DRAINGSIDE OF FALEIGH RALEIGH, NC 27507 ROUNDERS ALMANAY STATEMENT OF DESCRIPCIES RALEIGH, NC 27507 RECOMBERGENCH AUTON SHOULD BE GRAND DESCRIPCING AND SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE COMPATTE AND SH	ATEMENT	f Health Service Requ of pericencies r connection	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SOUTHWARDS OF PROVIDER OF RALEIGH PAPER TAG SEACH DESCENSIVE MUST BE PRECEDED & FULL PAPER TAG (D 000) Initial Comments Tho Addrt Care Licensure Section conducted a follow up survey on 01/03/23 - 01/04/23. (D 007) 10A NCAC 13F, 0305 Physical Environment (P) The routinments for outside entrances and existers (A) In homes with at least one resident who is determined by a physical and following that it can be heard by self. If a central system of remote sounding devices his provided, the control panel for the system shall be equipped with a sounding device has been accessed 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 observations, interviews and record reviews, the facility falled to ensure the front door in the Assisted Living (AL) unit had a working sounding devices had activated when the door opened while 25 of 35 residents residing in the AL were determined by a physical to the administrator of the facility falled to ensure the front door in the Assisted Living (AL) unit had a working sounding device what activated when the door opened while 25 of 35 residents residing in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical sounding in the AL were determined by a physical		764		p was		
INDININGIBLE OF RALEIGH ROTALISCH ROTALISC						
DOBATINGSIDE OF RALEIGH PAUL OF STANDARY STATEMENT OF DESPONDENCES. PAUL OR STANDARY STATEMENT OF DESPONDENCE OF THE PAUL OR STANDARY ST	AME OF PE	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STA	re, zip code	
PAYIND SUMMANY STRIBLEST OF DESICIENCIES PROGRAMS AND SECULATION SECUCION SECULATION SECULATION SECULATION SECULATION SECURIOR SECULATION SECULATION SECULATION SECULATION SECULATION SECURIOR SECULATION Securification of a source of configures. The recommendation of the definition of the seculation seculation of the seculation seculation seculation seculation securification of a securification of	restar.	eine of gal eigh				
(D 000) Initial Comments The Adult Care Licensure Section conducted a follow up survey on 01/03/22 - 01/04/23. (D 007) 10A NCAC 13F .0305 (h)(4) 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 disordented or a vandeure, each exit door accessible by residents shall be equipped with a sounding devices 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, the interest and exits 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 35 residents residing in the AL were determined by a phiglacten to be disoriented. Ween of teath seeds Regulation	MORNING	SIDE OF IONEION	RALEIG	H, NC 27607		
The Adult Care Licensure Section conducted a follow up survey on 01/03/23 - 01/04/23. (D 057) 10A NCAC 13F .0305 (h)(4) Physical Environment (h) The requirements for outside entrances and exits are: (4) In hormes 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 suitefent 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 observations, interviews and record reviews, the facility falled 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 35 residents residing in the AL were determined by a physician to be disoriented.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI	IDBE COMPLETE
10A NCAC 13F .0305 (h)(4) Physical Environment (h) The requirements for outside entrances and exits are: 1(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 no 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-compilance 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 35 residents residing in the AL were determined by a physician to be disariented. **Motion of Health Envices Regulation** **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 35 residents residing in the AL were determined by a physician to be disariented.	(D 000)	The Adult Care Licen	sure Section conducted a 01/03/23 - 01/04/23.	(D 000)	not constitute an admission by the facility of the facility of the facils concluding set forth in the	on or agreement alleged or statement of
(h) The requirements for outside entrances and exits are: (d) In homes with at least one resident who is determined by a physician or is otherwise known to be discriented 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 ATYPE 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 35 residents residing in the AL were determined by a physician to be discrimined. **THIS IS ATYPE B VIOLATION** Based on observations, interviews and record reviews, the facility failed to ensure the front door opened while 25 of 35 residents residing in the AL were determined by a physician to be discrimented. **THIS IS ATYPE B VIOLATION** Based on observations, interviews and record reviews, the facility failed to ensure the front door opened while 25 of 35 residents residing in the AL were determined by a physician to be discrimented. **THIS IS ATYPE B VIOLATION** Based on observations, interviews and record reviews, the facility failed to ensure the front door opened while 25 of 35 residents residing in the AL were determined by a physician to be discrimented.	{D 067}	10A NCAC 13F .030	5(h)(4) Physical Environment	(D 067)	as a matter of compliance	with the law.
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. 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.		(h) The requirement exits are: (4) In homes with at determined by a phyto be disoriented or a accessible by reside sounding device that opened. The sound that it can be heard it of remote sounding control panel for the the office of the admiaccessible only to stadministrator to open this Rule is not melected. This Rule is not melected.	s for outside entrances and least one resident who is sician or is otherwise known wanderer, each exit door nts shall be equipped with a its activated when the door is shall be of sufficient volume by staff. If a central system devices is provided, the system shall be located in infistrator or in a location aff authorized by the rate the control panel. It as evidenced by: TPE B VIOLATION lings, the previous Type B		corrected by Maintenand Director 1/5/23 by replace batteries. Maintenance E will check weekly. Additionally, entrance do chime was hardwired intended permanent power supply 2/15/23. All staff that enters and the front entrance on a chasis will ensure the doc chime is functioning proport, staff is to immediate notify a supervisor.	ee eing the Director oor oo a y on exits laily or oerly. If
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 35 residents residing in the AL were determined by a physician to be disoriented. Makes of Health Service Regulation		continues.			established for residents exit the front entrance th	s who lat go
		Based on observation reviews, the facility in the Assisted Livin sounding device who opened while 25 of	ons, interviews and record failed to ensure the front door g (AL) unit had a working ich activated when the door 35 residents residing in the AL	; ;	front porch. This is moni by the front receptionist	tored and
	Mislon of H	osith Service Regulation	USUPPLIER REPRESENTATIVE'S SIGNATI	URE	THE EXECTIVE	Wirdwood 3

