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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on March 19, 2025 to March 20, 2025.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free of hazards including personal care items, and aerosol air freshener in residents' rooms that were accessible to residents on the special care unit (SCU). The findings are: Review of the facility's Environmental Safety policy for the SCU with an effective date of 07/01/19 revealed in accordance with applicable state and federal laws and regulations, environments for residents were designed to enhance safety and meet the needs and abilities of the residents. Observations on the special care unit (SCU) on 03/19/25 between 9:35am and 10:20am revealed: -The Special Care Coordinator (SCC) asked staff to help her check resident rooms.	D 079		

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D 079	Continued From page 1 -A personal care aide (PCA) was observed coming out of either room 230 or 232 with personal care products. -The SCC was observed walking up the hall from the direction of residents; rooms with personal care products in her hands to include bottled products a white bar of soap. -There were SCU residents ambulating up and down the hall. -There were SCU away from their rooms, sitting in the community room and at the door of the community room just down the hall. -There were SCU residents not in their rooms and their room doors were open. Observation of room 236 on 03/19/25 at 9:55am revealed: -There was lotion, toothpaste, and lipstick on the bathroom sink. -There was no warning label on the lotion or lipstick. -The warning label on the toothpaste stated if more that used for bushing is accidentally swallowed, get medical help or contact Poison Control Center right away. Observation of room 235 on 03/19/25 at 10:04am revealed: -There was a 2 in 1 shampoo/body wash and a gold bar of soap in the shower. -There was no warning label on the shampoo/body wash. -There was no wrapper on the soap. Observation of room 231 on 03/19/25 at 10:09am revealed: -There were adult wipes and liquid dial hand soap on the bathroom sink. -The label on the adult wipes cautioned against the danger of suffocation from the plastic bag that	D 079		

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contained the wipes.
-The liquid dial hand soap had no label.

Observation of room 230 on 03/19/25 at 10:11am revealed:
-There was denture adhesive, a bar of soap, wipes and lipstick on the sink, a bar of soap in the shower and a can of air freshener next to 2 pillows in an open storage area in the room.
-The warning label on the wipes addressed the danger of suffocation from the plastic bag that contained the wipes.
-The lipstick had no warning label.
-There was no warning label on the denture adhesive.
-The bar of soap was not in a wrapper.
-The warning label on the can of air freshener read: "Eye irritant. May cause skin irritation. Contents under pressure."

Observation of a the personal care item storage area on 03/19/25 at 10:30am revealed:
-The room was locked with keypad code entry required.
-Each resident had a basket with their name on it stored on shelves.
-Personal care products were stored in each individual basket.

Interview with the resident in room 230 on 03/19/25 at 10:11am revealed:
-Staff assisted her with her shower.
-She had not showered for the day.
-She did not know what the can of air freshener was.

Interview with a personal care aide (PCA) on 03/19/25 at 10:20am revealed:
-She was told upon hire, in April 2024, that SCU residents were not allowed to have personal care

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products in their rooms.
-She was asked by the SCC, today (03/19/25), to help check resident's rooms for anything that should not be there.
-Personal care products may have been left in rooms because night shift staff forgot to remove them after giving showers.
-First shift staff removed personal care products right after giving showers.
-Personal care products were stored in a locked room where each resident had a basket with their name on it and the baskets contained each resident's personal care products.
-Personal care products could possibly be a danger to SCU residents because they go into each other's rooms and other residents could take the items that were left out.
-The SCC frequently and consistently asked the staff to check the residents' rooms on a weekly basis.

Interview with the SCC on 03/19/25 at 10:01am revealed:
-She was aware SCU residents were not supposed to have personal care products in their rooms.
-She thought the products were in the resident rooms because showers had been given earlier in the morning.

Second interview with the SCC on 03/20/25 at 9:05am revealed:
-She was aware SCU residents were not supposed to have anything ingestible or sharp in their rooms.
-She conducted daily room checks after 9:00am because family often brought things into the rooms for the residents.
-Daily room checks were also conducted to look for missing items such as cups, mugs, napkins,

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silverware and decorations.
-She was concerned that the residents could eat the personal care products.
-Showers occurred yesterday morning (03/19/25) and that was why personal care products were in resident rooms.
-Personal care products should have been in the shower caddies in a locked room.
-No resident had been harmed by or ingested any personal care products that she was aware of.

Interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am revealed:
-She had not seen or reviewed any policy related to personal care product storage on the SCU.
-She was not aware of the state regulation regarding storage of personal care products on the SCU.
-She was not aware personal care products had been left in resident rooms on the SCU.
-She spent most of her time on the SCU and was familiar with the residents.
-She was concerned that some of the residents on the SCU would ingest the personal care products.
-Several of the residents on the SCU had memory problems that would cause issues with them having personal care products in their rooms.
-Some of the residents on the SCU put everything in their mouth.
-Some of the residents on the SCU were not aware of where they were at times.
-The SCC was responsible for ensuring personal care products were stored away from the residents on the SCU.
-The SCC randomly checked resident rooms, looking for personal care products, things that could cause falls, sharp objects, dining utensils glass items, dirty clothing and sheets; and to

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make sure there were not resident belongings in another resident's room.
-She expected personal care products to be stored properly and not in resident rooms.
-She expected all personal care products in resident rooms to be removed immediately.
-She did not know why personal care products were left in resident rooms.
-Family could have brought personal care products in and did not tell staff.
-There was a new Standard of Operation (SOP) being developed regarding personal care products that included documenting when products were found in rooms and that family had to bring all personal care products to staff when they brought them in.

Interview with the Administrator on 03/20/24 at 11:41am revealed:
-SCU residents should not have personal care products in their rooms.
-Personal care products on the SCU should be kept in a box or tote in a locked area.
-She was made aware that personal care products were in the rooms of SCU residents yesterday (03/19/25).
-Daily room checks should have been conducted.
-The SCC was responsible for ensuring personal care products were stored away from resident rooms on the SCU.
-Residents on the SCC having personal care products in their rooms was a safety issue.
-Residents on the SCU have the potential to use personal care products inappropriately which could cause poisoning.
-Personal care products on the SCU needed to be stored properly to keep the residents safe.

Telephone interview with the primary care provider (PCP) on 03/20/25 at 4:20pm revealed:

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D 079	Continued From page 6 -She was the provider for most of the residents in the SCU. -The residents on the SCU could hurt themselves with things you would not normally think could hurt someone. -There were residents on the SCU that wander and eat things that were not edible. -Many of the residents in the SCU have the potential to eat things that are not edible. -She was not aware personal care products were being stored in the residence rooms on the SCU. -She was not aware of any incidents with residents being harmed by personal care products on the SCU.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 fixtures located in residents' rooms. The findings are:	D 113		

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D 113	Continued From page 7 Review of the facility's current license effective 01/01/25 revealed the facility was licensed with a capacity of 101 beds. Review of the facility's census reports provided on 01/07/25 revealed the facility's in-house census was 72 residents. Observation of room 100 at 9:30am revealed the water temperature was 74.7 degrees Fahrenheit (F) in the kitchen sink. Observation of room 142 at 9:51am revealed the water temperature was 96 degrees F in the bathroom sink and 98 degrees F in the shower. Observation of room 135 at 10:00am revealed the water temperature was 96 degrees F in the bathroom sink Observation of room 126 at 10:20am revealed the water temperature was 98 degrees F in the shower. Interview with the resident who resided in room 142 on 03/19/25 at 9:55am revealed the water was always cool and never got very warm for several months. Interview with the resident who resided in room 135 on 03/19/25 at 10:00am revealed the hot water in the sink did not heat up and the water never got hot and this has been going on for months. Interview with the resident who resided in room 126 on 03/19/25 at 10:10 am revealed the hot water never got hot and not sure how long.	D 113		

