STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 survey, and a complaint investigation from September 14, 2023, to September 18, 2023, with an exit conference via telephone on September 19, 2023.	C 000		
C 201	10A NCAC 13G .0701 (b) Admission Of Residents 10A NCAC 13G .0701 Admissions Of Residents (b) Exceptions. People are not to be admitted: (1) for treatment of mental illness, or alcohol or drug abuse; (2) for maternity care; (3) for professional nursing care under continuous medical supervision; (4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or (5) who pose a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure 2 of 3 sampled residents (#1, #2) were not admitted for the treatment of a mental illness. The findings are: 1. Review of Resident #1's current FL-2 dated 08/16/23 revealed: -The diagnosis was schizoaffective disorder. -The resident was documented as ambulatory.	C 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 201	Continued From page 1	C 201		

-The recommended level of care was domiciliary.
-There was no other documented diagnoses.

Review of Resident #1's record revealed the resident did not have a Resident Register.

Review of Resident #1's record revealed the resident did not have a Care Plan.

Telephone interview with Resident #1's psychiatrist on 09/19/23 at 4:00pm revealed:
-He provided outpatient psychiatry services to Resident #1.
-He was not aware that the facility could not admit a resident who was only receiving treatment for a mental health diagnosis.
-He was aware that the resident had been admitted to a family care home.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 09/18/23 at 1:49pm was unsuccessful.

Interview with the Administrator/owner on 09/15/23 at 1:50pm revealed:
-Resident #1 was admitted on 07/18/23 from another family care home.
-He had not looked for another placement for Resident #1 because he was not aware that the resident could not be admitted to the home for treatment of mental illness.
-Resident #1 did not have any medical problems and only received medication for his mental health diagnosis.
-The resident saw a psychiatrist for management of his mental health diagnosis and medications.

2. Review of Resident #2's current FL-2 dated 01/26/23 revealed:
-Diagnosis was schizoaffective disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 201	Continued From page 2	C 201		

-The resident was documented as ambulatory.
-The recommended level of care was supervised living.
-There was no other documented diagnoses.

Review of Resident #2's Resident Register dated 01/13/23 revealed the resident was admitted on 01/13/23.

Review of Resident #2's current Care Plan dated 01/06/23 revealed:
-The resident had wandering behaviors, was verbally abusive and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.

Telephone interview with Resident #2's psychiatrist on 09/14/23 at 2:47pm revealed:
-He provided outpatient psychiatry services to Resident #2.
-He had talked with the Administrator/owner about the resident possibly moving to a facility that provided a higher level of care due to his repeated wandering and elopement behaviors at the facility.
-He was not aware that the facility could not admit a resident who was only receiving treatment for a mental health diagnosis.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 09/18/23 at 1:49pm was unsuccessful.

Interview with the Administrator/owner on 09/15/23 at 1:50pm revealed:
-Resident #2 was admitted on 01/26/23 from an inpatient behavioral health hospital.
-He had not looked for another placement for Resident #2 because he was not aware that the resident could not be admitted to the home for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 201	Continued From page 3 treatment for mental illness. -Resident #2 did not have any medical problems and only received medication for his mental health diagnosis. -The resident saw a psychiatrist for management of his mental health diagnosis and medications. _____ The facility failed to ensure 2 of 3 sampled residents (#1, #2) were provided appropriate placement to receive treatment for mental health illnesses. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2023.	C 201		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the	C 212		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 212	Continued From page 4 Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Resident Register was completed within 72 hours of admission to the facility for 2 of 3 sampled residents (#1, and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 08/16/23 revealed: -The diagnosis was schizoaffective disorder. -The resident was documented as ambulatory. Review of Resident #1's record revealed there was no Resident Register. Refer to interview with the Administrator on 09/14/23 at 1:30pm. 2. Review of Resident #3's current FL-2 dated 07/06/23 revealed: -Diagnoses included bipolar disorder, major depression, and schizophrenia. -The resident was documented as ambulatory. Review of Resident #1's record revealed there was no Resident Register. Refer to interview with the Administrator on 09/14/23 at 1:30pm. _____ Interview with the Administrator on 09/14/23 at 1:30pm revealed: -He had forgotten to complete the Resident Register for Resident #1 and Resident #3. -He knew the Resident Register was to be completed within 72 hours of a resident being admitted to the facility but had forgotten to	C 212		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 212	Continued From page 5 complete the resident register for Resident #1 and Resident #3.	C 212		
C 224	10A NCAC 13G .0705 (f) Discharge Of Residents 10A NCAC 13G .0705 Discharge Of Residents (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) notifying staff in the county department of social services responsible for placement services; (2) explaining to the resident and responsible person or legal representative why the discharge is necessary; (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2; (B) a copy of the resident's most current assessment and care plan; (C) a copy of the resident's current physician orders; (D) a list of the resident's current medications; (E) the resident's current medications; and (F) a record of the resident's vaccinations and TB screening. (5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule: (A) the regional long term care ombudsman; and (B) the protection and advocacy agency	C 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 224	Continued From page 6 established under federal law for persons with disabilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide a safe and orderly discharge for 1 of 3 sampled residents (#3) as evidenced by failing to coordinate a specific date, time and preparation of discharge for the resident, who was taken to a local emergency department (ED) and left at the local ED by the Administrator/owner without notifying the resident's legal guardian, not providing a proper discharge notice to the residents legal guardian, not providing a copy of the resident's most current FL-2, a copy of the resident's physician orders, a list of the resident's current medications, and a copy of the resident's vaccinations, resulting in two family members being unable to locate the resident the next day. The findings are: Review of Resident #3's current FL-2 dated 07/06/23 revealed diagnoses included bipolar disorder, major depression, and schizophrenia. Review of Resident #3's record on 09/14/23 revealed the resident did not have a Resident Register. Review of the facility's policies on 09/14/23 revealed there was not a discharge policy available.	C 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 224	Continued From page 7 Review of the facility's policy on identification and supervision of a wandering resident revealed: -If it is determined that the facility can no longer provide services for the resident, the resident will receive a 30 day notice of discharge to be given to the resident or the resident's responsible party. -The Administrator/owner will assist with the relocation of the residents. Review of the facility's declaration of resident's rights revealed that every resident shall be given at least 60 days advance notice to ensure an orderly transfer or discharge. Review of Resident #3's facility record revealed the Department of Social Services (DSS) was appointed as the resident's legal guardian on 08/09/22. Review of Resident #3's facility record revealed: -There was a medical treatment form for wards residing at a facility consent form. -The document was signed by the Administrator/owner of the facility and Resident #3's legal guardian with DSS on 07/21/23. -The medical treatment document listed that facility staff would notify the guardian or guardian's representative immediately in all instances where the ward had been injured, or was to be admitted to a medical facility, or required emergency care outside of a medical facility. -Facility staff would not consent to any care, counsel, or treatment for the ward without the guardian's consent. -If an emergency situation (meaning the delay in rendering medical treatment would seriously worsen the physical condition or endanger the life of the ward) occurs, facility staff would contact the guardian or the guardian's representative during	C 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 224	Continued From page 8	C 224		

normal business hours or the after hours worker after normal business hours and on the weekend.
-After diligent attempts, facility staff were unable to reach the guardian or the guardian's representative, the facility would explain to the treating physician that the guardian could not be contacted.
-Physicians may choose to treat patients in emergency situations, without consent to save the patient's life.