RECEIVED AND ACKNOWLEDGED ON 04/06/23 BY



STATEME	of Health Service Red NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	I non surre		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL892217	8. WING		R-C 01/04/2023
NAME OF	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, ST	ATE ZID AARD	0 110412023
ACRAIN	GSIDE OF RALEIGH		E TRAIL	AIE, ZIP CODE	
	GOIDE OF RALEIGH		H, NC 27607		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DESIGNATION	ID	CDOMPON D. W. C. C.	
TAG	REGULATORY OR	DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.RE CONTO
(D 067)	Continued From page	e 1	{D 067}	1	
	The findings are:			vane	
	Observation				1
1	the facility on 04/02/0	proaching the front doors of		Continued from page 1	Ì
	that denoted ITL	3 at 9:00am revealed a sign			
	hours of 7:20-	doors are secured during the		A receptionist will be at the	Front deal, dell
İ	8:00pm -8:00pm -8:3(Dam Monday - Friday and		during normal business hou	nont desk dall
	8:00pm -8:00am on S	aturday and Sunday.		the front entrance.	ars to monitor
	listed'. Thank you."	ell or call the facility number	¥	and none entrance.	
	notoo. Thank you.				1
1	Observations upon en	trance to the facility at the			
1	Assisted Living door o	n 01/03/23 at 0:00cm and			1
	intermittently througho	out the day until 5:15pm		The Executive Director and	ml 8.4 m i t
1	revealed:		1	Director will discuss mainte	d Maintenance
1	 The exterior and inter 	ior sliding glass doors were	1	weekly and immediately	enance issues
	uniocked.			weekly and immediately co deficiencies.	orrect any
١,	There was no audible	sounding device heard	1	deliciencies.	
1.1	when the front exterior	and interior entrance/exit	1		
10	doors were opened.		1		į.
	There was no attenda	nt seated at the front	1		1
	entrance at the reception	onist's desk.			
	There was one female	resident seated in a	1		
V	vneeichair with a priva	te sitter with her in the			
	There was area next to	the receptionist's desk.			
w	heelchair near the See	nale resident seated in a it resident and her sitter.			
	The sitter was unable t	is resident and her sitter,			
re	esident.	to identify the second			
		staff seen upon entering			1
th	e facility.	about apout critering			
0	bservations on 01/03/2	23 from 9:00am to			
, 1:	30pm and from 2:30pr	m to 5:00pm of the	Į		
re	ceptionist's desk rever	sled there was no			
re	ceptionist seen at the	desk during that day.			
O	servation of the assis	ted living unit entrance			
lot	by on 01/04/23 at 7:4	5am revealed:	•		
-T	nere was no attendant	at the recentionists			ľ
de	sk.	receptionsts	1		Ü

