NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 20, 2020

Ms. Gwendolyn Artis, Administrator
Ms. Joyce Applewhite, Licensee
Morning Glory Family Care
112 S. Church Road
Eureka, NC 27830

email address: gwensmith2boys@aol.com

Re: Receipt of Plan of Correction (4WY111)
Facility: Morning Glory Family Care
Licensure Number: FCL-096-038
County: Wayne

Dear Ms. Artis:

Based on our telephone conversation on March 19, 2020 there was an addendum to the Plan of Correction for the Statement of Deficiencies dated January 23, 2020. The pages noting the addendum are provided for your records.

Please do not hesitate to contact me at 919-817-4385, if you have questions or we may be of further assistance.

Sincerely,

Deloris Dawson-Rogers

Deloris Dawson-Rogers, BS, BSN, MPA
Licensure Consultant-RN
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure

cc: Ms. Ashley Dawson, Supervisor, Wayne County Department of Social Services
Ms. Suzy Morgan, Team Supervisor, Eastern Region, Adult Care Licensure Section
Raleigh File

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
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on January 23, 2020.	C 000	RECEIVED MAR 18 2020 ADULT CARE LICENSURE SECTION RALEIGH	
C 098	10A NCAC 13G .0316 (c) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (c) Any fire safety requirements required by city ordinances or county building inspectors shall be met. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain fire safety requirement required by the city ordinances or county building inspection. The findings are: Observation of a fire safety permit revealed the date of inspection was 10/26/18. Interview with the Supervisor-in-Charge (SIC) on 01/23/20 at 3:49 pm revealed: -She did not know the fire inspection was not current. -The fire inspection should be completed annually. -She just forgot to get the fire inspection completed for 2019. -She was responsible for getting the fire inspection completed annually. -She would make a chart of the fire inspections as a reminder of when the fire inspection was due.	C 098	The building fire inspection was done on 1/28/2020. 1/28/2020 I will make a chart of the fire inspections as a reminder of when the fire inspections as a reminder of when the fire inspection is due.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE FORM 6899 4WY111 If continuation sheet 1 of 7

Gwendolyn Antwo 3/6/2020 POC "Revicwed and Accepted with Revisions"
Administrator
D. Dawson-Rogers
03/19/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 098	Continued From page 1 -She would go to the fire inspection office on 01/24/20 and pay the fee. -The fee for the fire inspection had to be paid before a date could be scheduled for the inspection at the facility. Telephone interview with the Administrator on 01/23/20 at 7:22 pm revealed: -She did not know the fire inspection was not current. -The fire inspection should be completed annually. -The SIC was responsible for keeping up with the annual fire inspection. -She would start auditing the fire inspection annually to assure it was current.	C 098		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family 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 the ceiling heat in 1 of 3 resident's room was maintained in safe operating condition. The findings are: Interview with a resident on 01/23/20 at 11:00 am	C 102	A new central heating and air system was put In the home. We used the fire place for heating while the central heat and air was being placed. I will call the heat repair as soon as I am aware that the heat is not working in the resident room. 3/13/2020	

