Turner, Abigail L

From: Jones, Beverly <BJones1@5SSL.COM>
Sent: Tuesday, January 25, 2022 2:13 PM
To: Turner, Abigail L
Subject: [External] FW: Scanned from NC32PR30
Attachments: 2539_001.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Here you go!
Bev

From: NC32PR30 <scanner@5ssl.com>
Sent: Tuesday, January 25, 2022 1:19 PM
To: Jones, Beverly <BJones1@5SSL.COM>
Subject: Scanned from NC32PR30

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 12/09/2021

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 000}	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow-up survey on 12/08/21-12/09/21.	{D 000}	**D 079**	
{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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazardous substances and chemicals left accessible to the 24 residents including cleaning agents stored in the kitchen not monitored by staff and personal hygiene items stored unsecured in multiple residents' bedrooms and bathrooms in the SCU, and that the Assisted Living (AL) unit was free of hazards by not properly storing oxygen canisters in two residents' rooms. The findings are: 1. Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a	{D 079}	**To assure facility remains in compliance With State regulations, Maintenance Director removed chemicals/hazardous Substances from SCU. Maintenance placed screws in cabinet doors in SCU kitchen.** **This will alleviate any chemicals/hazardous substances being stored in cabinets. Doors of cabinets secured at all times.** **The BTR kitchen will be monitored daily to assure no chemicals/hazardous substances are left on countertops.** **Education provided to all team members related to hazardous items/chemical storage.** **Executive Director implemented audit- BTR resident Check list for personal items/BTR kitchen. Audit to be conducted daily from 6a to 10 p** **This audit will be monitored by BTR Director/ Med Aide/Designee.** **Audit check list will be kept in a binder located nurses station.** **Date of Completion: 01-24-2022**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beverly H. Jones — TITLE: Executive Director — (X6) DATE: 01-24-2022

Reviewed and Acknowledged ——— AVT 01.31.22

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 12/09/2021

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 079}	Continued From page 1 capacity of 101 residents with a Special Care Unit (SCU) capacity of 28 residents. Review of the facility's resident roster revealed the facility's SCU census was 24 on 12/08/21. a. Request for the facility's policy and procedures for Storage of Chemicals on the SCU on 12/09/21 revealed there was no policy on how chemicals were stored to protect the residents residing on the SCU. Observation of the SCU kitchen on 12/08/21 at 1:47pm revealed: -The SCU kitchen door was unlocked and readily accessible to residents. -There were no staff or residents present in the kitchen. -The cabinet above the stove was unlocked and had 6 bottles of cleaning products in it. -There was a 7-ounce spray bottle disinfectant with a warning label to keep out of reach of children and that the product caused eye irritation, if contact with eyes hold eye open and rinse slowly and gently with water for 15-20 minutes. Call a poison control center or doctor for treatment advice, avoid contact with eyes or clothing. -There was a 32-ounce container of professional fabric refresher liquid. -The bottle of cleaner had a warning label to keep away from heat, sparks, open flames and hot surfaces, if on skin remove all contaminated clothing immediately, rinse skin with water, avoid contact with eyes, rinse with plenty of water, if ingested drink 1 or 2 glasses of water and get medical attention immediately if symptoms occur. -There was 32-ounce container of professional ready to use sanitizing fabric refresher with a warning label to avoid ingestion, avoid contact with eyes and skin.	{D 079}		

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 12/09/2021

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 079}	Continued From page 2 -There was a one-gallon container of disinfecting floor and surface cleaner with a warning label that the product was fatal if inhaled and caused severe skin burns and eye damage. If in eyes rinse with water for several minutes, if on skin remove contaminated clothing, rinse with water, if inhaled move to fresh air and call poison center immediately, and if swallowed rinse mouth, drink 1 to 2 glasses of water and contact the poison center immediately. -There was a 32-ounce bottle of one step disinfectant cleaner with a warning label that protective gloves and eye protection should be worn, if in eyes flush with water and hold eyelids open for 15 minutes, if contact with skin wash with water, if inhaled move to fresh air and if ingested drink water and seek medical attention immediately. -There was a 16-ounce aerosol container stainless steel cleaner with a warning label to keep away from heat, hot surfaces, sparks and open flames, if in eyes rinse with water and if ingested rinse mouth with water. Interview with a personal care aide (PCA) on 12/08/21 at 11:53am revealed: -The kitchenette on the SCU was always unlocked. -She was not aware that there were chemicals unlocked in the SCU kitchen. -She was concerned that if a resident ingested chemical they could choke or die. Interview with the Special Care Unit (SCU) Director on 12/08/21 at 2:12pm revealed: -Chemicals were expected to be locked up on the SCU. -She was not sure where housekeeping kept the items on the unit. -She was not aware that there were chemicals	{D 079}		

