for ambulation and the direction of the bed was changed to reduce injury from falls.
-She was not aware of all the falls Resident #2 had between 10/31/22 and 01/01/23.
-Staff had not been completing incident/accident reports consistently and when the report was completed it was not given to her for review.
-Completed reports were going directly to the RCD's box or the Administrator's box in the medication room on the assisted living (AL) side.
-She was not working 12/24/22 through 01/01/23 and did not know what measures what put in place for the resident's continued falls.
-The RCD was covering the SCU during that time.

Interview with the RCD on 01/04/23 at 11:48am and 4:20pm revealed:
-On admission to the facility Resident #2 was ambulatory.
-Ambulation was his only significant change in ability and did not meet the facility's criteria for level of care change.
-Resident #2 needed an updated care plan to include staff offering assistance with ambulation and transfers and a new referral to PT.
-The updated care plan in the electronic charting system would automatically update the ADL sheets that staff used to identify each resident's needs.
-Staff also needed to improve consistency with documenting acute charting every shift for 72 hours after a fall.

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-C 01/04/2023

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 270}	Continued From page 14	{D 270}		

-Acute charting notes were kept in binders at each medication cart so staff knew which residents needed monitoring and documentation each shift.
-She had not been able to monitor the acute charting binders for staff adherence to facility procedures for some time due to resident deaths, hospitalizations and illness in the facility.
-Staff huddles were done twice daily on the SCU to inform staff of residents who were a high risk to fall, residents who had changes in condition and of elopement prevention strategies.
-The SCU Director actively supervised by staff by being out on the unit throughout the day.
-She and the SCU Director made unannounced weekly visits to the SCU on evening, night and weekend shifts to ensure staff were adherent to safety procedures.

Interview with the Regional Director of Operations (RDO) on 01/04/23 at 5:07pm revealed he was at the facility on average 2 days per week to ensure staff were adherent to measures put in place for the safety of all residents.

The facility failed to supervise Resident #2 which resulted in 9 falls in 2 months with one needing emergency room evaluation for head and back pain and a second causing a head laceration. The failure of the facility was detrimental to the health, safety and wellbeing of Resident #2 and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/23 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 18, 2023.

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-C 01/04/2023

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