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D 113	Continued From page 8 Interview with the resident who resided in room 100 on 03/19/25 at 2:50pm revealed that she was not sure how long it had been since she had hot water in the kitchen sink. Interview with a personal care aide (PCA) on 03/19/25 at 11:00am revealed: -The hot water had been cool on day shift for several months. -The residents had a difficult time taking a shower with the cool water. -She had informed the Administrator several months ago and she said she would look into it. Interview with another PCA on 03/19/25 at 11:15am revealed: -She had worked at the facility for a couple of months. -The water had been barely warm since she had worked at the facility. -The residents did not like taking a shower because of the cool water. Second observation of room 100 on 03/19/25 at 2:50pm revealed the water temperature was 72 degrees F in the kitchen sink. Second observation of room 142 on 03/19/25 at 2:55pm revealed the water temperature was 82 degrees F in the bathroom sink and 90 degrees F in the shower. Second observation of room 135 on 03/19/25 at 3:05pm revealed the water temperature was 98 degrees F in the bathroom sink. Second observation of room 126 on 03/19/25 at 3:15pm revealed the water temperature was 84 degrees F in the shower and 82 degrees F in the bathroom sink, the bathroom sink was	D 113		

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compliance during first observation.

Interview with the Maintenance Director (MD) on 03/19/25 at 3:30pm revealed:
-He had worked at the facility for one year.
-The boiler had been having problems since he started working at the facility.
-He had not measured any low temperatures.
-He had mainly measured high temperatures.
-He was not able to calibrate his thermometer.
Review of the facility's water temperature log for resident rooms dated 01/03/25-01/27/25 revealed the hot water temperatures ranged from 100.2 degrees F to 115.9 degrees F.

Review of the facility's water temperature log for resident rooms dated 02/05/25-02/24/25 revealed the hot water temperatures ranged from 101.8 degrees F to 114.3 degrees F.

Review of the facility's water temperature log for resident rooms dated 03/03/25-03/17/25 revealed the hot water temperatures ranged from 103.8 degrees F to 114.2 degrees F.

Interview with the facility's plumber on 03/19/25 at 3:45pm revealed:
-He had been called to the facility 6-7 times in the past year related to fluctuating hot water temperatures.
-He had replaced two recirculating pumps in December 2024.
-He had replaced one mixing valve in the past year.
-He had installed a drop loop for the incoming water about four months ago.
-He had replaced cartridges in several showers because they were not working correctly, this caused the water to be either hot or cold in the showers when they were not working correctly.

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D 113	Continued From page 10 -He was at the facility today to look at the third recirculating pump on the hot water line that was leaking and the seal needed to be replaced, this could cause temperature fluctuations but the temperature valves did not look like they had been affected by the leak, the valve leaving the mixing temperature valve was at 112 degrees F and the hot water valve before going to the mixing valve was at 142 degrees F. Third observation of room 100 on 03/19/25 at 4:00pm revealed the water temperature was 65.3 degrees F in the kitchen sink with the MD's thermometer and 68 degrees F with the surveyor's thermometer. Third observation of room 142 on 03/19/25 at 3:55pm revealed the water temperature was 100.6 degrees F in the bathroom sink with the MD's thermometer and 90 degrees F with the surveyor's thermometer and 101.3 degrees F in the shower with the MD's thermometer and 94 degrees F with the surveyor's thermometer. Third observation of room 135 on 03/19/25 at 3:50pm revealed the water temperature was 101.2 degrees F in the bathroom sink with the MD's thermometer and 98 degrees F with the surveyor's thermometer and 101.1 degrees F in the shower with the MD's thermometer and 100 degrees F with the surveyor's thermometer. Third observation of room 126 on 03/19/25 at 3:41pm revealed the water temperature was 100 degrees F in the shower with the MD's thermometer and 84 degrees F with the surveyor's thermometer and 103.1 degrees F in the bathroom sink with the MD's thermometer and 96 degrees F with the surveyor's thermometer.	D 113		

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D 113	Continued From page 11 Fourth observation of room 100 on 03/20/25 at 2:50pm revealed the water temperature was 68 degrees F in the kitchen sink. Fourth observation of room 142 on 03/20/25 at 3:20pm revealed the water temperature was 82 degrees F in the bathroom sink and 80 degrees F in the shower. Fourth observation of room 135 on 03/20/25 at 3:10pm revealed the water temperature was 80 degrees F in the bathroom sink and 84 degrees F in the shower. Fourth observation of room 126 on 03/20/25 at 3:15pm revealed the water temperature was 86 degrees F in the shower and 82 degrees F the bathroom sink. Second interview with the MD on 03/20/25 at 3:30pm revealed that the recirculating pump on the hot water line was replaced today, and it would take several hours for the hot water tank to heat up. Interview with the Administrator on 03/19/25 at 4:00pm revealed: -The water temperature should be between 100-116 degrees F. -The MD made random daily temperature checks when he worked. -She had not been informed that the temperatures were running low. -The MD should have a thermometer that could be calibrated.	D 113		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan	D 262		

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D 262	Continued From page 12 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 5 of 5 sampled residents had an accurate care plan that was signed by the assessor upon completion (#1, #2, #3, #4, and #5) . The findings are: 1. Review of Resident #1's FL2 dated 01/30/25 revealed diagnoses included dementia, memory loss, hypertension and hyperlipidemia. Review of Resident #1's Resident Register revealed she was admitted on 01/20/25. Review of Resident #1's undated care plan titled "Service Plan Report" revealed: -The care plan was not signed by the assessor. -She needed physical assistance with bathing but could participate in part of the bathing activity. -She needed standby supervision, set up, and verbal cues and/or reminders to complete grooming tasks. -She needed verbal cues/reminders or assistance with zippers, buttons, and shoes. -She was independent with toileting, ambulation and transfers. Observation of Resident #3 in her room on 03/20/25 at 9:49am revealed: -The personal care aide (PCA) had just finished helping her change clothes. -She was brushing her teeth as the PCA stood by.	D 262		

