Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	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 annual survey on August 16-17, 2017.	D 000		
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the chairs on the front porch was maintained in a clean and safe condition. The findings are: Observation of the front porch on 8/17/17 at 12:33 p.m. revealed: -There were nine chairs outside on the front porch by the main entrance into the facility. -There was a metal folding chair with a completely rusted seat. -The second chair had a large cut in the middle of the seat exposing the padding. -One area of this chair was taped with duct tape. -The third chair had four rips in the seat cushion exposing the padding. -The fourth chair had a long rip in the middle of the seat cushion. -The fifth chair had a round sunken area in the middle of the seat cushion about the size of a	D 072	All furniture on the front porch will be replaced with new furniture. Any chairs around the building on the outside not in good repair will be removed. The area will be monitored monthly by administrator to ensure that the furniture	10/6/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Hunt — TITLE: Administrator — (X6) DATE: 10/3/17

Stamp date 10/12/17

Reviewed and Accepted with Revisions KW 10/20/17

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D 072	Continued From page 1 basketball. -The sixth and seventh chairs each had rips in the seat cushions of the chair. -The wood on the chairs was faded. -The eighth chair was covered in cigarette ashes. -The ninth chair was wooden and the entire chair was covered in scratches. Observation of the front porch on 8/17/17 at 12:45 p.m. revealed there were five residents seated outside in the chairs smoking cigarettes. Interview with two residents on 8/17/17 at 12:48 p.m. revealed: -The chairs on the front porch had always looked that way. -The residents had never seen staff cleaning the chairs. Interview with a third resident on 8/17/17 at 12:51 p.m. revealed: -The chairs had been out front for a while, possibly over a year. -The chairs looked the same as they always had. -He did not recall staff cleaning the chairs. Interview with a fourth resident on 8/17/17 at 12:53 p.m. revealed: -The chairs had been out front for at least a year or maybe longer. -The chairs looked the same and still had tears and stains. -He was unsure if staff cleaned the chairs. Interview with a Supervisor on 8/17/17 at 1:13 p.m. revealed: -The furniture on the porch "looked like that" for a couple of months. -None of the residents complained about the furniture.	D 072	Staff inaged repair.	

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D 072	Continued From page 2 Interview with Administrator on 8/17/17 at 1:20 p.m. revealed: -She was aware the furniture needed to be replaced at the facility. -The furniture on the front porch had been stained for one year. -She had tried to replace the furniture, but she needed to replace other "things" at the facility. -The Administrator and the Office Manager walked through the facility weekly to make sure it was cleaned, including the furniture.	D 072		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings, and floors were cleaned and in good repair in 3 bathrooms and 6 bedrooms to include 3 doors, 4 areas of tile, 8 walls, a light fixture and a vent. The findings are: Observation of the men's' bathroom on 8/16/17 at 10:57 a.m. revealed there was a rusty vent on the ceiling.	D 074	The rusty vent will be cleaned and painted in the men's bathrooms.	10/31/17

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D 074	Continued From page 3 Observation of the hall bathroom on 8/16/17 at 10:51 a.m. revealed: -There was a golf ball size area of the wall that was missing paint about two feet above the grab bar. -There was a wooden border on the end of the bathtub that appeared to be chipping. -There were areas of white build up and rust on the wall above the tub. -There was an area measuring about a foot and a half of broken tile on the floor around the base of the toilet. Observation of the hall shower room on 8/16/17 at 11:02 a.m. revealed: -There was a white boarded area on the wall to the right of the door entrance that had several black scrapes. -There was a raised area in the painted wall to the left of the toilet about the size of a fist. -There was a scratched, unpainted area behind the door measuring about a foot and a half. Observation of the first bedroom on the right side of the hall on 8/16/17 at 10:59 a.m. revealed: -There were five areas of white paint on two of the blue walls. -There was an area of four tiles behind the bedroom door that were raised from the floor. Observation of the second bedroom on the right side of the hall on 8/16/17 at 11:09 a.m. revealed: -There was a foot long scratch of white paint about two inches wide on the wall. -There were several small holes and dark smudges on the wall beside the bed. Observation of the last bedroom on the right side of the hall on 8/17/17 at 9:24 a.m. revealed: -There was a large water stain surrounding the	D 074	Hall bathroom. - The wall above the grab bar will be repainted. - The wooden border on the end of the bathtub will be fixed. - The white build up and rust on the wall above the tub will be cleaned. - The broken tile will be replaced. Hall shower - The wall to the right of the door entrance will be cleaned of the black scrapes. - The raised area in the wall to the left of the toilet will be repaired. - The scratched and unpainted area behind the door will be repaired.	

