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 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 11-13, 2026.	D 000		
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: Based on interviews and record reviews, the facility failed to ensure referral and follow up to meet the acute health care needs for 1 of 5 sampled residents (#3) pertaining to a referral for a gynecology evaluation. The findings are: Review of Resident #3's current FL-2 dated 01/29/26 revealed diagnoses included hypothyroidism, acute kidney failure, hypertension, chronic obstructive pulmonary disease, mild cognitive impairment, gastro-esophageal reflux disease with esophagitis, and major depressive disorder. Review of Resident #3's primary care provider (PCP) visit note dated 06/23/26 revealed: -The chief complaint for the visit was hypertension and chronic kidney disease presenting for chronic condition management and follow-up of vaginal bleeding. -The history of present illness relating to the visit was the patient presented with light vaginal bleeding that was noted by staff and family. -The resident reported that vaginal bleeding was not new and had been present for some time.	D 273		

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-She denied any pain in the perineal area or lower abdomen.
-Assessment included the diagnosis of vaginal bleeding.
-The resident had been experiencing vaginal bleeding for some time.
-She reported no other associated symptoms.
-Under plan, referred the patient to gynecology (GYN) for further work-up and evaluation to determine the underlying cause of the bleeding was listed.
-Orders for the visit included referral to GYN for vaginal bleeding.

Review of a Physician Communication form for Resident #3 revealed:
-There was a handwritten order to refer the resident to GYN.
-The form was signed by Resident #3's PCP and dated 06/23/26.

Review of Resident #3's record revealed there were no GYN visit notes.

Review of an undated progress note provided on 08/12/26 for Resident #3 revealed:
-The resident was referred to a named GYN practice.
-Per the GYN office, they received the referral and followed up with Resident #3's Power of Attorney (POA) but did not receive a return call from the resident's POA and a chart was set up.
-The Health and Wellness Director (HWD) spoke with the resident's POA, and she would be following up with the GYN practice.
-Per the GYN office, they were no longer accepting new patients with Resident #3's insurance.

Interview with Resident #3 on 08/12/26 at

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11:24am revealed:
-She had not seen a GYN specialist.
-She had vaginal bleeding that "comes and goes" and she thought the bleeding came from the "folds".
-She denied vaginal bleeding currently and was unsure when she last experienced vaginal bleeding.
-She denied abdominal pain or perineal discomfort.

Telephone interview with Resident #3's responsible party (RP) on 08/12/26 at 2:26pm revealed:
-Resident #3 had a history of light vaginal bleeding her whole life and they thought she had surgery for this in the past.
-Resident #3 had a history of lumps in the vaginal area that would rupture and bleed.
-She had been contacted a while back by staff, she could not remember the name, from the facility that Resident #3 was being referred to GYN for vaginal bleeding, but she never heard anything further about the GYN referral until today (08/12/26) when the HWD from the facility contacted her and gave her the phone number of the GYN office that Resident #3 was referred to.
-She had contacted the GYN office today to schedule an appointment for Resident #3 but had to leave a voice mail and had not received a phone call back.
-She planned to take Resident #3 to her GYN appointment whenever it was scheduled.

Telephone interview with an appointment scheduler with the GYN office on 08/12/26 at 1:35pm revealed:
-A referral was received for Resident #3 from Resident #3's PCP on 06/26/26.
-The referral for Resident #3 was reviewed and

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declined by their referral's coordinator on 07/02/26 because the practice no longer accepted new patients with Resident #3's insurance.
-A fax notification that Resident #3's referral was declined due to insurance was sent to Resident #3's PCP on 07/02/26.
-There was no other documentation of contact on behalf of Resident #3 for a GYN consultation.

Interview with a medication aide (MA) on 08/13/26 at 9:39am revealed any orders written by the residents' PCP including referrals were given to the HWD.

Interview with the Resident Care Coordinator (RCC) on 08/12/26 at 12:50pm revealed:
-If a resident required a referral to an outside provider, the PCP contacted the resident's RP or POA to notify of the referral and the resident's PCP made the referral.
-The residents' RP or POA contacted the facility to notify staff when the appointment was set up so staff could have the resident ready the day of the appointment or if the resident's POA or RP could not transport the resident to their appointment, the facility could transport the resident to their appointment.
-There was no current process in place to follow-up on outside referrals for the residents.

Interview with the HWD on 08/12/26 at 12:57pm revealed:
-When the facility's PCP ordered a referral to an outside provider, the PCP's medical assistant sent the referral information to the requested provider and the requested provider's office reached out to the resident's POA with the appointment information.
-The resident's POA contacted the facility to let

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them know when the resident's appointment would be, so the resident would be ready the day of the appointment or to notify if the resident needed the facility to transport them to the appointment.
-Resident #3 did not have a GYN appointment.
-She had contacted the GYN office about Resident #3's referral and was told a chart had been made for Resident #3, but the office had not been able to contact Resident #3's RP.
-No one had investigated the status of Resident #3's GYN referral until the GYN visit notes were requested during the survey.
-There currently was no process for tracking referrals for the residents.

Second interview with the HWD on 08/12/26 at 2:56pm revealed:
-She spoke with Resident #3's RP today and notified her of the GYN referral for Resident #3 and Resident #3's RP was going to contact the GYN office today.
-She was made aware today that the GYN office no longer accepted Resident #3's insurance.
-She documented the undated progress noted for Resident #3 regarding the GYN referral today 08/12/26.
-It was the facility's responsibility to make sure referrals were completed but there were currently no procedures in place to follow-up on referrals.

Interview with the Administrator on 08/13/26 at 10:23am revealed:
-The HWD was responsible for following up on resident referrals.
-If a resident needed a referral, the PCP's office sent the referral to the outside provider's office.
-The outside provider contacted the resident's POA or RP with the appointment information, and the RP or POA communicated the appointment

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information to the facility.
-There was no process for following up on referrals.

Telephone interview with Resident #3's PCP on 08/12/26 at 3:46pm revealed:
-Resident #3 was relatively new to her, she had seen her once and was scheduled to see her again on 08/13/26.
-She saw in Resident #3's record that she had been referred to GYN for vaginal bleeding on 06/23/26.
-She was not aware that Resident #3 had not been seen by GYN.
-Several things could cause vaginal bleeding such as cancer, polyps, dry skin, or the bleeding could possibly come from the bladder.
-A GYN consult was recommended for Resident #3, so a more thorough exam could be performed to determine the cause of the vaginal bleeding.
-If Resident #3 had persistent vaginal bleeding it could cause her hemoglobin (an iron-rich protein found in red blood cells) to drop which could result in fatigue and weakness.
-Resident #3's hemoglobin on 08/03/26 was 12 which was normal.
-Referrals were sent by her office but she expected the facility to follow up on the referrals to make sure the residents received and attended their appointments.

Attempted telephone interview with the Medical Assistant with Resident #3's PCP's office on 08/12/26 at 1:16pm was unsuccessful.