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D 262	Continued From page 13 Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm. Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 2. Review of Resident #3's FL2 dated 12/02/24 revealed diagnoses included dementia, loss of appetite, basal cell carcinoma and hypertension. Review of Resident #3's Resident Register revealed she was admitted on 01/20/25. Review of Resident #3's undated care plan titled "Service Plan Report" revealed: -The care plan was not signed by the assessor. -Resident #3 required prompting/assistance to vacate the building in an emergency. -She needed physical assistance with bathing and grooming but could participate in part of the bathing and grooming activity. -She needed verbal cues/reminders or assistance with zippers, buttons, and shoes. -She needed verbal cues/reminders to attend meals, assistance with menu selection and assistance opening containers and packets. -She needed verbal cues/reminders to use the bathroom but was independent in toileting. -She was independent with transfers. Observation of Resident #3 in her room on 03/19/25 at 10:09am revealed: -Resident #3 sitting in a chair watching television. -She was not interviewable.	D 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 262	Continued From page 14 Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm. Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 3. Review of Resident #2's FL2 dated 06/07/24 revealed: -Diagnoses included acute vulvitis, cellulitis of the right lower extremity, anxiety disorder, dehydration, dementia, Alzheimer's Disease, dermatitis, disorder of skin and subcutaneous tissue. -Resident #2 was incontinent in both bladder and bowel. -Resident #2 was nonambulatory and used a walker for ambulation assistance. Review of Resident #2's Resident Register revealed she was admitted on 08/17/21. Review of Resident #2's undated care plan titled "Service Plan Report": -The care plan was not signed by Resident #2's primary care provider (PCP). -She was dependent on staff with bathing. -Staff were to assist as needed with eating, toileting, transfers, grooming and dressing. -She needed verbal cues to be reminded to use her walker. Observation of Resident #2 in her room on 03/19/25 at 9:45am revealed Resident #2 was seated in her wheelchair and she self-propelled around her room.	D 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 262	Continued From page 15 Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm. Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 4. Review of Resident #4's FL2 dated 01/17/25 revealed: -Diagnoses included nontraumatic chronic subdural hemorrhage, type 2 diabetes mellitus without complications, hypo-osmolality, hyponatremia, atherosclerosis heart disease of native, coronary artery without angina pectens, anemia, benign prostate hyperplasia with lower urinary tract symptoms, hyperlipidemia, gastro-esophageal/reflux disease without esophagitis, vitamin D deficiency, metabolic encephalopathy, abnormal results of liver functions, history of falling, cognitive community deficit, muscle weakness (generalized) and difficulty in walking not elsewhere specified. -Resident #3 was continent in both bladder and bowel. -Resident #3 was ambulatory. Review of Resident #4's Resident Register revealed he was admitted on 01/09/25. Review of Resident #4's undated care plan titled "Service Plan Report": -The care plan was not signed by Resident #4's primary care provider (PCP). -There was documentation that Resident #4 used a walker and needed for verbal ques to use his walker. -Resident #4 needed verbal cues and some	D 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 262	Continued From page 16 assistance with dressing and grooming. Observation of Resident #4 in his room on 03/19/25 at 9:47am revealed there was a walker in Resident #4's room. Interview with Resident #4 on 03/19/25 at 9:47am revealed: -He used the walker to "help with getting around the facility". -He was able to dress and bathe himself but would ask for assistance when needed. Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm. Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 5. Review of Resident #5's current FL-2 dated 01/21/25 revealed diagnoses included diabetes, hypertension, hyperlipidemia, Alzheimer's, glaucoma, gastrointestinal reflux disease, gait instability, and depression Review of Resident #5's Resident Register revealed she was admitted on 01/23/25. Review of Resident #5's undated care plan titled "Service Plan Report" revealed: -The care plan was not signed by the assessor. -She needed occasional verbal cues and/or reminders when using a cane, walker, or wheelchair. -She needed physical assistance with bathing. -She needed physical assistance with dressing.	D 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 262	Continued From page 17 -She needed staff escort to meals-secondary to forgetfulness. -She had severe confusion that required constant redirection and monitoring. -She needed physical assistance with toileting. Resident #5 was out of the facility and unable to be observed. Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm. Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. _____ Interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm revealed: -She had been the DHW since January 2025. -She identified the Service Plan Report as the form used for the Care Plan. -She did not know who was responsible for ensuring care plans were completed and signed. -Staff used the care plan in their computer system to care for residents. Interview with the Administrator on 03/20/25 at 11:41am revealed: -The care plan used was the form titled "Service Plan Report". -Care plans were to be completed every six months or when there was a change in condition and 30 days after admission. -The DHW was responsible for ensuring care plans were completed and signed. -The DHW was new to the role and some of the	D 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 262	Continued From page 18 care plans were not signed prior to her taking that position. -She checked behind the DHW periodically to ensure care plans were up to date. -She expected care plans to be sent to the primary care provider (PCP) for signature after completion. -She became aware that some care plans were unsigned yesterday. Interview with the PCP on 03/20/25 at 4:20pm revealed: -She signed off on care plans yearly. -She could not say the last time she signed off a care plan for any specific resident. -The facility put care plans in her folder at the facility for her to sign or they faxed the care plan to her office for signature and her office faxed the signed care plan back to the facility. -If she signed a care plan at the facility, she gave the care plan back to the facility staff.	D 262		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by:	D 263		

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D 263	Continued From page 19	D 263		

Based on record reviews and interviews, the facility failed to ensure that the physician certified the care plan by signing and dating within 15 calendar days of completion of the assessment for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) .

The findings are:

1. Review of Resident #1's FL2 dated 01/30/25 revealed diagnoses included dementia, memory loss, hypertension and hyperlipidemia.

Review of Resident #1's Resident Register revealed she was admitted on 01/20/25.

Review of Resident #1's undated care plan titled "Service Plan Report" revealed:
-The care plan was not signed by Resident #3's primary care provider (PCP).
-She needed physical assistance with bathing but could participate in part of the bathing activity.
-She needed standby supervision, set up, and verbal cues and/or reminders to complete grooming tasks.
-She needed verbal cues/reminders or assistance with zippers, buttons, and shoes.
-She was independent with toileting, ambulation and transfers.

Observation of Resident #3 in her room on 03/20/25 at 9:49am revealed:
-The personal care aide (PCA) had just finished helping her change clothes.
-She was brushing her teeth as the PCA stood by.

Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm.

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D 263	Continued From page 20 Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 2. Review of Resident #3's FL2 dated 12/02/24 revealed diagnoses included dementia, loss of appetite, basal cell carcinoma and hypertension. Review of Resident #3's Resident Register revealed she was admitted on 01/20/25. Review of Resident #3's undated care plan titled "Service Plan Report" revealed: -The care plan was not signed by Resident #3's primary care provider (PCP). -Resident #3 required prompting/assistance to vacate the building in an emergency. -She needed physical assistance with bathing and grooming but could participate in part of the bathing and grooming activity. -She needed verbal cues/reminders or assistance with zippers, buttons, and shoes. -She needed verbal cues/reminders to attend meals, assistance with menu selection and assistance opening containers and packets. -She needed verbal cues/reminders to use the bathroom but was independent in toileting. -She was independent with transfers. Observation of Resident #3 in her room on 03/19/25 at 10:09am revealed: -Resident #3 sitting in a chair watching television. -She was not interviewable. Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm.	D 263		

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D 263	Continued From page 21 Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 3. Review of Resident #2's FL2 dated 06/07/24 revealed: -Diagnoses included acute vulvitis, cellulitis of the right lower extremity, anxiety disorder, dehydration, dementia, Alzheimer's Disease, dermatitis, disorder of skin and subcutaneous tissue. -Resident #2 was incontinent in both bladder and bowel. -Resident #2 was nonambulatory and used a walker for ambulation assistance. Review of Resident #2's Resident Register revealed she was admitted on 08/17/21. Review of Resident #2's undated care plan titled "Service Plan Report": -The care plan was not signed by Resident #2's primary care provider (PCP). -She was dependent on staff with bathing. -Staff were to assist as needed with eating, toileting, transfers, grooming and dressing. -She needed verbal cues to be reminded to use her walker. Observation of Resident #2 in her room on 03/19/25 at 9:45am revealed Resident #2 was seated in her wheelchair and she self-propelled around her room. Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm.	D 263		

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D 263	Continued From page 22	D 263		

Refer to interview with the Administrator on 03/20/25 at 11:45am.

Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm.