Review of a local emergency department (ED) visit for Resident #3 dated 08/01/23 revealed:
-The resident arrived at the local ED on 08/01/23 at 6:39pm.
-There was documentation that the resident came to the local ED because he was staying in a group home, did not like the "man's attitude" so he came to the local ED to find somewhere to live.

Telephone interview with Resident #3's legal guardian with a DSS on 09/15/23 at 11:00am revealed:
-Resident #3 was not able to live independently and required supervision due to his diagnosis of schizoaffective disorder.
-The resident needed assistance taking his medications and managing his finances.
-The resident could become easily agitated and was easily manipulated by others.
-The legal guardian was on vacation from 07/31/23 to 08/07/23.
-The legal guardian updated her work voicemail to notify callers that she was on vacation from 07/31/23 to 08/07/23, and if anyone needed assistance with a resident to contact the DSS adult services supervisor or the operator in her absence.
-She returned to her office on 08/07/23 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 224	Continued From page 9 listened to a voicemail left from the Administrator/owner of the facility on 08/01/23. -The Administrator/owner left the legal guardian a voicemail on 08/01/23 that the resident continued to leave the facility unsupervised. -The Administrator/owner left her a voicemail on 08/01/23 at 4:36pm that the resident no longer wanted to live at the facility, the resident was not happy at the facility and that he was having issues with the resident leaving the facility without permission. -The Administrator/owner did not leave her a voicemail that he had taken the resident to the local ED and left him at the front entrance on 08/01/23. -The legal guardian called the Administrator/owner of the facility on 08/07/23 to speak with Resident #3. -The Administrator/owner informed the legal guardian on 08/07/23 that the resident was no longer at the facility and that he had taken the resident to the local ED on 08/01/23 because the resident did not want to stay at the facility and wanted to go to the local ED. -The Administrator/owner did not take the resident's paperwork or medications to the local ED on 08/01/23. -The Administrator/owner did not contact the DSS adult services supervisor or operator as her voicemail directed to report he left the resident at the local ED. Telephone interview with Resident #3 on 09/15/23 at 12:00pm revealed: -On 08/01/23 he left the facility and went to a local convenience store to purchase snacks and cigarettes for another resident that resided at the facility. -When he returned from the convenience store it was dinner time.	C 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 224	Continued From page 10	C 224		

-The Administrator/owner asked him if he was happy at the facility, and he informed the Administrator/owner that he was not and wanted to go to the local ED.
-The Administrator/owner took the resident in the facility van with the facility's other residents to the local ED and left the resident at the front entrance of the local ED.

Telephone interview with Resident #3's family member on 09/15/23 at 11:27am revealed:
-He received a telephone call from Resident #3 on 08/02/23 between 12:00am and 1:00am.
-The resident informed him that the Administrator/owner dropped him off at the local ED on 08/01/23 and that he wanted his family member to pick him up from the local ED.
-The resident's family member was unable to come pick the resident up on 08/02/23 because he lived approximately 2 hours and 40 minutes away from the local ED and it was too late to drive.
-Resident #3's family member and another family member went to look for the resident on 08/02/23 and were unable to locate him at the local ED or in the community.
-He did not realize that the resident had not been discharged back to the facility until he received a call from the resident's legal guardian on 08/07/23 informing him that the resident could not be located.

Telephone interview with Resident #3's second family member on 09/15/23 at 11:40am revealed:
-He was informed by telephone by the resident early in the morning on 08/02/23 that the resident asked the Administrator/owner to take him to the convenience store before dinner on 08/01/23 to get snacks and cigarettes.
-The resident informed him that he got tired of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 224	Continued From page 11	C 224		

waiting for the Administrator/owner to take him to the convenience store, so the resident walked away from the facility and went to the convenience store by himself.
-The resident reported that he returned to the facility and the Administrator/owner was upset with him for leaving the facility without permission.
-The resident informed him that he told the Administrator/owner that he wanted to go to the local ED and did not want to stay at the facility.
-The resident informed him that the Administrator/owner took him and the other residents that resided at the facility in the facility van.
-The resident reported to his family member that the Administrator/owner drove to the local ED, dropped the resident off at the entrance of the local ED, and he walked into the local ED by himself.
-His family member informed him on 08/07/23 that the resident's legal guardian was unable to locate the resident.
-He and his family member located the resident in a neighboring county where he was staying with a friend on 08/08/23.

Interview with the Administrator/owner on 09/14/23 at 9:00am revealed:
-Resident #3 was admitted on 07/18/23.
-Resident #3 was scheduled to see a psychiatrist on 08/10/23 for his first appointment.
-The resident left the facility several times without permission or supervision.
-He had explained to the resident on several occasions that he was not allowed to leave the facility without proper supervision.
-The resident walked off from the facility several times on 08/01/23.
-When the resident returned to the facility on 08/01/23 before dinner, he spoke with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 224	Continued From page 12	C 224		

resident again about not following the facility rules and explained to him that he was not allowed to leave the facility without supervision.
-The resident became angry and told the Administrator/owner that he did not want to live at the facility and wanted to be taken to the local ED.
-He loaded all the residents of the facility into the facility van and dropped the resident off at the local ED.
-He did not escort the resident into the local ED, did not take any of the resident's paperwork or his medications.
-He did not take any of the resident's medications to the local ED because he thought the resident's legal guardian would come to the facility later in the week to pick up his medications.

A second interview with the Administrator/owner on 09/14/23 at 12:35pm revealed:
-The facility provided supervised living.
-On 08/01/23, he noticed Resident #3 walking back to the facility from a local convenience store.
-When the resident was admitted to the facility, he explained to the resident that he could not wander off from the facility without supervision.
-The other residents that lived in the facility helped take the residents belongings to the front entrance door of the local ED.
-The Administrator did not get out of the facility van to take the resident into the local ED because "he was on his own, he was leaving me."
-Once he returned to the facility, he called the resident's legal guardian at DSS and left a voicemail that the resident became upset, did not want to stay at the facility, and he took him to the local ED because that is where the resident wanted to go.
-The DSS voicemail had information about the legal guardian being on vacation but still left a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 224	Continued From page 13 voicemail. -He thought there were directions on the voicemail to call someone else if he was not able to reach the legal guardian. -He did not call the other number or contact person because he just did not get around to it. -He thought the local ED would call the resident's legal guardian and get in touch with the resident's legal guardian because he assumed the resident would inform staff at the local ED that DSS was his legal guardian -He did not provide the resident with a discharge notice. -He was not sure what type of discharge notice he was expected to give the resident when the resident wanted to leave. _____ The facility failed to provide a safe and orderly discharge for Resident #3 by not coordinating a specific date, time and preparation of discharge for the resident, not communicating with the resident's legal guardian about the resident being taken to the local ED and leaving the resident at the entrance of the local ED, not providing a current FL-2 for the resident, a copy of the resident's physician orders, a list of the resident's medications, a copy of the resident's vaccinations, two family members of the residents not being able to locate the resident the next day, and the legal guardian or her representatives not being informed of the resident's discharge until 08/07/23. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation.	C 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 224	Continued From page 14 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2023.	C 224		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#2) as evidenced by a resident with a history wandering behaviors, who ran into a moving vehicle on a five lane highway which resulted in a fractured wrist and fractured rib. The findings are: Review of the facility's policy on identification and supervision of wandering residents revealed: -The facility was responsible for the identification and supervision of residents that wandered. -The facility should provide supervision of the residents in accordance with each resident's assessed needs, care plan, and current symptoms. -Once staff understands the cause of a resident's wandering behaviors, staff should develop a plan to try to minimize the wandering behavior. -The following steps should be taken to keep the	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 15	C 243		

resident from wandering: put in an alarm system, assign the resident to the bedroom closest to the staff bedroom, make regular checks on the resident, involve resident in activities that will distract attention from wandering.
-The staff will respond immediately to try to locate the resident by searching the facility and grounds, call 911, continue to search until the authorities have arrived, give a description of the resident and a picture of the resident to the authorities, give the time the resident was last seen, contact the responsible person and Department of Social Services (DSS) to inform that the resident has disappeared.

