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D 000	Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted a follow up and annual survey and complaint investigation on May 13, 2026 and May 14, 2026. The complaint investigation was initiated by the Robeson County Department of Social Services on April 27, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the facility was free from hazards related to the bathroom shower leaking water into the hall and a resident's bedroom and unsecured oxygen cylinders in a resident's bedroom. The findings are:	D 079		

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D 079	Continued From page 1 1. Review of the facility's sanitation inspection report dated 03/18/26 revealed: -One demerit was issued for flooring throughout the facility being clean and buildup/staining observed behind doors in room 3. -One demerit was issued for water damage on the wall beside the hopper in the laundry room. Observations of the facility on 4/27/26 at 3:00pm revealed: -There was white caulking along the bottom tiles of the shower and the wall entrance of the bathroom. -The wooden threshold was missing wood at the bottom of the entrance and exit of the bathroom door from what appeared to be excessive water damage. -There was loose molding along the wall at the entrance of the bathroom. -The floor tiles outside and in front of the bathroom were black in color from water damage. -There was missing wood at the bottom of the entrance and exit of bedroom 3. -The tile in Resident #1 's bedroom looked brown and discolored. -There was white caulking along the bottom tiles that adjoined the shower and entrance of Resident #1's bedroom. Observations during a second facility tour on 5/11/26 at 3:00pm revealed: -The shower was turned on for less than five minutes and water leaked into the hall area in front of the bathroom. -Water ran along the front wall of the shower near the entrance and out into the hallway leaving a visible water puddle that settled midway the hall covering two to three floor tiles. -The water drained back towards bedroom 3.	D 079		

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D 079	Continued From page 2 -Facility staff mopped up the water and placed a wet floor sign in the hall. Interview with a resident on 4/27/26 at 3:45pm revealed: -The shower was leaking when she first moved into the facility because she would see water on the floor. -She had not seen water on the floor for a while now. -She did not remember how long it had been since she first started seeing water on the floor from the shower or how long it has been since she last saw water on the floor. Interview with a second resident on 4/27/26 at 3:50pm revealed: -She had seen water leaking from the shower when it was cold. -When she went to take a shower, the water came from under the door and ran along the wall outside of the shower and into the hall floor which could cause someone to fall. -Water from the shower leaked into the hall every morning. -The maintenance staff did not fix the shower, but would turn the water on and off and would check the lavatory to see if the water was coming from there. -The water was not coming from the lavatory but was coming from the shower. -She thought it was shameful when there was not a decent bathroom to go to. Interview with a resident's family member on 5/13/26 at 2:38pm revealed: -The bathroom next to the resident's room leaked and there was mold in the resident's room and on the hall and the wall because it was flooding into her room.	D 079		

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D 079	Continued From page 3 -She saw water damage on the floor in the resident's room and mold. -The watermark from the shower leakage had left a visible watermark on the floor coming into the resident's room. -She saw the water damage behind the door where it looked like the tiles were lifting. Interview with a medication aide (MA) on 4/27/26 at 4:45pm revealed: -She saw water coming from the shower and under the bathroom door one day last week. -Neither of the residents whose bedrooms were next to the shower said anything to her about the shower leaking into their rooms or about the water in the hall. -She knew that repairs were completed to the shower a while back, but she could not remember exactly when it had been done. -Staff normally mopped the water up or used bed sheets to get the water up. Interview with the Office Manager on 4/27/26 at 3:30pm revealed: -There were residents living in the rooms on both sides of the shower bathroom. -There had been an ongoing issue with water from the shower leaking out underneath the wall into the hallway. -She had not had any complaints from residents about water going into their rooms. -She knew that when it was caulked initially the leaking of water from the shower had stopped, but it had started back in the past 2 weeks. -She told maintenance that it was leaking again either last week or the week before but he had not been able to get back to this facility due to other responsibilities. -When there was a water leak from the shower, the staff would put the wet floor signs down and	D 079		

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mop or put a sheet down to dry up the water.

