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 _____	11/01/2024

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 an annual survey and complaint investigation from 10/31/24 to 11/1/24.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to ensure a medication prescribed for anxiety and agitation was administered to 2 of 3 sampled residents (#2 and #3) as ordered by the physician. The findings are: 1. Review of Resident #1's current FL-2 dated 01/17/24 revealed diagnoses included Schizophrenia, hypertension, anemia, type 2 diabetes and atrial fibrillation. Review of Resident #1's Physician's Orders dated 09/16/24 revealed there was an order for Lorazepam 1mg, 1 tablet daily at bedtime. (Lorazepam is used to treat anxiety and agitation.) Observations of medications on hand on 11/01/24 at 11:53am revealed:	D 358		

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-There was a medication card dispensed on 10/14/24 that contained 30 Lorazepam tablets.
-There were 13 tablets of Lorazepam 1mg remaining.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) on 10/31/24 revealed:
-There was an entry for Lorazepam 1mg to be administered 1 tablet daily at 8:00pm.
-Lorazepam 1mg was documented as administered on 10/15/24 at 8:00pm.

Review of Resident #1's October 2024 controlled substance log (CS) on 11/01/24 revealed there was no documentation of Lorazepam 1mg being administered on 10/15/24.

Interview with a medication aide (MA) on 11/01/24 at 3:14pm revealed:
-The MA was responsible for documenting on the eMAR and CS log when administering a CS.
-She administered medication based on the eMAR and documented on the CS log.

Refer to interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm.

Refer to interview with the Administrator on 11/01/24 at 4:15pm.

2. Review of Resident #2's current FL-2 dated 05/29/24 revealed diagnoses included Hypertension, heart failure, atrial fibrillation, type 2 diabetes, presence of cardiac pacemaker, cerebral infarction, atherosclerosis heart disease of native coronary artery.

Review of Resident #2's Physician's Orders dated 09/16/24 revealed there was an order for

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Lorazepam 0.5mg, 1 tablet daily as needed for anxiety.

Observations of medications on hand on 11/01/24 at 11:53am revealed:
-There was a medication card dispensed on 09/20/24 labeled 1 tablet daily as needed that contained 30 Lorazepam tablets.
-There were 25 tablets of Lorazepam 0.5mg remaining.

Review of Resident #2's October 2024 CS log on 11/01/24 revealed:
-It was labeled Lorazepam 0.5mg, take one tablet daily as needed.
-30 tablets were dispensed 09/20/24.
-Lorazepam was documented as administered on 10/21/24 at 8:00pm.
-Lorazepam was documented as administered on 10/22/24 at 8:00am.
-Lorazepam was documented as administered on 10/22/24 at 8:00pm.
-Lorazepam was documented as administered on 10/23/24 at 8:00am.
-Lorazepam was documented as administered on 10/23/24 at 8:00pm.
-Lorazepam was documented as administered on 10/24/24 at 8:00am.
-It was documented that there were 24 Lorazepam tablets remaining.
-Lorazepam was administered twice daily on 2 occasions.

Review of Resident #2's October 2024 eMAR on 10/31/24 revealed:
-There was an entry for Lorazepam 0.5mg, 1 tablet daily as needed.
-Lorazepam 0.5mg, 1 tablet daily as needed was not documented as administered from 10/01/24 to 10/31/24.

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D 358	Continued From page 3 Interview with an medication aide (MA) on 11/01/24 at 3:14pm revealed: -The MA was responsible for documenting on the eMAR and CS log when administering a CS. -She administered medication based on the eMAR and documented on the CS log. Refer to interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm. Refer to interview with the Administrator on 11/01/24 at 4:15pm. _____ Interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm revealed: -There was no process in place to check the CS count behind the MAs. -Cart audits were done every 1 to 2 months. -Cart audits were done to make sure refills were in and the CS count was correct. -She had not done a cart audit. -MAs were responsible for cart audits. -The MAs had been doing cart audits but had not been documenting the cart audits. -She did not know when the last cart audit was done. -She expected the MAs to count the medication and check off on the CS log when the medication was administered, after each pill; and finish with one resident before moving to another resident. Interview with the Administrator on 11/01/24 at 4:15pm revealed: -The MA was responsible for documenting a CS on the eMAR and CS log as soon as the medication was administered. -If the count was off, the MAs were supposed to contact the Supervisor for assistance in finding	D 358		

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D 358	Continued From page 4 out why the medication count was off. -The Administrator and the Director of Nursing (DON) were supposed to do cart audits monthly. -Cart audits had not been done since the end of July 2024. -During cart audits, eMARS and CS logs were pulled. -Cart audits were done to ensure all medications were on the cart, any discontinued medications were removed from the cart, and there were no expired medications on the cart. -She did not know why the count was off for the Lorazepam and Tramadol for Resident #1 and the Lorazepam for Resident #2 other than the MA just did not document.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be	D 367		

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documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure that electronic medication administration records (eMAR) were complete and accurate for 1 of 3 sampled residents (#2).

