STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
02056	HAL078065	A. BUILDING _____ B. WING _____	R 02/01/2017

FEB 24 2017 ADULT CARE LICENSURE SECTION RALEIGH

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(D 000)	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 02/01/17.	(D 000)		
(D 310)	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that thickened liquids were served as ordered by the resident's physician for 1 of 3 sampled residents (Resident #1) who had orders for honey thickened liquids. The findings are: Review of Resident #1's current FL-2 dated 08/02/16 revealed: -Diagnoses included Alzheimer's disease, mental retardation, depression, history of spastic seizures, and arthritis. -The resident was constantly disoriented and non-ambulatory. -There was a physician's order for a regular pureed diet with nectar thick liquids. -There was a physician's order under the medication section for Thick-it powder, 2 scoops to every 2 ounces of liquid patient drinks daily. (Thick-It is a powder that is dissolved in liquids to thicken thin liquids to a desired consistency when thin liquids are difficult to swallow, to prevent choking and prevent liquids from entering the	(D 310)	In order to measure the Thick-It correctly, measuring spoons and a measuring cup has been purchased. Each staff member has been shown how to measure the Thick-It with the items bought. This area will be monitored by the RCC and Administrator daily to ensure compliance.	3/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Hurst — TITLE: Administrator — (X6) DATE: 2/22/17

* The plan of correction with addendum was reviewed and accepted on 3/2/17. Refer to addendum on pages 2 and 8 of this Statement of Deficiencies.
W. Williams
3/2/17

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{D 310}	Continued From page 1 lungs during the swallowing process). Review of a subsequent physician's diet order for Resident #1 dated 11/12/16 revealed pureed, honey consistency, may give medication with plain water. Review of an undated therapeutic diet list posted in the kitchen revealed Resident #1 was on a regular puree, honey consistency diet. Interview the Administrator on 02/01/17 at 11:22 a.m. revealed the Personal Care Aides and Medication Aides were responsible for mixing Thick-It for Resident #1. Review of the manufacturer's instructions for Thick-it revealed: -The usage chart included amounts of Thick-it to be used per 4 ounces of liquids. -4-5 teaspoons for each 4 ounces of water, fruit juice, coffee or tea were required for honey thickened consistency. Observation of the PCA (PCA)/Medication Aide (MA) #1 on 02/01/17 at 12:05 p.m. revealed: -The PCA/MA filled a Sippy cup to approximately 3/4th full with tea. -The Sippy cup appeared to be between 8 to 10 ounces. -The PCA/MA opened the Thick-it container and used the provided blue tablespoon measuring device inside of the Thick-It Container. -The PCA/MA added 4 tablespoons of Thick-It powder that was not leveled and only filled approximately 3/4ths full to Resident #1's tea. -The PCA/MA used a spoon and stirred the tea with the added Thick-It. The PCA/MA added an additional 4 tablespoons of Thick-It powder that was not leveled and only filled approximately	{D 310}	D310 Addendum per telephone with Ms. Karen Hunt on 3/1/17; PCAs and MAs are responsible for mixing thickened liquids. They have been trained to use appropriate measuring devices for accurate measuring of the thick-it powder and the liquids served by the Administrator. They are also validated on the LTPS tasks for thickened liquids by the RN. Order for thick-it was clarified and is clear and complete. The REC and Administrator will monitor daily by random observations of staff mixing the thickened liquids and serving to the resident(s). They will monitor to assure the consistency served matches the physician's order. W. Williams 3/1/17	

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{D 310}	Continued From page 2 3/4ths full, then re-stirred the tea. -The PCA/MA did not refer to the manufacturer's labeled directions on the Thick-It container. Interview with PCA/MA #1 on 02/01/17 at 12:11 p.m. revealed: -Resident #1 was the only resident that required thickened liquids. -Resident #1's liquids should be thickened to a honey thick consistency. -The Administrator told her the Sippy cup was 8 ounces. -The PCA/MA realized Resident #1's tea in the Sippy cup was too thick but she could add more tea to the Sippy cup. Observation of the PCA/MA #1 on 02/01/17 at 12:13 p.m. revealed: - Upon notification by the surveyor, the PCA/MA referred to the manufacturer's labeled directions on the Thick-It container. -The PCA/MA discarded Resident #1's tea and refilled the same Sippy cup 3/4ths full with tea. -The PCA/MA used the blue teaspoon measuring device inside of the Thick-It Container and added 8 teaspoons of Thick-It powder. -The PCA/MA stirred the tea with the added Thick-It with a spoon. Interview with the PCA/MA #1 on 02/01/17 at 12:15 p.m. revealed: -Resident #1's tea was now thickened to honey thick. -She must have mixed the Thick-It for Resident #1 wrong earlier. Observation of the lunch meal on 02/01/17 at 12:15 p.m. revealed: -Resident #1 was sitting in a Geri-chair at a dining room table.	{D 310}		