Review of the facility's missing resident policy revealed:
-The facility had a curfew of 9:00pm.
-In the event a resident did not return to the facility by 9:00pm, within 30 minutes the staff should respond immediately to try to locate the resident by searching the facility and grounds, call 911 and provide a description of the resident, name, age, picture of the resident and the name of the responsible party, time the resident was last seen, notify the responsible party, call for additional assistance, so that the other residents can be attended to, document the incident and the results of the incident.

Review of Resident #2's current FL-2 dated 01/26/23 revealed diagnosis was schizoaffective disorder.

Review of Resident #2's Resident Register dated 01/13/23 revealed the resident was admitted to the facility on 01/13/23.

Review of Resident #2's current Care Plan dated 01/06/23 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 16	C 243		

-The resident had wandering behaviors, was verbally abusive and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.

Review of a police report dated 06/27/23 at 1:08pm revealed:
-Resident #2 collided with a vehicle on a five lane highway with a speed limit of 35 miles per hour.
-Resident #2 attempted to cross the five lane highway when a vehicle was in the far right lane traveling east.
-The driver of the vehicle slowed down when he observed the resident attempt to cross the highway.
-The driver of the vehicle almost came to a complete stop to avoid hitting the resident.
-The driver reported that the resident stopped in the turning lane, then the resident started to run across the road toward his vehicle as the driver attempted to swerve and miss him.
-The resident ran into the left side of the driver's vehicle when the vehicle collided with the right curb.
-Security footage of the scene confirmed the driver's report with a note that the resident had a possible psychological or cognitive condition and that the resident collided with the moving vehicle.
-The resident stated he was crossing the roadway and saw the vehicle far away; he believed that the driver of the vehicle intentionally collided with him then dragged him a short distance.
-The resident was not dragged by the vehicle according to the police report.

Review of an after visit report from the local emergency department (ED) dated 06/29/23 revealed:
-Resident #2 was seen for an automobile versus pedestrian accident, with complaints of arm and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 17	C 243		

chest pain.
-The resident was diagnosed with a closed fracture of the distal end of his right radius (a fractured wrist) and a closed fracture to one rib on the right side.
-The resident's right wrist was placed in a sugar-tong splint (a sugar-tong splint is used to stabilize injuries of the wrist by preventing forearm rotation and wrist motion).

Review of an after visit report from the local ED dated 07/06/23 revealed:
-Resident #2 was diagnosed with homelessness, right wrist pain and rib pain on the right side.
-The resident's right wrist pain was caused by poor healing of the wrist fracture.
-The resident was provided with a split to wear to assist in the healing of his wrist fracture.

Telephone interview with Resident #2's legal guardian at the Department of Social Services (DSS) on 09/18/23 at 12:45pm revealed:
-The Administrator/owner notified her by telephone on 06/27/23 that the resident left the facility on 06/26/23 and was hit by a vehicle on 06/27/23.
-The Administrator/owner contacted her by telephone each time the resident eloped from the facility.
-She and the Administrator/owner discussed the resident needing a higher level of care (LOC) due to his frequent elopements from the facility several times.
-The Administrator/owner had contacted her by telephone a few weeks ago to ask if she could provide a letter explaining that the resident needed additional supervision.
-When the resident was previously discharged from the hospital, she communicated to the discharge coordinator that the resident needed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 18	C 243		

increased LOC to provide him with increased supervision due to his elopements and wandering behaviors.
-She had spoken with the resident's psychiatrist to request that his FL-2 be updated with an increased LOC due to safety concerns due to his repeated elopements from the facility.
-The resident was seen by his psychiatrist on 09/01/23 and his psychiatrist made a referral to a neurologist, but an appointment had not been scheduled.
-She saw the resident on 09/06/23 and provided the resident with his monthly funds.
-On 09/06/23, the resident told her that he did not want to stay at the facility any longer.
-She left the resident at the facility on 09/06/23 at 11:13am and the resident left the facility on 09/07/23 at 1:16pm.
-The resident was admitted to an inpatient behavioral health hospital on 09/07/23 and was still in the hospital.
-She had spoken with the discharge coordinator at the inpatient behavioral health hospital regarding the resident's need for an increase LOC due to his frequent elopements and need for increased supervision.

Interview with the Administrator/owner on 09/14/23 at 12:03pm revealed:
-The resident had a history of walking away from the facility unsupervised, he was manic and agitated at times; he would go in and out of the facility pacing and go to the backyard to smoke.
-The resident would try to be at the facility on the third or fourth of each month to get his check.
-When the resident left the facility, he would usually be gone for 4 to 5 days, he did not increase supervision of the resident.
-He would notify the residents legal guardian when he left the facility and attempt to find the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 19 resident in the community. -The resident was very talkative on 06/26/23, and wanted to know when his check would come in. -The resident walked away from the facility on 06/26/23 and the next day 06/27/23 he was hit by a vehicle when he was crossing a five lane highway. -He did not call local law enforcement about the resident walking away from the facility because he could not force the resident to stay at the facility, the resident left the facility often and he eventually returned to the facility. -He supervised the resident by observing him all day, but after five to ten minutes he would notice the resident had left the facility again. -He would try to talk with the resident to come back to the home when he spoke with him in the street, but the resident would continue walking and leave the facility. -The resident would call his legal guardian because she managed his money. -Sometimes the resident went to the homeless shelter; his legal guardian would go to the homeless shelter, pick him up and return him to the facility. -Sometimes the resident's legal guardian located the resident by calling the homeless shelter and she would call the Administrator/owner to go pick the resident up from the homeless shelter. -He was not able to physically restrain the resident when he wanted to leave, so he let him leave the facility. -He picked up the resident at the hospital after he was struck by a vehicle on 06/27/23. -The resident had a splint placed on his arm due to a broken wrist from the accident on 06/27/23. -He had not issued a discharge notice for the resident to a facility that could provide him with a higher LOC.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 20 Interview with the Administrator/owner on 09/15/23 at 1:50pm revealed: -Residents were not allowed to leave the facility by themselves because they all required supervision. -Around the middle of August 2023, Resident #2 received his allowance of $70.00. -He was unable to locate Resident #2 in the home. -He went outside to the backyard to ask the other residents of the facility if they had seen Resident #2. -The residents in the backyard informed him that Resident #2 was next door on the back porch. -He observed Resident #2 on the back porch of a home next door with a male from the neighborhood. -He asked the male resident from the neighborhood to leave the property. -He observed Resident #2 place something in his pants pocket. -He asked the resident to remove any items from his pants pocket and the resident removed a crack pipe from his pants pocket. -The crack pipe did not feel hot, and he disposed of the crack pipe in the facility outside trash container. -The resident would not tell him if he smoked the crack pipe or not, however he observed that the resident was very lethargic and had "slowed down considerably" physically. -He asked the resident to come into the facility, the resident was compliant and went to his bedroom and took a nap. -He notified the resident's psychiatrist by telephone that the resident possibly smoked crack earlier in the day. -He notified the residents legal guardian with the department of social services (DSS). -The resident was fine after he woke up from his	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 21	C 243		

nap.
-He spoke with the resident's legal guardian at DSS to inform her of the challenges he had with the resident leaving the facility without a responsible party with him.
-The legal guardian had spoken with the resident's psychiatrist and his discharge planner to request a higher level of care.