Interview with the maintenance staff on 4/27/26 at 5:07pm revealed:
-He knew about the shower leaking because he and one of the owners had talked about the shower leaking.
-In his opinion, all the bathroom flooring would need to be taken up to find the leak.
-In his opinion, he really thought the water was coming from under the floor which was cement and he knew that it was going to be an expensive venture.
-The owners had researched getting some shower basins, but was not sure it would be feasible for a commercial shower due to the shower having to accommodate for wheelchair access.
-The facility owners were aware of the water leaking in the shower but he did not know what they had planned to do about it.
-He had recaulked the shower two times within the past year the shower had also been recaulked two other times.
-It was a year or so ago when the water initially was going into room 3 and he recaulked it, which stopped the leak.
-He had not had any issues with water leaking from the shower and he had not heard of water leaking into the adjoining room on the other side of the shower.

Second interview with the Office Manager on 5/11/26 at 2:15pm revealed:
-The water leak from the bathroom happened often.
-Maintenance staff had installed a clear caulking in the shower on 4/29/26.
-She had not heard any complaints from residents or seen any water in the hall since it

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was recaulked.
-She thought that if the owners intended to repair the shower they would have to tear down the wall to repair the leak.
-The shower leaked more when one particular resident showered around lunch time.
-The staff usually saw water on the floor more when the resident who showered longer than fifteen minutes got in the shower.

Interview with the facility owner on 5/14/26 at 4:30pm revealed:
-The water leak from the shower had been an ongoing issue.
-He did not remember the exact date of when the leak initially started.
-The showers tended to leak and had to be resealed periodically.
-He found out today that the shower was leaking again.
-He was unsure of who told him on of the shower leaking again, he overheard the conversation the Administrator was having with someone on the front porch.
-It was not a plumbing issue, it was a tile issue, and the tile had to be replaced.

2. According to guidance from the National Fire Protection Association (NFPA) compressed oxygen (O2) cylinders must be secured in a rack or stand to prevent tipping over.

Review of Resident #1's current FL-2 dated 01/12/26 revealed diagnoses included chronic obstructive pulmonary disease, and chronic respiratory failure unspecified with hypoxia (decreased oxygen supply) or hypercapnia (shallow breathing).

Observation of Resident #1's room on 05/13/26 at

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D 079	Continued From page 6 9:45am revealed: -There was an oxygen (O2) cylinder, with oxygen tubing attached, standing on the floor against the wall close to an electrical plug by the closet door. -There was no gauge on the O2 cylinder with tubing to indicate the amount of oxygen in the tank. -There were two O2 cylinders with a green seal around the top portion of the O2 cylinders that were standing on the floor in front of a nightstand next to a hospital bed. -There were two small O2 cylinders with white seals stored in a cardboard crate inside the closed closet. Interview with the medication aide (MA) on 05/13/26 at 9:58am revealed: -Resident #1 was supposed to use oxygen (O2). -Resident #1 refused to wear O2. -The O2 cylinders with a green tag around the top had recently been delivered to the facility. -She was not sure of the exact date of delivered and was not sure why the O2 cylinders were not stored in the cardboard crate. Interview with the Administrator on 05/13/26 at 10:02am revealed: -There was usually a cardboard box supplied for storing oxygen (O2) cylinders. -Staff were supposed to make sure O2 cylinders were placed in the storage rack. -She did not know when the O2 cylinders for Resident #1 were delivered. -O2 cylinders were pressurized. -Oxygen leaking out of the O2 cylinder was a possibility. -There should not be flames around O2. -She was not sure what would happen if there were flames around O2.	D 079		