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D 074	Continued From page 4 light fixture in the ceiling. -The sockets holding both light bulbs were completely rusted. Interview with a resident on 8/17/17 at 4:11 p.m. revealed: -Staff would dust every once in a while but not very often. -Staff did dust earlier that day on 8/17/17. Interview with a second resident on 8/17/17 at 4:15 p.m. revealed: -Staff dusted the facility. -The scratched areas on the wall had always been there. Interview with a third resident on 8/17/17 at 9:04 a.m. revealed: -The facility was last painted about three months ago. -Staff mopped the facility about every other day. -Staff cleaned the vents at times but they were rusted in some places. Observation on 8/16/17 at 11:08 a.m. of Resident Room #1 revealed: -The lower side of the entrance door on the hall had dark brown and black stains. -The area around the door knob and above the door knob had peeled paint. Observation on 8/16/17 at 11:09 a.m. of Resident Room #2 revealed: -The lower side of the entrance door on the hall had dark brown and black stains. -The the wax (clear coating) on the brown tiled floor had been removed. -The tile was not shiny. -Some of the tiles on the floor near a resident's bed were discolored.	D 074	- Light fixture in the ceiling has been replaced and the ceiling will be painted. Room #1 - The door will be repainted. Room # 2 The door will be repainted - The floor will be cleaned of discolored tile.	

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D 074	Continued From page 5 Observation on 8/16/17 at 11:12 a.m. of Resident Room #3 revealed: -The lower side of the entrance door on the hall had dark black stains. -The wax on the floor had been removed from the floor in the room. -Some of the tiles on the floor near a resident's bed were discolored a lighter brown. Interview with a Supervisor on 8/17/17 at 10:41 a.m. revealed: -The doors in the facility were just painted two months ago. -The walls in the hallway, dining room, the television room and some of the resident rooms were painted March 2017 or April 2017. -The painter asked the residents not to push the beds near the wall so that it would not mess up the paint. -She was told by another Supervisor, the floors in the facility were waxed two weeks ago. -The week of 8/3/17, the floors were buffed in the hallway and the dining room. -The resident rooms had not been buffed. -She mopped and swept the resident rooms daily. -She swept, mopped and cleaned the bathrooms daily. -The vents in the facility were painted two months ago. -She did not dust the vents. Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed: -She would look at the raised area of paint on the wall in the resident bathroom. -She was not aware of this raised area on the wall. -Some of the rooms were repainted sometime after October 2016.	D 074	Room # 3 - The door will be repainted. - The floor will be cleaned. The RCC and Administrator will monitor this area monthly to ensure the facility is in good repair.	

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D 074	Continued From page 6 -She did not know the date it was repainted. -Staff was supposed to clean the stains on the door as needed. -The hallway was buffed and waxed on 8/1/17. -The living room and dining room floor had not been buffed and waxed. -Staff should clean the floors daily. -The stains on the walls should be cleaned as needed. -The Maintenance person does touch up on paint as needed. -The Administrator and the Office Manager walked through the facility weekly to make sure it was cleaned.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the furniture in the dining room and living room were in good repair. The findings are: Observation of the dining room on 8/16/17 at 11:27 a.m. revealed: -There were six chairs at each dining room table (2). -The legs of eleven of the twelve chairs were rusted. -The eleven chairs had metal backing and the	D 076	The dining room chairs will be cleaned of all rust and painted. All living room furniture will be replaced with new leather furniture that can be cleaned easy.	10/31/17

