STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078067	A. BUILDING: _____ B. WING _____	10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL #4	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 on October 27 - 28, 2015.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the walls in the dayroom, ceilings in the dining room, bathrooms, and residents' room, and floors in the bathroom were kept clean and in good repair. The findings are: Observation of the dining room on 10/27/2015 at 9:50am revealed: -The ceiling covering on the side of the dining room closest to the small bathroom was detached for a length of approximately 4 - 6 inches where the wall and ceiling meet. -There were areas of peeled paint on the ceiling covering in multiple areas. -There was an approximate 12 inch by 4 inch area of a white colored plaster looking dried substance on the wall below the area where the ceiling was detached. -There was a large irregular shaped area of a	D 074		

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D 074	Continued From page 1 brown colored stain on the ceiling. Observation of the shower room/bathroom on 10/27/2015 from 10:00am to 10:20am revealed: -The shower stall floor tile was stained a brownish-tan color covering approximately ¼ to ½ of the shower stall floor. -The area where the wall and floor met was stained with a dark brownish-black substance around the entire shower stall floor. -There was a brownish-tan substance on the wall around the right side and back of the shower stall. -The shower head was loose and detaching from the wall. -There was an area on the shower stall wall approximately 4 inches by 4 inches where the soap dish was missing. -There was a small area of peeling paint on the ceiling close to the shower. -There was peeling paint on the wall behind the toilet below the handrail. -The wall covering was bubbled on the wall in multiple places behind the toilet below the handrail. -The ceiling above the toilet was sagging near the ceiling vent. -There was peeling paint from the ceiling above the toilet in multiple areas and of multiples sizes. -There were brown stained spots on the ceiling close to the light fixture. -There was cracked and peeling paint above the toilet expanding the entire width of the toilet water lid cover. Observation of the small bathroom on 10/27/2015 at 10:40am revealed: -There were multiple brown stained areas on the wall across the top of the sink extending approximately 3/ the width of the sink. -There was a black substance along the right	D 074		

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D 074	Continued From page 2	D 074		

corner of the wall and ceiling.
-There were brownish-black stained areas on the ceiling over the sink.
-There were three areas of a dark brownish color staining on the inside of the ceiling light fixture.

Observations in the dayroom on 10/27/2015 at 12:45pm revealed two areas on the wall across from the window below the wall railing where the wall covering was missing.

Interview with the Resident Care Coordinator (RCC) on 10/27/2015 at 10:25am revealed:
-The dark stains in the shower stall had not gotten dark until all the rain a couple of weeks ago.
-The Administrator had been made aware by the workers about how the shower stall floor looked.
-The facility had not been able to clean the stains off the floor in the shower stall.
-The third shift workers were responsible to do thorough cleaning at the facility.
-The RCC was constantly talking to staff about cleaning in the facility.
-The shower stall had been recaulked before and the caulking was clear.
-The RCC became aware of the shower stall floor after the rain.
-"If the shower stall floor was like that before, the rain, I had not seen it."
-The RCC did "walk throughs of building maybe once a week. If staff don't tell me something drastically wrong, I might just look in the door. I just don't walk in and look at shower."

Interview with the Administrator on 10/27/2015 at 11:15am revealed:
-In the small bathroom, the peeling paint behind the toilet did not happen with the rain, but everywhere else where the paint was peeling

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D 074	Continued From page 3	D 074		

came with the rain.
-There was a water leak that came down the wall in the small bathroom causing the damages to the wall and ceiling.
-The shower stall damages occurred when a water leak came down the wall when it rained causing the dark stained grout.

Interviews with two Personal Care Aides on 10/27/2015 during the survey revealed the staining on the floor in the shower room had gotten worse after the big rain about 2-3 weeks ago.

Observations in the dining room on 10/28/2015 at 9:55am revealed:
-A white loose powdery substance fell to the floor from the dining room ceiling where the ceiling covering was detached.
-A long tape-looking stripping from the falling ceiling matter became lodged on the back of a picture hanging on the dining room wall.

Observation of room #5 on 10/28/2015 at 10:00am revealed:
-There were multiple brown colored stained areas in the ceiling of multiple sizes.
-A small section of the ceiling was detached at the seam where the wall and ceiling met.

-Interview with the Personal Care Aide (PCA) on 10/28/2015 at 10:05am revealed:
-The PCA had not noticed the white matter on the floor earlier in the morning.
-The dining room ceiling matter had never fallen before.
-Putty had been applied to the area once before.
-The roof shingles must have weakened about 2-3 weeks ago when there had been wind and rain.