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 12/09/2021

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 079}	Continued From page 3 unlocked in the kitchenette area. -She was not aware of any instances in which a resident ingested any personal care items. -She was concerned that based on the resident population in the SCU that residents might try and drink or eat any items left out. Telephone interview with a primary care provider (PCP) for residents on the SCU on 12/09/21 at 12:45pm revealed: -She expected cleaning supplies to be secured on the SCU. -She was concerned that residents on the SCU may ingest cleaning supplies left unsecured based on their diagnoses which would cause potential harm to the residents. b. Request for the facility's policy and procedures for Storage of Chemicals on the SCU on 12/09/21 revealed there was no policy on how toiletries were stored to protect the residents residing on the SCU. Observation of resident room #228 on 12/08/21 at 8:59am revealed: -There were two, 2.6-ounce bottles of solid deodorant stored on top of the dresser with labeled instructions for external use only. -There was no staff in the room to supervise the toiletry items stored in the residents' bedroom. -The two residents assigned to resident room #228 were in the television room. Observation in the bathroom of resident room #240 on 12/08/21 at 9:11am revealed: -There was a 1-ounce bottle full of tea tree oil with labeled instructions for external use only and do not ingest. -There was no staff in the room to supervise the toiletry items stored in the residents' bathroom.	{D 079}	**D 079** All hygiene products were removed from residents rooms and placed in individual containers in a secured locked location by the BTR nursing station. To assure facility remains in compliance with State regulations, Executive Director implemented Audit- BTR Resident Personal Hygiene Checklist. Monitored daily BTR Director/Med Aide Designee from 6a to 10p. **Date of Completion: 01-24-2022**	

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 12/09/2021

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 079}	Continued From page 4 -There two residents assigned to resident room #240 were in the television room. Observation of resident room #235 on 12/08/21 at 9:09am revealed: -There was a box of antibacterial denture cleaning tablets located in a plastic drawer in an unlocked closet with a warning labels to keep out of reach of children and those at risk of accidentally swallowing the tablets, do not place tablets in mouth, do not drink cleaning solution or use as mouthwash. If swallowed call poison control center or physician, do not touch mouth or eyes after handling the tablets, wash hands thoroughly after handling tablets. Serious eye irritation could occur, rinse eyes with water for several minutes. -There was a 5-ounce container of shaving cream with a warning label that prolonged contact with living tissue could cause acute caustic burns, avoid contact with eyes and the product should not be ingested. First aide measures included for eye contact flush eye with warm water for ten minutes and seek medical attention, if swallowed give 2 glasses of water and seek medical attention immediately. Observation of the SCU hallway on 12/08/21 at 1:55pm revealed there was a resident that wandered into room #242 where she did not reside. Observation of resident room #235 on 12/09/21 at 9:06am revealed there was a box of antibacterial denture cleaning tablets and 5-ounce container of shaving cream located in a plastic drawer in an unlocked closet. Interview with the Special Care Unit Director (SCUD) on 12/08/21 at 2:12pm revealed:	{D 079}		

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 12/09/2021

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 079}	Continued From page 5 -Personal care items were expected to be secured in resident specific bins and locked in the storage room. -It was the responsibility of whomever was performing personal care to secure the personal care items. -She rounded on the unit daily to ensure there were no personal care items left in the rooms. -She completed rounds on the morning of 12/08/21 but did not see the items left out in the resident's rooms and bathrooms. -There was a resident who was known to wander into other resident's rooms. -SCU staff were expected to perform rooms rounds every 2 hours which included looking for personal care items left out. -She was not aware of any instances in which a resident ingested any personal care items. -She was concerned that based on the resident population in the SCU that residents might try and drink or eat any items left out. Telephone interview with a primary care provider (PCP) for residents on the SCU on 12/09/21 at 12:45pm revealed: -She expected personal care items to be secured on the SCU. -She was concerned that residents on the SCU may ingest personal care items left unsecured based on their diagnoses which would cause potential harm to the residents. Interview with the Administrator on 12/08/21 at 2:34pm revealed: -Personal care items should be locked up so that they were not accessible to residents. -Staff had toured the SCU today and removed any personal care items that were accessible to residents. -She expected staff to keep personal care items	{D 079}		