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D 076	Continued From page 7 metal under the seat of each chair also had areas of rust. -There was one upholstered chair being used that had a brown stain on the seat. Observation of the living room on 8/17/17 at 8:46 a.m. revealed: -There were ten chairs in the living room. -Each chair was stained with brown stains and water marks on the seat cushions. Interview with a resident on 8/17/17 at 4:15 p.m. revealed: -The living room chairs had been there at least two months. -The dining room chairs had been there for over six months. Interview with a second resident on 8/17/17 at 9:04 a.m. revealed: -The chairs in the living room had been the same for some years. -The chairs always had stains. -The chairs in the dining room usually were polished but they were in need of cleaning now. Observation on 8/16/17 at 11:09 a.m. of Resident Room #2 revealed: -One of six wooden chest drawers had a latch loose from the drawer. -The bottom of the wooden chest was stained light and dark brown. Observation on 8/16/17 at 11:28 a.m. of the desk and the night stand in the dining room revealed: -The top of the desk, both sides of the desk, the two shelves, and the top of the drawers had dust. -The top of the nightstand, both sides of the stand, the drawer and the bottom shelf had dust. -The top of the nightstand, both sides of the	D 076	This area will be monitored monthly by Administrator to ensure that the furniture is clean and free of rust and any stains.	

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D 076	Continued From page 8	D 076		

stand, the sides three sides of the drawer, the bottom of the nightstand had scratches.
-The nightstand drawer had a missing knob.

Interview with a Supervisor on 8/17/17 at 10:41 a.m. revealed:
-The chairs in the living room hade stains, because the residents spilled liquids in the chairs.
-The chairs had been stained for one week.
-She cleaned the chairs in the living room as needed with a [named] cleaning solution.
-She dusted the furniture every two weeks.
-She last dusted the furniture in the facility two weeks ago.
-If something needed to be repaired, she informed the Office Manager, another Supervisor or the Administrator.
-The chair with the rusted legs in the dining room had been in the dining room for the past 3-4 years.
-She used a [named] cleaning solution to clean the chairs daily and as needed.

Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed:
-She was aware the furniture needed to be replaced at the facility.
-The furniture in the living room, the dining room and the resident rooms had been stained for one year.
-She had tried to replace the furniture, but she needed to replace other "things" at the facility.
-Staff was supposed to clean the stains in the living room chair as needed with a [named] cleaning solution.
-The Administrator and the Office Manager walked through the facility weekly to make sure it was cleaned, including the furniture.
-Staff was supposed to dust the furniture weekly.

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D 105	Continued From page 9	D 105		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 1 of 2 reach-in cooler's were working in a safe and operable condition. The findings are: Observation of the outside pantry on 8/16/17 at 12:00 p.m. revealed: -Two reach-in cooler's were in the pantry. -The outside thermometer of the reach-in cooler, which was located above the outside door of the reach-in cooler, read 65 degrees Fahrenheit (F). -There was no thermometer inside of the refrigerator. -There were 3 boxes of eggs and 5 gallons of milk. -The milk and the boxes of eggs were between cool and less than cool to touch. Interview with a Supervisor on 8/16/17 at 12:00 p.m. revealed the eggs and the milk in the above reach-in cooler had not been served to the residents. Interview with a Supervisor on 8/16/17 at 12:00 p.m. revealed: -The reach-in cooler was repaired one week (between 8/6-8/12/17) ago, because it was not working properly.	D 105	Thermometers have been placed in each Cooler and a new cooler was purchased. The broken cooler has been repaired and will be monitored weekly to ensure that the temp is Correct and in working order. Administrator will monitor weekly. 10/31/17	