4. Review of Resident #4's FL2 dated 01/17/25 revealed:
-Diagnoses included nontraumatic chronic subdural hemorrhage, type 2 diabetes mellitus without complications, hypo-osmolality, hyponatremia, atherosclerosis heart disease of native, coronary artery without angina pectens, anemia, benign prostate hyperplasia with lower urinary tract symptoms, hyperlipidemia, gastro-esophageal/reflux disease without esophagitis, vitamin D deficiency, metabolic encephalopathy, abnormal results of liver functions, history of falling, cognitive community deficit, muscle weakness (generalized) and difficulty in walking not elsewhere specified.
-Resident #3 was continent in both bladder and bowel.
-Resident #3 was ambulatory.

Review of Resident #4's Resident Register revealed he was admitted on 01/09/25.

Review of Resident #4's undated care plan titled "Service Plan Report":
-The care plan was not signed by Resident #4's primary care provider (PCP).
-There was documentation that Resident #4 used a walker and needed for verbal ques to use his walker.
-Resident #4 needed verbal cues and some assistance with dressing and grooming.

Observation of Resident #4 in his room on 03/19/25 at 9:47am revealed there was a walker

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D 263	Continued From page 23 in Resident #4's room. Interview with Resident #4 on 03/19/25 at 9:47am revealed: -He used the walker to "help with getting around the facility". -He was able to dress and bathe himself but would ask for assistance when needed. Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm. Refer to interview with the Administrator on 03/20/25 at 11:45am. Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm. 5. Review of Resident #5's current FL-2 dated 01/21/25 revealed diagnoses included diabetes, hypertension, hyperlipidemia, Alzheimer's, glaucoma, gastrointestinal reflux disease, gait instability, and depression Review of Resident #5's Resident Register revealed she was admitted on 01/23/25. Review of Resident #5's undated care plan titled "Service Plan Report" revealed: -The care plan was not signed by Resident #5's primary care provider (PCP). -She needed occasional verbal cues and/or reminders when using a cane, walker, or wheelchair. -She needed physical assistance with bathing. -She needed physical assistance with dressing. -She needed staff escort to meals-secondary to forgetfulness. -She had severe confusion that required constant	D 263		

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D 263	Continued From page 24	D 263		

redirection and monitoring.
-She needed physical assistance with toileting.

Resident #5 was out of the facility and unable to be observed.

Refer to interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm.

Refer to interview with the Administrator on 03/20/25 at 11:45am.

Refer to interview with the primary care provider (PCP) on 03/20/25 at 4:20pm.

_____

Interview with the Director of Health and Wellness (DHW) on 03/20/25 at 10:20am and 5:41pm revealed:
-She had been the DHW since January 2025.
-She identified the Service Plan Report as the form used for the Care Plan.
-She did not know who was responsible for ensuring care plans were completed and signed.
-Staff used the care plan in their computer system to care for residents.

Interview with the Administrator on 03/20/25 at 11:41am revealed:
-The care plan used was the form titled "Service Plan Report".
-Care plans were to be completed every six months or when there was a change in condition and 30 days after admission.
-The DHW was responsible for ensuring care plans were completed and signed.
-The DHW was new to the role and some of the care plans were not signed prior to her taking that position.
-She checked behind the DHW periodically to

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D 263	Continued From page 25 ensure care plans were up to date. -She expected care plans to be sent to the primary care provider (PCP) for signature after completion. -She became aware that some care plans were unsigned yesterday. Interview with the PCP on 03/20/25 at 4:20pm revealed: -She signed off on care plans yearly. -She could not say the last time she signed off a care plan for any specific resident. -The facility put care plans in her folder at the facility for her to sign or they faxed the care plan to her office for signature and her office faxed the signed care plan back to the facility. -If she signed a care plan at the facility, she gave the care plan back to the facility staff.	D 263		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to notify the primary care provider for 1 of 5 sampled residents who had multiple falls and a hospital admission. The findings are: Review of the facility's Fall Management and	D 273		

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Investigation Policy dated 03/19/24 revealed:
-The residents, family member/responsible person and physician are notified of falls.
-Fall interventions are reported to the state as required by state laws and regulations.
-Fall interventions are documented in the resident's service plan.
-Communication is provided to residents, family members, and teams members on fall interventions.

Review of Resident #5's current FL-2 dated 01/25/25 revealed:
-Diagnoses included diabetes, hypertension, hyperlipidemia, Alzheimer's, gastroesophageal reflux, bilateral glaucoma, gait instability, and depression.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident had functional limitations related to sight and hearing.

Review of Resident #5's Resident Register revealed that she was admitted on 01/23/25.

Review of Resident #5's Care Plan revealed there was not a signed care plan by the primary care provider (PCP).

Review of Resident #5's facility progress notes revealed:
-On 02/01/25 at 7:27am, the medication aide (MA) documented that the resident was on the floor, the Power of Attorney (POA) was left a voice message, and she was unable to notify the PCP because she did not have a phone number.
-On 02/27/25 at 4:11am, the MA documented that the resident was found on the floor around 11:00pm on 02/26/25, Emergency Medical Services (EMS) were called and when they

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	HAL065045	A. BUILDING: _____ B. WING _____	R 03/20/2025

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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

(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
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arrived the resident had a 45 second "seizure". Attempted to call POA twice, no answer and was unable to call or fax PCP due to not having a phone or fax number. Documentation left for dayshift to send to PCP once a phone or fax number was obtained.
-On 03/16/25 at 3:19am, the MA documented that the resident was observed having a seizure, uncontrolled jerking and shaking and hit her head on the side of her table. POA and provider were notified.

Review of the Emergency Department (ED) Encounter dated 02/27/25 revealed:
-Upon arrival at the nursing facility where Resident #5 lived EMS witnessed a seizure that lasted 45 seconds.
-Computed tomography (CT) scan dated 02/27/25 of the cervical spine revealed no acute cervical fracture detected.

Review of the ED After Visit Summary dated 02/27/25 revealed:
-Resident #5 was seen for seizures.
-Resident #5's diagnoses were fall and seizure.
-There was an order for Resident #5 to follow up with her PCP.

Review of the Hospital Discharge Summary dated 03/20/25 revealed:
-Resident #5 was admitted to the hospital on 03/16/25 and discharged on 03/20/25.
-Resident #5 was admitted on 03/16/25 for new onset seizures and found to have a C1 cervical vertebral fracture (The C1 Vertebra is located at the very top of the spine and directly supports the head and connects the head to the rest of the body).
-CT scan of the cervical spine dated 03/16/25 revealed a mildly displaced and impacted fracture

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of the left lateral mass of C1.
-Wear cervical collar for 3 months.
-Physical Therapy (PT) and Occupational Therapy (OT) evaluation recommended skilled nursing facility.
-Discharge to a skilled nursing facility (SNF).
-Follow up with neurosurgery in 6 weeks (05/01/25) with repeat x-ray.
-Follow up with Internal Medicine in one week (03/27/25).

Interview with the Director of Health and Wellness (DHW) on 03/20/25 at 2:15pm revealed.
-She had been employed at the facility for 2 months.
-She did not know who was responsible for notifying the PCP for falls or hospital admissions.
-She was not aware that Resident #5 needed a follow-up appointment after her ED visit on 02/27/25 and was not sure who was responsible for making the follow-up appointments.
-She had not reviewed the documentation from the ED dated 02/27/25.
-There should have been an incident report on all visits to the ED and then she followed up on the incident reports once they were triggered in the facility computer system.
-She did not know that there were no completed incident reports for 02/01/25 and 02/27/25.
-She did not know that Resident #5 was sent to the hospital on 03/16/25 and admitted until she received an internal email dated 03/17/25 at 5:02pm.
-She received an email daily documenting the residents that are out of the facility.
-She had no way of knowing that a resident had a fall or trip to the ED if an incident report was not completed.
-She had not implemented any interventions related to Resident #5's falls.