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 12/09/2021

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 079}	Continued From page 6 and chemicals locked up so that residents on the SCU did not accidentally ingest something that could cause them serious harm or death. Interview with the previous Administrator on 12/09/21 at 9:12am revealed: -All personal care items had been removed from resident rooms on 12/08/21. -He was not aware that staff had not removed the box of antibacterial denture cleaning tablets and the 5-ounce container of shaving cream from room #235. -He was not sure why staff had not removed the personal care items yesterday from room #235 as instructed. -He expected all personal care items to be locked up when not in use to prevent residents from being harmed. 2. Review of the facility's Oxygen Safety General Guidelines dated 09/01/19 revealed oxygen equipment on the floor must be secured with a base for stability during storage, transport and use. a. Observation of resident room #120 on the Assisted Living (AL) unit on 12/08/21 at 10:17am revealed: -There was an empty oxygen canister sitting in the middle of the resident's room on the floor. -The empty oxygen canister was not in a container or transport stand. -The empty oxygen canister was next to a full oxygen canister in a transport stand. -A resident was sitting in the recliner without oxygen on. -There was an oxygen condenser in the resident's room by the door. Interview with the resident in room #120 on	{D 079}	D 079 All oxygen canisters have been removed from From Resident/s rooms. Have been stored in a Designated closet located by stairwell 2 - cottage Hall. This will assure oxygen being stored safely in container or transport stand. Audit form implemented by Executive Director, Kept in closet on clip board. Maintenance Director will monitor weekly. Med aide will utilize oxygen room whenever Resident needs new canister/ or DME needs To pick up empty canisters. **Date of Completion: 01-24-2022**	

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 12/09/2021

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 079}	Continued From page 7 12/08/21 at 10:32am revealed: -He was getting ready to go to a doctor appointment and he knew he would need the portable tank. -He did not wear oxygen continuously, only when he was short of breath with exertion. -He brought the empty canister out of the closet to remember to tell staff that it was empty. -He normally kept oxygen canisters in the closet in a storage container. Interview with a personal care aide (PCA) on 12/08/21 at 10:38am revealed: -Oxygen cylinders should be stored in the storage crate in the resident's rooms, but he was not sure where it was in resident room #120. -It was dangerous to keep oxygen canisters out of the crates or transportation container. Observation of resident room #215 on the AL unit on 12/08/21 at 9:55am revealed there were three unsecured empty unsecured oxygen canisters on the floor to the right of the door entrance. Interview with a medication aide (MA) on 12/08/21 at 10:00am revealed: -There were not any unsecured oxygen canisters in residents' rooms on the AL unit. -The MAs made rounds each shift to ensure there were not any unsecured oxygen canisters in residents' rooms. -She observed all oxygen canisters in a secured crate earlier this morning in resident room #215. -She was not aware that there were 3 unsecured oxygen canisters in resident room #215. Interview with the Administrator on 12/08/21 at 2:34pm revealed: -All oxygen canisters should be stored safely and not left out in residents' rooms freestanding.	{D 079}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 12/09/2021

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 079}	Continued From page 8 -There was not currently a oxygen storage closet in the facility. -Oxygen was delivered directly to resident's rooms. -She was not aware that there were any unsecured oxygen canisters in the facility. -She expected MAs to make rounds each shift to ensure there were no unsecured oxygen canisters in the facility. The facility failed to secure hazardous substances to protect the residents diagnosed with dementia in a Special Care Unit (SCU) and at least one resident with wandering behaviors including cleaning products containing bleach; and a fabric freshener, toiletries consisting of liquids, deodorants and aerosols. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/08/21.	{D 079}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure referral and follow-up of health care needs for 2 of 5 sampled residents	{D 273}	D 273 Administrator implementing New Order tracking form. All new orders, Treatments, discharge summaries FI2's will be placed in DRC bin to be Reviewed daily to assure referral And follow up of health care needs Of residents are being met. Education provided to Medication Aides. DRC/ARCD Designee monitor daily. **Date of Completion: 01-24-2022**	

