STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R-C 05/23/2024

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MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 05/22/24 - 05/23/24. The complaint investigation was initiated by the Wake County Department of Social Services on 03/18/24.	D 000		
D 452	10A NCAC 13F .1212(b)(c) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information: (1) resident's name; (2) name of staff who discovered the accident or incident; (3) name of the person preparing the report; (4) how, when and where the accident or incident occurred; (5) nature of the injury; (6) what was done for the resident, including any follow-up care; (7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and (8) signature of the administrator or administrator-in-charge. (c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.	D 452		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) within 48 hours for incidents involving 2 of 3 sampled residents (#1, #4) including a resident who sustained injuries from a fall that required emergency medical evaluation and treatment (#1) and a resident who alleged being inappropriately touched by a staff person requiring emergency medical evaluation and treatment (#4).

The findings are:

1. Review of Resident #4's current FL-2 dated 10/26/23 revealed diagnoses included anxiety disorder, unspecified dementia without behavioral disturbance, insomnia, and essential hypertension.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 10/21/21.

Review of Resident #4's current assessment and care plan dated 01/04/24 revealed:
-The resident was documented as requiring supervision by staff with bathing.
-The resident was documented as being independent with all other activities of daily living.
-The resident was documented as having memory loss and cognitive impairment.

Review of Resident #4's hospital emergency

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room (ER) provider notes dated 03/09/24 revealed:
-Resident #4 was seen in the ER on 03/09/24 with a concern for assault.
-Per emergency medical services (EMS), the family requested evaluation for possible assault.
-The police and management of the facility had been involved.
-The allegation was related to the resident being placed on her bed and a female inserted her hand inside the resident's vagina.
-The hospital staff did not see signs of trauma or injury or signs of secondary infection.
-It was noted the resident had a right upper thigh bruise and a possible bruise to left lower jaw.
-The resident had a history of dementia and stated she remembered being awakened by a woman and she could feel the woman watching her; she was right in the resident's face; the woman did not do anything; she just looked at the resident and left.
-The resident was able to repeat the same story several times to the registered nurse.
-The resident denied being touch by "that woman".

Review of a 24-hour/5-day Health Care Personnel Registry (HCPR) report for Resident #4 revealed:
-The date the facility became aware of the incident was 03/09/24.
-The resident advised an employee touched her private area while bathing her.
-The resident's family member reported another resident was told by Resident #4 that she was touched inappropriately during a shower.
-The facility was conducting an investigation and the employee who gave the shower had been suspended.
-The local police department had been notified.
-The resident when to the hospital and the

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hospital discharge summary indicated the resident indicated no one touched her.
-The resident was documented as being oriented to self only and having very poor memory.
-The facility did not substantiate the allegation.
-The HCPR reported was signed and dated 03/14/24 by the Administrator.

Review of Resident #4's accident/incident report dated 03/09/24 revealed:
-On 03/09/24, Resident #4 reported to a family member that she was touched inappropriately during a shower.
-The family member called the local police department.
-The resident was sent to the hospital per facility request for further evaluation.
-There were no injuries noted in the hospital.
-The primary care provider (PCP), Department of Health and Human Services (DHHS), and the facility's regional team were notified.
-The incident was being investigated by the facility at that time.
-The resident's family was notified on 03/09/24 at 3:00pm.
-There was no documentation the local Department of Social Services (DSS) was notified.
-The report was signed and dated by the Director of Resident Care (DRC) on 03/14/24.

Telephone interview with the Adult Home Specialist (AHS) with the local DSS on 05/23/24 at 5:48pm revealed:
-She received a copy of Resident #4's accident/incident report dated 03/09/24 via email on 03/14/24.
-She did not receive a copy of the report prior to 03/14/24.