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(D 310)	Continued From page 3 -The PCA/MA #1 placed the Sippy cup and the plated pureed food on the table. -The PCA/MA #1 fed Resident #1 her meal. -The PCA/MA #1 gave Resident #1's tea from the Sippy cup. -The tea in the Sippy cup appeared to be a thin, honey thick consistency. -Resident #1 did not have any coughing or gagging throughout the meal. Observation in the kitchen with the PCA/MA #1 on 02/01/17 at 1:15 p.m. revealed: -The PCA/MA measured 8 ounces of water in a measuring cup. -The PCA/MA poured the 8 ounces of water into Resident #1's Sippy cup. - The 8 ounces of water filled Resident #1's Sippy cup 3/4ths full. Observation of the supper meal on 02/01/17 at 5:35 p.m. revealed: -Resident #1 was sitting in a Geri-chair at a dining room table. -The PCA/MA #2 placed the Sippy cup and the plated pureed food on the table. -The PCA/MA #2 sat beside Resident #1. -Resident #1's beverage in the Sippy cup appeared to be less than honey thick. -Upon notification by the surveyor, PCA/MA #2 returned to the kitchen with Resident #1's Sippy cup. -Resident #1 had not yet drank any of the beverage. Interview with PCA/MA #2 on 02/01/17 at 5:38 p.m. revealed: -The PCA/MA had added 2 "small" scoops to every 4 ounces of Thick-It to Resident #1's Sippy cup. -The PCA/MA used the blue small ended	(D 310)		

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{D 310}	Continued From page 4 measuring device (1 teaspoon) inside of the Thick-It container when she mixed the thickener in Resident #1's beverage. -Resident #1's Sippy cup held 6 or 8 ounces. -She thought Resident #2 should receive nectar thick liquids. -The PCA/MA had referred to the pharmacy's labeled directions on Resident #1's Thick-It container which had to use 2 scoops to every 2 ounces of liquid. Observation of PCA/MA #2 on 02/01/17 at 5:42 p.m. revealed: -The PCA/MA reviewed Resident #1's record and referred to the FL-2 dated 08/02/16. -After the surveyor questioned PCA/MA, she reviewed the posted resident diets in the kitchen that listed honey thick liquids for Resident #1. -Upon notification by the surveyor, the PCA/MA referred to the manufacturer's labeled directions on the Thick-It container. -The PCA/MA filled Resident #1's Sippy cup 3/4ths full with grape flavored drink. -The PCA/MA added 8 teaspoons of Thick-It to Resident #1's Sippy cup using the blue measuring device inside of the Thick-It container. Review of the prescription label dated 01/03/17 on the Thick-It container for Resident #1 revealed to add 2 scoops to every 2 ounces of liquid daily. Interview with the PCA/MA #2 on 02/01/17 at 5:48 p.m. revealed: -She would have noticed that Resident #1's beverage was not thick enough prior to giving it to her, "We cannot give it to her if it's too thin". -She had worked at the facility for 11 years. -She received training on how to mix thickened liquids years ago but did not remember who trained her.	{D 310}		