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D 105	Continued From page 10 -A Repairman was supposed to come back to the facility on last week after he repaired the reach-in cooler to get it, but he did not come back to the facility. Interview with the Administrator on 8/16/17 at 12:00 p.m. revealed: -She was aware there were 1 of 2 reach-in cooler's was not working properly. -She bought the eggs on 8/14/17. -She bought the milk on 8/15/17. -Since the cooler had not been working properly and before the milk and eggs had gotten to a temperature that was not safe for consumption, staff took the milk and eggs to the sister facilities to store in the coolers. Observation of the facility on 8/16/17 at 12:00 p.m. revealed there were a cluster of three sister facilities between 50 to 200 feet apart. Observation of the broken reach-in cooler, which was located in the outside pantry, on 8/17/17 at 11:40 a.m. revealed: -The outside thermometer read 57 degrees F. -There was no thermometer inside of the cooler. -The milk and the eggs had been removed from inside of the cooler. -There were greater than 3 cabbage heads inside of the cooler. Interview with a Supervisor on 8/17/17 at 11:40 a.m. revealed the facility needed to get a new reach-in cooler. Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed: -She ordered another cooler the night of 8/16/17. -On 8/16/17 staff took the milk and eggs out of the broken cooler and placed it in the sister	D 105		

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D 105	Continued From page 11 facility coolers. -When the Repairman for the cooler came on last week (between 8/6-8/12/17) to fix the cooler, he told her he needed to take it away from the facility, so he could repair it. -The Repairman had not been back to the facility to repair it. -Staff had been taking the milk and eggs from the broken cooler and taking it to the sister facilities, since last week (between 8/6-8/12/17).	D 105		
D 112	10A NCAC 13F .0311 (c) Other Requirements 10A NCAC 13F .0311 Other requirements (c) Air conditioning or at least one fan per resident bedroom and living and dining areas shall be provided when the temperature in the main center corridor exceeds 80 degrees F (26.7 degrees C). This rule apply to new and existing facilities This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the air conditioning or at least one fan per resident bedroom and living and dining areas were provided to residents, when the temperature in the main center corridor exceeded 80 degrees F. The findings are: Interview with the Supervisor on 8/16/17 at 4:19 p.m. revealed: -The building usually was warmer in the afternoons and much cooler at night. -It did not seem to bother the residents as they	D 112	The AC unit has been repaired and in good working order. The Administrator will monitor this area weekly to ensure that the corridors do not exceed 80 degreese.	10/30/17

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D 112	Continued From page 12 wore long sleeves and jackets most of the time. -The Supervisor checked the thermostat of the facility. -She would call the company to come out and check it. Observation of the facility thermostat on 8/16/17 at 4:19 p.m. revealed the temperature inside was 81 degrees despite being set to 72 degrees. Interview with a resident on 8/16/17 at 4:21 p.m. revealed: -It could get hot in the building during the day. -It was much cooler in the building at night. -He believed the staff turned the air conditioning down at night. Interview with two residents on 8/16/17 at 4:11 p.m. revealed: -Their room often got hot during the day around 1 or 2 o'clock. -They would leave the door open when it was hot. -They did not complain to staff about the temperature. -They had never been offered a fan. Interview with a fourth resident on 8/16/17 at 4:16 p.m. revealed: -The resident was hot inside of the facility. -"It's like that all of the time." -"It's hot during the day most of the time." Observation of the above resident on 8/16/17 at 4:16 p.m. revealed the resident had on short sleeves. Observation on 8/16/17 in the living room from 4:17 p.m. to 4:22 p.m. reveald: -The temperature in the living room went from 82 degrees Fahrenheit (F) to 79 degrees F.	D 112		

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 112	Continued From page 13 -There was no fan in the living room. Interview with a Supervisor on 8/16/17 at 4:52 p.m. revealed when it was hot in the facility, the residents put up fans. Observation of the temperature in the dining room from 8:36 a.m.to 8:41 a.m. revealed the temperature in the dining room was 76 degrees F. Observation of the temperature in the living room from 8:43 a.m. to 8:45 a.m. revealed the temperature in the living room was 72 degrees F. Interview with a second Supervisor on 8/17/17 at 8:47 a.m. revealed: -The "air conditioner (AC) guy" came to the facility on 8/16/17 and changed the filter in the facility. -The "AC guy" was coming back to the facility today (8/17/17) to clean the AC units at the facility. Observation on 8/17/17 at 9:50 a.m. revealed the Repairman from the local AC repair company arrived at the facility to repair the AC. Interview on 8/17/17 at 11:10 a.m. with the above Repairman revealed: -The AC was not blowing cool air, because all 4 filters were "clogged" and the AC unit was dirty. -The AC was serviced yearly. -The local AC repair company came to the facility the night of 8/16/17 to repair the AC. -Before the night of 8/16/17, the AC repair company was at the facility one year ago (2016) to service the AC unit. -He did not have any information in reference to if the AC unit had ever broken down at the facility prior or who called the company to request a	D 112		

