Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Morningside of Raleigh
Address: 801 Dixie Trail, Raleigh, NC 27607
County: Wake
License Number: HAL-092-217

II. Date(s) of Visit(s): 02/15/23, 03/20/23 and 04/14/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 04/14/23

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0305(f)(4)(B), Physical Environment	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use.		
Level of Non-Compliance: A1 VIOLATION		
Findings: Based on observations, interviews and record reviews, the facility failed to ensure the Special Care Unit (SCU) kitchenette door was locked and not accessible to residents resulting in 1 of 5 sampled residents (#1) who had wandering behaviors entering the kitchenette and ingesting mechanical dish detergent.		

Findings:

Review of the facility's Chemical Safety Policy and procedures revealed:
-All areas where hazardous chemicals were stored must remain locked at all times when not working in that area.
-Areas with hazardous chemicals should be labeled as "Employee-Only."
-Products in use will not be left unattended in non-employee areas.

Review of Resident #1's current FL-2 dated 06/30/22 revealed:
-The resident's recommended level of care was the Special Care Unit (SCU).
-Diagnoses included Alzheimer's Dementia.
-She was intermittently disoriented, ambulatory, had wandering behaviors and was able to communicate needs verbally.

Review of Resident #1's Care Plan dated 08/12/22 revealed:
-The resident had wandering behaviors.
-She was ambulatory and adequate for daily activities.
-She was always disoriented, forgetful and needed reminders.
-Her speech and communication method were normal.
-She was independent of eating, toileting, ambulation, dressing and transferring.
-The resident had no Licensed Health Professional Support tasks identified.

Review of Resident #1's Accident/Incident Report dated 02/11/23 at 10:50 am revealed:
-The resident was on the floor in the hallway at 10:45 am complaining of chest and abdominal pain.
-The Medication Aide (MA) checked the resident for injury and observed red liquid in and around her mouth.
-The MA immediately called Emergency Medical Services (EMS) and stayed with the resident until they arrived.
-The resident's Power of Attorney (POA) and Primary Care Provider (PCP) were notified.
-The resident remained hospitalized.

Review of Resident #1's Progress Notes dated 02/11/23 at 10:40 am revealed:
-The notes were created by the Resident Care Director (RCD).
-EMS was paged per request of the resident, complaining of chest and abdominal pain.
-The resident was taken to the hospital.
-The resident's POA was on the way to the hospital.

Review of Resident #1's EMS Report on 02/11/23 at 11:08 am revealed:
-The resident's primary clinical impression was poisoning/drug ingestion, and the secondary impression was chest pain/discomfort.
-The resident was alert and oriented to baseline, upon their arrival.
-The facility staff told Emergency Medical Services (EMS) the resident had accidentally ingested dishwasher detergent.
-The resident had swelling to her lips and tongue but denied any difficulty swallowing or breathing.
-The resident reported numbness in her tongue, painful burning in her lips and throat and described chest pain as sharp in nature or burning occasionally.
-The resident was transported to the Emergency Department (ED) by EMS.

Review of Resident #1's ED visit notes dated 02/11/23 revealed:
-The resident's chief complaint was poisoning.
-Resident #1 accidentally ingested dish detergent.
-Resident #1 had visible excoriations (damage to the surface) of her lips, tongue, and oral cavity, as well as the uvula and the visible pharynx.
-She had increased salivation and secretions.
-She had diffused esophageal wall thickening, which is consistent with chemical esophagitis (swelling of the esophagus).
-The ED spoke with poison control at 12:19 pm and they reviewed the ingredient profile of the dish detergent and stated it was primarily an alkaline caustic injury.
-Given the risk of complications, the Thoracic and Ear, Nose and Throat doctors believed she would be better at an academic medical center that would be better equipped to manage issues that may arise.
-On 02/11/23 at 5:53 pm, Resident #1 was transferred to an Acute Care Hospital.

