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 _____	R 05/04/2017

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 Robeson County Department of Social Services conducted a follow-up survey on May 4, 2017.	{D 000}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (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. This Rule is not met as evidenced by: FOLLOW UP TO A TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to provide personal care in accordance with the assessed needs of 2 of 3 residents sampled (#1, #2). The findings are: 1. Review of Resident #1's current FL-2 dated 02/03/17 revealed: -Diagnoses included schizophrenia, dementia, diastolic heart failure, and chronic kidney disease. -Resident #1 was semi-ambulatory, had a wheelchair, and was intermittently disoriented. Observation of Resident #1 on 05/04/17 at 9:27am revealed: -He was sitting in a wheelchair in the common	{D 269}		

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{D 269}	Continued From page 1 living room. -He had a yellow colored bracelet on his left arm which read "fall risk." -He had a cast on his right arm. Interview with Resident #1 on 05/04/17 at 9:27am revealed he "fell" and broke his arm (he did not know when he fell). Interview with a Supervisor on 05/04/17 at 9:29am revealed: -Resident #1 fell and injured his arm, she was not sure but thought it was "around 04/18/17." -Resident #1 had not had any other falls. -Resident #1 could not walk and required staff assistance with transfers. Review of Resident #1's Assessment and Care Plan dated 02/03/17 revealed Resident #1 required extensive assistance with transfers. Observation on 05/04/17 from 12:24pm-1:27pm revealed: -There were nine residents and one Personal Care Aide (PCA) in the dining room during the lunch meal; the PCA remained in the dining room or kitchen between 12:24pm-1:27pm plating, serving, and cleaning both areas. -At 12:40pm, Resident #1 entered the dining room in his wheelchair after returning to the facility from a physician's appointment. -At 12:43pm, the PCA served Resident #1 his meal and he began to eat. -The Administrator was in the kitchen and dining room from 12:38pm-12:44pm. -At 12:58pm, Resident #1 told the PCA he was "tired" and wanted to go lay down; the PCA told Resident #1 he would "have to wait." -At 1:00pm, Resident #1 was using his feet to propel his wheelchair out of the dining room and	{D 269}		

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{D 269}	Continued From page 2	{D 269}		

down the hallway.
-At 1:06pm, Resident #1 was in his bed.
-At 1:27pm, the PCA was still in the dining room and kitchen; she did not leave to assist Resident #1 to transfer from the wheelchair to his bed as he had requested.

Interview with Resident #1 on 05/04/17 at 3:42pm revealed:
-He put himself to bed because staff was busy.
-Sometimes staff helped him get in bed, but sometimes staff were busy so he got in bed by himself.

Telephone interview with Resident #1's family member on 05/04/17 at 4:22pm revealed:
-Resident #1 required assistance with all his activities of daily living (ADLs).
-The family member did not know if staff assisted Resident #1 with transfers.

Interview with a PCA/Medication Aide (MA) on 05/04/17 at 3:55pm revealed there were usually two staff present in the facility during meals: one staff served the food and the other stayed in the dining room to watch and assist residents when needed.

Interview with the Resident Care Coordinator (RCC) on 05/04/17 at 3:35pm revealed:
-Staff on duty were responsible for providing personal care.
-Staff from next door came to the facility to assist with rounds every two hours so there were two staff available for rounds.
-The RCC had not thought about who was responsible for personal care when the PCA was busy with meal service.

Interview with the Administrator on 05/04/17 at

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{D 269}	Continued From page 3 3:20pm revealed: -Resident #1 could maneuver his wheelchair without assistance but required staff assistance with transferring in and out of bed. -She expected staff to assist Resident #1 with transfers. -There was usually two staff members present at meals to provide the meal service and monitor and/or assist residents as needed. -She would discuss personal care with staff during the staff meeting on 05/05/17. 2. Review of Resident #2's current FL-2 dated 02/03/17 revealed: -Diagnoses included history of cerebral vascular accident (CVA), "dementia 2nd to CVA", hypertension, and left above the knee amputation. -Resident #2 was non-ambulatory and had a geri-chair. Review of Resident #2's current Assessment and Care Plan dated 02/03/17 revealed: -Resident #2 was non-ambulatory and had a geri-chair. -Resident #2 was "totally dependent" on staff for assistance with "ambulation/locomotion," transferring, bathing, dressing, grooming, and toileting. Interview with a Personal Care Aide (PCA) on 05/04/17 at 9:40am revealed Resident #2 could not walk and required assistance with all activities of daily living (ADLs) except he could feed himself. Observation of Resident #2 on 05/04/17 at 9:42am revealed: -He was sitting in a geri-chair with a hoyer lift type mat underneath him.	{D 269}		

