| 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 _____ | R 11/14/2016 |

| 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<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 11/9/16 and 11/10/16 with an exit conference via telephone on 11/14/16. | D 000 | | |
| D 074 | 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to maintain the walls and floors clean and in good repair as evidenced by holes and missing paint in three common bathrooms, dirt and grime build up on the floors throughout the facility and a warped and rotting composite baseboard in the kitchen pantry.<br><br>The findings are:<br><br>Observations on 11/9/16 from 10:51am through 12:45pm revealed:<br>-There were three common bathrooms in the facility: (A) with a sink and toilet, (B) with a sink, toilet and tub and (C) with a sink, toilet and wheelchair accessible shower.<br>-In bathroom A, there were four small holes in the wall above the toilet paper holder and one hole in the wall under the sink.<br>-In bathroom B, there were four small holes in the wall above the toilet paper holder and one hole in the wall behind the door.<br>-In bathroom C, there were four small holes in the | D 074 | | |

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|---|---|---|---|
| | HAL078065 | A. BUILDING: _____ B. WING _____ | R 11/14/2016 |

| 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 074 | Continued From page 1 | D 074 | | |

wall above the toilet paper holder, multiple areas of missing and peeling paint, a black substance in the caulk/grout line where the wall met the floor of the shower and heavy dirt build up generally on the floor and especially in the corner near under the sink.
-There was dirt and grime build up along the edges and in corners of all floors and dirt build up on the floors throughout the facility including resident rooms, the living room, dining room, kitchen and hallway.
-The base board made of composite type wood at the front of the elevated pantry floor, was warped and had missing and rotted pieces along the edge.

Interview with a resident on 11/9/16 at 11:15am revealed she had not noticed the holes in the walls, missing and peeling paint and dirt build up on the floors.

Interview with a second resident on 11/9/16 at 11:18am revealed:
-She had not noticed the holes in the walls, missing and peeling paint and dirt build up on the floors.
-Staff cleaned the facility every shift.
-She had not seen any maintenance person at the facility recently.

Interview with a third resident on 11/9/16 at 11:27am revealed:
-The walls in the bathrooms had been that way for years.
-The facility was getting ready to strip, clean and wax the floors but they had not done that before that she had seen and she lived at the facility for several years.
-Staff were supposed to clean so many rooms each day but they did not.

| 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 _____ | R 11/14/2016 |

| 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 074 | Continued From page 2<br><br>Review of the facility's sanitation inspection report dated 8/18/16 revealed there was one demerit for walls and ceilings with an attached comment to repair the hole in the wall behind the door in the common bathroom with the tub.<br><br>Interview with a Personal Care Aide (PCA) on 11/9/16 at 12:04pm revealed:<br>-She had worked at the facility as a PCA on 1st shift for one and one half years.<br>-All staff were responsible for cleaning the facility although most of the cleaning was done on 3rd shift.<br>-The 3rd shift staff were responsible for cleaning bathrooms, the hallway and the dining room.<br>-The 1st and 2nd shift staff were responsible for cleaning three resident rooms each and the bathrooms.<br>-The floors needed to be scrubbed and the facility was planning for a guy to come and strip and wax the floors and do repairs when he finished at a sister facility.<br>-She did not know how long the holes had been in the walls and the paint was missing and peeling in the bathrooms.<br><br>Review of the facility's 1st and 2nd shift cleaning schedule dated 5/2/16 revealed each shift staff were responsible for cleaning the bathrooms, three resident rooms and mopping the floors in the three resident rooms and the hallway.<br><br>Review of the facility's 3rd shift cleaning schedule (undated) revealed the 3rd shift staff were responsible for mopping the floors in the hallway, living room, dining room and all bathrooms.<br><br>Interview with a Medication Aide (MA)/Supervisor on 11/9/16 at 12:45pm and 2:15pm revealed: | D 074 | | |

| 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 _____ | R 11/14/2016 |

| 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 074 | Continued From page 3 | D 074 | | |

-The cook was responsible for cleaning the kitchen and the kitchen floors.
-Staff were responsible for cleaning the facility including the floors every shift and there was a cleaning schedule for each shifts cleaning duties.
-She did not know how long the pantry floor had been that way.
-She did not know how long there had been holes and missing/peeling paint on the bathroom walls.
-She did not know if the needed repairs had been reported to anyone.
-The MA and the Resident Care Coordinator (RCC) were responsible for checking the cleanliness of the facility daily.
-If the MA or the RCC found any repair or cleaning concerns, they reported it to the Administrator.
-The facility was in the process of doing repairs.

Interview with the Administrator on 11/9/16 at 2:45pm revealed:
-She was aware of the condition of the floors and the floors were scheduled to be cleaned on 11/10/16 starting with the common areas and then residents' rooms.
-The holes in the walls in each bathroom above the toilet paper holders came from replacing and relocating the toilet paper holders approximately 5-6 months ago.
-She was aware of the missing and peeling paint in bathroom C.
-There was a repair man was working in a sister facility and would make necessary repairs at the facility on 11/10/16.
-The Supervisor was responsible for checking the cleanliness of the building "and evidently this was not done because of this (bathroom C floor and shower) was not cleaned."