Review of Resident #1's Hospital Admission documents dated 02/11/23 revealed:
-Due to concern for significant esophageal injury, the resident was transferred to this hospital for an evaluation by thoracic surgery.
-A Computerized Tomography (CT) scan of her chest on 02/11/23 showed esophageal wall thickening consistent with esophagitis without evidence for perforation.
-She underwent an Esophagogastroduodenoscopy (EGD or Upper Endoscopy is a procedure that allows the doctor to

examine the inside of the esophagus, stomach, and duodenum) on 02/12/23 that showed significant Zargar Caustic Ingestion Injury grade 2B esophagitis at risk for perforation and stricture development: the stomach and duodenum were normal.
-A physical exam revealed caustic burns to the lips, tongue, and buccal mucosa with no evidence of stridor, respiratory distress, abdominal pain, or difficulty controlling secretions.
-Resident #1 was discharged from the hospital on 02/27/23.

Review of Resident #1's Progress Notes dated 02/12/23 at 1:21 pm revealed:
-The notes were created by the RCD.
-The POA told the RCD the resident would remain in the hospital for a few days with a temporary nasogastric intubation tube (medical process involving the insertion of a plastic tube through the nose, down the esophagus, and down into the stomach).

Observation of the SCU kitchenette on 02/15/23 at 10:54 am revealed:
-The kitchenette had a double hung door with a key-pad lock on the bottom half of the door to enter.
-On the other side of the door, above the doorknob, was a little knob you could turn to lock or unlock the door.
-The kitchenette contained a refrigerator/freezer, a small commercial dishwasher and two compartment sink.
-The dishwasher was on the right side of the sink sitting on the floor, under the extended counter of the sink and three-gallon sized jug containers were sitting on the floor on the left side of the dishwasher in front of the sink.
-There was tubing running from the top of each jug, which led into the dishwasher.
-The jug with red liquid was mechanical dish detergent (ingredients: water, sodium hydroxide, methyl glycine diacetic acid 3NA – salt, trisodium citrate, amino trimethyl phosphonic acid sodium salt, sodium polyacrylate).

Interview with Personal Care Aide (PCA) on 02/15/23 at 11:23 am revealed:
-Resident #1 was a high functioning resident and sometimes helped staff set up the place settings in the dining room.
-The Dietary Aide (DA) had asked her to come and help get Resident #1 out of the dining room.
-The DA told her she had already removed Resident #1 from the kitchenette around 10:40 am.
-Resident #1 was sitting at a table with another resident.
-The PCA walked Resident #1 back to her room and she went to catch the elevator.

-While at the elevator, the agency sitter (hired to monitor hallway emergency exits to prevent resident elopements) alerted her that Resident #1 was on the floor. -The PCA went to Resident #1, and she was spitting on the floor. -She went to get the MA on the other hall, so he could check on Resident #1. -The MA called EMS. -She remembered a glass on the table Resident #1 was sitting at in the dining room, so she went back into the dining room. -The glass on the table contained some red liquid and someone had squeezed the contents of a pudding cup on top of the red liquid in the glass. -The door to the kitchenette was open. -She had not observed any red juice in the kitchenette; however, there was a bottle of detergent on the floor and the seal had been ripped off the container. -It was a new bottle of detergent. -She immediately took the bottle with the red liquid to EMS personnel. -EMS took photos of the bottle and label. -The kitchenette was supposed to be closed and locked when it was not in use. -She did not know who left the door open and/or unlocked. Review of the facility's Investigatory Interview Form: PCA Employee Interview dated 02/11/23 revealed: -Around 10:30 am the cook asked me to get Resident #1 out of the dining room. -Earlier, the DA had removed Resident #1 from the kitchenette. -When the PCA arrived in the dining room, Resident #1 was in the kitchenette. -The PCA removed the resident from the kitchenette and examined the door lock. -The PCA examined the door lock to the kitchenette. -The cook stated she had just closed the door. -The door lock was in the up-right position, which meant that it was unlocked, and one doesn't have to use the code to enter the kitchenette. -The PCA showed the DA the correct position to lock the lock on the kitchenette's door. -The PCA took Resident #1 to her room, because she seemed agitated and upset. -She returned to her work area and was about to get onto the elevator and the agency sitter told her Resident #1 was on the floor.		