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 12/09/2021

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 273}	Continued From page 9 (#3 and #4) related to follow up care for a resident's sutures (#3) and a neurological referral (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 10/29/21 revealed: -Diagnoses included dementia, anxiety and agitation, debility, aphasia, atrial fibrillation, hypersensitivity lung disease, and type 2 diabetes. -The resident was ambulatory and intermittently disoriented. Review of Resident #3's incident report dated 11/07/21 revealed: -The resident had a behavioral incident and suffered a leg injury which required sutures. -The resident was treated by emergency medical services (EMS) at the facility. Review of a hospital discharge summary dated 11/04/21 for Resident #3 revealed: -There was a 5 centimeter laceration to the left lower leg that required sutures. -The resident had an order to follow up in 10-14 days to have sutures removed. Review of a physician visit note from Resident #3's primary care provider (PCP) on 11/12/21 revealed no mention of the resident's leg wound or follow up for suture removal. Review of Resident #3's facility progress note dated 11/16/21 revealed: -The resident's left lower leg had a large open scabbed wound with necrotic tissue with drainage. -The facility nurse was notified of the leg wound.	{D 273}		

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 12/09/2021

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 273}	Continued From page 10 Interview with a medication aide (MA) on 12/09/21 at 2:35pm revealed: -She was not sure of the date related to Resident #3's incident. -She had no knowledge of any leg injury or sutures related to Resident #3. -She learned from a personal care aide (PCA) that Resident #3 had a wound and that the wound wept. -She informed the facility nurse that Resident #3 had a wound that wept. -She found hospital discharge paperwork for Resident #3 in her chart that indicated that the resident needed follow up in 10-14 days to remove sutures. Review of a physician's progress note from 11/22/21 revealed that the resident was seen by her PCP for her leg injury and torn sutures, and it was noted that she would need Home Health Referral for wound management and antibiotics. Interview with the Special Care Unit Director (SCUD) on 12/09/21 at 3:09pm revealed: -There were actually two incidents that occurred regarding Resident #3. -Resident #3 was sent to the hospital regarding the first incident but was not sent to the hospital for the second incident. -She was not able to recall dates of either incident. -She would expect staff to document in the residents' progress notes regarding any incident regarding a resident and any follow up required. -She found out about Resident #3's sutures a few days later. -There was no documentation in Resident #3's progress notes of an incident and sutures at the time of injury.	{D 273}		

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 12/09/2021

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 273}	Continued From page 11 Interview with the Regional Resident Care Specialist (RRCS) on 12/09/21 at 11:35am revealed: -She was not aware of the date of the incident related to Resident #3 but did recall cleaning the resident's leg with soap and water. -It was when she was cleaning the wound that she noticed there were still some sutures present. -She notified the PCP after cleaning the wound. -Resident #3 picked at the scab. -She had no knowledge about sutures for Resident #3 until the MA brought it to her attention. -She would expect staff to document notes in Resident #3's progress notes related to the resident's sutures, any emergency medical services (EMS) incidents, and any follow up needed for the resident. -She indicated that it was important for notes to be in the resident records because otherwise things may be missed that a doctor ordered. -She expected the medication aide (MA) to initiate getting copies of any new orders related to a resident's encounter and scan the notes into the computer system. -She expected staff to monitor Resident #3's injury. Interview with the Administrator on 12/09/21 at 3:25pm revealed she would expect any medical orders or referrals to be followed or implemented including suture removal for Resident #3's leg injury. Telephone interview with Resident #3's PCP on 12/09/21 at 12. 45pm revealed: -She expected staff to follow discharge instructions from 11/04/21 for suture removal. -Resident #3 picked at scabs so she believed that	{D 273}		

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 12/09/2021

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 273}	Continued From page 12 contributed to her wound infection. -She was not aware that Resident #3 had sutures placed 11/04/21. 2. Review of Resident #4's current FL-2 dated 08/17/21 revealed: -Diagnoses included acute respiratory failure with hypoxia, dysphagia, chronic kidney disease, hyperlipidemia, epilepsy, iron deficiency anemia, obstructive sleep apnea, type 2 diabetes mellitus, and vascular dementia without behavioral disturbance. -The resident was ambulatory and intermittently disoriented. Review of Resident #4's record revealed no documentation of a neurological appointment. Interview with Resident #4 on 12/09/21 at 11:10am revealed: -The resident was admitted to the facility in August 2021. -The resident did not recall having a neurological appointment since admission. -The facility was responsible for making his appointments. Interview with a medication aide (MA) on 12/09/21 at 2:35pm revealed: -Resident #4 was ambulatory. -Staff monitored Resident #4 more frequently than every 2 hours. -Resident #4 would get dizzy at times and staff often reminded the resident to use call bell for assistance. -She did not recall Resident #4 going to a neurologist appointment since admission to the facility. Interview with the Regional Resident Care	{D 273}		