| 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 _____ | R 11/14/2016 |

| 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 079 | Continued From page 4 | D 079 | | |
| D 079 | 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br>(a) Adult care homes shall<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to maintain an environment free of hazards as evidenced by sinks with cracked sealant and loose on the wall in all three common bathrooms and a loose protruding electrical outlet in a resident room.<br><br>The findings are:<br><br>Observations on 11/9/16 from 10:51am until 11:08am revealed:<br>-There were three common bathrooms in the facility: (A) with a sink and toilet, (B) with a sink, toilet and tub and (C) with a sink, toilet and wheelchair accessible shower.<br>-In bathroom A, the sink had loose, cracked caulking/sealant around the edge that meets the wall causing the sink to move on the wall when the faucet was used.<br>-In bathroom B, the sink had loose, cracked caulking/sealant around the edge that meets the wall where the sink moved on the wall when touched.<br>-In bathroom C, the sink had loose, cracked caulking/sealant around the edge that meets the | D 079 | | |

| 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 _____ | R 11/14/2016 |

| 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 079 | Continued From page 5 | D 079 | | |

wall where the sink moved on the wall when touched.
-In resident room #4, there was an electrical outlet on the wall between the closet and the window that was loose and protruding from the wall.

Interview with a resident on 11/9/16 at 11:15am revealed she had not noticed the loose sinks in the bathrooms.

Interview with a second resident on 11/9/16 at 11:18am revealed:
-She had not noticed the loose sinks in the bathrooms.
-She had not seen any maintenance person at the facility recently.

Interview with a third resident on 11/9/16 at 11:27am revealed the sinks in the bathrooms had been that way for years.

Review of the facility's sanitation inspection report dated 8/18/16 revealed there was one demerit for lighting and ventilation with an attached comment to repair the electrical outlet in resident room #4.

Interview with a Personal Care Aide (PCA) on 11/9/16 at 12:04pm revealed:
-She had worked at the facility as a PCA on 1st shift for one and one half years.
-She did not know how long the sinks in the bathrooms had been loose on the wall.
-The facility had a guy coming to do repairs when he finished at a sister facility.

Interview with a Medication Aide (MA)/Supervisor on 11/9/16 at 12:45pm and 2:15pm revealed:
-She did not know how long the sinks had been loose on the wall in the bathrooms.

| 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 _____ | R 11/14/2016 |

| 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 079 | Continued From page 6<br>-She did not know if the loose sinks had been reported to anyone.<br>-The MA and the Resident Care Coordinator (RCC) were responsible for checking the facility daily.<br>-If the MA or the RCC found any repair concerns, they reported it to the Administrator.<br>-The facility was in the process of doing repairs.<br><br>Interview with the Administrator on 11/9/16 at 2:45pm revealed:<br>-She was not aware of the loose, cracked caulk/sealant around the sinks and the sinks being loose on the wall.<br>-She thought the loose electrical outlet in resident room #4 which was vacant, had been repaired.<br>-She would make sure the electrical outlet was repaired before any resident moved in the room.<br>-There was a repair man was working in a sister facility and would make necessary repairs at the facility on 11/10/16. | D 079 | | |
| D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to provide repositioning and incontinence care according to facility | D 269 | | |

| 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 _____ | R 11/14/2016 |

| 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 269 | Continued From page 7 | D 269 | | |

procedures of every two hours for 2 of 2 resident's (Resident # 2 and #3) who required assistance with all activities of daily living.

The findings are:

1. Review of Resident #2's current FL-2 dated 8/2/16 revealed:
-Diagnoses included Alzheimer's Dementia, Mental Retardation, Depression, Spastic Seizures and Arthritis.
-The resident was constantly disoriented, incontinent of bladder and bowel and was non-ambulatory.
-The resident required assistance with bathing, feeding, dressing and total care.

Review of Resident #2's current Care Plan dated 2/10/16 revealed:
-Resident #2 was non-ambulatory, had limited hand-eye coordination and daily incontinence of her bladder and bowel.
-Resident #2 was totally dependent on staff for eating, toileting, bathing, dressing, grooming, transfer and ambulation.

Observations on 11/9/16 from 11:40am through 5:45pm revealed:
-The Personal Care Aide (PCA) transferred Resident #2 from the Geri-chair to her bed via Hoyer lift at 12:04pm
-The PCA removed Resident #2's pants and a moderately saturated incontinent brief and cleaned the resident with cleansing wipes at approximately 12:06pm.
-There was no skin breakdown observed.
-Resident #2's hands were contracted into fists, her left arm was turned outward and her right arm was drawn to her chest.
-She did not assist the PCA with undressing,

| 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 _____ | R 11/14/2016 |

| 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 269 | Continued From page 8 | D 269 | | |

changing the incontinence brief or dressing.
-From 12:21pm through 5:45pm Resident #2 was in her Geri-chair in the dining room for lunch, in the living room area between lunch and dinner and again in the dining room for dinner without incontinence care.

Based on observations, interviews and record reviews, Resident #2 was not interviewable.

Interview with a Personal Care Aide (PCA) on 11/9/16 at 12:04pm revealed:
-She had worked at the facility as a PCA on the 1st shift for one and one half years.
-She had the supplies she needed to provide care to the all the residents.
-Resident #2 and another resident were the only two residents who required staff assistance with feeding, incontinence care and transfers throughout the day.
-Resident #2 urinated frequently and needed to be changed every two hours.