-The PCA went to Resident #1 on the floor and the resident complained of chest pains.
-Resident #1 complained of the pains going from her heart to her stomach.
-The PCA got the MA, and he called EMS.
-At this time, the PCA thought of the cup she saw Resident #1 with when she took the resident out of the dining room.
-The cup contained a red liquid and the resident had added a pudding cup to it.
-The PCA went into the kitchenette area to locate the red drink she had seen in the resident's cup and there was no red drink in the kitchenette.
-The PCA found a container of dish detergent on the floor of the kitchenette, and it had been opened.

Review of the facility's Investigatory Interview Form: PCA Employee Interview dated 02/14/23 revealed:
-The DA was trying to clean up, after breakfast and Resident #1 would not stay out of the kitchenette
-The DA went to get the PCA and when they arrived in the dining room, the door to the kitchenette was propped open.
-The red liquid was in a tall, glass juice cup and there was pudding floating on top and the smushed pudding container was nearby.

Review of the facility's Investigatory Interview Form: DA's Employee Interview dated 02/11/23 revealed:
-The Cook went to the SCU around 10:30 am to clean up the kitchenette, retrieve the warmer and dump the trash.
-The DA thought she had locked the kitchenette's door when she had finished.
-The DA returned to the SCU around 11:00 am to reset the dining room.
-She went into the kitchenette and noticed the door was unlocked.
-Resident #1 followed her into the kitchenette and put some water in a small glass vase.
-The DA told Resident #1 she was not allowed in the kitchenette, and she had to leave immediately.
-Resident #1 took the glass vase into the dining and drank from it, then threw the vase on the floor.
-Immediately, the DA went to get the PCA.
-"While the DA was getting the nurse, she noticed a glass by Resident #1 had pudding in it."
-The DA was not sure when Resident #1 "put a chemical into her pudding."
-"Later on, it was found out that someone disengaged the keypad lock system."

-"The DA had no way of knowing this."

Attempted telephone interview on 02/23/23 at 10:12 am with the DA was unsuccessful.

Telephone interview with an agency sitter on 02/23/23 at 9:20 am revealed:
-She worked on 02/11/23 from 7:00 am to 5:00 pm on the SCU floor as a sitter and was responsible for redirecting residents if they tried to elope from the east or west hallway emergency door exits.
-She sat in the hallway near the elevator, in front of the hallway that led to the SCU dining room.
-Resident #1 was agitated to get outside the facility, prior to her incident with the liquid.
-She was sitting in the hallway and the PCA was at the elevator when they saw Resident #1 coming from the dining room and she looked unsteady on her feet.
-She and the PCA went to Resident #1 and that was when she saw a pinkish liquid on the resident's shirt.
-When Resident #1 burped, bubbles came out and you could smell the liquid on her breath.
-While the PCA was with Resident #1, she went into the dining room and saw a glass on the table with pinkish liquid and it had pudding floating on top.
-She walked back to her chair in the hallway and the MA was with Resident #1 and he had called EMS.

Review of the facility's Investigatory Interview Form: MA Employee Interview dated 02/11/23 revealed:
-The PCA asked me to come down the hallway where Resident #1 was lying on the floor.
-Resident #1 was responsive, complained of chest pains and requested to go to the hospital.
-He called EMS.
-EMS had instructed him to give Resident #1 one 81 mg Aspirin.
-While they were waiting for EMS to arrive, the PCA told him she found a cup containing some red liquid with some pudding in it.
-The MA shared the information regarding the red liquid and pudding in a glass with EMS.
-The resident was taken to the hospital.
-The MA contacted Resident #1's POA.