Division of Health Service Re STATEMENT OF DEFICIENCIES				FORM APPROVE
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	B. WING		R-C
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIR CODE	01/04/2023
MORNINGSIDE OF RALEIGH		E TRAIL	A CODE	
	RALEIG	H, NC 27607		
(X4) ID SUMMARY S PREFIX (EACH DEFICIENT	TATEMENT OF DEFINITION	JD.	PAGE 11	
THE SUBSTICKT OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·
(D 067); Continued From pag	e 2	{D 067}		
 The entrance/exit do unalarmed. 	oors were unlocked and	(= 55.)		
-There were 4 reside	nts seated in the lobby/living			
room area in meir Wr	leeichairs near the dinine			1
ruum door and chira	ice.			
-There were no staff	seen in the lobby/living room	d d d d d d d d d d d d d d d d d d d		
-There were 37 reside	urrent residents residing on 23 revealed: ant FL-2s that were			
reviewed.				
-There were 26 reside	ent FL-2s that indicated a	Î		
diagnosis of dementia intermittent disoriental	Alzheimer's or indiana.	1		
a. Review of Resident	#1's current FL-2 dated			4
10/03/22 revealed:	22355 P	1		1
heart failure, acquired	steoporosis, congestive			
history of breast cance	r, dermatitis, and rosacea.	1		
-The residents admiss	ion date was 02/05/19.			
-The resident was inter	mittently disoriented.			
Review of Resident #11	s current care plan with an			
ecocosinglif date of 01/	14/22 revealed the			
resident was forgetful a	nd needed reminders.	1		
Observations of Reside 9:30am revealed:	nt #1 on 01/03/23 at	3		
-The resident was in he	ream making has be d	j		1
-She was oriented to se	f and place.	ŀ		1
revealed;	#1 on 01/03/23 at 9:30am	ļ.		
-She referenced the pre-	rious facility in which she			
-She did not remember to	red thoro last month	į		
seen her doctor. Health Service Regulation	The same and the			1

Division of Health Service Ru	egulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	COMPLETED
	1			R-C
	HAL092217	B. WING		01/04/2023
	0.000	ADDRESS, CITY, STATE	7ID CODE	1 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -
NAME OF PROVIDER OR SUPPLIER			ZIP CODE	
MORNINGSIDE OF RALEIGH		IE TRAIL		Ì
		H, NC 27607	CONTRACTOR OF CORPORATION	J 055
PREFIX (EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
(D 067): Continued From p	age 3	{D 067}		
-She planned to g	et her son to move her back to	1		
the other facility.				
-"It was nicer there	s; I had more room in my			
apartment."				
th Davidson of Basis	doubt #21a assessed El. 2 detect	1		
10/13/22 revealed	dent #3's current FL-2 dated			
-His diagnosis wa				
-The resident was				
	intermittently disoriented.			
1				
	nt #3's current care plan with an			
	of 09/16/22 revealed the			
	ys disoriented, forgetful, and	1		
needed reminders	J.	A.		
Review of Reside	nt #3's Elopement Assessment			
dated 09/23/22 re	vealed Resident #3 had a			
history of elopeme	ent.			
5		1		1
	ations, record reviews and ent #3 was not interviewable.	1		-1
illerviews, Reside	SIL NO WAS HOLIHOIVE WORLD			
c. Observation of	a female resident on 01/04/23	1		
at 12:50pm - 12:5				
-She was ambula	ting with a walker on the AL hall			
near the elevator.				
	heard to say to herself 'I can't			ï
find my room'.	II. I documents the			
	ed by a housekeeper to the er room was located.			
	nd and started walking down the			
other hall to her ro		į.		
-She looked at ea	ch name plate on each door			
	nber until she came upon her			
name plate for he	r room.	1		
Interview with a h	ousekeeper working on the			4
merview with a n	t on 01/04/23 at 12:50pm			
revealed:	OII O HOTEO OL IELOOPIII			
Philippo of Unith Course Postulation				