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D 112	Continued From page 14 Repairman. Interview on 8/17/17 at 1:20 p.m. with the Administrator revealed: -She did not know the AC was not working properly until she was told by a Supervisor on 8/16/17. -After she found out the AC was not working properly, she requested a Repairman. -When the repairman came to the facility on 8/17/17, they cleaned the coils and replaced the filters. -The Repairman came to the facility 6 months ago to clean the coils. -The Repairman come to the facility to repair the AC as needed. -If appliances were broken, staff was supposed to let her know. -The facility had fans in the building, but they did not keep it in the facility, because the "residents hog it."	D 112		
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 thermometers were placed in 2 of 2 reach-in coolers located in the outside pantry and the inside of 4 of 4 deep freezers were cleaned and protected from contamination.	D 283	The two coolers were cleaned and thermometers have been placed in each. A new cooler has been purchased to ensure that at least one working	10/6/17

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 283	Continued From page 15 The findings are: A. Observation of the outside pantry on 8/16/17 at 12:00 p.m. revealed: -Two reach-in cooler's were in the pantry. -The outside thermometer of reach-in cooler A (broken cooler) read 65 degrees Fahrenheit (F). -There was no thermometer inside of the cooler. -There were 3 boxes of eggs and 5 gallons of milk. -The milk and the boxes of eggs were between cool and less than cool to touch. -Reach-in cooler B did not have a thermometer on the inside or the outside of the cooler. -The food was cool to touch. Interview with a Supervisor on 8/16/17 at 12:00 p.m. revealed: -Both of the reach-in coolers did not have thermometers inside. -Thermometers were supposed to be inside the cooler's. Interview with the Administrator on 8/16/17 at 12:00 p.m. revealed: -She was aware 1 of 2 reach-in cooler's was not working properly. -She bought the eggs on 8/14/17. -She bought the milk on 8/15/17. -Staff had been taking the milk and eggs to the sister facilities to store in the coolers, since the cooler had not been working properly. -She was aware both of the reach-in coolers did not have thermometer's inside of them. Observation of the outside pantry on 8/17/17 at 11:40 a.m. revealed: -The outside thermometer read 57 degrees F for reach-in cooler A. -There were no thermometers inside reach-in	D 283	Cooler is in the building to hold milk and eggs. The four freezers have been cleaned and thermometers have been placed in each. The Administrator will monitor the coolers and freezers to ensure that they are clean and at the correct temp. The temps will be recorded and kept as documentation weekly to ensure Compliance.	

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 283	Continued From page 16 cooler A or B. -The milk and the eggs had been removed from inside of the cooler A. -There were greater than 3 cabbage heads inside of cooler A. Interview with a Supervisor on 8/17/17 at 11:40 a.m. revealed the thermometers were not inside both reach-in coolers, because the Administrator had not brought the thermometers to the facility. Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed: -The reach-in cooler's were supposed to have thermometers in them. -She had bought thermometers in the past and did not know why the thermometers were not in the coolers. -She was supposed to buy the thermometers for the coolers before she came to the facility on 8/17/17, but she did not get a chance to buy them. -She needed to buy thermometers for both reach-in coolers. -She ordered another reach-in cooler the night of 8/16/17. -On 8/16/17 staff took the milk and eggs out of the broken cooler and placed it in the sister facility's coolers. -Staff had been taking the milk and eggs from reach-in cooler A and taking it to the sister facilities, since last week (between 8/6-8/12/17). Observation of the facility on 8/16/17 at 12:00 p.m. revealed there were a cluster of three sister facilities between 50 to 200 feet apart. B. Observation of the outside pantry on 8/16/17 at 12:00 p.m. revealed: -There were 4 large deep freezers.	D 283		

