STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MORNING STAR SPECIAL CARE UNIT	**3017 DUNN ROAD FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey and Complaint Investigation on 03/12/24 to 03/13/24.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to dirty floors, shelves and walls in the walk-in cooler and ice buildup in the walk-in freezer. The findings are: Observation of the walk-in cooler on 03/12/24 at 9:39am revealed: -There was a black fuzzy substance on the right	D 283		

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wall and on a case of bottled water to the right of the door.
-The shelving on the right had black fuzzy build-up on the rungs where the food items were stored.
-There was a puddle of brownish colored water on the floor under the shelving on the left side of the unit.
-There was debris on the floor under the shelving with a case of water sitting in the debris.

Observation of the walk-in freezer on 03/12/24 at 9:41am revealed:
-There was ice build-up on the shelving to the left of the door that extended down to a box of food on the floor.
-The ice covered the ends of several packages of food items.
-The mound of ice build-up was approximately 4 to 5 inches long and was approximately 1 to 2 inches deep.

Review of the local Environmental Health Services (EHS) Inspection Report dated 02/12/24 revealed:
-The kitchen received a score of 95.
-The walk-in freezer had ice build-up.

Interview with the facility's cook on 03/13/24 at 10:00am revealed:
-All cooks were responsible for cleaning the walk-in cooler and freezer.
-The walk-in cooler and freezer were cleaned almost nightly, if they had time.
-There was not much of a cleaning schedule.
-He was informed of the standing water and black substance located in the walk-in cooler yesterday (03/12/24).
-The standing water in the walk-in cooler was from condensation in the unit which occurred

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when it was warm outside.
-He believed the black substance located in the walk-in cooler was grease.
-The walk-in cooler was cleaned yesterday.
-Prior to yesterday's cleaning, he cleaned the walk-in cooler Saturday or Sunday night (03/09/24 or 03/10/24).
-He did not notice standing water or the black substance in the walk-in cooler when he cleaned it.
-He may have spilled something in the walk-in cooler and did not notice it.
-The ice in the walk-in freezer was from condensation and he removed it three times a week.
-The local EHS advised the ice was normal and they needed to keep it clean.
-He went in the walk-in freezer every now and then and broke the ice up and threw it away.
-All 4 cooks checked behind each other and told each other when things were not clean.
-The Kitchen Manager (KM) and the Owner checked behind them, but he was unsure how often they checked.

Interview with the KM on 03/13/24 at 10:15am revealed:
-She was responsible for following up to ensure the kitchen staff cleaned the walk-in cooler and freezer.
-They tried to clean the walk-in cooler and freezer by the week or as needed; there was no set cleaning schedule.
-The maintenance crew did a deep cleaning of the walk-in cooler and freezer once per month and they normally used a pressure washer.
-A deep cleaning of the walk-in cooler and freezer was done approximately 2 months ago.
-They did not keep a cleaning log.
-EHS conducted an inspection in February 2024,

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and she thought that was the last time the walk-in cooler and freezer were cleaned.
-EHS conducted a re-inspection on 02/12/24.
-She was not aware of the black substance in the walk-in cooler until the cook informed her yesterday.
-She had the walk-in cooler cleaned and some items thrown out yesterday.
-She was unsure what caused the puddle of water on the floor of the walk-in cooler.
-There was a pipe in the walk-in freezer that had been leaking for about two weeks and that leak was causing the ice to build up.
-A maintenance appointment to fix the leaking pipe had not been scheduled.
-There was no reason for not following up on the leaking pipe sooner; they just did not get to it yet.
-She read the sanitation report from EHS.

Telephone interview with the Administrator on 03/13/24 at 12:09pm revealed:
-The KM handled the cleaning of the walk-in cooler and freezer.
-She was not aware of the black substance found in the walk-in refrigerator or the ice buildup found in the walk-in freezer.
-She expected the walk-in cooler and freezer to be cleaned daily.
-Extra staff were assigned for deep cleaning at least once per month.
-There was no cleaning schedule and cleaning was done as needed.
-She really did not look at the EHS sanitation report because she left that to the other Owner and KM.
-She did not know why the walk-in cooler and freezer had not been serviced.
-Maintenance would be better able to answer questions regarding servicing of the walk-in cooler and freezer.