XUQQ12

STATEMENT	of Health Service Regi of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092217	(X2) MULTIPLE CO A. BUILDING: B. WING	ONSTRUCTION	CONPLETED R-C 01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
		801 DIX	IE TRAIL		
MORNING	SIDE OF RALEIGH		H, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETE TE DATE
{D 067}	Continued From pag	je 4	{D 067}		
	-She knew when she	saw this resident on that	1		
		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	i l		
	01/04/23 at 3:00pm				
		g with her walker and asked	and the same of th		
	where to go for dinn		The state of the s		
		it was 3:00pm and dinner	į.		
	was not served until 5:00pm and offered BINGO being played in dining room.		1		
	-Resident refused activities and snack and				
	stated, "I wanted din		1		
	Review of the secon	nd female resident's			
		ent dated 09/23/22 revealed:	-		
	-The resident had si				
	-She ambulated with	ı a walker.	į		
	-She had wandering	and/or elopement behaviors.			
	Interview with the fro	ont desk attendant on	1		
		n and 2:55pm revealed:	1		
	-She normally works				
	afternoons and ever		1		
		d in to work today (01/04/23).			
		ew employee who was			
		is Friday (01/06/23) to be the	,		
	day receptionist.	ow long the door chime had			
	not been working.	ON KING DIE GOOF CHILITE HAG	İ		
		working as it helped her know	-		
		coming in or going out of the	J.		
	The state of the s	the receptionist desk and			
		but there were times when	'		
		copier room behind the desk			
		he television to change the			
	TV channels for the	residents and she would not			

Division of Health Service Rec	ulation	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
AND PLAN OF CORRECTION		7000000		R-C
		B, WING		01/04/2023
	HAL092217	B, WING	ACCUSATION OF THE PROPERTY OF	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE	
NAME OF PROVIDER OR SOFF LICE	801 DIXIE			
MORNINGSIDE OF RALEIGH		I, NC 27607		
			PROVIDER'S PLAN OF CORRECTION	(X5)
(FACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPETITE
(D 067) Continued From pa	age 5	{D 067}		
be able to see the	front door			
be able to see the	unit front doors were locked			
	duit nour goors are a losses			
around 7:30pm.				
Intensions with the	Resident Care Director (RCD)	1		
on 01/04/23 at 8:4	Nam revealed:			
The provious Eve	cutive Director had placed a			
sounding device of	n the front door.			
-There were reside	ents living on the assisted living			
unit of the facility v	who were confused and	1		
disoriented.		İ		
-The front entrance	e/exit doors to the assisted			
living unit had a "c	hime" that sounded when the	1		
door opened.				T T
-There was not all	ways someone at the front desk			
of the assisted livi	ng unit.			1
-Entrance/exit doc	ors were locked until 7:00am.			
-She was not sure	when the device had been			
placed on the from	t door and thought it worked,			
Interview with the	maintenance director on			
01/04/23 at 9:30a	m and 10:45am revealed:			
-The front entrand	e to the AL unit had a sounding	I.		
device installed be	efore the previous ED was left in		-	
November 2022.				
-He was not awar	e of how long the sounding			
device had not we	orked by making an audible			
sound when the fi	ront doors opened and closed.		2000	
, -There was not a	system in place for him to check			
the front door to e	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 th	e current device.			
-The desk attend	ant monitored the front entrance			
door from 8:00an	n - 7:00pm and afterwards, the			
	d with no sounding device			
engaged.	- data the better in the contest			
-He had determin	ned that the battery in the contact			
sensor on the do	or had died and he replaced it.			
-The sounding de	svice worked, and an audible			