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

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MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 283	Continued From page 17 -One deep freezer had all frozen breads, a second deep freezer had all frozen meats, a third deep freezer had all frozen vegetables and a fourth deep freezer had large bags of sugar and flour. -All four deep freezers had built-up frozen ice on all four walls inside of the freezers. Interview with a Supervisor on 8/17/17 at 11:40 a.m. revealed: -Her, the Administrator and the Office Manager cleaned the deep freezers every month. -She last cleaned the deep freezers one month ago. Observation of the outside pantry on 8/17/17 at 11:40 a.m. revealed all four deep freezers had built-up frozen ice on all four walls inside of the freezers. Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed: -Her, the Office Manager and a Supervisor cleaned the deep freezers every two months. -They needed to take the foods out of the freezers, so it could defrost. -The last time they cleaned the deep freezers was one month ago. -She could not remember the date. -She was aware the ice had built-up in the deep freezers, but she did not realize it could contaminate the food..	D 283		
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	D 310		

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 18 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 2 of 2 Residents (#1, #3) on the No Concentrated Sweets (NCS) diet received the diet as ordered by the primary care physician. The findings are: 1. Review of Resident #3's current FL-2 dated 11/29/16 revealed: -Diagnoses included Hypertension, Chronic Renal Failure, and Diabetes Mellitus. -There was a diet order for a NCS diet. Review of the diet list (not dated) revealed Resident #3 was on a NCS diet. Review of the facility's Week 2 Day 4 NCS Lunch Menu revealed the resident's meal included 1/2 cup (cp) of diet fruit cobbler and 1 cp of a diet beverage. Observation of Resident #3 during the lunch meal on 8/16/17 at 12:48 p.m. revealed the resident's meal included 2 ounces (oz) vanilla pudding and 1 cp grape Kool-aid with regular sugar. Observation of Resident #3 during the lunch on 8/16/17 at 12:53 p.m. revealed: -He did not eat the pudding. -He drank all of the Kool-aid. Review of the ingredient label on the vanilla pudding package revealed the pudding had 26	D 310	An in-service will be conducted on No Concentrated sweets diets and reminders on how to prepair beverages and deserts for the diabetres. Diabetre snacks and deserts will be purchased to ensure that NCS diets are followed. The in ~~service~~ service will be peformed by Administator and monitored weekly for Compliance. The Administator will order diabetre deserts.	10/30/17

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 310	Continued From page 19 grams of sugar per serving. Observation of Resident #3 during the dinner meal on 8/16/17 at 5:51 p.m. revealed the resident's meal included 1/2 cp pears and 1 cp grape Kool-aid with regular sugar. Observation of Resident #3 on 8/16/17 at 6:03 p.m. revealed: -Resident #3 ate all of the pears. -He was served Kool-Aid and water and drank all of it. Interview with Resident #3 on 8/17/17 at 9:04 a.m. revealed: -He was typically served unsweetened pudding. -The pears from dinner last night had a sugary taste. Interview with the Nurse Practitioner on 8/17/17 at 10:40 a.m. revealed: -Resident #3 consistently had good blood sugars. -Resident #3's diabetes was well controlled. -She had recently discontinued his sliding scale insulin because it was no longer needed. -She did not think it would be harmful for Resident #3 to have an occasional sweet. Refer to observation of the outside pantry on 8/17/17 at 11:40 a.m. Refer to interview with the Cook on 8/16/17 at 11:54 a.m. Refer to interview with a Supervisor on 8/16/17 at 12:51 p.m. Refer to interview with a second Supervisor on 8/17/17 at 10:41 a.m.	D 310		