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{D 269}	Continued From page 4 -He was neatly dressed and groomed. Interview with Resident #2 on 05/04/17 at 9:42am revealed: -He required staff assistance with bathing, dressing, changing/toileting, and transfers. -He did not have any complaints about the care he received at the facility. Observation on 05/04/17 from 12:24pm-1:22pm revealed: -There were nine residents and one PCA in the dining room during the lunch meal; the PCA remained in the dining room or kitchen between 12:24pm-1:22pm plating, serving, and cleaning both areas. -Resident #2 was in the dining room in his geri-chair. -From 1:18pm-1:22pm, Resident #2 was attempting to self-propel himself away from the dining room table using his right leg (he has a left above the knee amputation); the PCA was in the kitchen washing dishes. -There was no staff available to assist Resident #2 with the locomotion of his geri-chair. Interview with Resident #2 on 05/04/17 at 1:22pm revealed: -He tried to "push" himself. -He "very seldom" asked staff for assistance because "they tell me can't you see I'm busy, so I don't bother with it." -He thought staff would help him if he asked. Interview with the Resident Care Coordinator (RCC) on 05/04/17 at 3:35pm revealed: -Staff on duty were responsible for providing residents' personal care. -The RCC had not thought about who was responsible for personal care when the PCA was	{D 269}		

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{D 269}	Continued From page 5 busy with meal service. Interview with the Administrator on 05/04/17 at 3:20pm revealed: -Resident #2 was "total care" and required assistance with all ADLs except eating. -Resident #2 could not walk and had a geri-chair due to a history of multiple falls when using a wheelchair. -Resident #2 let staff know if he needed help. -Staff usually maneuvered Resident #2 around in his geri-chair. -The Administrator expected staff to assist Resident #2 with his ADLs as needed. -There were usually two staff present during meal times to provide meals, monitor, and provide personal care as needed. -She would discuss personal care with staff at the staff meeting the next day (05/05/17).	{D 269}		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure snacks and meals were served in a manner to prevent contamination as evidenced by flies in the kitchen, dining room, and common living room and a bag of trash being placed on the kitchen counter. The findings are:	D 283		

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D 283	Continued From page 6 Observation on 05/04/17 from 10:12am-10:30am revealed: -At 10:12am, Personal Care Aide (PCA) was in the kitchen preparing the morning snack; there were three flies in the kitchen landing on the counters, cabinets, and window. -At 10:16am, the PCA began serving snack to eight residents who were all seated in the common living room; there were two flies flying around the common living room as the residents ate snack. Interview with a PCA on 05/04/17 at 10:14am revealed: -"Every time" the door was opened, the flies came in. -There were so many flies because "there are chicken houses around here." -Staff tried to kill the flies. Interview with a resident on 05/04/17 at 10:18am revealed the flies did not bother the resident while he was eating his snack. Interview with a second resident on 05/04/17 at 10:25am revealed: -He had noticed "a few" flies in the room at snack and meals times. -The flies did not bother him. Observation of the dining room on 05/04/17 at 12:07pm revealed there were three flies on the dining room tables. Observation of the lunch meal on 05/04/17 from 12:24pm-1:27pm revealed: -At 12:24pm, the food arrived from the other building and was taken into the kitchen. -The PCA began opening the containers of food	D 283		

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and plating the food; there were several flies flying around the kitchen.
-There was a clear plastic trash bag laying on the counter to the right side of the stove which contained dirty gloves, paper, and other items.
-At 12:27pm, the PCA swatted a fly away from a plate of food and said "get away."
-At 12:36pm, there were two flies on the lid of the tea pitcher.
-At 12:37pm, the Administrator washed off the lid of the tea pitcher.
-At 12:39pm, the Administrator was using a fly swatter at the window over the kitchen sink while the PCA was still plating food.
-At 12:43pm, the Administrator told the PCA to remove the trash from the counter after she was finished plating the food.
-At 12:50pm, there were three flies flying around the dining room.
-At 12:57pm, a fly in the dining room landed on a resident's mashed potatoes while the resident was still eating her meal.

Interview with the Administrator on 05/04/17 at 12:44pm revealed:
-When the doors were opened, flies came in.
-If the flies got "too bad," the kitchen and/or dining room were supposed to be closed off and sprayed to kill the flies.
-The Administrator acknowledged the trash should not be placed on the kitchen counter.
-The facility would come up with a "new system" for the trash.