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D 074	Continued From page 4 Interview with the Memory Care Manager (MCM) and Personal Care Aide (PCA) together on 10/28/2015 at 10:10am revealed: -The PCA had not noticed the brown spots in the ceiling in room #5. -The MCM had not seen the brown spots in the ceiling in room #5 before today (10/28/2015). -The MCM felt the damages to the ceiling happened when there was wind and rain about 3 weeks ago. Observation of the Administrator on 10/28/2015 at 10:25am revealed: -The Administrator touched the floor in the dining room in the corner where the ceiling was detaching and stated the floor was wet. -The Administrator instructed the PCA to mop up the water and to put a towel on the floor to catch any further water leakage. Interview with the Administrator on 10/28/2015 at 10:30am revealed: -The Administrator was sending a family member today to get some tarps to cover the back side of the facility roof where all the leaks are happening. -The Administrator would have the sheetrock replaced that was sagging in the dining room and in room #5. -The Administrator thought all the leaks appeared to be on the right side of the facility. -Facility staff notified the Administrator on the day of the storm that they could see the ceiling getting wet but the facility could not do anything while the storm was occurring. -The insurance company had been contacted about the damages and the insurance adjuster had been to the facility but did not leave any information or recommendations.	D 074		

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D 074	Continued From page 5 Interview with the Administrator on 10/28/2015 at 10:40am revealed: -The black substance would be cleaned from the wall and ceiling in the small bathroom and the damaged area in the ceiling would be cut out and the sheetrock would be replace replaced today (10/28/2015). -The shower room ceiling would be scraped today (10/28/2015) where the paint was peeling. -The brown stained areas in the ceilings in room #5 and in the dining room would be cut out and the sheetrock replaced today (10/28/2015). -The Administrator did not think about covering the roof with tarps until today (10/28/2015). Interviews with residents revealed the residents had not observed any problems with leaks in the building. _____ The facility submitted the following Plan of Protection on 10/28/2015: -The roof would be fixed where it is leaking and the sheetrock will be replaced where it is sagging today. -The sheetrock in the small bathroom, resident room, and dining room will be replaced where it is sagging today. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 12, 2015.	D 074		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to assure 1 of 2 residents (Resident #2) who required sliding scale insulin for 3 opportunities, was administered the sliding scale insulin as ordered.

The findings are:

Review of Resident #2's current FL-2 dated 06/25/2015 revealed diagnoses included Dementia secondary to Cerebrovascular Accident, Mood Disorder, History of Cerebrovascular Accident, Hypertension, Left Above Knee Amputation, and Coronary Artery Disease.

Review of Resident #2's physician orders dated 08/18/2015 revealed:
-A physician's order for Novolog Flexpen (an injectable form of insulin used to lower blood sugar levels in diabetics) with four times daily dosing before meals and at bedtime (ac & hs) using sliding scale parameters of 200-250=5 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=25 units and call, call if blood sugar less than 70 or greater than 450.

Review of the fingerstick blood sugar readings for Resident #2 for September 2015 and October 2015 revealed:
-On September 30, 2015 at 4:30pm Resident #2's fingerstick blood sugar reading was documented

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D 358	Continued From page 7 as 206. -On October 9, 2015 at 11:30am Resident #2's fingerstick blood sugar reading was documented as 207. -On October 11, 2015 at 11:30am Resident #2's fingerstick blood sugar reading was documented as 247. Review of September 2015 Medication Administration Records (MARs) and October 2015 MARs revealed: -Novolog 100 units/ml Flexpen inject before meals and at bedtime per SSI (sliding scale insulin) 200-250=5 units; 251-300=10 units; 301-350=15 units; 351-400=20 units; 401-450=25 units was printed on the MARs. -The Novolog SSI was scheduled for administration "PRN" (as needed). -There was no documentation of administration of the Novolog Flexpen insulin using the sliding scale parameters ordered by the physician. Review of September 2015 Sliding Scale Insulin sheet revealed: -A sliding scale order for " Novolog 200-250=5 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=25 units, > [greater than] 450 call doctor, less than 70 call MD " was handwritten on the Sliding Scale Insulin sheet. -The Sliding Scale Insulin sheet contained a column for the date of the month, and four columns each for the fingerstick blood sugar reading (FSBS), units, site, and initials. -Documentation of a FSBS reading of 206 on September 30, 2015, was noted in the third column. -No documentation of administration of units of insulin using the sliding scale parameters ordered by the physician for a FSBS of 206 (Novolog Flexpen 5 units required).	D 358		