Observations on 11/10/16 from 7:40am through 12:46pm revealed:
-From 7:40am until 8:00am Resident #2 was in her Geri-Chair in the dining room eating breakfast assisted by staff.
-From 8:00am until 9:45am Resident #2 was in her Geri-chair in the living room area.
-At 9:45am, Resident #2 was taken to a sister facility in her Geri-chair because the living room floor was going to be stripped and waxed.
-At 9:55am, Resident #2 was returned to the facility dining room in her Geri-chair after staff decided the resident would be better cared for in the facility and that the floors could be done one room at a time.
-From 10:00am until 12:40pm (after lunch) Resident #2 remained in her Geri-chair in the

| 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 _____ | R 11/14/2016 |

| 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 269 | Continued From page 9 | D 269 | | |

dining room.
-From 11:50am until 12:40pm Resident #2 had a saddened look on her face, was grimacing at times and had a whining tone to her garbled speech with the MA saying to her "I'm going to take you to your room after lunch."
-At 12:40pm the Medication Aide (MA) and the Resident Care Coordinator (RCC) took Resident #2 to her room for incontinence care.
-At 12:46pm the RCC transferred Resident #2 to her bed via Hoyer lift, removed her pants and a saturated incontinence brief and cleaned her with cleansing wipes.
-Resident #2 went from 7:40am until 12:46pm without incontinence checks or care.

Interview with a Medication Aide (MA)/Supervisor on 11/10/16 at 12:46pm revealed:
-Staff checked Resident #2 every two hours and changed her as needed.
-Resident #2 was changed last at 9:30am on 11/10/16 and she had been checked by staff between 9:30am and 12:40pm and was not wet.
-The MA could not recall which staff person had changed Resident #2 at 9:30am and the MA said that she had checked Resident #2 and she was not wet at 9:30am.
-The MA did not have a response for how the resident was checked for incontinence while in the dining room.

Interview with the Administrator on 11/10/16 at 4:15pm revealed Resident #2 would let staff know when she was wet because she would start whining, getting loud and at times say "I pee."

Refer to interview with a Medication Aide (MA)/Supervisor on 11/10/16 at 12:46pm.

Refer to interview with the Resident Care

| 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 _____ | R 11/14/2016 |

| 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 269 | Continued From page 10 | D 269 | | |

Coordinator (RCC) on 11/10/16 at 12:46pm.

Refer to interview with the Administrator on 11/10/16 at 4:15pm.

2. Review of Resident #3's current FL-2 dated 6/7/16 revealed:
-Diagnoses included Mood Disorder, Dementia, Hypertension, Cerebral Vascular Accident and Metabolic Encephalopathy.
-The resident was intermittently disoriented, continent of bladder and bowel and was non-ambulatory.
-The resident needed assistance with bathing, feeding and dressing.

Review of Resident #3's current Care Plan dated 6/8/16 revealed:
-Resident #3 was non-ambulatory, had limited range of motion of her right arm and daily incontinence of her bladder and bowel.
-Resident #3 was totally dependent on staff for toileting, bathing, dressing, grooming, transfer and ambulation.
-Resident #3 required staff supervision with meals.

Review of a Primary Care Provider visit note dated 4/6/16 revealed Resident #3 had been experiencing weakness, increased falls, her condition had declined and Resident #3 had been referred to Hospice.

Observations on 11/9/16 from 11:40am through 5:45pm revealed:
-At 11:40am the Personal Care Aide (PCA) transferred Resident #3 from her Geri-chair to her bed via Hoyer lift, removed her pants and incontinence brief which had been torn into many pieces leaving numerous pieces of stuffing all

| 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 _____ | R 11/14/2016 |

| 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 269 | Continued From page 11 | D 269 | | |

over the bed.
-The PCA said to the resident "You really tore your diaper up," and the resident replied, "Yeah."
-The PCA removed all of the stuffing pieces and wiped the resident with the dry incontinent pad she was laying on.
-There was feces in the resident's gluteal fold that was not completely removed after the PCA wiped the resident with the dry incontinence pad.
-There was no skin breakdown observed.
-The PCA put a new incontinence brief on the resident and put her pants back on.
-Resident #3 was bathed and changed by the Hospice Aide between 1pm and 2pm and remained in her bed until 5:45pm.

Interview with a Personal Care Aide (PCA) on 11/9/16 between 11:40am and 12:00pm revealed:
-The PCA normally used wipes to clean the residents but there was none in the room.
-The wipes were usually kept in the residents' rooms but someone must have moved them.
-She would get more wipes out of the office for Resident #3 and her roommate.
-Hospice staff was coming to shower the resident shortly.

Interview with Resident #3 on 11/9/16 between 11:40am and 12:00pm revealed:
-She had lived at the facility for one year and it was okay.
-Some staff were good and some were not.
-She could not remember the names of staff or which shift they worked.
-Staff normally wiped her off with cleansing wipes when they changed her.

Observations on 11/10/16 from 7:40am through 10:51am revealed:
-From 7:40am until 8:00am Resident #3 was in

| 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 _____ | R 11/14/2016 |

| 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 269 | Continued From page 12 | D 269 | | |

her Geri-Chair in the dining room eating breakfast assisted by staff.
-From 8:00am until 9:45am Resident #3 was in her Geri-chair in the living room area.
-At 9:45am Resident #3 was taken to a sister facility in her Geri-chair because the living room floor was going to be stripped and waxed.
-At 9:55am Resident #3 was returned to the facility dining room in her Geri-chair after staff decided the resident would be better cared for in the facility and that the floors could be done one room at a time.
-Resident #3 remained in her Geri-chair in the dining room from 9:55am until 10:50am when the Hospice PCA arrived to bath and change her.
-There was no redness or breakdown observed at her groin or buttocks areas.
-Resident #2 went from 7:40am until 10:50am without incontinence checks or care.