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Interview with the facility Owner on 03/13/24 at 2:00pm revealed:
-The kitchen staff were responsible for cleaning the walk-in cooler and freezer.
-He and the KM were responsible for ensuring that the walk-in cooler and freezer were cleaned by the kitchen staff.
-They tried to do extra cleaning once per month.
-Cleaning of the walk-in cooler and freezer was done about 3 to 4 weeks ago, approximately a week before the EHS inspection.
-There was a cleaning schedule at one time, but he was not sure how long ago and he did not know if there was a current cleaning schedule.
-He was not aware of the black substance found in the walk-in cooler until today.
-The drainpipe in the walk-in freezer came apart and that was what caused the ice buildup.
-He did not look at the EHS sanitation report but gave the report to the Maintenance Director (MD).
-The MD was responsible for making sure the walk-in cooler and freezer were working properly.

Interview with the facility's MD on 03/13/24 at 2:20pm revealed:
-There was no current cleaning schedule for the walk-in cooler and freezer, and staff cleaned as needed
-Staff tried to clean the walk-in cooler and freezer every 2 to 3 months.
-He was responsible for checking behind the kitchen staff to make sure the cleaning had been done.
-He had not noticed the black substance or puddle of water in the walk-in cooler prior to yesterday as he had been out for 2 weeks.
-He cleaned the walk-in cooler yesterday and sealed the pipe in the walk-in freezer, so the ice would not build up again.

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D 283	Continued From page 5 -He read the EHS sanitation report. Attempted telephone interview with the local EHS on 03/13/24 at 12:00pm and 4:10pm was unsuccessful.	D 283		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews and record reviews, the facility failed to ensure residents were protected and free from abuse by Staff A who was witnessed by other staff dragging a resident backwards in a seated position down the hallway by her arms. The findings are: Review of Resident #1's current FL-2 dated 11/28/23 revealed: -Diagnoses included dementia Hashiamto's encephalopathy, and hypothyroidism. -She was ambulatory with the use of a rollator. -The recommended level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 11/28/23. Review of the facility's video footage dated	D 338		

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02/29/24 at 9:15pm revealed:
-Resident #1 was dragged backwards down the hallway in a seated position by Staff A who held on to Resident #1's arms as she dragged the resident at least 45 feet.
-A male staff witnessed Staff A dragging Resident #1 but did not intervene.
-Once Staff A stopped dragging Resident #1, the male staff assisted Resident #1 to her feet.
-A third staff (female) came into view on the video and assisted the male staff with Resident #1 while Staff A walked back down the hallway.

Review of Staff A's timecard revealed she had clocked out at 9:45pm on 02/29/24 and did not work on 03/01/24.

Review of the Facility Manager's file for the incident revealed:
-The Facility Manager was notified on 03/01/24 at 8:30pm of the incident.
-She contacted the County Sheriff's Department to report the incident on 03/01/24 at 8:45pm.
-She called Resident #1's Power of Attorney (POA) and explained the incident involving the resident and the employee.
-On 03/01/24 at 9:53pm, the Sheriff's Department officer arrived and filed a report.
-On 03/05/24, the five-day working report was faxed to the Division of Health Care Personnel Registry and the county Department of Social Services.
-On 03/05/24, a copy of the police report was obtained.
-On 03/05/24, the video was sent to the Sheriff's Detective covering the case.

Telephone interview with Resident #1's Power of Attorney on 03/13/24 at 1:52pm revealed:
-She was notified Thursday night (03/01/24) by

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the facility manager that her family member was hurt by an employee.
-She was told by the Facility Manager that the Sheriff's Department was contacted.
-She was told that the staff was terminated.
-Her family member, Resident #1, was taken to the hospital.
-She was told by the Sheriff's Department that the employee was charged with a felony and was arrested on Friday (03/02/24).

Interview with a resident on 03/13/24 at 6:15pm revealed he did not remember the details of the incident.

Telephone interview on 03/14/24 at 2:39pm with female staff member who was seen on the video footage as a witness revealed:
-She heard a commotion and saw Staff A holding Resident #1 by her arms and dragging her down the hallway.
-The other two PCAs helped get Resident #1 up and down to her room.
-She had worked at the facility for 2 days and seeing that incident shook her up.
-She did not know all the staff or residents by name yet.
-The next day, after she told the Medication Aide Supervisor about the incident was her last day working at the facility.
-The supervisor was giving her assignment for that day 03/01/24, so it had to be around 3:00pm when she informed her of the incident which occurred on 02/29/24.
-She was afraid to say anything after she saw how Staff A had treated the resident.

Review of Staff A's personnel record revealed:
-Staff A was hired as a Housekeeper on 05/11/23.
-Staff A completed the 80-hour personal care aide

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training on 10/10/23.