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MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 310	Continued From page 20 Refer to interview with the Administrator on 8/17/17 at 1:20 p.m. 2. Review of Resident #1's current FL-2 dated 8/11/16 revealed: -Diagnoses included Type 2 Diabetes Mellitus, schizophrenia and hyperlipidemia. -There was a diet order for the NCS diet. Review of the diet list (not dated) revealed Resident #1 was on a NCS diet. Review of the facility's Week 2 Day 4 NCS Lunch Menu revealed the resident's meal included 1/2 cup (cp) of diet fruit cobbler and 1 cp of a die beverage. Observation of Resident #1's lunch meal on 8/16/17 at 12:15 p.m. included 1 cp of grape koolaid with regular sugar and 2 ounces (oz) of vanilla pudding (regular). Review of the ingredient label on the vanilla pudding package revealed the pudding had 26 grams of sugar per serving. Observation of Resident #1 on 8/16/17 at 1:11 p.m. during the lunch meal revealed the resident drank all of the kool-aid and had eaten all of the vanilla pudding. Observation of Resident #1's dinner meal on 8/16/17 at 5:51 p.m. included 1/2 cp pears and 1 cp of grape kool-aid with regular sugar. Observation of Resident #1 on 8/16/17 at 6:09 p.m. revealed the resident ate all of the pears and drank all of the kool-aid. Interview with Resident #1 on 8/17/17 at 12:05	D 310		

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MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 310	Continued From page 21 p.m. revealed: -He was told by staff he was on a diabetic diet. -He could not remember how long he had been on the diabetic diet. -He was allowed to have sugar with his desserts. -The grape kool-aid he received for lunch and dinner on yesterday (8/16/17) was a little sweet. -The beverages were usually sweet when he received it with the meals. Telephone interview with the Nurse Practitioner on 8/17/17 at 10:40 a.m. revealed: -Resident #1 was on a NCS diet. -Resident #1 was noncompliant with his diet. -Resident #1 would often find ways to get other foods. -She adjusted Resident #1's medications due to noncompliance with his diet. -Resident #1 consistently had higher blood sugars. -She believed the facility tried to work within the limitations as best as they could. Review of Resident #1's August 2017 blood sugars tracking log revealed: -The blood sugars were taken three times daily. -The blood sugar readings had three columns with no times or any indication if it was taken before a meal documented. -In the first column, the blood sugar readings from 8/1-8/16/17 ranged from 76-157. -In the second column, the blood sugar reading from 8/1-8/16/17 ranged from 73-215. -In the third column, the blood sugar readings from 8/1-8/16/17 ranged from 136-253. Review of Resident #1's August 2017 Medication Administration Record revealed the blood sugars were taken at 6:30 a.m., 11:30 a.m. and 4:30 p.m.	D 310		

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 310	Continued From page 22 Refer to observation of the outside pantry on 8/17/17 at 11:40 a.m. Refer to interview with the Cook on 8/16/17 at 11:54 a.m. Refer to interview with a Supervisor on 8/16/17 at 12:51 p.m. Refer to interview with a second Supervisor on 8/17/17 at 10:41 a.m. Refer to interview with the Administrator on 8/17/17 at 1:20 p.m. Observation of the outside pantry on 8/17/17 at 11:40 a.m. revealed: -There was no sugar free pudding. -The canned pears were in light syrup. Interview with the Cook on 8/16/17 at 11:54 a.m. revealed: -The diabetics received 1/2 of whatever was served for the regular dessert. -If the diabetics received canned fruit, she rinsed it off before serving it to the residents. Interview with a Supervisor on 8/16/17 at 12:51 p.m. revealed: -All of the residents including the diabetics received the kool-aid with regular sugar with the lunch meal on 8/16/17. -When residents are served tea, the tea has regular sugar already added and all the residents received the same tea. Interview with a second Supervisor on 8/17/17 at 10:41 a.m. revealed: -The diabetics received sugar free desserts and	D 310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	941 GOINS ROAD PEMBROKE, NC 28372

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D 310	Continued From page 23 beverages. -Resident #1 was on a sugar free diet. -The resident was non compliant with his diet. -Resident #1 got regular sodas from the vending machine. -When the resident got the sodas, staff encouraged him not to drink it and they contact his primary care physician. Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed: -For residents on the NCS diet, they should receive unsweetened beverages and desserts. -She was told by a Supervisor on 8/16/17 that the diabetics received regular pudding instead of fruit and koolaid with regular sugar instead of sugar free kool-aid on that day during the meals. -Her expectation was for staff to serve the meals to the diabetics, based on what diabetics were supposed to receive. -Her, a Supervisor and the Office Manager monitored the meals in the facility 2 to 3 times weekly. -She last monitored the meals in the facility "a couple of weeks ago" and there was no problems with the meals.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the	D 317	Activities will be offered to residents at a minimum of 14 hours a week. Documentation will be kept in order to	