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D 273	Continued From page 29 -She was responsible for the care and supervision of all residents and clinical staff. Interview with the Administrator on 03/20/25 at 4:09pm revealed: -The facility policy required a review of the residents after each fall. -An incident report when completed by the MA for a fall triggered the fall risk assessment to be performed by the DHW. -If an incident report was not completed then the trigger for the fall risk assessment would not take place. -There were no an incident reports for Resident #5 on 02/01/25 and 02/27/25. -She was not aware that the internal facility incident reports for the falls dated 02/01/25 and 02/27/25 were not completed. -The DHW was responsible for ensuring that the PCP was contacted by the MA and if not, she notified the PCP. -The staff that received the resident back from a medical visit was responsible for making sure follow-up appointments were scheduled. -The DHW reviewed resident returns from outside healthcare visits daily. -The facility process failed because there were no triggers without the reports completed. -She was not aware that Resident #5 had her first documented seizure at the facility on 02/27/25. -She was not aware that Resident #5's PCP was not notified after each incident of falling, having a seizure, or admitted to the hospital. -She was not aware that the follow up appointment was not made after Resident #5 returned from the hospital. -She expected the staff to complete the internal reports so that the facility process from these reports would be triggered.	D 273		

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D 273	Continued From page 30 Telephone interview with the primary care provider's certified medical assistant on 03/20/25 at 4:41pm revealed: -There were not any reports received by the PCP's office for Resident #5's PCP related to falls, seizures, or hospital admission dated 02/01/25, 02/27/25, and 03/16/25. -The PCP was notified by the Hospital on 03/18/25 that Resident #5 had been admitted. -The PCP's office did not receive any faxed documents or voice messages related to the fall Resident #5 had on 02/01/25. -The PCP's office did not receive any faxed documents or voice messages related to the fall, seizure, or ED visit dated 02/27/25. -The PCP's office did not receive any faxed documents or voice messages related to the fall, seizure, or hospital admission dated 03/16/25. -There was no documentation in Resident #5's medical history that she had a history of seizures. -The PCP did not have any documentation in Resident #5 having had a fall at the facility since admission. -It was an expectation of the PCP to be notified by the facility when a resident falls, had a change in medical condition, or was admitted to the hospital. -An appointment for follow up after her first seizure would have been made to potentially avoid having the second seizure which resulted in a C1 cervical fracture which could have been life threatening. Review of Resident #5's PCP's progress note dated 02/06/25 revealed there was no mention of any falls prior to this date. Telephone interview with Resident #5's Power of Attorney on 03/20/25 at 5:53pm revealed: -He was notified about Resident #5's fall on	D 273		

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D 273	Continued From page 31 02/01/25 and that she was not transported to the ED. -He was notified about Resident #5's fall and seizure on 02/27/25 and that she was transported to the ED. -He was notified about Resident #5's fall and seizure 03/16/25 and that she was transported to the ED. -Resident #5 was admitted to a Long-Term Care facility for rehabilitation on 03/20/25 after she was discharged from the hospital. -Resident #5 had been diagnosed with seizures over 34 years ago and that she had not had a seizure in the past 34 years. _____ The facility failed to notify a resident's PCP of a fall on 02/01/25, a fall and seizure on 02/27/25 that required an evaluation in the ED, and a fall and seizure on 03/16/25 that required the resident to be admitted to the hospital for seizures and a C1 cervical fracture. The facility failed to notify the primary care provider of the resident falls, new onset seizures, and admission to the hospital and failed to make a follow up appointment as ordered after the resident's fall and first documented seizure since admission to the facility. The facility's failure resulted in serious physical harm to the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/20/25 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED April 19, 2025.	D 273		

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D 306	Continued From page 32	D 306		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal, in addition to other beverages. The findings are: Observation of the breakfast meal in the assisted living (AL) dining room on 03/20/25 at 7:15revealed: -There were 24 residents present for the breakfast meal. -None of the residents had a glass or bottle of water. -There were 4 glasses at each place setting on the dining table for an additional beverage or water. -There was a beverage cart that had 8-8oz bottles of water. -There was not a pitcher or container of water placed on the beverage cart. Observation of the beverage cart on 03/20/25 at 7:33am revealed there was a pitcher of ice water placed on the beverage cart.	D 306		

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D 306	Continued From page 33 Interview with a resident on 03/20/25 at 7:36am revealed: -Water was not served with any meal unless a resident asked for water. -Resident observed the other two empty glasses at her and others' place setting and said, "What was the purposed of having the other glasses on the table if the staff would not serve water." Interview with a second resident on 03/20/25 at 7:25am revealed: -He ate his breakfast meal in his room. -He was never served water with his any of his meals. Interview with a dietary server on 03/20/25 at 7:21am revealed: -Residents were served water only if they ask for water to drink. -There was bottles of water kept on the beverage cart for residents who requested water. -The extra drinking glasses placed on the table were for water and any other beverages. Observation of the breakfast meal in the special care unit (SCU) dining room on 03/20/25 from 7:54am to 8:28am revealed: -There were 13 residents present for the breakfast meal. -The residents who were served only a juice of their choice, milk and/or coffee. -The residents were not served or offered water. -There were not a pitcher or container of water placed in the dining room to offer to residents. Interview with a special care aide (PCA) on 03/20/25 at 7:25am revealed: -The dietary staff bring the beverage cart to SCU. -She did not know why water was not served to	D 306		

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the residents with their breakfast meal.
-There was a kitchen on SCU and if residents wanted water, she could get a glass of water from the SCU kitchen.

Interview with a dietary server on 03/20/25 at 3:56pm revealed:
-The dietary aides prepared the beverage carts for the assisted living and SCU dining rooms.
-Water was only placed on the AL beverage cart.
-The SCU staff were to prepare pitchers of water and serve water to the SCU residents.
-She prepared the beverage cart for the SCU but did not place water of the beverage cart.

Interview with the Cook on 03/20/25 at 3:44pm revealed it was the responsibility of the dietary servers to prepare the beverage carts and place water on the beverage carts.

Interview with a Primary Care Provider on 03/202/25 at 4:20pm revealed residents should be served water with their meals and encouraged to drink water daily in order to prevent dehydration and urinary tract infections.

Interview with the Special Care Unit Program Director on 03/20/25 at 12:26pm revealed:
-If water was not placed on the beverage cart, the SCU had a kitchen where the SCU staff could prepare pitchers of water and served to the residents.
-Residents were to be served water with each meal.

Interview with the Administrator on 03/20/25 at 5:51pm revealed:
-A water glass was to be placed at each resident place setting at every meal.
-All residents on the AL and SCU were to be

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D 306	Continued From page 35 served water at each meal.	D 306		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a current list with physician's ordered therapeutic or modified diets for guidance of food service for 2 of 5 sampled residents (#1 and #5). The findings are: 1. Review of Resident #1's FL2 dated 01/30/25 revealed diagnoses included dementia, memory loss, hypertension and hyperlipidemia. Review of Resident #1's diet order dated 11/18/24 revealed: -Resident #1 diet was a pureed meal. -Resident #1 was to receive a supplement 3 times daily as needed (PRN). Observation of the kitchen on 03/19/25 at 11:02am revealed there was not a diet list of	D 309		

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residents on therapeutic diets.