Telephone interview with Resident #2's psychiatrist on 09/14/23 at 2:47pm revealed:
-He provided outpatient psychiatry services to Resident #2.
-The resident was oriented, but the resident was non compliant and did not follow directions.
-The resident could be defiant and not follow the rules at the facility.
-The resident had a history of eloping from the facility, the resident would just walk away when he felt like it and did not feel he needed supervision.
-The resident needed one on one supervision for his safety due to his illogical thinking.
-The resident would benefit from a higher level of care if it provided him with one on one supervision.
-He was notified by the Administrator/owner that the resident was struck by a vehicle and had a broken wrist.
-The resident did not have logical thinking; the resident had shared with him that if he crossed the highway and got hit by a vehicle, he would get money from suing them.
-The resident had a borderline intelligence quotient (IQ), (borderline IQ means an individual's cognitive ability is below average, which can cause difficulty adapting to changes, learning new skills, living independently, and managing emotions) he had attempted to schedule the resident for testing at the hospital however the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 243	Continued From page 22 resident had refused to come to the appointments. _____ The facility failed to provide supervision for a resident that had a history of wandering from the facility for several days at a time before returning to the facility, walking into a moving vehicle on a five lane highway resulting in a broken wrist and broken rib, and the Administrator/owner finding a crack pipe in the resident's pocket when the resident was on the back porch of the home next door (#2). The failure resulted in serious physical harm and serious neglect and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/14/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2023.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a resident who was newly admitted (#3) attended an appointment with a mental health provider following a discharge from an inpatient behavioral health hospitalization, the resident had multiple	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 246	Continued From page 23	C 246		

elopements from the facility and was unable to be located after he left a local emergency department (ED) on 08/01/23 and was not located until 08/08/23.

The findings are:

Review of Resident #3's current FL-2 dated 07/06/23 revealed diagnoses included diabetes, bipolar disorder, major depression, and schizophrenia.

Review of Resident #3's record revealed the resident did not have a Resident Register.

Review of Resident #3's record revealed the resident did not have a Care Plan.

Review of a discharge summary for Resident #3 dated 07/18/23 revealed:
-The resident was discharged to the facility on 07/18/23 at 1:30pm from an inpatient behavioral health hospital with a diagnosis of schizophrenia, bipolar disorder, and major depression.
-The resident had a follow up appointment scheduled with an outpatient mental health provider on 07/20/23.

Telephone interview with a medical receptionist at an outpatient mental health clinic on 09/18/23 at 1:30pm revealed:
-The hospital had scheduled Resident #3 for a follow up appointment on 07/20/23 at 1:30pm.
-The purpose of the follow up appointment was to complete his registration with the outpatient mental health clinic and to see an outpatient therapist to complete a comprehensive clinical assessment.
-The resident did not come to the follow up appointment on 07/20/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 246	Continued From page 24 Telephone interview with Resident #3's legal guardian with DSS on 09/15/23 at 11:00am revealed: -Resident #3 had a diagnosis of schizoaffective disorder and could become easily agitated. -The legal guardian was on vacation from 07/31/23 to 08/07/23, when she returned from vacation on 08/07/23 -The Administrator/owner left her a voicemail on 08/01/23 regarding Resident #3 not following the facility rules and was leaving the facility unsupervised. -The legal guardian called the Administrator/owner of the facility on 08/07/23 to speak with Resident #3. -The Administrator/owner informed the legal guardian on 08/07/23 that the resident was no longer at the facility and that he had taken the resident to the local ED on 08/01/23 because the resident did not want to stay at the facility and wanted to go to the local ED. Review of a local police incident report dated 08/07/23 at 5:01pm revealed the adult services supervisor with the Department of Social Services (DSS) called to file a missing person report for Resident #3. Telephone interview with Resident #3 on 09/15/23 at 12:00pm revealed: -He was frustrated with the Administrator/owner because he did not want him to leave the facility to go to the convenience store. -He enjoyed going to the store and did not want to stay at the facility all day, so he walked to the store without asking for permission from the Administrator/owner. -He became upset with the Administrator/owner on 08/01/23 when he returned from a local	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 246	Continued From page 25	C 246		

convenience store because the Administrator/owner told him he could not eat dinner because he did not follow the rules of the facility.
-He asked the Administrator/owner to take him to the local ED because he wanted to go live somewhere else.
-The Administrator/owner dropped him off at the front entrance of the local ED, the resident left the local ED later that night and got a ride with a friend to a neighboring town.
-The resident's family member came to from another town to pick him up on 08/08/23 and he returned to his family member's home.
-He did not have any mental health appointments when he resided at the facility.

Interview with the Administrator/owner 09/15/23 at 1:50pm revealed:
-Resident #3 was admitted to the facility on 07/18/23 from an inpatient behavioral health hospital.
-He did not realize he had missed the resident's mental health appointment scheduled for 07/20/23.
-The appointment was listed in the resident's discharge summary from the inpatient behavioral health hospital, but he had overlooked it.
-He had scheduled the resident for a visit with the facility's psychiatrist on 08/10/23, but the resident demanded to go to the local ED on 08/01/23 and never came back to the facility.
-The resident could have benefited from attending his mental health follow up appointment on 07/20/23, his medications could have been adjusted to help him cope with a different environment since he was new to the facility.

_____

The facility failed to ensure a resident who was a new admission to the facility from an inpatient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 246	Continued From page 26 behavioral health hospital for schizophrenia, bipolar disorder, and major depression with orders to follow up with an outpatient mental health provider two days after discharge to complete a comprehensive clinical assessment. The resident became upset and frustrated with the Administrator because he was not permitted to go to the store and demanded he be taken to the local ED for discharge. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2023.	C 246		
C 301	10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services 10A NCAC 13G .0906 Other Resident Services (f) Visiting. (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator; (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home; (3) A signout register must be maintained for	C 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 301	Continued From page 27 planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews for 1 of 3 sampled residents, the facility failed to immediately notify local law enforcement when a resident eloped numerous times from the facility and the resident was missing from the facility 4-5 days at a time with his whereabouts were unknown (#2). The findings are: Review of the facility's missing resident policy revealed: -The facility had a curfew of 9:00pm. -In the event a resident did not return to the facility by 9:00pm, within 30 minutes the staff should respond immediately to try to locate the resident by searching the facility and grounds, call 911 and provide a description of the resident, name, age, picture of the resident and the name of the responsible party, time the resident was last seen, notify the responsible party, call for	C 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 301	Continued From page 28	C 301		

additional assistance, so that the other residents can be attended to, document the incident and the results of the incident.

1. Review of Resident #2's current FL-2 dated 01/26/23 revealed a diagnosis of schizoaffective disorder.

Review of Resident #2's Resident Register dated 01/13/23 revealed the resident was admitted to the facility on 01/13/23.

Review of Resident #2's current Care Plan dated 01/06/23 revealed:
-The resident had wandering behaviors, was verbally abusive and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.