Addendum
Telephone Interview with the Administraton on 3/19/2020 at 2:44 pm revealed She would contact the repair technician with in the same day or 24 hours if needed Repairs at the facility.
3/19/2020 D. Dawson-Rogers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 102	Continued From page 2 revealed the ceiling heat had not been working properly for a month. Interview with the Supervisor-in-Charge (SIC) on 01/23/20 at 11:55 am revealed: -The ceiling heat had not been working correctly for about a month. -She turned on the heat in the bathroom which connected to bedroom #1 and open the door to help warm the room. -She had not notified the Administrator of the ceiling heat in bedroom #1 not working correctly. -She had not called a heating repair company prior to 01/23/20 at 12:00 pm regarding the ceiling heat not working correctly in bedroom #1. Interview with a heating repair technician on 01/23/20 at 1:05 pm revealed. -He was not able to fix the ceiling heat in bedroom #1 -A heating repair technician supervisor would come to the facility on 01/24/20 to see if he could repair the ceiling heat in bedroom #1. Telephone interview with the Administrator on 01/23/20 at 7:22 pm revealed: -She did not know the ceiling heat in bedroom #1 had not been working correctly for about a month. -If the ceiling heat was not working correctly, the staff should notify the SIC. -The SIC should call the heating repair company the same day if possible. -The SIC would be responsible for calling the heating repair company.	C 102		
C 103	10A NCAC 13G .0317 (b) Building Service Equipment	C 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 103	Continued From page 3 10A NCAC 13G .0317 Building Service Equipment (b) There shall be a central heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. Built-in electric heaters, if used, shall be installed or protected so as to avoid hazards to residents and room furnishings. Unvented fuel burning room heaters and portable electric heaters are prohibited. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to prevent the use of electric heaters in 1 of 3 resident rooms. The findings are: Observation bedroom #1 on 01/23/20 at 10:30 am revealed: -An electric heater was sitting about 12 inches from the foot of the bed #2. -The thermostat was set at 77 degrees Fahrenheit. Interview with a resident on 01/23/20 at 11:00 am revealed the Supervisor-in-Charge (SIC) put the electric heater in the room about a month ago. Interview with the SIC on 01/23/20 at 11:55 am revealed: -She did know about the electric heater being in bedroom #1. -She put an electric heater in bedroom #1 about a month ago. -The ceiling heat had not been working correctly for about a month. -She did know an electric heater should not be used in a resident's room because it could be a	C 103	The heater in bedroom 1 was removed on 1/23/20 and the staff is aware that the electric heater should not be used. They are prohibited.	1/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 103	Continued From page 4 hazard. -She did not tell the Administrator about the electric heater being used in bedroom #1. Telephone interview with the Administrator on 01/23/20 at 7:22 pm revealed: -She did not know an electric heater was sitting in a resident's bedroom. -She did not know an electric heater could not be used in a resident's room. -She would do an interservice with the staff to assure electric heaters were not used in the resident's room.	C 103		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 176	Continued From page 5 facility failed to assure at least one staff person was on the premises at all times who had completed a cardio-pulmonary resuscitation (CPR) and choking management course within the last 24 months for 2 of 3 sampled staff (Staff A and B). The findings are: 1.Review of Staff A's Supervisor-in-Charge (SIC), personnel record revealed: -She was hired on 04/05/01. -There was documentation of successful completion of a CPR course on 07/22/17 with an expiration date of 07/22/19. -There was no documentation Staff A had completed an additional CPR course. Interview with Staff A on 01/23/20 at 3:49 pm revealed: -She did not know her CPR certification expired on 07/22/19. -Staff A thought she had a current CPR certification. -She notified the nurse on 01/23/20 at 4:15 pm that the staff CPR certification had expired. -The nurse would come to the facility on 01/25/20 at 10:00 am to do CPR training for the staff -She was responsible for scheduling CPR classes for the staff. Telephone interview with the Administrator on 01/23/20 at 7:22 pm revealed the last time Staff A completed CPR was on 07/22/17. Refer to interview with the Administrator on 01/23/20 at 7:22 pm. 2. Review of Staff B's personal care aide, personnel record revealed:	C 176	CPR class was given 1/25/2020. I will make sure everyone keep their CPR up-to-date. I will check CPR certification yearly to make sure we stay up-to-date.	1/25/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096038	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY FAMILY CARE	112 SOUTH CHURCH STREET EUREKA, NC 27830

(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
C 176	Continued From page 6 -She was hired on 07/29/10. -There was documentation of successful completion of a CPR course on 07/22/17 with an expiration date of 07/22/19. -There was no documentation Staff B had completed an additional CPR course. Interview with Staff B on 01/23/20 at 3:50 pm revealed the last time she completed a CPR class was on 07/22/17, but she did not know CPR certificate had expired. Interview with the SIC/Staff A on 01/23/20 at 3:49 pm revealed: -She did not know Staff B's CPR certification expired on 07/22/19. -She was responsible for scheduling CPR classes for the staff. Telephone interview with the Administrator on 01/23/20 at 7:22 pm revealed the last time Staff B completed CPR was on 07/22/17. Refer to interview with the Administrator on 01/23/20 at 7:22 pm. Telephone interview with the Administrator on 01/23/20 at 7:22 pm revealed: -She did not know staff did not have a current CPR certification. -The nurse usually kept her updated when CPR certification expired. -The Administrator was responsible for making sure staff had a current CPR certification. -She would be auditing the staff qualifications annually to assure staff had a current CPR certification.	C 176		