The findings are:

Review of Resident #2's current FL-2 dated 05/29/24 revealed diagnoses included Hypertension, heart failure, atrial fibrillation, type 2 diabetes, presence of cardiac pacemaker, cerebral infarction, atherosclerosis heart disease of native coronary artery.

Review of Resident #2's Physician's Orders dated 09/16/24 revealed there was an order for Lorazepam 0.5mg, 1 tablet daily as needed for anxiety.

Observations of medications on hand on 11/01/24 at 11:53am revealed:
-There was a medication card dispensed on 09/20/24 labeled 1 tablet daily as needed that contained 30 Lorazepam tablets.
-There were 25 tablets of Lorazepam 0.5mg remaining.

Review of Resident #2's October 2024 CS log on 11/01/24 revealed:
-It was labeled Lorazepam 0.5mg, take one tablet daily as needed.
-30 tablets were dispensed 09/20/24.
-Lorazepam was documented as administered on 10/21/24 at 8:00pm.

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-Lorazepam was documented as administered on 10/22/24 at 8:00am.
-Lorazepam was documented as administered on 10/22/24 at 8:00pm.
-Lorazepam was documented as administered on 10/23/24 at 8:00am.
-Lorazepam was documented as administered on 10/23/24 at 8:00pm.
-Lorazepam was documented as administered on 10/24/24 at 8:00am.
-It was documented that there were 24 Lorazepam tablets remaining.

Review of Resident #2's October 2024 eMAR on 10/31/24 revealed:
-There was an entry for Lorazepam 0.5mg, 1 tablet daily as needed.
-Lorazepam 0.5mg, 1 tablet daily as needed was not documented as administered from 10/01/24 to 10/31/24.

Interview with an medication aide (MA) on 11/01/24 at 3:14pm revealed:
-The MA was responsible for documenting on the eMAR and CS log when administering a CS.
-She administered medication based on the eMAR and documented on the CS log.

Interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm revealed:
-Cart audits were done every 1 to 2 months.
-Cart audits were done to make sure refills were in and the CS count was correct.
-She had not done a cart audit.
-MAs were responsible for cart audits.
-The MAs had been doing cart audits but had not been documenting the cart audits.
-She did not know when the last cart audit was done.
-She expected the MAs to count the medication

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D 367	Continued From page 7 and check off on the CS log when the medication was administered, after each pill; and finish with one resident before moving to another resident. Interview with the Administrator on 11/01/24 at 4:15pm revealed: -The MA was responsible for documenting a CS on the eMAR and CS log as soon as the medication was administered. -The Administrator and the Director of Nursing (DON) were supposed to do cart audits monthly. -Cart audits had not been done since the end of July 2024. -During cart audits, eMARS and CS logs were pulled. -Cart audits were done to ensure all medications were on the cart, any discontinued medications were removed from the cart, and there were no expired medications on the cart.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the documentation of a controlled substance (CS) on the controlled substance log for 1 of 3 sampled residents, including medication used for agitation and anxiety (#1).	D 392		

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D 392	Continued From page 8 The findings are: Review of the facility's undated Medication and Medication Control Count Policy revealed: -The medication aides were responsible for counting all narcotics at the end of their shift before the keys to the medication cart in room were given to the next staff person taking over the shift. -Documentation was to be kept as a record of each narcotic count. Review of Resident #1's current FL-2 dated 01/17/24 revealed diagnoses included Schizophrenia, hypertension, anemia, type 2 diabetes and atrial fibrillation. a. Review of Resident #1's Physician's Orders dated 09/16/24 revealed there was an order for Lorazepam 1mg, 1 tablet daily at bedtime. (Lorazepam is used to treat anxiety and agitation.) Observations of medications on hand on 11/01/24 at 11:53am revealed: -There was a medication card dispensed on 10/14/24 that contained 30 Lorazepam tablets. -There were 13 tablets of Lorazepam 1mg remaining. Review of Resident #1's October 2024 CS log on 11/01/24 revealed: -It was labeled Lorazepam 1mg, take one tablet daily at bedtime. -30 tablets were dispensed 10/14/24. -There was no documentation of Lorazepam 1mg being administered on 10/15/24 and 10/31/24. -There were 15 tablets of Lorazepam documented as remaining.	D 392		

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Review of Resident #1's October 2024 eMAR on 10/31/24 revealed:
-There was an entry for Lorazepam 1mg to be administered daily at 8:00pm.
-Lorazepam 1mg was documented as administered on 10/15/24 at 8:00pm.
-The 10/31/24 Lorazepam 1mg had not yet been documented as it was not due to be administered until 8:00pm.