Interview with the Hospice PCA on 11/10/16 at 10:51am revealed:
-She assisted Resident #3 five days per week with bathing and dressing.
-Resident #3 was usually "not too wet" when the PCA arrived to bath her.
-Sometimes Resident #3's skin would be "a little red but no breakdown."

Refer to interview with a Medication Aide (MA)/Supervisor on 11/10/16 at 12:46pm.

Refer to interview with the Resident Care Coordinator (RCC) on 11/10/16 at 12:46pm.

Refer to interview with the Administrator on 11/10/16 at 4:15pm.

_____

Interview with a Medication Aide (MA)/Supervisor on 11/10/16 at 12:46pm revealed:

| 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 _____ | R 11/14/2016 |

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

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|---|---|---|---|---|
| D 269 | Continued From page 13<br>-The MA was unable to operate the Hoyer lift or perform heavy lifting so she had to have assistance from another staff person when she was working directly caring for the residents.<br>-The MA had been working as single staff and directly caring for residents for 2nd shift on 11/9/16 and 1st shift on 11/10/16.<br>-Staff from sister facilities would come and help when she requested help with changing residents.<br>-She usually administered medications only and did not work providing direct care to residents on a regular basis, only to cover staff call ins.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/10/16 at 12:46pm revealed staff were expected to check residents every two hours and change them if they had been incontinent.<br><br>Interview with the Administrator on 11/10/16 at 4:15pm revealed:<br>-Staff were expected to check residents every two hours and change them if they had been incontinent.<br>-Staff were expected to reposition residents who needed assistance every two hours. | D 269 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION | D 273 | | |

| 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 _____ | R 11/14/2016 |

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

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|---|---|---|---|---|
| D 273 | Continued From page 14 | D 273 | | |

Based on observations, interviews and record reviews, the facility failed to assure appointments were made for a cardiologist and a neurologist for 2 of 3 sampled residents (#1 and #3); and that Resident #3 had a drug level done as ordered following a subtherapeutic level.

The findings are:

1. Review of Resident #1's current FL-2 dated 1/27/16 revealed diagnoses included Seasonal Affective Disorder, Tobacco use Disorder, Intellectual Disability, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Hypertension, Schizoaffective Disorder and Gastroesophageal Reflux Disease.

Review of Emergency Room (ER) discharge instructions dated 8/10/16 for Resident #1 revealed:
-Her discharge diagnosis was Chest Pain.
-She needed a follow up appointment scheduled with a cardiologist for an outpatient stress test.

Interview with Resident #1 on 11/10/16 at 9:05am revealed:
-She had a heart murmur and saw a doctor regularly but he was not a heart doctor.
-She remembered going to the ER with chest pain but could not remember seeing a heart doctor or having any tests after she left the ER.
-She denied having had any chest pain.

Attempted interview with Resident #1's Responsible Person on 11/10/16 at 8:59am was unsuccessful.

Interview with a Medication Aide (MA)/Supervisor on 11/9/16 at 4:35pm revealed she thought

| 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 _____ | R 11/14/2016 |

| 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 273 | Continued From page 15<br>Resident #1 had been seen by a cardiologist but would have to look into which doctor and when.<br><br>Review of "Resident Notes" and Primary Care Provider (PCP) notes for Resident #1 revealed there was no documentation of a cardiology appointment or stress test.<br><br>Attempted interview with Resident #1's Primary Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.<br><br>Telephone interview with an office assistant at the cardiologist's office referenced on the ER discharge instructions on 11/10/16 at 8:56am revealed they did not have a record of Resident #1 being seen or having an appointment with the cardiologist.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/10/16 at 9:16am revealed she had contacted the cardiologist's office on 11/10/16 to schedule the appointment and was waiting to hear back.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 11/10/16 at 9:16am.<br><br>Refer to interview with the MA/Supervisor on 11/10/16 at 9:16am.<br><br>Refer to interview with the Administrator on 11/10/16 at 10:33am.<br><br>2. Review of Resident #3's current FL-2 dated 6/7/16 revealed diagnoses included Mood Disorder, Dementia, Hypertension, Cerebral Vascular Accident and Metabolic Encephalopathy.<br><br>Review of hospital discharge instructions and | D 273 | | |

| 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 _____ | R 11/14/2016 |

| 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 273 | Continued From page 16 | D 273 | | |

summary dated 3/7/16 for Resident #3 revealed:
-The admission diagnoses were Bradycardia and Unresponsiveness.
-Resident #3 was to have a follow up appointment scheduled for one week with a neurologist.
-Resident #3 needed a Valproic acid level drawn in 5 days. (Valproic acid levels are used to determine dosing for the drug Valproic acid or Depakote, which is used to treat seizure disorders.)
-Resident #3 was admitted with a subtherapeutic Valproic acid level and her Depakote had been adjusted as an inpatient.

Review of "Resident Notes", Primary Care Provider visit notes and lab results for Resident #3 revealed:
-There was no documentation that she was seen by a neurologist.
-There was no documentation that a Valproic Acid level had been done.

