STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078065	A. BUILDING: _____ B. WING _____	03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 3	941 GOINS ROAD PEMBROKE, NC 28372

(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 Robeson County Department of Social Services conducted an annual survey and complaint investigation on March 24-25, 2015. The complaint investigation was initiated by the Robeson County Department of Social Services on March 17, 2015.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the freezer which was part of the refrigerator and located in the kitchen was working in a safe condition maintaining a temperature of 0 degrees Fahrenhiet (F) or by keeping all of the food frozen solid. The findings are: Observation of the refrigerator on 3/24/15 12:45 p.m. revealed: -The thermometer in the freezer read 16 degrees F. -Three packs of bologna were in the freezer and were not completely frozen. -Three packs of broccoli were in the freezer and were frozen. -The ice was frozen inside the ice trays. Interview with the Dietary Supervisor on 3/24/15 at 12:45 p.m. revealed:	D 105		

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D 105	Continued From page 1	D 105		

-The freezer had been working properly.
-The freezer had not had a problem freezing the food.
-She had taken the bologna out of the deep freezer the night of 3/23/15 and placed it inside of the freezer.

Observation of the freezer compartment of to the refrigerator on 3/25/15 at 8:34 a.m. revealed the freezer read 11 degrees F.

Interview with a Medication Aide (MA)/Personal Care Aide (PCA) on 3/25/15 at 8:33 a.m. revealed the evening of 3/24/15 the Cook took out meat from the deep freezer and put the meat in the freezer in the kitchen.

Observation of the freezer on 3/25/15 at 8:33 a.m. revealed:
-Three packs of broccoli were in the freezer frozen.
-A frozen ham was in the freezer.
-The ice was frozen inside the ice trays.
-A packet of 30 hotdogs were not completely frozen.

Interview with the Cook on 3/25/15 at 10:02 a.m. revealed:
-The first thermometer which had been in the freezer was not broken.
-The freezer does not get cold like it should.
-It takes one night for the ice to freeze.

Interview with the Resident Care Coordinator (RCC) on 3/25/15 at 10:31 a.m. revealed:
-The RCC was not aware the freezer had not been at the proper temperature to keep the food frozen.
-The Cook should have informed her if the freezer was not freezing properly.

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D 105	Continued From page 2 -The RCC last checked the refrigerator in the kitchen one month ago. There were no problems with the freezer. Interview with the Administrator on 3/25/15 at 11:13 a.m. revealed: -The Administrator was not aware the freezer had not kept the food completely frozen. -The Dietary staff should inform her if the refrigerator/freezer is not working properly. -The Administrator would get someone to come and look at the refrigerator/freezer.	D 105		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the refrigerator/freezer and three deep freezers were cleaned and protected from contamination. The findings are: Observation of the freezer which was part of the refrigerator located in the kitchen on 3/24/15 at 12:30 p.m. revealed: -The inside of the freezer had three areas of dried brown liquid at the bottom of the freezer. -Inside the freezer were dark brown speckles at the bottom of the freezer. -Three racks on the inside of the freezer and	D 283		

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D 283	Continued From page 3 three racks on the side of the freezer, which contained food, had brown and black dried food stains. Interview with the Dietary Supervisor on 3/24/15 at 12:45 p.m. revealed: -The refrigerator and freezer are cleaned daily. -The Dietary Supervisor last cleaned the refrigerator and freezer on 3/23/15. -The spillage inside of the freezer happened on 3/23/15 and had not been cleaned. Observation of the outside of the refrigerator on 3/24/15 at 12:50 revealed the vent on the bottom of the refrigerator had brown dried food stains and dust. Observation of the deep freezers located outside in a storage area on 3/24/15 at 1:00 p.m. revealed: -Deep freezer #1 had rust on the outside of the freezer (lid and side). The inside lid had brown ply wood attached, which was exposed to the food inside of the freezer. Frozen blood from the meats was on the floor of the freezer. -Deep freezer #2 had rust on the outside of the freezer and multiple areas of rust on the inside of the freezer. -Deep freezer #3 had rust on the outside of the freezer. The inside of the freezer had ice on all four walls of the freezer. -The food in all three deep freezers were closed. Interview with the Dietary Supervisor on 3/24/15 at 1:03 p.m. revealed: -The Dietary Supervisor had only cleaned deep freezer #1 sometime within the past two months. -The Dietary Supervisor did not know how long the ice had been in freezer #3. -The Dietary Supervisor could not remember the	D 283		