Interview with the Administrator/owner on 09/14/23 at 12:03pm revealed:
-Resident #2 left the facility on 06/26/23 and did not return to the facility until 06/29/23.
-He did not call local law enforcement about the resident walking away from the facility because he could not force the resident to stay at the facility, the resident left the facility often and he eventually returned to the facility.
-The resident walked into a moving vehicle on 06/27/23.
-Local police notified him that the resident had walked into a moving vehicle and was at the local ED for treatment.
-He did not keep any progress notes on residents and only had a copy of the accident report.

Observation of the five lane highway where Resident #2's walked into a moving vehicle on 09/18/23 at 3:00pm to 3:05pm revealed:
-Resident #2 walked into a moving vehicle on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

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C 301	Continued From page 29	C 301		

five lane highway resulting in a broken wrist and broken rib.
-Observation of traffic on the five lane highway revealed the posted speed limit was 35 miles per hour.
-There were 18 vehicles that traveled east and west on the five lane highway within the five minute observation of the highway.
-Resident #2 walked to the five lane highway that was 0.7 miles away from the facility and the time required to walk 0.7 miles at an average pace was approximately 15 minutes away from the facility.

Second interview with the Administrator/owner on 09/14/23 at 12:03pm revealed:
-The resident had a history of walking away from the facility unsupervised.
-When the resident left the facility, he would usually be gone for 4 to 5 days.
-He would notify the residents legal guardian when he left the facility.
-He did not notify the Adult Home Specialist (AHS) with the local Department of Social Services (DSS), he only notified the resident's legal guardian.
-He had contacted the local police once to notify them that the resident's whereabouts were unknown, but they were not able to force the resident to stay at the facility.
-The resident's legal guardian returned him to the facility when she was able to locate him.
-The resident walked to a local soup kitchen and stayed at the train station downtown at times.
-He supervised the resident by observing him all day, but after five to ten minutes he would notice the resident had left the facility again.
-He would try to talk with the resident to come back to the home when he spoke with him in the street, but the resident would continue walking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 301	Continued From page 30	C 301		

and leave the facility.
-He was not able to physically restrain the resident when he wanted to leave, so he let him leave the facility.
-The resident did not want to stay at the facility, he felt the resident was street smart and would eventually return to the facility.

Third interview with the Administrator/owner on 09/18/23 at 11:00am revealed:
-Local law enforcement brought the resident back to the facility one time; he could not remember if he had notified the local police that the resident's whereabouts were unknown or if the local law enforcement just found him and returned him to the facility.
-When the resident left the facility, he did not go look for him because if the resident ran away from the facility, he would not go and pick up the resident because he knew the resident would not return to the facility with him.
-He only notified Resident #2's legal guardian when he left the facility.
-He did not realize that he needed to contact the AHS with the local DSS or local law enforcement when the resident's whereabouts were unknown.

Telephone interview with Resident #2 psychiatrist on 09/14/23 at 2:47pm revealed:
-He provided outpatient psychiatry services to Resident #2.
-The resident had a history of eloping from the facility, he would just walk away when he felt like it and the resident did not feel he needed supervision.
-The resident needed one on one supervision for his safety due to his illogical thinking.
-The resident did not have logical thinking; the resident's thought process was if he crossed the highway and got hit by a vehicle, he would get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 301	Continued From page 31 money from suing them. -The resident had a borderline intelligence quotient (IQ), (borderline IQ means an individual's cognitive ability is below average, which can cause difficulty adapting to changes, learning new skills, living independently, and managing emotions) he had attempted to schedule the resident for testing at the hospital however the resident had refused to come to the appointments. _____ The facility failed to notify local law enforcement immediately and the Adult Home Specialist with the Department of Social Services that Resident #2 was observed missing from the facility at times for up to 4-5 days when his whereabouts were unknown, and the resident was at a local homeless shelter, a local train station and walking a busy five lane highway where he walked into a busy street where he was struck by a vehicle which fractured his wrist and rib. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/14/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2023.	C 301		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 32	C 311		

and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#3) were treated with dignity and respect by failing to allow the resident access to telephone usage at a reasonable hour to communicate with a family member, free from exploitation related to a resident being asked to complete chores and being reprimanded if not completed, and free from neglect related to being left at a local emergency department (ED) without a proper discharge notice, and being denied food for leaving the facility unsupervised.

The findings are:

Review of Resident #3's current FL-2 dated 07/06/23 revealed diagnoses included bipolar disorder, major depression, and schizophrenia.

1. Telephone interview with Resident #3 on 09/15/23 at 12:00pm revealed:
-On 08/01/23, he left the facility and went to a local convenience store to purchase snacks and cigarettes for another resident that resided at the facility.
-When he returned from the convenience store it was dinner time.
-The Administrator/owner told him that since he did not follow the facility rules and left the facility that he was not allowed to eat dinner with the other residents and that he needed to go back to the convenience store if he wanted something to eat.
-He was angry that the Administrator/owner told him to go back to the convenience store to get his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 33	C 311		

dinner because he was out of money, and he was hungry.
-He told the Administrator/owner he did not want to live at the facility anymore and he wanted to go to the local ED.
-The Administrator/owner did not allow the resident to eat dinner, took the resident to the local ED and left him outside at the front entrance.
-He entered the local ED by himself.
-He told a nurse at the local ED that he was hungry and spoke with two family members by telephone to inform them that he was hungry.
-When he was at the local ED, he informed staff that he was hungry, and he received a hot meal from hospital staff.

Telephone interview with Resident #3's family member on 09/15/23 at 11:27am revealed:
-He received a telephone call from Resident #3 on 08/02/23 between 12:00am and 1:00am.
-The resident informed him that he told the Administrator/owner that he did not want to stay at the facility and that he wanted to go to the local ED.
-Resident #3 told him that on 08/01/23 he returned to the facility from a convenience store before dinner and sat down in the kitchen to eat with the other residents.
-The resident reported that after he sat down to eat dinner, the Administrator/owner told him he was not going to eat dinner with the other residents because he kept leaving the facility that he could go back to the convenience store to get his dinner.
-The resident informed him that the Administrator/owner took him in the facility van with the other residents and left him at the front entrance of the local ED on 08/01/23.
-Resident #3's informed his family member that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 34	C 311		

he was hungry when he was dropped off by the Administrator/owner at the local ED and had not eaten dinner.
-The family member spoke with a nurse at the local ED on 08/02/23 after 12:00am and she informed him that the resident was begging for food.
-The family member asked the nurse if the resident could be provided with a hot meal while he was at the local ED.
-He was upset that the Administrator/owner of the facility left the resident at the entrance of the local ED and "just dropped him off" because he needed supervision.

Interview with the Administrator on 09/14/23 at 9:00am revealed:
-Resident #3 was admitted to the facility on 07/18/23 and had a history of leaving the facility unsupervised.
-He had spoken with the resident several times to remind him that he was not allowed to leave the facility unsupervised.
-The resident walked off from the facility several times on 08/01/23.
-When the resident returned to the facility on 08/01/23 he reminded the resident that he was not allowed to leave the facility without supervision.
-The resident became angry and told the Administrator/owner that he did not want to live at the facility and wanted to be taken to the local ED.
-He asked all the residents to get into the facility van and transported the resident to the local ED.
-He did not escort the resident into the local ED, he did not speak with staff at the local ED, he did not take any of the resident's paperwork or his medications.
-He did not take any of the resident's medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 35	C 311		

to the local ED because he thought the resident's legal guardian would come to the facility later in the week to pick up his medications.