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D 452	Continued From page 4 Interview with the DRC on 05/23/24 at 11:36am revealed: -She forwarded the 24-hour/5-day HCPR report completed by the Administrator to the state agency on 03/14/24. -She was not aware she still had to send an accident/incident report to the local county DSS since she had sent the HCPR report to the state agency. -The Administrator told her she still had to send an accident/incident report to the county DSS so she completed the report on 03/14/24 and sent it to DSS on 03/14/24. Interview with the Administrator on 05/23/24 at 4:24pm revealed: -The DRC was responsible for sending reportable accident/incident reports to the local DSS. -He thought the DRC sent Resident #4's accident/incident report to DSS within 48 hours of the facility becoming aware of the alleged incident. -The facility staff determined the date of the alleged incident was 03/07/24, when Resident #4 received a shower by the accused employee and the resident reported the alleged incident on 03/09/24. -He was responsible for monitoring to ensure that accident/incident reports were sent to DSS within the required timeframe. -He had not noticed until today, 05/23/24, that Resident #4's incident report was signed and dated by the DRC on 03/14/24. 2. Review of Resident #1's current FL-2 dated 02/02/24 revealed diagnoses included osteoporosis without current pathological fracture 01/17/24, other spondylosis 01/17/24, wedge compression fracture of 1st-3rd lumbar vertebrae 01/17/24, wedge compression fracture of T5-T6	D 452		

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D 452	Continued From page 5 vertebrae 01/17/24, and unspecified fall 01/17/24. Review of the Resident Register dated 01/31/24 for Resident #1 revealed: -Resident #1 was admitted to the facility from a nursing and rehabilitation facility. -The resident register was incomplete, including no date of admission. Review of a staff progress note for Resident #1 dated 02/07/24 revealed: -The resident's move-in date was 02/06/24. -The resident was admitted from a rehabilitation facility after being treated for compression fractures. Review of a staff progress note for Resident #1 dated 05/01/24 revealed: -The resident was found on the floor by staff upon making rounds. -The resident was lying face down wrapped in her blanket next to the bed. -Emergency medical services (EMS) was called for further evaluation. -The resident had a swollen left eye, laceration above left eye, and skin tear on the left arm. -The Power of Attorney (POA), Primary Care Provider (PCP), and hospice agency were notified. Review of an accident/incident report for Resident #1 dated 05/08/24 revealed: -Resident #1 was found on the floor next to the bed upon staff making rounds. -The description of the resident injury was documented as resident sustained a laceration above the left eye, left eye was swollen, and skin tear to left arm. -The action taken was documented as EMS was called, resident sent out for further evaluation,	D 452		

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POA and PCP and hospice agency notified.
-There was no documentation for notification to the local county Department of Social Services (DSS) of Resident #1 being sent to the local hospital for evaluation and treatment for the injuries sustained.
-The accident/incident report was filed by the Director of Resident Care (DRC).

Review of an After Visit Summary dated 05/01/24 from the emergency department of the local hospital revealed Resident #1's reason for hospital visit was documented as a fall.

Interview with the DRC on 05/23/24 at 5:45pm revealed:
-She sent a report of the 05/01/24 accident/incident report for Resident #1 to the county DSS on 05/08/24.
-She was away from the facility on 05/01/24 when the accident/incident occurred.
-When she returned to the facility and found out the report had not been sent to the local county DSS, she completed the report and sent a copy of the accident/incident report to the local DSS.
-She was responsible for sending accident/incident reports to the local county DSS.

Telephone interview with the Adult Home Specialist (AHS) at the local county DSS on 05/23/24 at 5:50pm revealed she received notification of the 05/01/24 accident/incident for Resident #1 on 05/08/24 by email from the facility's DRC.

Interview with the Administrator on 05/23/24 at 6:30pm revealed:
-The DRC "normally" sent notification to the county DSS regarding accidents/incidents.
-He had not notified the local county DSS of the

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D 452	Continued From page 7 05/01/24 accident/incident for Resident #1. -He was aware that the county DSS was supposed to be notified of Resident #1's 05/01/24 accident/incident within 48 hours of the resident being sent to the local hospital for care.	D 452		