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D 283	Continued From page 4 last time she cleaned the other deep freezers. Observation of the refrigerator/freezer located inside of the kitchen on 3/25/15 at 8:33 a.m. revealed the refrigerator/freezer had been cleaned. Observation of the deep freezers located outside in a storage area on 3/25/15 at 10:50 a.m. revealed the deep freezers had not been cleaned. Interview with a Cook on 3/25/15 at 9:55 a.m. revealed: -Dietary staff cleaned the refrigerator daily. She had not worked at the facility for the past two days. -The Dietary Supervisor cleaned the deep freezers weekly. Interview with the Resident Care Coordinator (RCC) on 3/25/15 at 10:31 a.m. revealed: -The refrigerator should be cleaned every week and as needed. -The freezers should be cleaned every two months. -The Dietary Supervisor was responsible for making sure the refrigerator and freezers are cleaned. -The RCC last checked the refrigerator and freezers one month ago and there were no problems. Interview with the Administrator on 3/25/15 at 11:13 a.m. revealed: -The Administrator expect for the refrigerators and freezers to be cleaned weekly. -The Administrator and the RCC are responsible for keeping the deep freezers cleaned. -The deep freezers are cleaned as needed and were last cleaned January 2015.	D 283		

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D 283	Continued From page 5 -The Administrator was aware the deep freezers needed to be cleaned.	D 283		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a combination therapeutic diet menu for 1 of 1 Residents (#4) with a physician order for a No Added Salt (NAS)/No Concentrated Sweets (NCS) diet. The findings are: Review of Resident #4's current FL-2 dated 5/29/14 revealed: -The resident's diagnoses included high blood pressure, cerebral vascular accident and Type II Diabetes Mellitus. -The resident had an order for a NAS diet. Review of Resident #4's current Care Plan dated 5/29/14 revealed the resident was on a NCS diet. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 3/28/12. Review of Resident #4's physician orders revealed no subsequent diet orders.	D 296		

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D 296	Continued From page 6 Review of the diet list revealed Resident #4 was on a NAS and a NCS diet. Review of the Cycle 1 Week 2 Day 3 NAS dinner menu included 6 ounces vegetable soup; 1 packet saltine crackers; 1 deli sandwich; 3/4 cup cucumber salad; one 2 by 3 lemon bar. Review of the Cycle 1 Week 2 Day 3 NCS dinner menu included the residents were to receive 6 ounces vegetable soup; 1 packet saltine crackers; 1 deli sandwich; 3/4 cup cucumber salad; 4 vanilla wafers. Observation of the dinner meal on 3/24/15 at 5:30 p.m. revealed Resident #4's meal included 1 cup vegetable soup; 4-6 saltine crackers; 1 cup sweet pea salad, 1/2 cup pears; 1 bologna sandwich. Observation on 3/24/15 at 6:02 p.m. revealed Resident #4 had eaten 1/4 of the meal. The resident was still eating the meal. Interview with the Dietary Supervisor on 3/25/15 at 12:30 p.m. revealed: -The Dietary Supervisor did not cook with salt when preparing the NAS diets. -The NCS diets received unsweetened beverages. Interview with a Cook on 3/25/15 at 11:40 a.m. revealed: -When preparing the NAS diet she added a little salt while cooking. -The facility did not have a NAS/NCS combination menu. -She followed the NAS menu and the NCS menu when preparing Resident #4's diet and she had been preparing the diet the same way for the past 6 months.	D 296		