Observation of the regular diet menu for the breakfast meal on 03/19/25 at 11:19am revealed:
-The menu was on week 3 cycle.
-The breakfast meal for 03/20/25 was western scrambled eggs with ham, peppers and onions.

Refer to the interview with the cook on 03/19/25 at 11:12am.

Refer to interview with a second cook on 03/20/25 at 3:44pm.

Refer to the interview with the Directory of Health and Wellness (DHW) on 02/27/25 at 11:54am.

Refer to the interview with the Administrator on 03/20/25 at 5:51pm.

2. Review of Resident #5's current FL-2 dated 07/31/24 revealed diagnoses included essential hypertension, hyperlipidemia, seizures and major depressive disorder-recurrent.

Review of Resident #5's diet order dated 11/28/24 revealed a mechanical soft diet.

Observation of the kitchen on 03/19/25 at 11:02am revealed there was not a diet list of residents on therapeutic diets.

Interview with Resident #5 on 03/20/25 at 7:36am revealed:
-Her breakfast meal was good.
-She was able to chew her food.

Refer to the interview with the cook on 03/19/25 at 11:12am.

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D 309	Continued From page 37 Refer to interview with a second cook on 03/20/25 at 3:44pm. Refer to the interview with the Directory of Health and Wellness (DHW) on 02/27/25 at 11:54am. Refer to the interview with the Administrator on 03/20/25 at 5:51pm. _____ Interview with the cook on 03/19/25 at 11:12am revealed: -The cooks only received copies of diet orders for new residents or when there was a change in a resident's diet. -There was not a therapeutic diet list posted. -The special care unit (SCU) staff prepared a menu order for each meal and submitted it to the cooks. -The menu order from SCU would list the diet order. Interview with a second cook on 03/20/25 at 3:44pm revealed: -There was not a posted therapeutic diet list. -He used the meal menu list completed by the residents as a guide to prepare their meals. Interview with the Director of Health and Wellness (DHW) on 03/20/25 at 5:37pm revealed the Administrator provides the dietary staff with all new and revised diet orders. Interview with the Administrator on 03/20/25 at 5:51pm revealed: -The DHW was responsible for providing the dietary staff with a list of all new and revised diet orders. -She was not aware of the diet orders not being posted.	D 309		

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D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain therapeutic diets menus for 1 of 5 residents sampled (#5) for a mechanical soft diet. The findings are: Review of Resident #5's current FL-2 dated 07/31/24 revealed diagnoses included essential hypertension, hyperlipidemia, seizures and major depressive disorder-recurrent. Review of Resident #5's diet order dated 11/28/24 revealed a mechanical soft diet. Observation of the breakfast meal on 03/20/25 at 7:17am revealed: -Resident #3 was served scrambled eggs with diced ham and peppers, a hashbrown, orange juice, milk and coffee. -She ate 100% of the breakfast meal. -Resident #5 was served a mechanical soft diet. Observation of the kitchen on 03/19/25 at 11:02am revealed there was not a therapeutic diet menu posted. Observation of the kitchen on 03/19/25 at 11:19am revealed there was regular diet menu for	D 310		

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D 310	Continued From page 39 week 3 cycle posted. Interview with Resident #5 on 03/20/25 at 7:36am revealed: -Her breakfast meal was good. -She was able to chew and swallow her food without any problems. Interview with the cook on 03/20/25 at 3:44pm revealed: -There was not a therapeutic diet menu posted. -He prepared most diet orders by memory. -He was not aware of the extended therapeutic menu. Interview with the Administrator on 03/20/25 at 5:51pm revealed she was not aware the dietary staff did not have a therapeutic diet menu to use as a guide for preparing the special diets.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a resident (Resident #6) with was fed with dignity and respect. The findings are:	D 312		

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D 312	Continued From page 40 Review of Resident #6 FL2 dated 05/28/24 revealed: -Diagnoses included dementia-unspecific severity, osteoarthritis, diabetes and hyperlipidemia. -There was a diet order for a regular diet. Review of Resident #6's Care Plan dated 02/11/25 revealed Resident #6 was independent with eating. Observation of breakfast meal on the Special Care Unit (SCU) on 03/20/25 at 7:25am to 7:54am revealed: -Resident #6 was seated at a dining table with two other residents. -Resident #6's breakfast meal was scrambled eggs with diced ham and peppers, hashbrown, milk and cranberry juice. -Resident #6 was receiving feeding assistance by a personal care aide (PCA). -The PCA was standing up on the left side of the resident while feeding Resident #6. -There was a second PCA standing on the right side of Resident #6 while she was being fed. -The second PCA was not assisting with feeding Resident #6. -When Resident #6 would not eat her breakfast meal, the PCA would feed Resident #6 and said, "That's why I have to keep feeding you". Observation of lunch meal on 03/20/25 at 12:05pm to 12:34pm revealed: -Resident #6 was seated at the dining table with two other residents. -Resident #6's lunch meal was lasagna, potato chips, zucchini, 2 cookies, orange drink, milk and water. -Resident #6 fed herself without assistance from	D 312		

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the SCU staff.
-Resident #6 paced herself with her lunch meal.
-Staff observed Resident #6 as they walked around the dining to ensure she was eating her food.
-Staff did not have to give Resident #6 cues to eat her meal.
-Resident #6 ate at 90% of her lunch meal.

Interview with a PCA 03/20/25 at 12:18pm revealed:
-She had been employed for at least one week.
-She had not been trained on feeding assistance for residents.
-She fed Resident #6 her breakfast meal because she would not always eat her food.

Interview with a second PCA on 03/20/25 at 12:08pm revealed:
-She stood to feed the resident because she had to watch the residents eat their food and to make sure they were not choking.
-Resident #6 would not eat her food unless she was fed.
-She had not completed training on feeding assistance for residents.

Telephone interview with the primary care provider (PCP) on 03/20/25 at 4:20pm revealed:
-The facility staff had not notified her of Resident #6 having any feeding issues.
-Staff may have given Resident #6 cues to eat her food because she would pace the halls on the SCU.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 12:34pm revealed:
-There were no residents who required feeding assistance.
-Resident #6 would need redirection at times

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D 312	Continued From page 42 when eating her meal but did not require feeding assistance. -Staff were required to sit beside the residents when providing feeding assistance. -Staff standing to feed a resident was insensitive. -The PCAs were trained on feeding assistance for residents. Interview with the Administrator on 03/20/25 at 5:51pm revealed staff are to always sit with and beside the residents when feeding them their meals.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medication as ordered by the provider related to a medication prescribed for a cough for 7 days being administered for almost 3 months after the stop date for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's FL2 dated 11/26/24 revealed diagnoses included dementia, loss of	D 358		

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appetite, basal cell carcinoma and hypertension.

Review of a progress note from Resident #3's primary care provider (PCP) dated 12/13/24 revealed there was an order for Robitussin 100mg/5mL liquid, take 10ml by mouth 3 times daily for 7 days. (Robitussin is used to thin secretions from the chest.}

Review of Resident #3's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Robitussin Syrup Plain 100mg/5mL, Give 10mL 3 times a day for cough for 7 days to be administered at 9:00am, 1:00pm and 5:00pm with an order date ot 12/13/24.
-Robitussin was documented as administered 01/01/25 through 01/17/25, 01/21/25, 01/23/25, 01/25/25 through 01/27/25 and 01/30/25 through 01/31/25 at 9:00am, 1:00pm and 5:00pm.

Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Robitussin Syrup Plain 100mg/5mL, Give 10mL 3 times a day for cough for 7 days to be administered at 9:00am, 1:00pm and 5:00pm.
-Robitussin was documented as administered 02/01/25 through 02/28/25 at 9:00am, 1:00pm and 5:00pm.

Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Robitussin Syrup Plain 100mg/5mL, Give 10mL 3 times a day for cough for 7 days to be administered at 9:00am, 1:00pm and 5:00pm.
-Robitussin was documented as administered

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D 358	Continued From page 44 03/01/25 through 03/19/25 at 9:00am and 1:00pm. -Robitussin was documented as administered 03/01/25 and 03/03/25 through 03/18/25 at 5:00pm. Observation of medications on hand for Resident #3 on 03/20/25 at 8:32am revealed there was no Robitussin available on the cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/20/25 at 4:11pm revealed: -Robitussin 100mg/5ml, 1 bottle was dispensed for Resident #3 on 12/15/24 and was to be taken for 7 days. -The strength of the prescription Robitussin and over the counter Robitussin were the same. -Pharmacy entered orders on the eMAR and the orders were transmitted to the facility to accept. -Pharmacy put a stop date of 12/23/24 on the eMAR for the Robitussin. -If the facility did not accept the orders, the order would continue on the eMAR beyond the stop date. -He was unsure if the facility accepted the orders. -He was not sure what happened to cause the Robitussin to continue to be on the eMAR. -Robitussin helped thin secretions from the chest. -Taking Robitussin longer than 7 days would not have had any real effect on Resident #3. -Resident #3 taking Robitussin longer than 7 days meant she was taking medication she did not need. -He did not know why the facility would continue to give the Robitussin after the dispensed bottle ran out. Interview with a medication aide (MA) on 03/20/25 at 8:46am revealed:	D 358		

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D 358	Continued From page 45 -The MA was responsible for administering medications. -Resident #3 had an order in the computer under "orders" dated 12/13/24 to give Robitussin 3 times a day for a cough for 7 days. -The Robitussin order should have been discontinued a long time ago. -She did not realize the order for Robitussin was for 7 days prior to today (03/20/25). -No one ever told her during hand off that the Robitussin was for 7 days. -She determined what medication to administer to residents by comparing the eMAR with the medications. -She did not give Resident #3 Robitussin this morning because the medication was not on the cart. -She last worked in the special care unit (SCU) this past weekend (approximately 03/14/25, 03/15/25 or 03/16/25) and she did not notice that the Robitussin was ordered for 7 days. -She had been previously administering Robitussin to Resident #3 and administered the medication to Resident #3 over the weekend (approximately 03/14/25-03/16/25). -House stock Robitussin had been available on the cart for Resident #3. -She wondered why Resident #3 was taking Robitussin so long. -She should have questioned someone as to why Resident #3 was still taking Robitussin. -When she noticed a medication needed to be discontinued, she notified the Director of Health and Wellness (DHW) and the DHW gave her verbal approval to discontinue the medication; or she was told to call the PCP to request a discontinue order. -She did not know why the Robitussin was not noticed by anyone prior to today (03/20/25). -She would start opening orders all the way on	D 358		

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the computer before administering any medication so she could read the entire order.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 9:05am revealed:
-She had nothing to do with the clinical operations of the unit.
-She had not been trained on the medication cart.
-The MA was responsible for reporting to the nurse (DHW) when medications needed to be discontinued.

Interview with the DHW on 03/20/25 at 10:20am revealed:
-MAs were responsible for administering medications as ordered.
-When MAs had questions, they sent communication to the PCP for clarification prior to administering medications.
-She was not aware of the 12/13/24 Robitussin order for Resident #3.
-Taking Robitussin for longer than 7 days could have caused an interaction with Resident #3's other medications.
-Resident #3 was being billed for a medication that she should not have been taking.

Interview with the Administrator on 03/20/25 at 11:41am revealed:
-The MAs were responsible for administering medications as ordered.
-The DHW was responsible for following up to ensure orders were entered correctly on the eMARs.
-She was made aware of the Robitussin order, and that the medication was administered past 7 days, late yesterday (03/19/25) or early this morning (03/20/25).
-Taking Robitussin past 7 days put Resident #3's safety at risk and the medication was not being

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D 358	Continued From page 47 taken as ordered. -The Robitussin order had no stop date, and this was why it continued to appear on the eMAR. -The DHW was supposed to do end of the month audits of the eMARs. -She did not know if end of the month audits of the eMARs were being done at the time of the Robitussin order. -The Assistant DHW was responsible for eMAR audits, but she left 01/19/25. -There was no DHW on 01/19/25. -She would follow up with the DHW today (03/20/25) to make sure an error report was done, and the PCP was notified. Telephone interview with Resident #3's primary care provider (PCP) on 03/20/25 at 4:20pm revealed: -She prescribed Robitussin 100mg 3 times daily for 7 days for Resident #3 on 12/13/24 for a bad cough. -She was not aware Resident #3 was still taking the Robitussin. -She prescribed plain Robitussin which would not harm Resident #3 if she took the medication past 7 days. -Resident #3 taking Robitussin past 7 days was unnecessary. -She expected the medication to be stopped on the stop date. -She hand wrote the order for 7 days and the facility put the order in the system. -She did not put a stop date on the order because medications sometimes took 2 to 3 days to come into the facility.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration	D 371		

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D 371	Continued From page 48 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures. The findings are: Review of the Administration of Eye Medication (Eye Drops) dated 09/01/19 revealed: -Wash hands and apply gloves before administering eye drops. -Once eye drops had been administered remove gloves and wash hands. Observation of the medication aide (MA) during the morning medication pass on 03/20/25 between 7:05am and 7:18am revealed: -The MA was ungloved and at the medication cart in the facility hallway. -She did not sanitize her hands before preparing the residents' medications. -There was a bottle of alcohol-based hand sanitizer on the medication cart. -She prepared the residents medication by punching the medication from the bubble cards into a medication cup and obtained an eye drop bottle from the medication cart. -She administered the resident's medication and then she administered an eye drop to both eyes without gloves and returned to the medication	D 371		

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cart.
-She used her key to unlock the medication cart and returned the bottle of eye drops.
-She sanitized her hands after replacing the eye drops in the medication cart.

Interview with the MA on 03/20/25 at 7:20am revealed:
-She was supposed to sanitize her hands before administering medications to a resident.
-She was supposed to wear gloves when administering eye drops.

Interview with the Director of Health and Wellness (DHW) on 03/20/25 at 11:00am revealed:
-She had worked at the facility for 2 months.
-She did not know what the MA training was related to administering eye drops.
-She did not know what the facility policy was on administering eye drops.
-There had not been any education provided to the Mas related to medication administration since she had worked at the facility.
-Gloves should be worn when administering eye drops because of infection control.

Interview with the Regional Director of Health and Wellness (RDHW) on 03/20/25 at 10:30am revealed:
-Infection control was part of the MA training.
-The MAs should have washed hands before putting on gloves, administered the eye drops, and then remove the gloves and either sanitize or wash their hands with soap and water.

Interview with the Administer on 03/20/25 at 12:05pm revealed:
-MAs should follow the infection control policy, sanitize their hands, wear gloves, and then sanitize after removing their gloves.