A second interview with the Administrator on 09/14/23 at 12:35pm revealed the Administrator/owner did not get out of the facility van to take the Resident #3 into the local ED because "he was on his own,

2. Telephone interview with Resident #3 on 09/15/23 at 12:00pm revealed:
-He was only allowed to use the facility telephone on Fridays.
-He had to ask the Administrator/owner on Fridays if he could call his family member.
-He wanted to speak with his family members more often than one day a week but was only allowed to use the facility telephone on Fridays.
-His family member informed him that the Administer/owner told her she could only call him once a month.
-He missed talking with his family members and wished he could call his family member a few times a week.
-He was sad and felt bad that he could not talk to his family members except for Friday's.

Telephone interview with a family member of Resident #3 on 09/15/23 at 11:40am revealed:
-One of the resident's family members informed him that the Administrator/owner told the family member that she was only allowed to speak to the resident by telephone once a month and could only visit the resident once a month.
-He called the Administrator/owner to ask about the family member being told that she could only call and visit the resident once a month.
-He reported that the Administrator/owner hung the telephone up on him when he asked about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 36	C 311		

the resident receiving telephone calls and visits once a month.
-He contacted the local police after the Administrator/owner hung the telephone up on him because he was unable to speak to Resident #3 and wanted to be sure the resident was safe.
-The local police contacted him by telephone and informed him that the resident was safe and did not have any complaints.

Interview with the Administrator/owner 09/15/23 at 1:50pm revealed:
-Residents could use the facility telephone to take calls anytime someone called them.
-Residents could make outgoing telephone calls every Friday.
-If a resident wanted to make a telephone call on a day other than Friday, he would try to determine why the resident needed to make the telephone call and allow them to make a call even if it was not on a Friday.
-He was not aware that Resident #3 wanted to call his family members other than on Fridays.

3. Telephone interview with Resident #3 on 09/15/23 at 12:00pm revealed:
-The Administrator/owner asked him to complete chores at the facility.
-He expected the resident to wash dishes after breakfast each morning.
-Some residents did not complete their chores, but he reminded residents that they were all expected to help with chores at the facility.
-The resident felt that he had to complete any chores the Administrator/owner asked him to complete because if he did not complete the chores, the Administrator/owner became angry, cursed at him, and made him feel guilty if he did not complete the chores.
-He cut the grass in the front yard or back yard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 37	C 311		

with a push mower when the Administrator/owner asked him to cut grass.
-He told the Administrator/owner several times that he did not want to cut the grass because it was too hot, but the Administrator/owner told him to go "do it now" so he cut the grass.

Interview with the Administrator/owner 09/15/23 at 1:50pm revealed:
-He had asked Resident #3 to help wash dishes, clean the resident's shared bathroom, and cut grass.
-He expected all residents to assist with chores in the facility since it was their home.
-All residents took turns cutting the grass, he would usually cut the back yard and a resident would cut the front yard.
-Resident #3 never became upset with him when he asked him to complete chores.

_____

The facility failed to ensure the residents were free from neglect when the Administrator/owner failed to ensure a resident's safety and rights (#3) and took the resident to a local ED and left him at the entrance of the local ED. The Administrator/owner failed to provide the residents with access to a telephone to contact their family member at a reasonable hour to communicate causing the resident mental distress because he was only able to contact his family member one day a week by telephone, and free from exploitation when the Administrator/owner required the resident to perform various chores including cutting the grass at the facility with a push mower when the resident complained it was too hot. The facility's failure resulted in serious exploitation and neglect of a resident and constitutes a Type A1 Violation.

_____

The facility provided a plan of protection in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 311	Continued From page 38 accordance with G.S. 131D-34 on 09/15/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2023.	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents (#1, #2, and #3) medications used to treat schizoaffective disorder (#1, #2), and diabetes (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 08/16/23 revealed diagnosis was schizoaffective disorder. Review of Resident #1's medication order dated 08/16/23 revealed there was an order for Fluoxetine 20mg, take one tablet at bedtime	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 39 (Fluoxetine is a medication used to treat depression). -The resident's FL2 had an order for Fluoxetine 20mg, take one tablet at bedtime. Review of Resident #1's September 2023 medication administration record (MAR) revealed: -There was an entry for Fluoxetine 20mg, take one tablet at bedtime, 7:00pm. -There was no documentation Fluoxetine 20mg was administered from 09/01/23 to 09/14/23, -On the front of the MAR for 09/01/23 to 09/14/23, there were no initials in the box with no designated time. -There was a handwritten note on the MAR that the medication was discontinued. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed: -The pharmacy had not dispensed Resident #1's Fluoxetine 20mg for the month of September 2023. -The Administrator/owner should have called the contracted pharmacy to ask if the medication had been delivered or was scheduled to be delivered. -Suddenly stopping Fluoxetine could cause the resident to experience increased irritability and increased agitation. Interview with the Administrator/owner on 09/18/23 at 10:05am revealed: -He wrote discontinue on Resident #1's September 2023 MAR because he thought the medication had been discontinued. -He could not find a discontinue order for Fluoxetine 20mg in the primary care providers (PCP) or psychiatrist orders. -There was not a discontinue order for Fluoxetine 20mg.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 40	C 330		

-The resident was scheduled for his first appointment with his psychiatrist 08/10/23.
-He did not know why he wrote discontinue on Resident #1 September 2023 MAR for Fluoxetine 20mg.
-Resident #1 did not receive Fluoxetine 20mg from 09/01/23 to 09/14/23.
-The facility's contracted pharmacy had not sent Resident #1's bubble pack medication card for Fluoxetine 20mg and he assumed the medication had been discontinued.
-He should have contacted the facility's contracted pharmacy when he realized that Fluoxetine 20mg was not on hand to administer to the resident.
-He did not know how he overlooked Resident #1 not receiving Fluoxetine 20mg from the facility's contracted pharmacy.

Telephone interview with Resident #1's psychiatrist on 09/19/23 at 4:01pm revealed the resident was scheduled for his first visit with the psychiatrist on 08/10/23 and the psychiatrist had not seen the resident.

2. Review of Resident #2's current FL-2 dated 01/26/23 revealed diagnosis was schizoaffective disorder.

a. Review of Resident #2's medication order dated 01/26/23 revealed there was an order for Benztropine 1mg, take one tablet twice a day (Benztropine is used to treat involuntary movements due to the side effects of certain antipsychotic medications).

Review of Resident #2's July 2023 MAR revealed:
-There was an entry for Benztropine 1mg tablet, take one table twice a day.
-There was no documentation Benztropine 1mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 41	C 330		

tablet was administered at 7:00am and 7:00pm on 07/05/23 and 07/06/23.
-There was no documentation on the MAR for the reason Benztropine 1mg was not administered.

Review of Resident #2's psychiatrist order dated 08/10/23 revealed there was an order to increase Benztropine 2mg, take one tablet twice day.

Review of Resident #2's August 2023 MAR revealed:
-There was an entry for Benztropine 1mg tablet, take one table twice a day scheduled for administration and 7:00am and 7:00pm.
-There was documentation Benztropine was administered at 7:00am and 7:00pm from 08/01/23 through 08/14/23.
-There was no entry on the MAR for Benztropine 2mg twice daily, which should have started on 8/10/23.
-There was no documentation Benztropine 2mg tablet was administered at 7:00pm on 08/14/23 and 7:00am and 7:00pm from 08/15/23 through 08/28/23.