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D 358	Continued From page 8 Review of October 2015 Sliding Scale Insulin sheet revealed: -A sliding scale order for " Novolog 200-250=5 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=25 units, > [greater than] 450 call doctor, less than 70 call MD " was handwritten on the Sliding Scale Insulin sheet. -The Sliding Scale Insulin sheet contained a column for the date of the month, and four columns each for the fingerstick blood sugar reading (FSBS), units, site, and initials. -Documentation of a FSBS reading of 207 on October 9, 2015 in the second column. -No documentation of administration of units of insulin using the sliding scale parameters ordered by the physician for a FSBS of 207 (Novolog Flexpen 5 units required). -Documentation of a FSBS reading of 247 on October 11, 2015 in the second column. -No documentation of administration of units of insulin using the sliding scale parameters ordered by the physician for a FSBS of 207 (Novolog Flexpen 5 units required). Confidential Interviews with Medication Aides (MAs) revealed: -Resident #2's sliding scale insulin administration parameters started at 200. -Documentation of insulin administration per sliding scale to Resident #2 would be documented on the MAR. -The administration of sliding scale insulin to Resident #2 would not be documented any place else. -One MA did not know how to verify whether insulin had been administered to Resident #2 if it was not documented on the MAR unless Resident #2 was asked, but did not know how	D 358		

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good Resident #2's memory would be.
-One MA had never administered the sliding scale insulin to Resident #2.
-Documentation of the fingerstick blood sugar reading and the amount of insulin administered would be on the MAR.
-The Memory Care Manager (MCM) or another MA usually transcribed the sliding scale insulin order and parameters on the blood sugar flowsheet. When the order was not transcribed to the blood sugar flowsheet, the MA questioned if Resident #2 was on sliding scale insulin. The MCM "went back and corrected the flow sheet adding the sliding scale order."

Interview with the Memory Care Manager at 11:15am on 10/28/2015 revealed:
-The MCM knew Resident #2 was prescribed sliding scale insulin.
-The insulin units administered and site of Insulin administration would be documented on the blood sugar flow sheet and MAR.
-The MCM was not aware of any instances when Resident #2 was supposed to have been administered Novolog insulin per sliding scale and had not been administered the Novolog sliding scale insulin as ordered.
-For blood sugar readings of 206, 207, and 247, Resident #2 should have been administered 5 units of Novolog insulin.

Interview with Memory Care Manager at 3:00pm on 10/28/2015 revealed:
-The MCM or another MA (named) were responsible to transcribe orders.
-The MCM was responsible to "fill out - write in sliding scale order, resident's name, month, circle frequency of blood sugar check" on the blood sugar flow sheet.
-The MCM "periodically, no certain time or day",

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D 358	Continued From page 10 looked at blood sugar flow sheets and MARs checking for "holes" on the MARs. -The MCM checked the MARs to make sure the right medicine was transcribed to the MAR. Interview with Resident #2 3:45pm on 10/28/2015 revealed: -Resident #2's blood sugar was checked before meals and before bedtime. -Resident #2 remembered "get a needle" in the evening. -Resident #2 remembered one time when he got a needle during the day but did not know what the needle was for.	D 358		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side	D 400		

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D 400	Continued From page 11 effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure pharmacy review of medications were completed at least quarterly for 3 of 3 residents (Residents #1, #2, and #3) sampled. The findings are: 1. Review of Resident #2's current FL-2 dated 06/25/2015 revealed diagnoses included Dementia secondary to Cerebrovascular Accident, Mood Disorder, History of Cerebrovascular Accident, Hypertension, Left Above Knee Amputation, and Coronary Artery Disease. Review of Resident #2's current FL-2 and subsequent orders revealed medication orders for 23 medications including orders for Novolog Flexpen (an injectable form of insulin used to lower blood sugar levels in diabetics) with four times daily dosing using sliding scale parameters of 200-250=5 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=25 units and call, call if blood sugar less than 70 or greater than 450.	D 400		

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Review of the fingerstick blood sugar readings for Resident #2 for September 2015 and October 2015 revealed:
-On September 30, 2015 at 4:30pm Resident #2's fingerstick blood sugar reading was documented as 206.
-On October 9, 2015 at 11:30am Resident #2's fingerstick blood sugar reading was documented as 207.
-On October 11, 2015 at 11:30am Resident #2's fingerstick blood sugar reading was documented as 247.

Review of September 2015 Medication Administration Records (MARs) and October 2015 MARs revealed no documentation of administration of the Novolog Flexpen insulin using the sliding scale parameters ordered by the physician.
Review of September 2015 and October 2015 Sliding Scale Insulin sheet revealed no documentation of administration of the Novolog Flexpen insulin using the sliding scale parameters ordered by the physician.

Review of Resident #2's quarterly medication reviews revealed:
-The most recent review was dated 06/06/2015.
-There was no quarterly pharmacy review date for 9/2015 or 10/2015.

Refer to interview with the Administrator on 10/28/2015 at 11:10am.

Refer to interview with the Memory Care Manager on 10/28/2015 at 11:15am.