Telephone interview with the MA on 02/23/23 at 8:38 am revealed:
-At the time of Resident #1's incident on 02/11/23, he was on the east side administering medications.
-The PCA alerted him that Resident #1 was on the floor in front of her bedroom.
-Resident #1 told him her heart was hurting.
-He immediately contacted EMS and explained the resident's symptoms.
-They told him to give her four 81 mg aspirins.
-Resident #1's lips were red, and he thought it was lipstick.
-The PCA told him she found a cup on the table with red liquid in it.
-Someone went into the kitchenette and found a jug of dish detergent.
-When he found out about the dish detergent, EMS had arrived on their floor to assist the resident.
-He contacted management, the resident's POA, PCP and completed an Incident/Accident Report.

Telephone interview with Resident #1's POA on 02/20/23 at 9:52 am revealed:
-She received a phone call from the MA at the facility on 02/11/23 at 11:26 am saying Resident #1 had ingested some dish soap and was in the ambulance on her way to the hospital.
-She drove to the facility and spoke with the MA in the SCU.
-The MA told her Resident #1 was coherent and he at first thought Resident #1 had a heart attack because she complained about her chest hurting.
-The MA thought Resident #1 had ingested the red liquid thinking it was juice in the kitchenette.
-The MA showed the POA where Resident #1 was laying on the floor in front of her bedroom.
-After leaving the facility, the POA went to be with Resident #1 at the hospital.
-Resident #1's lips were swollen and purplish in color, her tongue was swollen and covered with blisters.
-Resident #1's condition was more severe than the ED could handle, so she was transferred to another local hospital.
-Resident #1 went to the hospital around 7:00 pm.
-On 02/12/23, the hospital performed an endoscopy on Resident #1.
-The POA was told Resident #1's esophagus was severely damaged, and it was black with blisters.
-Initially Resident #1 received glucose sugar water through intravenous therapy.
-The hospital wanted to see how she managed her nutrition before deciding whether she required a feeding tube.

-Resident #1 was given water to drink on 02/15/23.
-At first, it hurt her to drink, but then she was able to tolerate little sips.
-On 02/16/23, the hospital was able to increase her beverages to a thicker consistency like ensure.
-After tolerating the thicker beverage, the hospital determined Resident #1 did not need a feeding tube.
-The hospital was switching her medications from injections back to pills so she can go back to the facility.

Interview with the RCD on 02/15/23 at 12:05 pm revealed:
-On 02/11/23, the Administrator called her on 02/11/23 at 11:30 am about the incident involving Resident #1 and requested she come to the facility.
-The PCA told her about Resident #1 drinking a red liquid in the dining room and was on the floor complaining of chest and abdominal pains.
-The door to the SCU kitchenette was supposed to be closed and locked at all times when it was not in use by staff.
-She did not know who left the kitchenette's door unlocked and/or open.

Interview with the Administrator on 03/20/23 at 12:30 pm revealed:
-On 02/11/23, the SCU Coordinator contacted him alerting him of the incident involving Resident #1.
-He contacted the RCD and asked her to go to the facility and get statements.
-The RCD updated him about the incident with Resident #1.
-Resident #1 was seen with a cup with red liquid with pudding in it.
-Resident #1 was found on the hallway floor and had red liquid coming out of her mouth.
-On 02/11/23, an investigation was started, immediately and staff completed written statements, as to what happened with Resident #1.

The facility failed to lock the Special Care Unit's kitchenette containing hazardous liquids resulting in a resident (#1) ingesting a mechanical dish detergent, requiring the resident to be hospitalized for sixteen days with esophageal burns. This failure resulted in serious physical harm which constitutes a Type A1 violation.

The facility's plan of protection in accordance with G.S. 131F-34 on 02/15/23 for this violation.

Facility Name: Morningside of Raleigh

Addendum to the 02/15/23's plan of protection: After reviewing rule area 10A NCAC 13F .0305(f)(4)(B) Physical Environment, that rule area was more accurate to the violation cited. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 14, 2023.		

IV. Delivered Via:	HAND DELIVERED	Date: 04/14/23
DSS Signature:	Von Brown	Return to DSS By: 05/05/23

V. CAR Received by:	Administrator/Designee (print name): Brandon Lanier	
	Signature:	Date: 4/14/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☐ *POC Accepted*	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*