Review of Resident #2's September 2023 MAR revealed:
-There was an entry for Benztropine 2mg tablet, take one tablet twice a day, scheduled for administration at 7:00am and 7:00pm.
-There was documentation Benztropine 2mg tablet was administered at 7:00am from 09/01/23 to 09/07/23.
-There was no documentation Benztropine 2mg tablet was administered at 7:00pm from 09/01/23 to 09/07/23.
-There was no documentation on the MAR for the reason Benztropine 1mg was not administered for the evening dose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 42 Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed: -The pharmacy dispensed medications for residents on a 30-day cycle. -4 tablets of Benztropine 1mg were dispensed on 06/05/23. -62 tablets of Benztropine 1mg were dispensed on 07/02/23. -56 tablets of Benztropine 2mg were dispensed on 08/10/23. -8 tablets of Benztropine 1mg were dispensed on 08/30/23. b. Review of Resident #2's record revealed an order from the resident's psychiatrist on 06/05/23 for Divalproex ER 500mg tablet, take one every morning and Divalproex ER 500mg, take two tablets every evening. (Divalproex is a medication used to treat bipolar disorder). Review of Resident #2's June 2023 MAR revealed: -There was an entry for Divalproex ER 500mg tablet, take one tablet every morning, scheduled at 7:00am. -There was an entry for Divalproex ER 500mg tablet, take two tablets at bedtime, scheduled at 7:00pm. -There was no documentation Divalproex ER 500mg tablet was administered 06/11/23 at 7:00am. -There was no documentation Divalproex ER 500mg tablet (two tablets 1,000mg) was administered at 7:00pm on 06/03/23, 06/07/23, 06/09/23, 06/10/23, 06/11/23 and 06/27/23. -There was no documentation on the MAR for the reason Divalproex ER 500mg was not administered.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 43 Review of Resident #2's psychiatrist order dated 07/12/23 revealed there was an order for Divalproex ER 500mg tablet, take two tablets twice a day. Review of Resident #2's July 2023 MAR revealed: -There was an entry for Divalproex ER 500mg tablet, take one tablet every morning, scheduled at 7:00am. -There was an entry for Divalproex ER 500mg tablet, take two tablets at bedtime, scheduled at 7:00pm. -There was no documentation Divalproex ER 500mg tablet was administered at 7:00am on 07/05/23 and 07/06/23. -There was no documentation Divalproex ER 500mg tablet (two tablets 1,000mg) was administered at 7:00pm on 07/05/23 and 07/06/23. -There was a handwritten note written on the original entry dated 07/11/23, "Take Two". Review of Resident #2's August 2023 MAR revealed: -There was an entry for Divalproex ER 500mg tablet, take two tablets twice a day. -There was no documentation Divalproex ER 500mg two tablets were administered at 7:00pm on 08/14/23 and 7:00am and 7:00pm from 08/15/23 through 08/28/23. -There was no documentation on the MAR for the reason Divalproex ER 500mg was not administered. Review of Resident #2's September 2023 MAR revealed there was an entry for Divalproex ER 500mg tablet, take two tablets twice a day and administered as ordered.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 44	C 330		

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed:
-The pharmacy dispensed medications for residents on a 30-day cycle.
-6 tablets of Divalproex ER 500mg were dispensed on 06/05/23.
-93 tablets of Divalproex ER 500mg were dispensed on 07/02/23.
-120 tablets of Divalproex ER 500mg were dispensed on 07/11/23.
-62 tablets of Divalproex ER 500mg were dispensed on 08/02/23.

d. Review of Resident #2's record revealed an order from the resident's psychiatrist on 06/05/23 for
Haloperidol 10mg tablet, take one tablet twice a day (Haloperidol is an antipsychotic medication used to treat schizophrenia).

Review of Resident #2's psychiatrist order dated 07/12/23 revealed there was an order for Haloperidol 10mg tablet, take two tablets twice a day.

Review of Resident #2's July 2023 MAR revealed:
-There was an entry for Haloperidol 10mg tablet, take one tablet twice a day scheduled for administration at 7:00am and 7:00pm.
-There was no documentation Haloperidol 10mg tablet was administered at 7:00am and 7:00pm on 07/05/23 and 07/06/23.
-There was no documentation on the MAR for the reason Haloperidol 10mg was not administered to Resident #2.
-There was a handwritten note written on the original entry dated 07/11/23, "Take Two".

Review of Resident #2's August 2023 MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 45	C 330		

revealed:
-There was an entry for Haloperidol 20mg tablet, one tablet twice a day.
-There was no documentation Haloperidol 20mg tablet, one was administered at 7:00pm on 08/14/23 and 7:00am and 7:00pm from 08/15/23 through 08/28/23.
-There was no documentation on the MAR for the reason Haloperidol 20mg was not administered to Resident #2.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed:
-The pharmacy dispensed medications for residents on a 30 day cycle.
-62 tablets of Haloperidol 10mg were dispensed for Resident #2 on 07/02/23.
-54 tablets of Haloperidol 20mg were dispensed for Resident #2 on 07/11/23.
-The Administrator/owner should have called the pharmacy after they only received a four-day supply of Haloperidol 10mg on 06/05/23.

e. Review of Resident #2's record revealed an order from the resident's psychiatrist on 06/05/23 for
Clonazepam 1mg, take two tablets every night (Clonazepam is a medication used to treat anxiety).

Review of Resident #2's July 2023 MAR revealed:
-There was an entry for Clonazepam 1mg, take two tablets every night.
-There was no documentation Clonazepam 1mg tablet two tablets was administered at 7:00pm on 07/05/23 and 07/06/23.

Review of Resident #2's August 2023 MAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 46 -There was an entry for Clonazepam 1mg, take two tablets every night. -There was no documentation Clonazepam 1mg, take two tablets was administered at 7:00pm on 08/14/23 and 7:00am and 7:00pm from 08/15/23 through 08/28/23. -There was no documentation on the MAR for the reason Haloperidol 20mg was not administered to Resident #2. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed: -The pharmacy dispensed medications for residents on a 30-day cycle. -42 tablets of Clonazepam 1mg were dispensed on 06/15/23. -54 tablets of Clonazepam 1mg were dispensed on 07/11/23. -62 tablets of Clonazepam 1mg were dispensed on 08/02/23. _____ Interview with the Administrator/owner on 09/15/23 at 1:50pm revealed: -The resident often walked away from the facility and was not there to take his medications. -The resident was noncompliant with taking medication because he left the facility often. -Resident #2 eloped from the facility frequently and he forgot to document that the resident was not in the facility to receive his medication. -Resident #2 was admitted to an inpatient behavioral health hospital on 09/07/23. -He was not sure if Resident #2 not receiving his medication as prescribed caused him to be admitted to an inpatient behavioral health hospital because he took his medication sporadically. Telephone interview with Resident #2 psychiatrist on 09/19/23 at 4:01pm	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 47	C 330		

-Resident #2 did not have much insight and was noncompliant at times.
-The resident was not always compliant with taking his medications because he left the facility without permission often and would stay in the community for several days.
-If the resident was more complaint with taking his medications, he may not be wander from the facility as often.
-He was not aware of all of the medications Resident #2 had not received.
-When the resident did not receive his scheduled medication he could experience increased paranoid delusions, increased illogical thinking, increased anxiety, and agitation.

3. Review of Resident #3's current FL-2 dated 07/06/23 revealed:
-Diagnoses included diabetes, bipolar disorder, major depression, and schizophrenia.
-There was an order for Lispro 4 units subcutaneously before meals (Lispro is an insulin used to treat high blood sugars).

Review of the legal guardian's admission paperwork for resident #3 revealed he was admitted to the facility on 07/18/23.

a. Review of a physician order for Resident #3's dated 07/18/23 revealed there was an order for Insulin Lispro Kwik Pen 100 unit/ml administer 4 units subcutaneously before meals.