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D 079	Continued From page 7 Observation of the Administrator on 05/13/26 at 10:09am revealed she positioned the three unsecured O2 cylinders in the cardboard crate inside the closed closet. Telephone interview with a representative from the oxygen supply company on 05/14/26 at 9:57am revealed: -The O2 supplier delivered an O2 concentrator and three O2 tanks with a regulator to the facility on 05/07/26 for Resident #1's use. -A green seal on the O2 cylinder meant the O2 cylinder was full. -Unused O2 tanks were recommended to be stored in a metal rack for better security. -O2 tanks created a lot of pressure and if an O2 tank fell there would be a concern for safety. -If an O2 cylinder fell and the top of the O2 cylinder came off, there could be an explosion that could blow through a wall. -The amount of damage from an O2 explosion depended on the size of the O2 tank. -O2 was flammable and could accelerate into a fire. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable. _____ The facility failed to ensure a hazard-free environment was maintained for the residents related to water leaking from the shower into the hallway creating an unsafe and hazardous environment and related to unsecured oxygen tanks stored in a resident's room, which could cause an explosion if overturned. This failure was detrimental to their health, safety, and welfare, and constitutes a Type B Violation. _____ A plan of protection was provided in accordance	D 079		

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D 079	Continued From page 8 with G.S. 131D-34 on 04/29/26 with an addendum completed on 05/14/26 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 28, 2026.	D 079		
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 record review and interview, the facility failed to ensure medications used to treat behaviors were administered as ordered by a prescribing practitioner for 1 of 3 sampled residents (#1). The findings are: Review of the facility medication administration policy dated 2020 revealed: -Medications would be administered in accordance with the prescribing practitioner's orders. -Medications would be administered within one hour before or one hour after the prescribed or scheduled time unless an emergency situation precluded the administration.	D 358		

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-Documentation would be provided for each dose of medication by the staff member who prepared the medications for administration.
-Documentation would be provided by the staff that administered medications to the resident on the medication administration record.
-Charting would identify if documentation errors, unavailability of medications or resident refusals of medication may have led to the error.

Review of Resident #1's current FL-2 dated 01/12/26 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, chronic respiratory failure, vitamin D deficiency, muscle spasms, mixed hyperlipidemia, vitamin B12 deficiency anemia, and local swelling mass and lump in lower extremities.

Review of a hospital after visit summary for Resident #1 dated 03/12/26 revealed:
-Resident #1 was admitted to the hospital on 03/07/26.
-Resident #1's admitting diagnoses included schizoaffective disorder, mild cognitive impairment, and encounter for assessment of decision-making capacity.
-Resident #1 was discharged from the hospital on 03/12/26 with a referral for hospice services.

a. Review of physician orders for Resident #1 revealed:
-There was a physician's order dated 01/12/26 for Lorazepam (used to treat behaviors such as anxiety and agitation) 2mg/ml (milligram/milliliter) oral concentrate take 0.5ml (1mg) three times a day, may add to drink.
-On 03/16/26 there was a verbal order from the hospice provider for Lorazepam 2mg/ml oral concentrate take 0.5ml (1mg) three times a day,

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D 358	Continued From page 10 may add to drink. Review of Resident #1's March 2026 electronic medication administration records (eMARs) revealed: -There was a printed entry for Lorazepam 2mg/ml oral concentrate take 1ml three times daily and scheduled for 8:00am, 2:00pm, and 8:00pm. -There was no documentation for administration of the Lorazepam 2mg/ml take1ml three times a day from 03/16/26 through 03/26/26. -There was no documentation of a reason for omission of the administration of the Lorazepam solution. Refer to the interview with the medication aide (MA) on 05/14/26 at 11:38am. Refer to the telephone interview with the contracted provider pharmacist on 05/14/26 at 2:17pm. Refer to the telephone interview with the hospice nurse on 05/14/26 at 3:55pm. Refer tot the interview with the Administrator on 05/14/26 at 3:00pm. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable. b. Review of physician orders for Resident #1 revealed: -There was a physician's order dated 01/12/26 for Risperidone (generic for Risperdal) solution (used to treat behaviors such as anxiety and agitation) 1mg/ml (milligram/milliliter) oral concentrate take 2ml two times a day, may add to drink. -Review of a physician's order for Resident #1	D 358		

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dated 02/11/26 revealed there was an order increasing Risperdal liquid 1mg/ml to take 4ml two times a day, may add to drink.
-On 03/16/26 there was a verbal order from the hospice provider for Risperdal liquid 1mg/ml take 4ml two times a day.