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 12/09/2021

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 273}	Continued From page 13 Specialist (RRCS) on 12/09/21 at 11:35am revealed: -She was not aware of the order to follow up with neurologist in two months on Resident #4's FL-2 dated 08/17/21. -As of 12/09/21, Resident #4 had not been seen by a neurologist since admission to the facility. -The Director of Resident Care (DRC) was responsible for reviewing the FL-2's for new admissions to ensure orders were implemented. Interview with the Administrator on 12/09/21 at 3:25pm revealed she would expect any orders or referrals to be followed or implemented including Resident #4's neurology referral.	{D 273}		
{D 433}	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement;	{D 433}	**D433** Upon resident/s return from Doctor appointments, hospital, or other medical visits, paperwork will be given to med tech. All documents will be placed in medical records bin. DRC/ARDC/Designee will review daily To assure orders entered properly, Follow up appointments made and Doctor notes and visits reviewed. All documents will be placed in file And scanned into PCC. Monitored daily by DRC/ADRC/Designee. **Date of Completion: 01-24-2022**	

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 12/09/2021

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 433}	Continued From page 14 (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to maintain resident records in an orderly manner and readily available for review for 1 of 5 sampled residents (#2). The findings are: Review of the Facility Request for Information form provided to the facility on 12/08/21 at 11:45am revealed a request for physician notes and consultations from 10/15/21 to 12/08/21. Review of a handwritten facility request for information provided to the facility dated 12/08/21 at 4:45pm revealed a request for Resident #2's physician notes and consultations from 10/15/21 to 12/08/21.	{D 433}		

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 12/09/2021

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 433}	Continued From page 15 Review of an electronic progress note revealed there was no documentation that Resident #2 had an ultrasound of his prostate or that the residents' urologist wanted Resident #2 referred to an oncologist. Review of a physician visit note provided by the facility revealed: -There was a physician visit note dated 11/22/21. -Resident #2 was seen by his primary care physician (PCP) at the facility. -The PCP documented that Resident #2 was seen by a urologist who completed an ultrasound of the residents' prostate; the urologist wanted Resident #2 to see an oncologist but there was no documentation available for her to review in the residents' chart on the day of her visit. Interview with Resident #2's family member revealed: -He provided transportation for Resident #2 to his medical appointments. -He had never been asked by the facility to bring back documentation or orders after Resident #2's medical appointments. Telephone interview with a primary care provider (PCP) for Resident #2 on 12/09/21 at 12:45pm revealed: -She had a difficult time searching for physician progress notes when the resident had been seen by other physicians for consultations or tests. -The facility needed to ensure that all medical records for each resident were scanned into their electronic medical record. Interview with the Administrator on 12/09/21 at 10:00am revealed: -The medication aides (MAs) should always	{D 433}	**D433** Upon resident/s return from Doctor appointments, hospital, or other medical visits, paperwork will be given to med tech. All documents will be placed in medical records bin. DRC/ARDC/Designee will review daily To assure orders entered properly, Follow up appointments made and Doctor notes and visits reviewed. All documents will be placed in file And scanned into PCC. Monitored daily by DRC/ADRC/Designee. **Date of Completion: 01-24-2022**	

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 12/09/2021

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 433}	Continued From page 16 follow up with the residents' doctor or family to ensure the facility received documentation of any medical visits and orders. -She did not know why the MAs had not received documentation from Resident #2's family member after appointments. -The failure to have physician notes, orders and tests in Resident #2's medical records was unacceptable because staff were unable to follow orders from physicians. -She expected the MAs to contact the physician to obtain a copy of orders and visit notes to ensure the resident received services	{D 433}		
{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 incidents resulting in injury requiring emergency medical evaluation and medical treatment for 3 of 3 residents sampled (#3, #4, and #5). The findings are: Review of the facility's "Policy for Incident Reporting and Investigation" dated September	{D 451}	**D 451** Incident/accident reports are placed Incident/Accident bin. The reports Are reviewed daily by DRC Administrator/ADRC/Designee. County Department of Social Services will be notified by fax of Any incident/accident resulting in Resident death or any accident Injury that requires emergency Medical evaluation, hospitalization, Or medical treatment other than First aid. Education provided to DRC /ADRC By Administrator. Monitored by DRC/ADRC **Date of Completion: 01-24-2022**	