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D 296	Continued From page 7 -The Cook started adding salt to the NAS diet for the past year. Interview with the Resident Care Coordinator (RCC) on 3/25/15 at 10:31 a.m. revealed: -The facility did not have a combination diet menu. -Dietary staff did not use salt when preparing Resident #4's diet. -The NCS diets are given fruit, unsweetened cake with no icing. -Resident #4 had a combination diet order for the past 2-3 years. -The RCC was not aware the facility needed a combination diet menu for the NAS/NCS diet order. Interview with the Administrator on 3/25/15 at 11:13 a.m. revealed: -The facility did not have a combination NAS/NCS menu. -The diabetics may receive fruit or sugar free ice cream for dessert. -The Cooks do not cook with a lot of salt. Salt is not offered to the residents. -The Administrator was not aware the facility needed a combination diet menu for the NAS/NCS diet order. Telephone interview with Resident #4's primary physician's nurse on 3/25/15 at 11:52 a.m. revealed: -Resident #4 had just starting going to the primary care physician on 12/8/14. -Resident #4 did not have a diet order on file.	D 296		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service	D 298		

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D 298	Continued From page 8 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to offer snacks 3 times a day to residents. The findings are: Interview with the Resident Care Coordinator (RCC) on 03/24/15 at 11:55 AM and Dietary Supervisor on 03/24/15 at 12:30 PM revealed snacks were offered at 10:00 AM, 3:00 PM and 8:00 PM. Observation on 03/24/15 from 3:00 PM to 4:00 PM revealed no announcement was made about snacks being available nor were snacks made available in the dining area. Interview with 5 of 5 residents on 03/24/15 at 4:00 PM revealed: -Snacks were not offered on 03/24/15 at 3:00 PM and snacks were not offered on 03/23/15 at 8:00 PM. -Snacks were not offered routinely 3 times per day. Interview with a resident on 03/25/15 at 8:20 AM revealed: -The resident does not eat breakfast or the 10:00 AM snack. -A snack was not offered on 3/24/15 at 8:00 PM. -If a snack had been offered on 3/24/15 at 8:00 PM, the resident would have eaten the snack because the resident was hungry.	D 298		

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D 298	Continued From page 9 Review of the diet menu posted revealed the residents were to receive portion sized "snack of the day". Interview with Administrator on 03/25/15 at 11:45 AM revealed: - The Administrator was not aware residents were not offered snacks at the scheduled times. - Low salt popcorn, canned or fresh fruit, regular or sugar- free ice cream are served to the residents for snacks. - There is plenty of food on hand for snacks. - The Administrator would discuss the snack schedule with staff to assure residents received snacks as scheduled. Observation and interview with the Medication Aide (MA)/Personal Care Aide (PCA) on 3/24/15 at 4:03 p.m. revealed: -The residents usually do not eat a snack. -The MA asked the Dietary Supervisor if the residents were offered a 3:00 p.m. snack and none of the residents wanted a snack. Interview with the Dietary Supervisor on 3/24/15 at 4:06 p.m. revealed she offered the residents the 3:00 p.m. snack at 2:50 p.m. Observation on 3/24/15 at 4:10 p.m. revealed: -A resident asked the Dietary Supervisor for a snack. -The resident was given 8 vanilla wafers and 1 cup of orange juice. -The resident ate aten all of the snack. Observation on 3/25/15 at 9:50 a.m. revealed the	D 298		

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MORNING STAR AL # 3	941 GOINS ROAD PEMBROKE, NC 28372

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D 298	Continued From page 10 MA/PCA was going around the facilty and asking residents if they wanted a snack. Observation on 3/25/15 at 10:02 a.m. revealed: -Snacks were offered to residents during an activity. -The residents received vanilla wafers and a cup of apple juice. -Two residents ate the snacks. Interview with the RCC on 3/25/15 at 10:31 a.m. revealed: -The Cook prepares and passes the snacks to the residents. -Snacks should be offered to residents three times daily.	D 298		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were	D 484		