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 2	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 317	Continued From page 24 facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure activities were offered to the residents daily. The findings are: Interview with a resident on 8/16/17 at 11:15 a.m. revealed: -The resident would like something to do at the facility. -They used to play Bingo but this had not happened in months. -The resident had not been on any outings. Interview with a second resident on 8/17/17 at 10:30 a.m. revealed: -There was nothing to do at the facility but smoke. -There were no activities offered daily. -He was unable to remember the last time there was an actiivty. Review of the August 2017 Activity Calendar revealed: -The activites listed on the calendar on 8/16/17 were sing along and bible study. -The activities listed on the calendar on 8/17/17 were ball toss, music, and popcorn. -Fourteen hours of activities were listed on on the calendar from 8/13/17 to 8/17/17.	D 317	Show that the activity program is being performed according to rules and regulations. A tracking form will be created to document time and dates of each activity. This will be monitored weekly by Administrator to ensure compliance.	10/30/17

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	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 317	Continued From page 25 Observation of the activity supplies on 8/17/17 in the living room at 1:14 p.m. revealed: -There was one board game. -There were three card games. -There was one car game. -There were six to seven movies. -There was a miniature pool table game. Confidential interview with a resident revealed: -Activities were not offered daily. -The last time activities were offered were the week of 8/6/17 to 8/12/17. -When activities are offered, they play bingo, checkers and have Bible study. -The resident liked to play basketball at the facility, but the resident had not played since the basketball goal had been bent (May 2016). Confidential interview with a second resident revealed: -Activities were offered to the residents. -The resident did not know the last time activities had been offered at the facility. -Activities had not been offered to the residents on "today." Interview with a Supervisor on 8/16/17 at 5:01 p.m. revealed: -The residents did not like to participate in activities. -The Activity Director was not at the facility due to personal reasons. -The Activity Director took the residents on outings monthly once they got paid. -No residents complained of wanting to do activities. -The residents mainly smoked and slept. -She did not know the last time the residents went on an outing. -In order to get the residents to do activities they	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078064	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 317	Continued From page 26 want money. -She offered residents activities on today (8/16/17), but the residents did not want to do any activities. Interview with a second Supervisor on 8/17/17 at 10:41 a.m. revealed: -Activities were offered to the residents daily, but the resident preferred to smoke, sleep or sit on the porch. -The residents had games, such as a card game. -She did not know when the last time the residents went on an outing, because the Activity Director took the residents on outings. Telephone interview with the Activity Director on 8/17/17 at 12:49 p.m. revealed: -She had been the Activity Director at the facility for the past 12 years. -The residents in the facility usually does not want to do any activities offered. -The residents liked to "sit and chat" with each other. -She had not been at the facility for the past 4 weeks due to personal reasons. -Only one resident in the facility liked to go on outings on Fridays. -When she was not at the facility, staff were supposed to offer activities with the residents. -Residents were offered checkers and woodened crafts. -She evaluated the activity program monthly, based on if the residents liked the activities offered or not. Interview with the Administrator on 8/17/17 at 1:20 p.m. revealed: -At the facility, residents usually liked to play board games, basketball and watch movies. -The only time you could get the residents in the	D 317		

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D 317	Continued From page 27 facility to participate in activities was when there was an ice cream social. -The residents went on outings every week. -The Activity Director had been out of the facility off and on for the past four weeks, due to personal reasons. -The Activity Director was not there to offer activities to the residents, the Supervisor was supposed to offer activities to the residents. -She was not aware the residents complained of not being offered activities. -She monitored activities at the facility every two months. -The only problem she had found with activities was that every resident did not want to participate in activities. Observation during the survey from 8/16-8/17/17, no activities were offered to 12 of 12 residents.	D 317	Addendum: Telephone interview with the Administrator on 10/20/17 at 12:00p.m. revealed, the Administrator and the Resident Care Coordinator will monitor all of the cited rule areas Daily. The on-site Supervisor will monitor all of the cited rule areas on the weekends. KW 10/20/17	