Review of Resident #3's July 2023 medication administration record (MAR) revealed:
-There was an entry for Insulin Lispro Kwik Pen, there was no dose to be administered and no scheduled times for administration.
-On 07/19/23, there was documentation of administration but time nor dose could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 48	C 330		

determined.
-There was no documentation that Insulin Lispro Kwik Pen 4 units were administered with meals from 07/20/23 to 07/31/23.
-There was no documentation for the reason Lispro 4 units was not administered.

Observation of medications on hand on 09/18/23 at 9:30am revealed Insulin Lispro was not available.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed:
-The pharmacy dispensed medications for residents on a 30-day cycle.
-Resident #3 was admitted to the pharmacy system on 07/21/23.
-Insulin Lispro was dispensed for Resident #3 to the facility on 07/21/23.

Interview with the Administrator on 09/18/23 at 1:45pm revealed:
-He did not receive a MAR from the facility's contracted pharmacy after Resident #3 was admitted on 07/18/23.
-The resident's medications were delivered to the facility on 07/19/23 and he used the prescription that came with the resident when he was admitted to the facility and completed a handwritten MAR for the resident.
-He took Resident #3's fingerstick blood sugar (FSBS) when he was at the facility prior to meals but did not document his FSBS readings in a log or the MAR.
-He did not remember the physician's order to administer 4 units of insulin before meals, but he used the same type of insulin (Lispro).
-He checked Resident #3's FSBS before meals and helped the resident administer his insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 49	C 330		

based on the sliding scale insulin (SSI) he (the Administrator/owner) used for himself.
-The Administrator/owner used a SSI for himself to administer 20 units of insulin if his FSBS was 300 or higher and to administer himself 10 units of insulin if his FSBS was 200 or below, and he applied this sliding scale to Resident #2.
-If the resident's FSBS was 300 or higher he dialed the resident's insulin pen to 20 units.
-If the resident's FSBS was 200 he dialed the resident's insulin pen to 10 units.
-The resident was able to inject himself with the insulin pen.
-He did not keep documentation of how many units of insulin he dialed on the insulin pen for Resident #3 and when the resident injected himself with the insulin.
-He placed one initial on the MAR on 07/19/23 to show insulin was administered, however he did not know why he did not put the number of units administered.
-He did not know why he did not document on 07/19/23 through 07/31/23 how many units of insulin Resident #3 received.
-He knew should have documented on the MAR, but he just overlooked keeping up with the documentation on the MAR.

b. Review of Resident #3's FL-2 dated 07/06/23 revealed there was an order for Metformin 500mg, take before breakfast and before dinner (Metformin is a medication used to treat high blood glucose).

Review of a physician order for Resident #3's dated 07/18/23 revealed there was an order for Metformin 1,000mg tablet, take twice a day.

Review of Resident #3's July 2023 MAR revealed:
-There was an entry for Metformin 500mg tablet,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 50	C 330		

there was no strength or dose or time the medication should be administered.
-On 07/19/23, there was documentation of administration, but time nor dose or strength could be determined.
-There was no documentation that Metformin 500mg was administered from 07/20/23 to 07/31/23.

Observation of medications on hand on 09/18/23 at 9:30am revealed there was no Metformin 500mg or Metformin 1000mg for Resident #3.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/23 at 4:40pm revealed:
-The pharmacy dispensed medications for residents on a 30-day cycle.
-Resident #3 was admitted to the pharmacy system on 07/21/23.
-Metformin was dispensed for Resident #3 to the facility on 07/21/23.

Interview with the Administrator on 09/18/23 at 1:45pm revealed:
-He did not receive a MAR from the facility's contracted pharmacy after Resident #3 was admitted on 07/18/23.
-The resident's medications were delivered to the facility on 07/19/23 and he used the prescription labels on the medication bubble pack to complete a handwritten MAR for Resident #3.
-He did not realize that he wrote the incorrect dose of Metformin on Resident #3's MAR.
-He thought he wrote Metformin 500mg tablet, take one tablet before breakfast and take one tablet before dinner, when he should have written Metformin 1,000mg tablet, take one tablet before breakfast and take one tablet before dinner.
-He placed one initial on the MAR on 07/19/23 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 330	Continued From page 51 show he administered Metformin; however, he did not know why he did not document his initials on the MAR when he administered the resident his Metformin after 07/18/23. -He had forgotten to document the resident's MAR when he administered the Metformin. _____ The facility failed to administer medications as ordered for 3 or 3 residents (#1, #2, and #3) used for schizoaffective disorder (#1) with the resident going 14 days without an antidepressant, a second resident with schizoaffective disorder and bipolar disorder going over 13 days without two antipsychotics, an anti-anxiety medication and an anti-tremor medication (#2) a third resident who did not receive an oral medication to manage his blood sugar for 11 days as well as being administered a sliding scale insulin according to the Administrators sliding scale insulin orders, rather than his own (#3). This failure placed the residents at risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2023.	C 330		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033014	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(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 444	Continued From page 52 incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to notify the county department of social services (DSS) for 1 of 3 (#2) residents after the resident sustained injuries from walking into a moving vehicle requiring an emergency department (ED) visit and receiving treatment a second time at the ED for pain related to the accident. The findings are: Review of the facility's undated policy on accidents and incidents revealed: -The facility will respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. -The facility will notify the local DSS, family or responsible person of any incident or accident resulting in the death of the resident or any incident resulting in injury to the resident requiring referral to an emergency evaluation, hospitalization, or medical treatment other than first aid. 1. Review of Resident #2's current FL-2 dated 01/26/23 revealed diagnoses included schizoaffective disorder. Review of Resident #2's Resident Register dated 01/13/23 revealed the resident was admitted to	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 444	Continued From page 53 the facility on 01/13/23. Review of Resident #2's current Care Plan dated 01/06/23 revealed: -The resident had wandering behaviors, was verbally abusive and had disruptive behaviors. -The resident was sometimes disoriented, forgetful and needed reminders. a. Review of a police report dated 06/27/23 at 1:08pm revealed: -Resident #2 collided with a vehicle on a five lane highway with a speed limit of 35 miles per hour. -Resident #2 attempted to cross the five lane highway when a vehicle was in the far right lane traveling east. -The resident ran toward the moving vehicle and struck the left side of the vehicle. Review of an after visit report from the local ED dated 06/29/23 revealed Resident #2 was seen for an automobile versus pedestrian accident, and was diagnosed with a closed fracture of the distal end of his right radius (a fractured wrist) and a closed fracture to one rib on the right side. b. Review of an after visit report from the local ED dated 07/06/23 revealed: -Resident #2 was diagnosed with homelessness, right wrist pain and rib pain on the right side. -The resident's right wrist pain was caused by poor healing of the wrist fracture. -The resident was provided with a split to wear to assist in the healing of his wrist fracture. Review of the Resident #2's record revealed that there was no record of an Incident and Accident (IA) report completed on 06/27/23 or 07/06/23. Interview with the Administrator/owner on	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 444	Continued From page 54 09/14/23 at 12:03pm revealed: -He did not complete an IA report for Resident #2 on 06/27/23 or 07/06/23. -He forgot that he needed to complete an IA report to send to the social worker at the local DSS. -He notified the resident's legal guardian who worked with a DSS office in another county. -He should have followed the facility's policy and notified the social worker at the local DSS of the resident's need for an ED evaluation.	C 444		