Review of Resident #1's March 2026 electronic medication administration records (eMARs) revealed:
-There was a printed entry for Risperdal 1mg/ml solution take 4ml (4mg) two times daily and scheduled for 8:00am and 8:00pm.
-There was no documentation for administration of the Risperdal 1mg/ml take 4ml two times a day from 03/16/26 through 03/26/26.
-There was no documentation of a reason for omission of the administration of the Lorazepam solution.

Refer to the interview with the medication aide (MA) on 05/14/26 at 11:38am.

Refer to the telephone interview with the contracted provider pharmacist on 05/14/26 at 2:17pm.

Refer to the telephone interview with the hospice nurse on 05/14/26 at 3:55pm.

Refer to the interview with the Administrator on 05/14/26 at 3:00pm.

Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable.

_____

Interview with the medication aide (MA) on 05/14/26 at 11:38am revealed:
-The physician sent orders to the provider

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pharmacy.
-The contracted provider pharmacy input the orders to the electronic medication administration records (eMARs).
-The MAs approved new orders that populated on resident eMARs with a green flag indicator.
-The Administrator received an electronic copy of a new order and provided a copy of the emailed order to the MAs for reference when the newly ordered medication was received at the facility.
-Medication cart audits were conducted every two weeks by the MAs.

Telephone interview with the contracted provider pharmacist on 05/14/26 at 2:17pm revealed:
-The pharmacy did not receive the physician orders dated 03/16/26 for Resident #1's Lorazepam and Risperdal.
-The pharmacy received orders for the Lorazepam and Risperdal concentrate on 03/25/26 from the hospice provider.

Telephone interview with the hospice nurse on 05/14/26 at 3:55pm revealed:
-She gave the facility medication aide (MA) a written order on 03/16/26 for Lorazepam 2mg/ml concentrate take 1mg three times a day and Risperdal 1mg/ml oral solution take 4mg two times a day .
-The facility MA was responsible to send the orders to the contracted provider pharmacy.
-She spoke to the Resident Care Coordinator (RCC) on 03/25/26 when she visited the facility and was informed the facility had not received the Lorazepam oral liquid or Risperdal oral solution when she asked about the medications.
-She and the RCC contacted the contracted provider pharmacy together and found out the pharmacy had not received the written order so she sent an electronic prescription to the

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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 358	Continued From page 13 contracted pharmacy provider on 03/25/26. -She was not sure what happened with the copy of the 03/16/26 verbal order for Resident #1's Lorazepam concentrate and Risperdal oral solution that she gave the MA for faxing to the pharmacy. -She was not aware of any impact to Resident #1 because of the missed doses of Lorazepam and Risperdal oral solutions from 03/16/26 through 03/25/26. -She had not received any reports from the facility regarding any increased agitation or anxiety for Resident #1. -There had not been any hospital visits for Resident #1 between 03/16/26 and 03/25/26. -Resident #1 became agitated even with taking medications due to her diagnosis of schizophrenia. -The facility told her that Resident #1 refused medications. Interview with the Administrator on 05/14/26 at 3:00pm revealed: -The MAs were supposed to send hospital discharge information to the primary care provider and/or mental health provider for review to ensure resident medications are administered as the provider wants the medications administered. -If medications were not administered according to the PCP directions, the resident could exhibit behaviors. -She did not know who was working when the 03/16/26 orders for Lorazepam and Risperdal were provided to the facility.	D 358		