STATEMENT	of Health Service Required From Services of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092217	(X2) MULTIPLE OF A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED R-C 01/04/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE	, ZIP CODE	
	SIDE OF RALEIGH	801 DIXII			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{D 067}	Continued From pag	e 6	{D 067}		
	sound was noted wh	en the front door opened.			
	Provider for residents on 01/05/23 at 2:10p -There were several confused or had diag	residents on AL who were poses of dementia. vere confused could elope			a.
,	Living (AL) unit of the be disoriented by a p the AL unit did not ha device which activate a designated staff to of the facility to ensu activated on the from designated staff, was	dents living in the Assisted e facility were determined to obspicion. The front door to ave a working sounding ed when the door opened, or monitor the door. The failure re a working sounding device t door when opened or a s detrimental to the health, if the AL residents who were			
		an to be disoriented and ated Type B Violation.			-
		a plan of protection in 1. 131D-34 on 01/04/23.			
(D 270)	10A NCAC 13F .090 Supervision	1(b) Personal Care and	{D 270}		
ı		e supervision of residents in h resident's assessed needs,			
	This Rule is not met	as evidenced by:			

STATEMENT	OF INCORED SERVICE REQU TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			A. BOILDING.	The state of the s	R-C
		HAL092217	B. WING	A CONTRACTOR OF THE PARTY OF TH	01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	
MORNING	SSIDE OF RALEIGH		IE TRAIL SH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
{D 270}	Continued From page	e 7	{D 270}		
	FOLLOW-UP TO TY	PE A2 VIOLATION			
	Violation was abated	ngs, the previous Type A2 . Noncompliance continues.	resi	c instructed all care staff to dents who were high risk for every two hours.	
	THIS IS A TYPE B VI	IOLATION	DD	C(ADDC will audit wooldy A	DL and 24
	reviews, the facility fa	ns, interviews and record ailed to provide supervision sidents (#2) who had a		C/ADRC will audit weekly A orts.	DL and 24
		ability and experienced 9		ntervention will be put in pla dent with multiple falls.	ace for any
	The findings are:			will be notified of frequent fa	alls for
		f2's current FL-2 revealed	1		
	 diagnoses included a encephalopathy, late 			esident encouraged to part vities and exercise activities	
	anticoagulation, hype	(C.) : [C.) (C.) (C.) (C.) (C.) (C.) (C.) (C.) (ngth, agility and endurance	Secretaria de la constante de
	Review of Resident #	2's current care plan dated	1		
		disoriented, forgetful and			
	-He was ambulatory to continent of bowel at the required extension				!
	toileting, bathing, dre				
	Observations during unit (SCU) on 01/03/:10:05am revealed:	the tour of the special care 2023 from 9:30am until	3		
	day room.	ling in a wheelchair in the			
	 There was one med personal care aides (room. 	ication aide (MA) and 3 (PCAs) In and out of the day	T I		

HAL092217 NAME OF PROVIDER OR SUPPLIER MORNINGSIDE OF RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE 801 DIXIE TRAIL RALEIGH, NC 27607 PROVIDER'S PLAN OF CORRECTION (KS)	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED
MORNINGSIDE OF RALEIGH MAIL PROPERTY SUMMARY STATEMENT OF DEPICIENCES PAPERTY REPORT		HAL092217	B. WING		R-C 01/04/2023	
DATE SUMMANY STATEMENT OF DEPICIENCING BEACH STAND PROPRIETS PLAN OF CORRECTION BEACH CORRE					, ZIP CODE	
(D 270) (D 270) Continued From page 8 —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 was attempting to sit in a chair and fell in the dining room, missed the chair and fell in the dining room, missed the chair and fell in the dining room, missed the chair and fell 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 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 bud. —He had an injury with dided blood on his left temple aress. —The primary care provider (PCP) was notified, and staff were instructed to send the realdent to the emergency room (ER) for severe headache, vomiling or changes in mental status or level of consclousness. 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. —te told staff he loat his balance while walking. —He did not have any injury and the PCP was notified.	MORNING	SIDE OF RALEIGH	RALEIG	H, NC 27607		
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 bad. Review of Resident #2's acute charting note dated 10/31/22 revealed at 12:50pm the resident was attempting to alt 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, vorniting 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 walkingHe did not have any injury and the PCP was notified.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE COMPLETE EAPPROPRIATE DATE
(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, vorniting 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.	{D 270}	Continued From page	÷ 8	(D 270)		
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in his roomHe told staff he lost his balance while walkingHe did not have any injury and the PCP was notified.		vomiting or changes consciousness. Review of Resident # report dated 11/20/22	in mental status or level of #2's handwritten incident 2 revealed:			a
Review of Resident #2's handwritten incident		-At 11:30am, the resi in his room. -He told staff he lost -He did not have any	dent was found on the floor his balance while walking.	1		
		Review of Resident	#2's handwritten incident			