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(D 310)	Continued From page 5 Observation of the supper meal on 02/01/17 at 5:50 p.m. revealed: -PCA/MA #2 was feeding Resident #1. -Resident #1's beverage appeared to be honey thick. -PCA/MA #2 gave Resident #1 her beverage using the Sippy cup. -Resident #1 did not have any coughing or gagging during the meal. Interview with the Head Supervisor on 02/01/17 at 6:04 p.m. revealed: -The contracted Licensed Health Professional Support (LHPS) nurse trained the PCAs and the MAs in thickened liquids during their skills check off. -All of the PCAs / MAs should know how to prepare thickened liquids for the residents. -It had been over a year since the Head Supervisor had observed the MAs and PCAs thicken any liquids. Interview with the Administrator on 02/01/17 at 6:15 p.m. revealed: -It was expected for the PCAs/MAs to follow the posted diet list to guide them when preparing thickened liquids. -She expected the PCAs/MAs to follow the labeled manufacturer's instructions on the Thick-It container. -A cup with measured increments should be used when preparing liquids to be thickened. -She would remove the dual measuring device inside the Thick-It container and provide a single measured increment utensil for staff to use when measuring Thick-It.	(D 310)		

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(D 358)	Continued From page 6	(D 358)		
(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, 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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#3) sampled whose orthopedic physician ordered Calcium and Vitamin D after a fractured ankle and the orders were never implemented and the medications were not administered. The findings are: Review of Resident #3's current FL-2 dated 01/07/17 revealed the resident's diagnoses included diabetes, hypertension, chronic obstructive pulmonary disease, gastroesophageal reflux disease, hyperlipidemia, schizophrenia, depression, and intellectual disabilities. Review of an orthopedic physician visit note dated 12/20/16 for Resident #3 revealed: -The resident had a right ankle fracture.	(D 358)	The physician for resident #3 has been notified in regards to the two medications that were not given. The medications have been ordered and the resident is currently receiving them. The RCC and Administrator will monitor this area weekly to ensure compliance.	3/1/17

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(D 358)	Continued From page 7 -The resident was given a prescription for a walker boot. Interview with the Administrator on 02/01/17 at 4:26 p.m. revealed: -Resident #3 hit her ankle on the bed and broke her ankle a couple of months ago. -The resident wore a cast and then changed to a boot. -Resident #3 was currently in the hospital unrelated to her ankle, due to mental status changes. Review of orders written by the orthopedic physician dated 01/10/17 for Resident #3 revealed: -There was an order for Calcium 2,000mg once daily. (Calcium is a mineral supplement used to build and protect bones.) -There was an order for Vitamin D 2,000 units once daily. (Vitamin D is needed for the absorption of Calcium and it protects bones.) Review of the January 2017 and February 2017 medication administration records (MARs) for Resident #3 revealed: -The orders for Calcium and Vitamin D were not transcribed or included on the MARs. -No Calcium or Vitamin D was documented as administered since ordered on 01/10/17. Review of medications on hand for Resident #3 on 02/01/17 revealed there was no Calcium or Vitamin D in the facility for the resident. Interview with the Administrator on 02/01/17 at 5:10 p.m. revealed: -The facility manager was responsible for transcribing new orders on the MARs and faxing the orders to the pharmacy.	(D 358)	0358 Addendum per telephone with Ms. Karen Hunt on 3/1/17: The Administrator and RCC audited all residents' records including MARs, orders, and meds on hand to assure meds were administered as ordered. They also do random record audits at least every 2 weeks. RCC is responsible for implementing new orders and order changes. RCC will transcribe orders and fax orders to the pharmacy. If RCC is unavailable, the supervisor on-duty will be responsible for implementing the orders. The RCC and Administrator will monitor weekly by reviewing MARs, meds on hand, and orders and observing random med passes. W. Williams 3/1/17	

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(D 358)	Continued From page 8 -The facility manager was currently out on medical leave and had been absent on and off for about a month. -The orders for Calcium and Vitamin D should have been transcribed on the January 2017 MAR when received. -If the orders had been faxed to the pharmacy when the order was received on 01/10/17, the orders would have printed on the February 2017 MARs. -The pharmacy was currently closed but she would contact them the next day to get the medications dispensed. -She would notify the orthopedic physician of the medication errors with Calcium and Vitamin D not being administered to the resident since ordered on 01/10/17. Review of an orthopedic physician visit note dated 01/30/17 for Resident #3 revealed: -The resident had a follow-up visit for right ankle fracture. -The resident was wearing a walker boot. -The resident could do weight bearing as tolerated. Attempt to interview the orthopedic physician on 02/01/17 was unsuccessful.	{D 358}		