Refer to interview with the Pharmacy Provider Representative on 10/28/2015 at 3:15pm.

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MORNING STAR AL #4	941 GOINS ROAD PEMBROKE, NC 28372

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D 400	Continued From page 13 2. Review of Resident #1's current FL-2 dated 04/21/2015 revealed diagnoses included Alzheimers, Cerebrovascular Accident, Vitamin B12 Deficiency, Transient Ischemic Attack, Migraines, Chronic Tremor, Hypertension, History of Falls, History of Gastrointestinal Bleeding, and Diabetes Mellitus Type II. Review of Resident #1's current FL-2 and subsequent orders revealed medication orders for 18 medications including orders for Novolog Insulin injections (used to lower blood sugar levels in diabetics) per sliding scale and Cyanocobalamin (used to treat Vitamin B12 deficiency) 1000mcg injection 1 ml [milliliter] every other month. Review of September 2015 Medication Administration Records (MARs) and October 2015 MARs revealed: -Cyanocobalamin 1,000 mcg inject 1 ml intramuscularly every other month was transcribed to the MARs. -Documentation for administration of Cyanocobalamin 1,000 mcg inject 1 ml intramuscularly on September 22, 2015 months by the Home Health Nurse (HHN). -Documentation for administration of Cyanocobalamin 1,000 mcg inject 1 ml intramuscularly on October 21, 2015 months by the Home Health Nurse (HHN). Review of the May 2015 through August 2015 MARs revealed the HHN had documented administration of the Cyanocobalamin injection every other month as ordered. Review of Resident #1's quarterly medication reviews revealed: -The most recent review was dated 06/06/2015.	D 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078067	A. BUILDING: _____ B. WING _____	10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL #4	941 GOINS ROAD PEMBROKE, NC 28372

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D 400	Continued From page 14 -There was no quarterly pharmacy review date for 09/2015 or 10/2015. Refer to interview with the Administrator on 10/28/2015 at 11:10am. Refer to interview with the Memory Care Manager on 10/28/2015 at 11:15am. Refer to interview with the pharmacy Provider Representative on 10/28/2015 at 3:15pm. 3. Review of Resident #3's current FL-2 dated 06/25/2015 revealed diagnoses included Dementia and Hypertension. Review of Resident #3's current FL-2 and subsequent orders revealed medication orders for 8 medications. Review of Resident #3's quarterly medication reviews revealed: -The most recent review was dated 06/06/2015. -There was no quarterly pharmacy review date for 9/2015 or 10/2015. Refer to interview with the Administrator on 10/28/2015 at 11:10am. Refer to interview with the Memory Care Manager on 10/28/2015 at 11:15am. Refer to interview with the Pharmacy Provider Representative on 10/28/2015 at 3:15pm. _____ Interview with the Administrator on 10/28/2015 at 11:10am revealed: -The Memory Care Manager (MCM) had been trying to contact the provider pharmacy about getting the pharmacy reviews completed.	D 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078067	A. BUILDING: _____ B. WING _____	10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 400	Continued From page 15 -The last call made to the pharmacy by the MCM was Friday (10/23/2015). -The Administrator was planning to switch to another pharmacy provider the first of December 2015. -The Administrator was aware the quarterly pharmacy reviews were last completed on 06/06/2015. Interview with the Memory Care Manager (MCM) on 10/28/2015 at 11:15am revealed: -The MCM was aware the pharmacy drug reviews were supposed to be done quarterly. -The MCM called the pharmacy provider on 10/23/2015 and was expecting a return call, but had not received a return call. -The MCM called the pharmacy on 10/26/2015 and was told the pharmacy was working on scheduling drug reviews. -The MCM had not called the pharmacy about the quarterly drug reviews before Friday, 10/23/2015. -The pharmacy provider usually called the facility and notified the facility when the pharmacy provider would be coming to the facility to complete the pharmacy reviews. -The MCM called the pharmacy provider when she (MCM) realized the quarterly pharmacy reviews had not been done. Telephone interview with the Pharmacy Provider Representative on 10/28/2015 at 3:15pm revealed pharmacy staff who were able to provide information regarding the pharmacy drug reviews for the facility were unavailable and would need to return a call. No return call was received by end of survey.	D 400		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078067	A. BUILDING: _____ B. WING _____	10/28/2015

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D912	Continued From page 16 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 interviews and record reviews, the facilty failed to ensure each resident received care and services which are adequate, appropriate and in compliance with federal and State laws, rules and regualtions related to housekeeping and furnishings. The findings are: Based on observations and interviews, the facility failed to assure the walls in the dayroom, ceilings in the dining room, bathrooms, and residents room, and floors in the bathroom were kept clean and in good repair. [Refer to Tag D 0074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings (Type B Violation)].	D912		