PAN

Livision	of Health Service Rec				FORM APPROVE
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	ONSTRUCTION	(X3) DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL092217	B. WING		R-C
NAME OF P	ROVIDER OR SUPPLIER	emert	4000000 000 0000		01/04/2023
			ADDRESS, CITY, STATE	, ZIP CODE	
NORNING	SSIDE OF RALEIGH		GE TRAIL GH, NC 27607		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
{D 270}	Continued From pag	e 9	{D 270}	The second secon	
1	report dated 12/04/2	2 revealed:			
	-At 10:30am, the resi	ident was found lying on his			
	back on the floor in h	is room	ĺ		ě
- 1	-He sustained a small	Il laceration to his left			i
	temple.	in lacer ation to his left			
		Director (RCD) treated the			
	laceration	Shector (NCD) realed the	1		
	-The PCP was notifie	d			
	Had Hould	.			
	Review of Resident #	2's physician's order dated			
	12/05/22 revealed an	order to wash, pat dry and			
	eave paper tane sutu	res to the resident's left			
	lemple in place until t	hey came off on their own.			
	temple in place dittil (ney came on on their own.	1		
	Review of Resident#	2's acute charting notes	1		
		5pm that the resident was			
l f	ound lying on the floo	or in his room with his head	1		
1	eaning on the side dr	amer			
_	He did not have any i	njury and the PCP was			
in	otified.	ider A mild mic L. Ol. Mas	1		
-	At 4:30pm, the PCP f	ound the resident on the	. 1		
fl	oor next to his bed wi	ithout laine			
-,	A fall mat and wheeld	hair were provided by the			
re	esident's family memb	ner			
-/	A third note document	ted the resident being	İ		
u	nsteady on his feet th	at evening and was on the			
fle	oor after the dinner m	est evening and was on the	1		
-1	he resident was bein	g watched closely for falls,			
R	eview of Resident #2	's acute charting note			
da	ated 12/24/22 reveale	ed:			
		nt was found on the floor			
be	tween his bed and th	e air conditioning unit with	0		
in:	s mattress on top of h	nirn.			
-14	e complained about i d sent to the ER.	head and lower back pain			
Re	view of Resident #2's	s electronic incident report			
da	ted 12/25/22 revealed	d:	1		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURV COMPLETE	
			,		R-C	
		HAL092217	B. WING		01/04/2	023
NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
		801 DIX	IE TRAIL			
MORNING	SIDE OF RALEIGH	RALEIG	H, NC 27607			N/E
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
(D 270)	Continued From pag	e 10	{D 270}			
	-At 1:00am, the resid	lent was found on the floor				
	between his bed and	the air conditioning unit with				
	the mattress lying on					
		he fell out of his bed and the	ĺ			
	mattress flipped over	r on top of him. headache and was sent to				
	the ER.	neadathe and was sent to				
	alo Li C					
	Review of Resident	#2's acute charting note	. 1			
	dated 12/26/22 reveal		1			
		und lying on his back on the				
	floor in his room with	out injury.				
	-The resident's PCP	was notified.				
	Review of Resident:	#2's electronic incident report				
	dated 12/26/22 reve	aled:				
	-At 8:55am, the resid	dent was found on the floor				
	next to his bed.					
		ell staff what happened and				
	did not have any visi	ible injury.				
	Review of Resident	#2's acute charting note	1		1	
		aled the resident had an			1	
	unwitnessed fall with		1			
		#2's handwritten incident				
	report dated 01/01/2	dent was found on the floor in				
	the recreational root		W.			
		eelchair and did not have any				
	visible injury.					
	-The PCP was notifi	ed.	ŧ.			
	Telephone intesticu	with a MA on 01/04/23 at				
ALIAN CHESTON	10:55am revealed:	MINI & IMM OIL O LIGHTS &				
COMPANY		esident #2's acute charting				
	note dated 11/04/22					
	-Other than finding t	the resident on the floor, he				
	did not remember d					
	-After a resident had	d a fall, the MA was			Committee of Summer	Harris and the second