Review of Emergency Room discharge instructions for Resident #3 revealed:
-She was seen 3/14/16 for a closed head injury related to a fall at the facility and a urinary tract infection.
-She was seen 3/21/16 for vomiting and dehydration.
-There was no documentation of a repeat Valproic acid level.

Review of a Primary Care Provider visit note dated 4/6/16 revealed Resident #3 had been experiencing weakness, increased falls, her condition had declined and Resident #3 had been referred to Hospice.

Interview with Resident #3 on 11/10/16 at

| 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 _____ | R 11/14/2016 |

| 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 273 | Continued From page 17<br>11:15am revealed she denied having had any recent falls and could not remember going to the hospital.<br><br>Attempted interview with Resident #3's Responsible Person on 11/10/16 at 3:50pm was unsuccessful.<br><br>Interview with the Medication Aide (MA)/Supervisor on 11/10/16 at 3:35pm revealed:<br>-She was unable to find any documentation for Resident #3 seeing a neurologist or having a Valproic Acid level drawn.<br>-The Resident Care Coordinator had contacted the Primary Care Provider (PCP) on 11/10/16 to get a new referral for a neurologist.<br><br>Attempted interview with Resident #3's Primary Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 11/10/16 at 9:16am.<br><br>Refer to interview with the MA/Supervisor on 11/10/16 at 9:16am.<br><br>Refer to interview with the Administrator on 11/10/16 at 10:33am.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/10/16 at 9:16am revealed:<br>-The facility usually kept a record of appointments on a calendar.<br>-She was responsible for reviewing discharge instructions when residents returned from the hospital and making any necessary appointments.<br>-If she was not at the facility, the MA/Supervisor would review the discharge instructions and | D 273 | | |

| 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 _____ | R 11/14/2016 |

| 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 273 | Continued From page 18<br>schedule appointments.<br><br>Interview with the MA/Supervisor on 11/10/16 at 9:16am revealed the hospital usually scheduled the appointments prior to discharge and let the facility know the date and time of the appointment.<br><br>Interview with the Administrator on 11/10/16 at 10:33am revealed:<br>-The missed follow up appointments were an oversight for staff.<br>-The RCC was usually very good at assuring all residents who needed follow up appointments had them scheduled and went.<br>-The appointments would be scheduled and the Primary Care Provider would be notified.<br>_____<br>Review of the facility's Plan of Correction dated 11/10/16 revealed:<br>-Facility staff have made calls to schedule the appointments that were overlooked.<br>-The appointment for Resident #2 with the cardiologist has been scheduled for 3/1/17.<br>-Resident #3 requires a referral from the PCP before the appointment can be scheduled.<br>-Staff had contacted the PCP's office and requested the referral.<br>-Any resident returning from the hospital with referrals will be followed up on by the RCC.<br>-Appointments will be made and documented in the resident's record showing the appointment.<br>-The Administrator will check the records of residents who have returned from the ER for any referrals or follow up on a monthly basis.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 12/29/16. | D 273 | | |

| 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 _____ | R 11/14/2016 |

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

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|---|---|---|---|---|
| D 310 | Continued From page 19 | D 310 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 residents (#2) received thickened liquids with medications as ordered by the primary care provider.<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 8/2/16 revealed:<br>-Diagnoses included Alzheimer's Dementia, Mental Retardation, Depression, Spastic Seizures and Arthritis.<br>-There was an order for nectar thick liquids.<br><br>Observation on 11/10/16 at 8:28am revealed:<br>-The Medication Aide (MA)/Supervisor administered Resident #2's morning medications with unthickened water she poured from the water pitcher for all residents on the medication cart.<br>-Resident #2 did not have any coughing or obvious difficulty swallowing the medication with the regular water.<br><br>Observation on 11/10/16 at 11:54am revealed:<br>-The MA/Supervisor administered a medication to Resident #2 with unthickened water she got from | D 310 | | |

| 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 _____ | R 11/14/2016 |

| 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 310 | Continued From page 20 | D 310 | | |

the water fountain in the dining room.
-Resident #2 did not have any coughing or obvious difficulty swallowing the medication with the regular water.

Review of Resident #2's September 2016 Medication Administration Record (MAR) revealed:
-There was a preprinted entry for Thick-it powder add two scoops to every two ounces of liquid (resident) drinks daily with hand written times for 7am, 12noon and 5pm.
-Staff documented administering 9/1/16 through 9/30/16 at 7am, 12noon and 5pm except at 5pm 9/1/16 through 9/6/16, 9/10/16 through 9/13/16; and 9/16/16 and 9/17/16.

Review of Resident #2's October 2016 MAR revealed:
-There was a preprinted entry for Thick-it powder add two scoops to every two ounces of liquid (resident) drinks daily with hand written times for 7am, 12noon and 5pm.
-Staff documented administering 10/1/16 through 10/31/16 at 7am, 12noon and 5pm except 10/17/16 at 5pm.

Review of Resident #2's November 2016 MAR revealed:
-There was a preprinted entry for Thick-it powder add two scoops to every two ounces of liquid (resident) drinks daily with hand written times for 7am, 12noon and 5pm.
-Staff documented administering 11/1/16 through 11/10/16 at 7am.