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D 484	Continued From page 11 unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 1 of 1 sampled resident (Resident #1) using bed rails had been assessed for the use of the bed rail, had a current order for the bedrails and had documentation for the approval for the bedrails from the responsible party . The findings are: Review of Resident #1's current FL-2 dated 9/25/14 revealed: -Resident #1 had diagnoses of Alzheimer's disease, depression, seizures and arthritis.	D 484		

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D 484	Continued From page 12 -Resident #1 was non ambulatory and constantly disoriented. -The resident used a geri chair. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 8/1/06. Review of Resident #1's current Care Plan dated 2/20/15 revealed: -Resident #1 was totally dependent on staff for all activities of daily living. -The resident had limited eye-hand coordination. -The geri chair was used for ambulation. -There was no order or any documentation for the use of bed rails on the Care Plan. Review of Resident #1's prior Care Plan dated 9/25/14 revealed no documentation for bedrails. Review of Resident #1's Licensed Health Professional Support Task assessments dated 1/27/15 and 10/24/14 revealed: -The resident used the geri chair. -There was no documentation of the use of bed rails. Review of Resident #1's record revealed: -The resident had an order dated 8/20/13 for bed rails to enable resident to move in bed. -There was no current order for bed rails in the resident's record. Observation of Resident #1 on 3/24/15 at 11:50 a.m. revealed: -The resident was sitting in the dining room in a geri chair at the table without a lap tray eating lunch. -Staff assisted and prompted the resident to eat.	D 484		

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D 484	Continued From page 13 Interview with a Medication Aide (MA)/Personal Care Aide (PCA) on 3/24/15 revealed: -Staff did everything for Resident #1. -Resident #1 used the bed rails in bed to keep the resident from falling out of bed. -Resident #1 had not fallen at the facility. -The bed rail is released every hour while Resident #1 was in bed for incontinent care. -Resident #1 had a geri chair, but the resident does not move while being in the chair. Observation of Resident #1 on 3/24/15 at 3:45 a.m. revealed: -The resident was sitting in the day room in the geri chair without a lap tray. -The resident only moved the arms while sitting in the chair. -The resident did not try to get out of the chair. Interview with the Resident Care Coordinator (RCC) on 3/25/15 at 8:56 a.m. revealed: -Resident #1 used the bed rails for safety to prevent the resident from falling out of bed. -The resident had not fallen at the facility. -Resident #1 cannot push the bedrails down. Observation of Resident #1 on 3/25/15 at 9:03 a.m. revealed: -The resident was lying in bed with the right side of the bed against the wall. -Only the ¾ full bedrail on the left side of the bed was up while the resident was in bed. -The resident was laying slanted towards the right side of the bed towards the wall. -The RCC asked Resident #1 to hold onto the bed rail with one of the hands. The resident could not follow command. Interview with the RCC on 3/25/15 at 9:03 a.m. revealed:	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078065	A. BUILDING: _____ B. WING _____	03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 3	941 GOINS ROAD PEMBROKE, NC 28372

(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 484	Continued From page 14 -The RCC had not completed nor was she aware Resident #1 needed an assessment including quarterly assessments for the bedrails, the least restrictive restraint needed to be used, there needed to be a current order for the bedrails and the responsible party needed to approve the restraint. -Resident #1 had been using the bedrail to prevent from falling out of bed since 2006. Interview with the Administrator on 3/25/15 at 11:13 a.m. revealed: -Resident #1 turned independently while lying in the bed. -The bed rails are used to prevent Resident #1 from falling out of bed. -Resident #1 had been using the bed rail to prevent from falling out of bed since 2006. -There were no current orders in Resident #1's record for bed rails. -The Administrator was aware Resident #1 needed an assessment for the bed rails including quarterly assessments for the bed rails, the least restrictive restraint needed to be used, there needed to be a current order for the bed rails and the responsible party needed to approve the restraint. -The Administrator did not provide any explanation to why the above had not been completed. -The Administrator revealed "she would take care of it." Based on observation, interview and record review, Resident #1 was not interviewable. Resident #1's responsible party and primary care physician could not be reached by the end of the survey.	D 484		