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 12/09/2021

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 451}	Continued From page 17 2018 revealed: -An incident: An unusual or unexpected event that is not consistent with the routine operation of the community or routine care of, or services provided to, a resident, an event involving a resident with unintended, undesirable or unexpected results/outcomes, or a reportable incident. -A reportable incident: An incident or adverse event that is serious in nature and required by applicable statue or regulation to be reported to outside state and/or federal agencies, such as the local Department of Health or Department of Human Services. -Reportable incidents include: falls resulting in in significant injury (sutures, staples, fracture, or dislocation), any resident injury requiring treatment in an acute care setting, and a significant change in the resident condition, and/or requiring treatment by transfer to an acute care setting. -Reportable incidents are reported to the applicable state Department of Health (or similar agency) in accordance with, within the timeframes prescribed by, and using any forms required by, applicable state laws and regulations. 1.Review of Resident #4's current FL-2 dated 08/17/21 revealed diagnoses included acute respiratory failure with hypoxia, dysphagia, chronic kidney disease, hyperlipidemia, epilepsy, iron deficiency anemia, obstructive sleep apnea, type 2 diabetes mellitus, and vascular dementia without behavioral disturbance. Review of Resident #4's electronic progress note dated 11/01/21 at 6:53am revealed: -Resident #4 was found on bathroom floor. -The resident had an injury on the left back side	{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 12/09/2021

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 451}	Continued From page 18 of head. -The resident had a lot of bleeding from the injury. -The resident was sent out to hospital by emergency medical services (EMS). -The resident's family and Primary Care Provider (PCP) were notified. -The progress noted was completed and electronically signed by a medication aide (MA) at 6:53am. Review of a hospital discharge summary dated 11/01/21 revealed: -Resident #4 went to the emergency room for a fall. -The resident fell while walking to the bathroom and hit his head on the tile floor. -When EMS arrived, there was a lot of blood on the ground with pulsatile bleeding from the back of the scalp. -The resident was admitted to trauma service and underwent surgical repair of the laceration to the scalp. -The final impression was documented as a closed head injury and scalp laceration. Review of facility incident report for Resident #4 dated 11/01/21 at 12:15am revealed: -The resident had an unwitnessed fall and was found on the floor in bathroom. -The resident was found in a sitting position with back against bathroom sink. -The resident injured back left side of head. -The resident was sent to hospital by EMS for evaluation. -The area related to notification to state agency was blank. Interview with the local Department of Social Services (DSS) Social Worker on 12/09/21 at 10:00am revealed she had not received an	{D 451}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 12/09/2021

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 451}	Continued From page 19 incident report for the 11/01/21 incident related to Resident #4. Refer to interview with MA on 12/09/21 at 2:20pm. Refer to interview with the Regional Resident Care Specialist (RRCS) on 12/09/21 at 11:35am. Refer to interview with the Social Worker for the local Department of Social Services on 12/09/21 at 10:00am. Refer to interview with the Administrator on 12/09/21 at 3:25pm. 2. Review of Resident #3's current FL-2 dated 10/29/21 revealed diagnoses included dementia, anxiety and agitation, aphasia (mild), atrial fibrillation (irregular heartbeat), hyperlipidemia, type 2 diabetes. Review of a discharge summary dated 11/04/21 revealed: -Resident #3 was sent to the emergency room for a laceration to left leg after it got caught in the door after an altercation with staff. -Resident #3 had sutures applied to the laceration. Review of facility incident report for Resident #3 dated 11/07/21 revealed: -Resident #3 had a behavioral incident that resulted in a leg injury. -The resident was treated in house by emergency medical services (EMS). Review of Resident 3's electronic progress note dated 11/07/21 revealed: -A staff member called EMS to have Resident #3 evaluated due to the resident's agitation.	{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 12/09/2021