Interview with the MA/Supervisor on 11/10/16 at 12:46pm and 1:14pm revealed:
-Resident #2 took her meds with plain water and had thickened liquids only with her meals.

| 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 _____ | R 11/14/2016 |

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

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|---|---|---|---|---|
| D 310 | Continued From page 21<br>-There was a Primary Care Provider (PCP) order for thickened liquids but there was no order specifying Resident #2 could have unthickened water with her medications.<br>-The Thick-It powder was kept in the kitchen, there was none on the medication cart.<br><br>The Resident Care Coordinator was present during the interview with the MA/Supervisor on 11/10/16 at 12:46pm and did not have any further comment.<br><br>Based on observations, interviews and record reviews, Resident #2 was not interviewable.<br><br>Attempted interview with Resident #2's Power of Attorney on 11/10/16 at 3:52pm was unsuccessful.<br><br>Attempted interview with Resident #2's Primary Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.<br><br>Interview with the Administrator on 11/10/16 at 4:15pm revealed:<br>-She was not previously aware staff had been administering Resident #2's medications with plain unthickened water.<br>-Staff will follow up with the PCP regarding the water with medications and get clarification.<br>-The Resident Care Coordinator and the Administrator were responsible for "spot checking" staff weekly with providing care for residents. | D 310 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration | D 358 | | |

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 22<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to assure medications including asthma control inhalers and allergy nasal sprays were administered to 3 of 3 residents (#2, #4 and #5).<br><br>The findings are:<br><br>1. Review of Resident #2's current FL-2 dated 8/2/16 revealed:<br>-Diagnoses included Alzheimer's Dementia, Mental Retardation, Depression, Spastic Seizures and Arthritis.<br>-Medication orders included ProAir HFA 90 mcg inhaler two puffs four times daily and Flonase 0.05% nasal spray two sprays each nostril daily. (ProAir is used to treat and prevent bronchospasms and Flonase is used to treat nasal allergy symptoms.)<br><br>Observation of the medication pass on 11/10/16 at 8:28am revealed:<br>-The Medication Aide (MA) administered Resident #2's oral medications in the common area with a cup of water after locking the medication cart and the medication room.<br>-She did not administer an inhaler or nasal spray.<br>-She reported the medications were done and | D 358 | | |

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 23<br>went to make a phone call at 8:30am.<br><br>Observation of Resident #2 on 11/10/16 from 8:28am until 11:54am revealed the MA did not administer an inhaler or nasal spray to Resident #2.<br><br>a. Review of Resident #2's September 2016 Medication Administration Record (MAR) revealed:<br>-There was an entry for ProAir HFA 90 mcg inhaler four times daily at 8am, 1pm, 4pm and 8pm.<br>-Staff documented administering on 9/1/16 through 9/30/16 at 8a, 1pm, 4pm and 8pm except 9/6/16 at 1pm, 9/16/16 at 1pm, 9/22/16 at 1pm, 9/23/16 at 1pm and 9/29/16 at 1pm.<br><br>Review of Resident #2's October 2016 MAR revealed:<br>-There was an entry for ProAir HFA 90 mcg inhaler four times daily at 8am, 1pm, 4pm and 8pm.<br>-Staff documented administering on 10/1/16 through 10/31/16 at 8am, 1pm, 4pm and 8pm.<br><br>Review of Resident #2's November 2016 MAR revealed:<br>-There was an entry for ProAir HFA 90 mcg inhaler four times daily at 8am, 1pm, 4pm and 8pm.<br>-Staff documented administering on 11/1/16 through 11/10/16 at 8am.<br><br>Observation of medications on hand for Resident #2 on 11/10/16 at 1:14pm revealed:<br>-There was a pharmacy labeled box for Resident #2 with a ProAir inhaler and instructions to take two puffs four times daily.<br>-The label indicated the inhaler was dispensed | D 358 | | |

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 24 | D 358 | | |

7/15/16 and the inhaler indicated it had 160 puffs remaining.
-There was an unopened pharmacy labeled box for Resident #2 with a ProAir inhaler indicating there were 200 inhalations and that it was dispensed 11/4/16.

Interview with the MA on 11/10/16 at 1:14pm revealed:
-Resident #2 was given her ProAir inhaler and she always gets it.
-The MA reported walking away and then going back and giving Resident #2 her ProAir inhaler following the medication pass.
-The MA did not have an explanation for why the 7/15/16 inhaler was on the medication cart with 160 puffs remaining.

Telephone interview with the Pharmacist on 11/14/16 at 11:34am revealed:
-Resident #2's ProAir inhaler was cycle filled on a monthly basis, it could also be requested by the facility and was last dispensed 11/4/16.
-Each ProAir inhaler was a 30 day supply and was intended for daily use to control asthma.

b. Review of Resident #2's September 2016 Medication Administration Record (MAR) revealed:
-There was an entry for Flonase 0.05% nasal spray two sprays each nostril daily at 8am.
-The entry was documented as administered 9/1/16 through 9/30/16 at 8am.

Review of Resident #2's October 2016 MAR revealed:
-There was an entry for Flonase 0.05% nasal spray two sprays each nostril daily at 8am.
-Staff documented administering on 10/1/16 through 10/31/16 at 8am.