Interview with a personal care aide (PCA) seen on the video footage on 03/13/24 at 4:15pm revealed:
-She was hired as a PCA about 4 weeks ago.
-She worked the second shift on 02/29/24.
-She heard a lot of noise in the hallway and turned to see what was going on and noticed Resident #1 sitting on the floor.
-She walked up to Resident #1 and assisted another PCA in helping her up from off the floor.
-She and the PCA escorted Resident #1 to her room.
-She helped Resident #1 prepare for bed by helping her change into her night clothes.
-She checked for bruises on Resident #1 arms and legs as she assisted with putting on Resident #1's night clothes but did not notice any bruises.
-She did not know why Resident #1 was on the floor.
-Resident #1 was not making any sounds when she was on the floor.
-She did not know the exact time of the incident but thought it occurred around 8:00pm to 10:00pm.
-She informed the medication aide (MA) that Resident #1 was observed sitting on the floor.
-She did not learn of Resident #1 being dragged down the hallway by Staff A until she arrived to work on 03/01/24.
-She had not received any training on reporting abuse and neglect but was given information during her orientation.

Interview with a 2nd PCA on 03/12/24 at 4:34pm revealed:
-She worked in the laundry room during the 2nd shift on 02/29/24.
-Staff A worked as a PCA on 02/29/24.

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-She did not learn about the 02/29/24 incident until she returned to work on 03/11/24 from another PCA.
-She had training on reporting abuse and neglect and if she witnessed the incident she would have reported the issue to the Administrator or the MA on duty immediately.

Interview with a 3rd PCA seen on the video footage on 03/12/24 at 4:46pm revealed:
-He worked the second shift on 02/29/24.
-He witnessed Staff A dragging Resident #1 down the hall by both of Resident #1's arms and her butt on the floor.
-He walked up to Resident #1 and helped her off the floor with the assistance from another PCA.
-He and the other PCA escorted Resident #1 to her room.
-He did not report the incident to the MA on duty because at the time of the incident the MA was not in the office, and he was busy with trying to get the other residents ready for bed and it had slipped his mind.
-The incident occurred after 5:00pm on 02/29/24 but he was not sure of the exact time.
-He was not sure if Staff A completed her shift because he did not know when she left for the evening.
-He did not learn of the full story until he returned to work on 03/02/24.
-He had completed trainings on reporting abuse and neglect of the residents.

Interview with a MA on 03/13/24 at 6:14pm revealed:
-She did not work on 02/29/24.
-She was informed from the PCA that she witnessed Staff A dragging Resident #1 down the hallway by both of Resident #1's arms.
-She immediately called the Resident Care

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Coordinator (RCC) after speaking with the PCA and reported the incident to the RCC.
-She worked with Staff A during the times when she was assigned to work in housekeeping but not as a PCA.
-She received training on reporting abuse and knew to report the incident to her supervisor immediately.

Interview with a 2nd MA on 03/13/24 on 8:08pm revealed:
-She worked as the MA Supervisor on 02/29/24.
-She was not aware of the 02/29/24 incident involving Staff A and Resident #1 until speaking with the Surveyor on 03/13/24.
-She received training on reporting abuse and was to report the any incidents of abuse and neglect to the RCC immediately.

Interview with the Facility Manager on 03/13/24 at 5:35pm revealed:
-She received a call from the RCC on the evening of 03/01/24 about the 02/29/24 incident.
-She came to the facility on 03/01/24 to speak with the MA Supervisor who had reported the incident to the RCC and the new PCA who witnessed the incident.
-She was informed of Staff A dragging Resident #1 down A hallway to the nurse's station by both her arms as Resident #1 was on her butt.
-She was able to review the camera and noticed the full incident.
-She called Staff A to discuss the incident.
-She was informed by Staff A that she grabbed Resident #1 and pulled her out of another resident room after Resident #1 tried to hit her when she went to escort Resident #1 out of the room.
-Staff A stated Resident #1 had tried to become physically aggressive with her.

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D 338	Continued From page 11 -Staff A had received training on abuse in May 2023. -Staff A worked in housekeeping and as a PCA when needed. -She informed Staff A that she would be placed on suspension pending an investigation. -Staff were to report any known or alleged abuse or neglect of residents immediately to the MA Supervisor and the MA Supervisor was to report the incident to the RCC who would report to the Facility Manager. ____________ The facility failed to ensure a resident was free of abuse when a resident was witnessed by staff being dragged down the hall, backwards, in a seated position by Staff A. Staff failed to intervene and staff did not immediately report the abuse to the Supervisor, RCC, Facility Manager or the Administrator. The failure to report placed residents in substantial risk of serious physical harm and constitutes a Type A2 Violation. ____________ The facility provided a plan of protection on 03/13/24 in accordance with G.S. 131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 12, 2024.	D 338		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for	D 463		

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admission to the special care unit:
(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.
(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.
(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure pre-admission screenings were completed prior to admission for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) residing in the Special Care Unit (SCU).