Refer to interview with MA on 11/01/24 at 3:14pm.

Refer to interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm.

Refer to interview with the Administrator on 11/01/24 at 4:15pm.

b. Review of Resident #1's Physician's Orders dated 09/16/24 revealed there was an order for Tramadol HCL 50mg, take 1 tablet twice daily at 8:00am and 8:00pm. (Tramadol is used to treat pain.)

Observations of medications on hand on 11/01/24 at 11:53am revealed:
-There was a medication card dispensed on 10/02/24 that contained 30 Tramadol tablets.
-There were 14 tablets of Tramadol 50mg remaining.

Review of Resident #1's October 2024 CS log on 11/01/24 revealed:
-It was labeled Tramadol HCL 50mg, take one tablet twice daily.
-30 tablets were dispensed 10/02/24.
-There was no documentation of Tramadol 50mg being administered on 10/31/24 at 8:00am and 8:00pm.
-There was documentation that there were 16

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D 392	Continued From page 10 Tramadol tablets remaining. Review of Resident #1's October 2024 eMAR on 10/31/24 revealed Tramadol 50mg was documented as administered on 10/31/24 at 8:00am. Interview with an MA on 11/01/24 at 3:14pm revealed: -The MA was responsible for documenting on the eMAR and CS log when administering a CS. -She administered medication based on the eMAR and documented on the CS log. -She forgot to document both the 8:00am and 8:00pm Tramadol 50mg on the CS log for Resident #1. Refer to interview with MA on 11/01/24 at 3:14pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm. Refer to interview with the Administrator on 11/01/24 at 4:15pm. _____ Interview with a medication aide (MA) on 11/01/24 at 3:14pm revealed: -The MA was responsible for documenting on the eMAR and CS log when administering a CS. -She administered medication based on the eMAR and documented on the CS log. -At shift change, the 2 MAs counted the CS together by pulling out the medication cards and counting. -After counting the CS, the MAs signed on and signed off at shift change on a sheet called Narcotic Count Sheet. -No one checked the CS behind the MAs. -She did not know what a cart audit was. -Once a month, when batch medications arrived,	D 392		

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the MA checked off the medications sent by the pharmacy using the medication list sent from the pharmacy.
-The medications that were already in the cart were not checked when batch medications arrived.

Interview with the Resident Care Coordinator (RCC) on 11/01/24 at 3:56pm revealed:
-There was a sheet in the medication room called the Narcotic Count Sheet where the MAs logged in; if the medication count was right, they signed off on that sheet.
-There was no process in place to check the CS count behind the MAs.
-Cart audits were done every 1 to 2 months.
-Cart audits were done to make sure refills were in and the CS count was correct.
-She had not done a cart audit.
-MAs were responsible for cart audits.
-The MAs had been doing cart audits but had not been documenting the cart audits.
-She did not know when the last cart audit was done.
-She expected the MAs to count the medication and check off on the CS log when the medication was administered, after each pill; and finish with one resident before moving to another resident.

Interview with the Administrator on 11/01/24 at 4:15pm revealed:
-The MA was responsible for documenting a CS on the eMAR and CS log as soon as the medication was administered.
-At shift change, the on-coming MA was not supposed to accept the medication cart keys until all narcotics were counted and the count was correct.
-The off going and on coming MA pulled each medication card out, counted the medication and

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D 392	Continued From page 12 matched the medication count with the CS log. -If the count was off, the MAs were supposed to contact the Supervisor for assistance in finding out why the medication count was off. -The RCC was responsible for checking behind the MA to ensure the CS count was accurate. -The Administrator and the Director of Nursing (DON) were supposed to do cart audits monthly. -Cart audits had not been done since the end of July 2024. -During cart audits, eMARS and CS logs were pulled. -Cart audits were done to ensure all medications were on the cart, any discontinued medications were removed from the cart, and there were no expired medications on the cart. -She was not aware the count for the Lorazepam and Tramadol was off for Resident #1. -She did not know why the count was off for the Lorazepam and Tramadol for Resident #1 other than the MA just did not document.	D 392		