TATEMENT	Health Service Requi OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	COMPLETED
ND PLAN OF	FCORRECTION	IDEALL INTO A LAGRACIA	A BUILDING:		R-C
		HAL092217	B. WING		01/04/2023
		The state of the s	DORESS, CITY, STATE	, ZIP CODE	
AME OF PR	ROVIDER OR SUPPLIER		ETRAIL		
ORNING	SIDE OF RALEIGH		H, NG 27607		
(X4) ID PREFIX TAG	IEACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) E COMPLETE ATE DATE
{D 270}	Continued From pag	ne 11	{D 270}		
(0 2.0)		king the resident for pain and	1		
		king the resident for pain and	1		
-	injuries.	nsible for Instructing PCAs on	1		
	-ine was respon	sident every hour and			
	generally keeping at	n eye on the resident for any			
	changes.				
			1		
	Interview with a sec	ond MA on 01/04/23 at	1		
	3:15pm revealed:		İ		
	-She was working o	n 12/22/22 on the SCU.			
	-After the first and s	econd fall on 12/22/22, staff			
	tried to get Residen	t #2 out of his room more.			
	-The resident was p	private and preferred to be in			
	his room.				
	-A fall mat and whe	elchair were put in place due			
	to the falls on 12/22	2/22.			
	-He continued to fal	Il so staff tried to keep him in	į		
	the common areas	with staff to keep an eye on			
	him.				
	Interview with a PC	A on 01/03/23 at 10:00am			
	revealed:		1		
	-There were no res	idents on the SCU who had	1		
	recent falls.				
	.There were no res	idents on the SCU who			1
	needed increased :	supervision and/or increased			
	safety checks due	to a high risk for falling.			
	Interview with a se	cond PCA on 01/04/23 at			
	2:37pm revealed:				
	-Resident #2 tried	to stand up on his own and			
	then would fall son	netimes.		1	
	-When she saw hir	m trying to stand, she			
	redirected him, too	ok him to the bathroom or took	7		
	him for a walk.				
	-Many times Resid	dent #2 Insisted on lying down			
	in his bed which w	as a concern because his room		1	
	was all the way do	own the hall.			
	-After a fall, the re-	sident was placed in one of the			100000000000000000000000000000000000000
	common areas for	staff to keep an eye on them.			NAME OF TAXABLE PARTY.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL092217	B, WING	The state of the s	R-C 01/04/2023		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MORNING	MORNINGSIDE OF RALEIGH 801 DIXIE TRAIL RALEIGH, NC 27607						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE		
(D 270)	-Every 15 minute che after a fail. -The resident was che changes in their condition interview with a third revealed: -Resident #2 was able his room but he stage. He did not seem to he call for assistance; she for help. -Sometimes he had diverbally. -He was at high risk for staggered when walk. -Residents were supplied hour on the SCU. Telephone interview to 1/05/23 at 2:09pm in She had been Residents was de of daily living (ADLs); she had never seen held second larger abrasic on his left temple. -The staff were discurted front desk to keep interview with the SC 4:04pm revealed: -Over the last 6 week increasingly unsteady	ecks were done for 24 hours ecked for safety and lition. PCA on 01/04/23 at 3:21pm te to get up and walk around gered at times. have the cognitive ability to the had never seen him call difficulty communicating for falls because he ting, posed to be checked every with Resident #2's PCP on evealed: lent #2's PCP since spendent on staff for activities the was able to stand but him walk. 05/22 which was the day arely visible abrasion and a on with paper tape sutures ssing moving him closer to to a closer eye on him. EU Director on 01/04/23 at the resident #2 was by with ambulation and tended	{D 270}	DEPICIENCY)			
	to walk fast with a for his risk of falling.	ward lean which increased					