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D 371	Continued From page 50 -This was part of their MA training.	D 371		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on pharmacy review recommendations for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's FL2 dated 11/26/24 revealed diagnoses included dementia, loss of appetite, basal cell carcinoma and hypertension. Review of a progress note from Resident #3's primary care provider (PCP) dated 12/13/24 revealed there was an order for Robitussin 100mg/5mL liquid, take 10ml by mouth 3 times daily for 7 days. Review of Resident #3's pharmacy consultation report dated 02/27/25 revealed: -The pharmacist documented that Robitussin 3 times daily for 7 days from a 12/13/24 order was still on the eMAR (electronic medication record) and was being charted as given. -The pharmacist recommended the medication	D 406		

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error be reported and the order be discontinued.
-The pharmacist recommended reviewing with staff to notify the Administrator if a medication was on the eMAR incorrectly.

Review of Resident #3's record revealed there was no documentation the PCP had been made aware of the pharmacist recommendations.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/20/25 at 4:11pm revealed:
-Robitussin 100mg was dispensed for Resident #3 on 12/15/24 and was to be taken for 7 days.
-The strength of the prescription Robitussin and over the counter Robitussin were the same.
-Pharmacy entered orders on the eMAR and the orders were transmitted to the facility to accept.
-Pharmacy put a stop date of 12/23/24 on the eMAR for the Robitussin.
-If the facility did not accept the orders, the order would continue on the eMAR beyond the stop date.
-He was unsure if the facility accepted the orders.
-He was not sure what happened to cause the Robitussin to continue to be on the eMAR.
-Robitussin helped thin secretions from the chest.
-Taking Robitussin longer than 7 days would not have had any real effect on Resident #3.
-Resident #3 taking Robitussin longer than 7 days meant she was taking medication she did not need.
-He was not familiar with the Pharmacy Consultation report recommendations from 02/27/25 because the report was done by a consulting Pharmacist.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 9:05am revealed:
-She had nothing to do with the clinical operations

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of the unit.
-She had not been trained on the medication cart.
-The MA was responsible for reporting to the nurse (DHW) when medications needed to be discontinued.
-She was not aware of the Pharmacy Consultation report regarding the Robitussin for Resident #3 dated 02/27/25.

Interview with the DHW on 03/20/25 at 10:20am revealed:
-MAs were responsible for administering medications.
-When MAs had questions, they sent communication to the PCP for clarification prior to administering medications.
-She was not aware of the 12/13/24 Robitussin order for Resident #3.
-The pharmacy completed the medication review and emailed the recommendations to the facility.
-She had not reviewed Resident #3's Pharmacy Consultation report.
-She was not aware of the recommendations regarding Robitussin for Resident #3 documented on the 02/27/25 Pharmacy Consultation report.
-She was responsible for reviewing the Pharmacy Consultation report recommendations and making sure they were followed.
-She became the DHW 12/30/24.
-She did not know the Pharmacy Consultation report policy because she had not received training in that area yet.

Interview with the Administrator on 03/20/25 at 11:41am revealed:
-The DHW was responsible for reviewing the recommendations from the Pharmacy Consultation report.
-She was unsure how much training the DHW had on Pharmacy Consultation reports.

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-The Pharmacy Consultation report went directly to the DHW.
-The DHW reviewed the report and sent recommendations to the PCP.
-She was not aware of the 02/27/25 Pharmacy Consultation report recommendations for Resident #3.
-She did not receive notification of the Pharmacy Consultation report recommendations because she had not been added to the email list.
-She had been the interim Administrator for 6 weeks.
-She was made aware of the Robitussin order, and that the medication was administered past 7 days, late yesterday or early this morning.
-The DHW was supposed to do end of the month audits of the eMARs.
-She did not know if end of the month audits of the eMARs was being done at the time of the Robitussin order.
- The Assistant DHW was responsible for eMAR audits, but she left 01/19/25.
-There was no DHW on 01/19/25.
-She would follow up with the DHW today (03/20/25) to make sure an error report was done and the PCP was notified.

Telephone interview with Resident #3's primary care provider (PCP) on 03/20/25 at 4:20pm revealed:
-She prescribed Robitussin 100mg 3 times daily for 7 days for Resident #3 on 12/13/24 for a bad cough.
-She was not aware Resident #3 was still taking the Robitussin.
-She prescribed plain Robitussin which would not harm Resident #3 if she took the medication past 7 days.
-Resident #3 taking Robitussin past 7 days was unnecessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

(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 406	Continued From page 54 -She expected the medication to be stopped on the stop date. -She hand wrote the order for 7 days and the facility put the order in the system. -She did not put a stop date on the order because medications sometimes took 2 to 3 days to come into the facility. -The pharmacy provided the consultation reports to the facility and the facility put the reports in her folder for review. -She was not aware of the Pharmacy Consultation report regarding Robitussin for Resident #3.	D 406		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the County Department of Social Services (DSS) of accident/incidents that required emergency medical evaluation for 1 of 5 sampled residents (5) who sustained falls requiring transport to the local hospital by emergency medical services (EMS).	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 451	Continued From page 55	D 451		

The findings are:

Review of Resident #5's current FL-2 dated 01/21/25 revealed:
-Diagnoses included diabetes, hypertension, hyperlipidemia, Alzheimer's, glaucoma, gastrointestinal reflux disease, gait instability, and depression.
-Resident #5 was intermittently disoriented.

Review of Resident #5's Resident Register revealed she was admitted on 01/23/25.

Review of Resident #5's electronic progress notes dated 02/27/25 revealed:
-Resident #5 was sent to the emergency department (ED) due to the resident being found on the floor with a skin tear to the right leg.
-When emergency medical services (EMS) arrived Resident #5 had a seizure that lasted 45 seconds.
-Resident #5 was transported to the ED.

Review of Resident #5's 02/27/25 ED after visit summary (AVS) revealed:
-Resident #5's diagnoses were fall, initial encounter and seizure.
-Resident #5 was discharged back to the facility.

Review of Resident #5's electronic progress notes dated 03/16/25 revealed:
-Resident #5 hit her head on the side of her table.
-Resident #5 was witnessed having a seizure, uncontrolled jerking and shaking.
-Resident #5 was transported to the ED.
-Resident #5 was admitted to the hospital on 03/16/25 for new onset seizures and found to have a C1 cervical fracture.

Review of the Hospital Discharge summary dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 451	Continued From page 56 03/20/2025 revealed: -Resident #5 was admitted to the hospital on 03/16/25 and discharged on 03/20/25. -Resident #5 was admitted on 03/16/25 for new onset seizures and found to have a C1 cervical vertebral fracture. Interview with the local DSS Adult Home Specialist (AHS) on 03/20/25 revealed that she had not received incident/accident reports for Resident #5 dated 02/27/25 or 03/16/25. Interview with Director of Health and Wellness (DHW) on 03/20/25 at 2:15pm revealed she did not know that the facility was required to fax incident/accident reports to DSS or who was responsible for sending them. Interview with the Administrator on 03/20/25 at 6:10pm revealed: -Incidents that resulted in an injury were to be faxed to DSS. -Incident reports were faxed by herself or the DHW. -She did not know if the incident reports were faxed to DSS after the fall on 02/27/25 or 03/16/25. -She was unable to locate confirmation that incident/accident reports had been faxed to DSS for Resident #5. -Staff should know the process for incident/accident reports.	D 451		