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 451}	Continued From page 20 -The resident was treated for behaviors by EMS doctor via a conference call. Interview with Special Care Unit Director (SCUD) on 12/9/21 at 3:09pm revealed: -The SCUD revealed that there were two incidents that occurred regarding Resident #3. -Resident #3 was sent to the hospital for evaluation for the first incident but did not require medical evaluation for the second incident. -The SCUD was not able to recall dates of either incident. Interview with the Regional Resident Care Specialist (RRCS) on 12/09/21 at 11:35am revealed she did not send an incident report to the county DSS for Resident #3 for either of the two incidents. Interview with the local Department of Social Services (DSS) Social Worker on 12/09/21 at 10:00am revealed she had not received an incident report for the 11/04/21 or 11/07/21 incident related to Resident #3. Refer to interview with MA on 12/09/21 at 2:20pm. Refer to interview with the Regional Resident Care Specialist (RRCS) on 12/09/21 at 11:35am. Refer to interview with the Social worker for the local Department of Social Services on 12/09/21 at 10:00am. Refer to interview with the Administrator on 12/09/21 at 3:25pm. 3. Review of Resident #5's current FL-2 dated 09/14/21 revealed diagnoses included respirator failure with hypoxia, acute congestive heart	{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 12/09/2021

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 451}	Continued From page 21 disease, muscle weakness and unsteadiness on feet. Review of an incident report for Resident #5 dated 12/06/21 revealed: -Resident #5 lost her balance and landed in an upright position beside a chair at 3:46am. -Resident #5 was transported by emergency medical services (EMS) to the emergency room at the local hospital for evaluation. Review of an EMS report dated 12/06/21 revealed: -EMS responded to a call at the facility following a fall by Resident #5. -Resident #5 complained of right posterior hip pain and was found to be hypoxic with oxygen saturation at 82%. Review of Resident #5's after visit summary from the local hospital's emergency department dated 12/06/21 revealed she was treated and released following a fall at the facility. Interview with the local Department of Social Services (DSS) Social Worker on 12/09/21 at 10:00am revealed she had not received an incident report for Resident #5 following the fall that resulted in an emergency room visit on 12/06/21 Refer to interview with MA on 12/09/21 at 2:20pm. Refer to interview with the Regional Resident Care Specialist (RRCS) on 12/09/21 at 11:35am. Refer to interview with the Social Worker for the local Department of Social Services on 12/09/21 at 10:00am.	{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 12/09/2021

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 451}	Continued From page 22 Refer to interview with the Administrator on 12/09/21 at 3:25pm. Interview with a medication aide (MA) on 12/09/21 at 2:20pm revealed: -The MAs were responsible for completing an incident/accident report (I/A) if a resident fell, hit head, or if the resident was sent to the hospital for evaluation. -After the MAs completed the I/A report, they placed them in the Director of Resident Care (DRC) box. -The MAs were not sure what happened with the I/A reports once given to the nurse. Interview with the Regional Resident Care Specialist (RRCS) on 12/09/21 at 11:35am revealed: -The MAs were responsible for completing the I/A reports. -She received the I/A reports from the MAs once completed. -She was not aware the county had to be notified of I/A reports. -She came from skilled nursing and was still learning the rules for assisted living. -She did not send I/A report to the county DSS for Residents #3, #4 or #5. Interview with the local Department of Social Services (DSS) Social Worker on 12/09/21 at 10:00am revealed the facility was responsible for faxing incident reports to DSS for any incident that happened which required more that first aide. Interview with Administrator on 12/09/21 at 10:35am and 3:25pm revealed: -The MAs were responsible for completing I/A reports and giving the I/A reports to the nurse. -The Administrator did not know if the DRC or	{D 451}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	R 12/09/2021

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 451}	Continued From page 23 previous Administrator was responsible for sending the I/A reports to DSS. -The Administrator would expect that I/A reports be sent to DSS if the resident was sent out to the hospital and required greater than first aide.	{D 451}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings. The findings are: Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazardous substances and chemicals left accessible to the 24 residents including cleaning agents stored in the kitchen not monitored by staff and personal hygiene items stored unsecured in multiple residents' bedrooms and bathrooms in the SCU, and that the Assisted Living (AL) unit was free of hazards by not properly storing oxygen canisters in two residents' rooms. [Refer to Tag D0079, 10A NCAC 13F .0306(a)(5) Housekeeping and	{D912}	**D912** All areas addressed – see comments under Prefix tag D 079 **Date of Completion: 01-24-2022**	

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 12/09/2021

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
{D912}	Continued From page 24 Furnishings (Unabated Type B Violation)].	{D912}		