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 25<br><br>Review of Resident #2's November 2016 MAR revealed:<br>-There was an entry for Flonase 0.05% nasal spray two sprays each nostril daily at 8am.<br>-Staff documented administering on 11/1/16 through 11/9/16 at 8am.<br><br>Observation of medications on hand for Resident #2 on 11/10/16 at 1:14pm revealed:<br>-There was a pharmacy labeled box for Resident #2 with a bottle of Flonase 0.05% nasal spray and instructions to use two sprays in each nostril daily.<br>-The label indicated the nasal spray was dispensed 7/15/16 and the bottle was nearly full with the liquid visible at the top of the label.<br>-There was an unopened pharmacy labeled box for Resident #2 of Flonase 0.05% nasal spray indicating it was dispensed 10/28/16.<br><br>Interview with the MA on 11/10/16 at 1:14pm revealed:<br>-Resident #2 was given her Flonase nasal spray and she always gets it.<br>-The MA reported walking away and then going back and giving Resident #2 her Flonase nasal spray following the medication pass.<br>-The MA did not have an explanation for why the 7/15/16 nasal spray was on the medication cart with a nearly full bottle remaining.<br><br>Based on observations, interviews and record reviews, Resident #2 was not interviewable.<br><br>Attempted interview with Resident #2's Power of Attorney on 11/10/16 at 3:52pm was unsuccessful.<br><br>Attempted interview with Resident #2's Primary | D 358 | | |

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 26 | D 358 | | |

Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.

Telephone interview with the Pharmacist on 11/14/16 at 11:34am revealed Resident #2's Flonase nasal spray was cycle filled on a monthly basis, it could also be requested by the facility, each bottle was a 30 day supply and was last dispensed 10/28/16.

Refer to interview with the Administrator on 11/10/16 at 4:15pm.

2. Review of Resident #4's current FL-2 dated 12/31/15 revealed:
-Diagnoses included Altered Mental Status, Deep Vein Thrombosis, Bipolar Disorder, Schizophrenia and Tardive Dyskinesia.
-Medication orders included Flonase 0.05% nasal spray two sprays each nostril daily. (Flonase is used to treat nasal allergy symptoms.)

Observation of the medication pass on 11/10/16 at 8:13am revealed:
-The Medication Aide (MA) administered Resident #4's oral medications at the door of the medication room with a cup of water.
-She did not administer nor offer a nasal spray prior to reporting the medications were done and went to make a phone call at 8:30am.

Review of Resident #4's November 2016 Medication Administration Record (MAR) revealed:
-There was an entry for Flonase 0.05% nasal spray two sprays each nostril daily at 8am.
-The entry was documented as administered 11/1/16 through 11/10/16 at 8am.

Observation of medications on hand for Resident

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 27 | D 358 | | |

#4 on 11/10/16 at 3:40pm revealed:
-There was a pharmacy labeled box for Resident #4 with a bottle of Flonase 0.05% nasal spray and instructions to use two sprays in each nostril daily.
-The label indicated the nasal spray was dispensed 10/28/16 and the bottle was nearly full with the liquid visible at the top of the label.

Interview with Resident #4 on 11/10/16 at 9:14am revealed:
-She normally received her nasal spray everyday but did not want it on 11/10/16.
-The nasal spray was used for allergies and she did not have allergies.

Interview with the MA on 11/10/16 at 8:13am revealed:
-The MA had forgotten to give Resident #4 her Flonase nasal spray at the time her oral medications were given but she went back and gave it after.
-The MA could not remember what time she gave Resident #4 her nasal spray.

Attempted interview with Resident #4's Primary Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.

Telephone interview with the Pharmacist on 11/14/16 at 11:34am revealed Resident #4's Flonase nasal spray was cycle filled on a monthly basis, it could also be requested by the facility, each bottle was a 30 day supply and was last dispensed 10/28/16.

Refer to interview with the Administrator on 11/10/16 at 4:15pm.

3. Review of Resident #5's current FL-2 dated

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 28<br><br>4/27/16 revealed:<br>-Diagnoses included Bipolar Disorder Manic, Diabetes Mellitus, Asthma and Seizure Disorder.<br>-Medication orders included QVar 40mcg inhaler two puffs daily. (QVar is used to treat inflammation in the lungs caused by asthma.)<br><br>Observation of the medication pass on 11/10/16 at 8:23am revealed:<br>-The Medication Aide (MA) administered Resident #5's oral medications at the door of the medication room with a cup of water.<br>-She did not administer an inhaler prior to reporting the medications were done and went to make a phone call at 8:30am.<br><br>Review of Resident #5's November 2016 Medication Administration Record (MAR) revealed:<br>-There was an entry for QVar 40mcg inhaler two puffs daily at 8am.<br>-The entry was documented as administered 11/1/16 through 11/10/16 at 8am.<br><br>Observation of medications on hand for Resident #5 revealed:<br>-There was a pharmacy labeled box for Resident #5 with a QVar inhaler and instructions to inhale two puffs daily.<br>-The label indicated the inhaler was dispensed 10/28/16 and the inhaler indicated 116 puffs remained.<br>-The box indicated there were 120 puffs in a new inhaler.<br><br>Interview with Resident #5 on 11/10/16 at 10:20am revealed:<br>-She used an inhaler on some days, she used an inhaler every day when the "other MA" was on duty. | D 358 | | |