Division of Health Service Reg STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED
	HAL092217 B. WING			R-C
NAME OF PROVIDER OR SUPPLIER	The state of the s			01/04/2023
9-10-40-10-10-10-10-10-10-10-10-10-10-10-10-10		ADDRESS, CITY, STATE	, ZIP CODE	
MORNINGSIDE OF RALEIGH		IETRAIL IH, NC 27667		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
(D 270) Continued From pag	e 13	{D 270}		
-Resident #2 had wo	rked with physical therapy			
(PT) since his admis	sion to the facility (08/31/22),	1		
but she was not sure	When and how long			
-She had found him t	wice in his room after a fall			
but could not remem	her the dates			
-Since the 3 falls on	12/22/22, a fall mat was put	į.		
in place, a wheelcha	ruse chicined for			
ambulation and the d	lirection of the bed was			
changed to reduce in	lury from falls			
-She was not aware	of all the falls Resident #2			
had between 10/31/2	2 and 01/01/23.			
-Staff had not been c	ompleting incident/accident			
reports consistently a	ind when the report was			
completed it was not	given to her for review.	ĺ		
 Completed reports w 	ere going directly to the	1		
RCD's box or the Adn	ninistrator's box in the	1		
medication room on ti	he assisted living (AL) side.	1		
-She was not working	12/24/22 through 01/01/23			
and did not know wha	at measures what put in			
place for the resident	s continued falls			
-The RCD was coveri	ng the SCU during that			
time.	and do during that	1		
Interview with the RCI	D on 01/04/23 at 11:48am	4		
and 4:20pm revealed:	011 0 1104725 at 1.40am			
-On admission to the	facility Resident #2 was			
ambulatory.	donty Resident #2 was			
	only significant change in			
ability and did not mee	et the facility's criteria for			
level of care change.	ot the monty o chang for			
-Resident #2 needed a	an updated care plan to			
include staff offering a	ssistance with ambulation			
and transfers and a ne	w referral to PT.			1
-The updated care pla	n in the electronic charting	**************************************		
system would automat	ically update the ADL	Maria .		
sheets that staff used	to identify each resident's			
needs.	1179	1		1.5
: -Staff also needed to in	mprove consistency with			
documenting acute cha	arting every shift for 72			
hours after a fall.	<u> </u>			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL092217	B. WING		R-C 01/04/2023	
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODÉ		
10.00-00			E TRAIL	,		
MORNING	SSIDE OF RALEIGH	RALEIG	H, NC 27607		and the state of t	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{D 270}	Continued From page	e 14	{D 270}			
	each medication cart					
	each shift.	nitoring and documentation	1			
		ole to monitor the acute taff adherence to facility				
	procedures for some time due to resident deaths,					
	hospitalizations and i	iliness in the facility. Ione twice daily on the SCU				
	to inform staff of residents who were a high risk to					
	fall, residents who hat of elopement prevent	nd changes in condition and				
	-The SCU Director a	ctively supervised by staff by				
	being out on the unit					
		rector made unannounced CU on evening, night and				
		sure staff were adherent to				
	Interview with the Re	gional Director of Operations				
		t 5:07pm revealed he was at e 2 days per week to ensure				
		o measures put in place for				
	the safety of all resid	ents.				
	The facility falled to s	supervise Resident #2 which				
		2 months with one needing aluation for head and back				
		ausing a head laceration.	and the second			
	The failure of the fac	ility was detrimental to the				
	health, safety and we constitutes a Type B	ellbeing of Resident #2 and				
			ł.			
		a plan of protection in i, 131D-34 on 01/04/23 for				
ł .		DATE FOR THE TYPE B	1			
	VIOLATION SHALL	NOT EXCEED FEBRUARY				

Division of Health Servic STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R-C 01/04/2023	
NAME OF PROVIDER OR SUPF	diener a	ADDRESS, CITY, STATE, 2	IP CODE		
MORNINGSIDE OF RALE	801 Di	KIE TRAIL GH, NC 27687			
TEACH!	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL STORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY)	(X5) COMPLETE TE DATE	
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		16		Ϋ́	
			*	*	