The findings are:

Review of the facility's current license effective 01/02/24 revealed the Special Care Unit (SCU) facility was licensed with a capacity of 44 residents.

Review of the facility's census on 03/12/24 revealed there were 33 residents in the Special Care Unit (SCU).

1. Review of Resident #1's current FL-2 dated 11/28/23 revealed:
-Diagnosis included dementia Hashiamto's, encephalopathy, and hypothyroidism.
-She was ambulatory with the use of a rollator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026066	A. BUILDING: ______ B. WING ______	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR SPECIAL CARE UNIT	**3017 DUNN ROAD FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 463	Continued From page 13	D 463		

-There was documentation that a Special Care Unit (SCU) was the recommended level of care.

Review of Resident #1's Resident Register revealed an admission date of 11/28/23.

Review of Resident #1's record revealed there was no Special Care Unit (SCU) pre-screening completed.

Telephone interview with Resident #1's Power of Attorney on 03/13/23 at 1:52pm revealed she was aware the facility was a Special Care Unit and that was where Resident #1's primary care provider (PCP) said Resident #1 needed to be placed due to her diagnosis of dementia.

Refer to interview with the Facility Manager on 03/12/24 at 4:15pm.

2. Review of Resident #2's current FL-2 dated 11/28/23 revealed:
-Diagnosis included vascular dementia, depression, diabetes, Parkinson's and deficiency, anemia, hypertensive urgency, congestive heart failure, and GERD.
-She was ambulatory with the use of a rollator.
-There was documentation that a Special Care Unit (SCU) was the recommended level of care.

Review of Resident #2's Resident Register revealed an admission date of 08/03/23.

Review of Resident #2's record revealed there was no Special Care Unit (SCU) pre-screening completed.

Refer to interview with the Facility Manager on 03/12/24 at 4:15pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026066	A. BUILDING: ______ B. WING ______	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR SPECIAL CARE UNIT	3017 DUNN ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 463	Continued From page 14	D 463		

3. Review of Resident #3's current FL-2 dated 02/21/24 revealed:
-Diagnosis included dementia and hypertension
-He was ambulatory.
-There was documentation that a Special Care Unit (SCU) was the recommended level of care.

Review of Resident #3's Resident Register revealed an admission date of 03/08/23.

Review of Resident #3's record revealed there was no Special Care Unit (SCU) pre-screening completed.

Refer to interview with the Facility Manager on 03/12/24 at 4:15pm.

4. Review of Resident #4's current FL-2 dated 05/25/23 revealed:
-Diagnosis included dementia and hypertension, arthritis, GERD, hyperlipidemia, BPH, history of spinal stenosis.
-He was semi-ambulatory (no ambulatory device/aide was documented).
-There was documentation that a Special Care Unit (SCU) was the recommended level of care.

Review of Resident #4's Resident Register revealed an admission date of 07/22/20.

Review of Resident #4's record revealed there was no SCU pre-screening.

Refer to interview with the Facility Manager on 03/12/24 at 4:15pm.

5. Review of Resident #5's current FL-2 dated 02/21/24 revealed:
-Diagnosis included dementia, chronic CVA, PTSD, and dilated ischemic cardiomyopathy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026066	A. BUILDING: ______ B. WING ______	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR SPECIAL CARE UNIT	**3017 DUNN ROAD FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 463	Continued From page 15 -He was semi-ambulatory with the use of a rollator. -There was documentation that a Special Care Unit (SCU) was the recommended level of care. Review of Resident #5's Resident Register revealed an admission date of 03/08/23. Review of Resident #5's record revealed there was no Special Care Unit (SCU) pre-screening. Refer to interview with the Facility Manager on 03/12/24 at 4:15pm. _____________________________ Interview with the Facility Manager on 03/12/24 at 4:15pm revealed: -She was responsible for completing the pre-screening assessments but did not complete the required documentation of the pre-screening assessments. -She was unable to locate the Special Care Unit (SCU) pre-screening for Residents #1, #2, #3, #4 or #5.	D 463		