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 29<br>-The MA must have been in a hurry on the morning of 11/10/16 and forgot to give the inhaler.<br>-She did not have any cough or shortness of breath and only felt short of breath if she ate too much and then walked around the building.<br><br>Attempted interview with Resident #5's Primary Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.<br><br>Telephone interview with the Pharmacist on 11/14/16 at 11:34am revealed:<br>-Resident #5's Qvar inhaler was cycle filled on a monthly basis, it could also be requested by the facility and was last dispensed 10/28/16.<br>-Each Qvar inhaler was a 30 day supply and was intended for daily use to control asthma.<br><br>Refer to interview with the Administrator on 11/10/16 at 4:15pm.<br><br>Interview with the Administrator on 11/10/16 at 4:15pm revealed:<br>-Staff were expected to administer medications as ordered by the physician.<br>-Staff would notify the primary care provider for each resident and medication that was missed on 11/10/16.<br><br>Review of the facility's Plan of Correction dated 11/10/16 revealed:<br>-The PCP would be notified for all missed medications for each resident on 11/10/16.<br>-Documentation the PCP was notified would be placed in each resident's record.<br>-A medication class for missed medications would be conducted by a Registered Nurse, scheduled and completed by 11/22/16.<br>-The Administrator will monitor medication administration weekly for compliance. | D 358 | | |

| 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 _____ | R 11/14/2016 |

| 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 358 | Continued From page 30<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 12/29/16. | D 358 | | |
| D 482 | 10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives<br><br>10A NCAC 13F .1501Use Of Physical Restraints And Alternatives<br>(a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:<br>(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;<br>(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;<br>(3) the least restrictive restraint that would provide safety;<br>(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.<br>(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;<br>(6) applied correctly according to the manufacturer's instructions and the physician's order; and<br>(7) used in conjunction with alternatives in an effort to reduce restraint use.<br>Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as | D 482 | | |

| 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 _____ | R 11/14/2016 |

| 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 482 | Continued From page 31 | D 482 | | |

opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure a full length side rail was used safely, with a current primary care provider order and in conjunction with an assessment and care plan for 1 of 1 residents (#2).

The findings are:

1. Review of Resident #2's current FL-2 dated 8/2/16 revealed diagnoses included Alzheimer's Dementia, Mental Retardation, Depression, Spastic Seizures and Arthritis.

Observations on 11/91/6 at 11:27am revealed Resident #2's bed was near the window in and was a hospital bed with a full side rail up.

Observations on 11/9/16 at 12:04pm revealed:
-Staff transferred Resident #2 from the Geri-chair to her bed via Hoyer lift at 12:04pm
-Resident #2's hands were contracted into fists, her left arm was turned outward and her right arm was drawn to her chest.

| 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 _____ | R 11/14/2016 |

| 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 482 | Continued From page 32 | D 482 | | |

-She was not able to use the side rail to assist with turning and positioning.

Observation on 11/10/16 at 12:46pm revealed staff provided incontinence care for Resident #2 and upon completion the raised the full side rail and Resident #2 remained in her bed for a nap.

Review of a Primary Care Provider order dated 3/30/15 for Resident #2 revealed an order to use side rails to prevent the resident from falling out of the bed.

Review of the current care plan dated 2/10/16 for Resident #2 revealed:
-She was totally dependent on staff for all activities of daily living.
-There was no notation for the use of side rails or staff monitoring with the use of side rails for Resident #2.

Review of Licensed Health Professional Support (LHPS) assessment and evaluation dated 10/27/16 for Resident #2 revealed:
-Care of residents who were physically restrained and use of care practices as alternatives to restraints was not included as an LHPS task for Resident #2.
-The use of side rails on Resident #2's bed was not included in the LHPS assessment and evaluation.

Interview with the Medication Aide (MA) on 11/10/16 at 10:44am revealed:
-Staff did not pull up Resident #2's side rail.
-On discussions of observations on 11/9/16 and 11/10/16, the MA reported the side rail was used for Resident #2's safety and prevent her from falling out of the bed.
-Resident #2 was not able to raise or lower the

| 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 _____ | R 11/14/2016 |

| 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 482 | Continued From page 33<br>side rail.<br>-There was no padding used with the side rail.<br>-There were no written orders since 3/30/15.<br>-There was no assessment, guardian consent or care plan including how staff will monitor Resident #2 when she was in the bed with the side rail raised.<br><br>Based on observations, interviews and record reviews, Resident #2 was not interviewable.<br><br>Attempted interview with Resident #2's Power of Attorney on 11/10/16 at 3:52pm was unsuccessful.<br><br>Attempted interview with Resident #2's Primary Care Provider on 11/10/16 at 3:54pm and 11/14/16 at 11:59am were unsuccessful.<br><br>Interview with the Administrator on 11/10/16 at 4:15pm revealed:<br>-Resident #2's Power of Attorney was in a nursing home and she had been unable to establish legal guardianship for Resident #2.<br>-She was not aware of the entirety of rules and regulations regarding the safe use of side rails.<br>-The Primary Care Provider would be contacted and staff would develop and appropriate care plan for the use of side rails for Resident #2.<br>-The Administrator would document in Resident #2's record all attempts to identify a guardian for Resident #2 to provide consent for the use of side rails. | D 482 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are | D912 | | |

| 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 _____ | R 11/14/2016 |

| 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 |
|---|---|---|---|---|
| D912 | Continued From page 34<br>adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration.<br><br>The findings are:<br><br>Based on observations, interviews and record reviews, the facility failed to assure appointments were made for a cardiologist and a neurologist for 2 of 3 sampled residents (#1 and #3); and that Resident #3 had a drug level done as ordered following a subtherapeutic level. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]<br><br>Based on observations, interviews and record reviews, the facility failed to assure medications including asthma control inhalers and allergy nasal sprays were administered to 3 of 3 residents (#2, #4 and #5). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)] | D912 | | |