STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078065	A. BUILDING: _____ B. WING _____	R 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR AL # 3	941 GOINS ROAD PEMBROKE, NC 28372

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on August 6, 2026.	{D 000}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a medication used to treat mood disorders were administered as ordered by a prescribing practitioner for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 02/09/26 revealed diagnoses included acute kidney injury, lumbar stenosis, dilated cardiomyopathy, and chronic systolic heart failure. Review of the facility medication administration policy dated 2020 revealed the policy included the following: -Medications would be administered in accordance with the prescribing practitioner's orders. -Medications would be administered within one hour before or one hour after the prescribed or	{D 358}		

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{D 358}	Continued From page 1	{D 358}		

scheduled time unless an emergency situation precluded the administration.
-Documentation would be provided for each dose of medication by the staff member who prepared the medications for administration.
-Documentation would be provided by the staff that administered medications to the resident on the medication administration record.
-Charting would identify if documentation errors, unavailability of medications or resident refusals of medication may have led to the error.
-If the facility got a prescription for a new medication that was needed immediately, the order was to be faxed to the pharmacy and marked on the order that it needed to be called in to the backup pharmacy. The pharmacy would call the prescription in to the backup pharmacy and notify the facility.
-The facility would ensure medications were provided for residents in accordance with the facility's medication management policies.
-Any pharmacy chosen by a resident would contract in writing with the facility and would agree to comply with the facility's medication management policies.

Review of a mental health provider (MHP) order for Resident #3 dated 06/18/26 revealed:
-There was an order for Lexapro (used to treat mood disorders such as anxiety and depressive symptoms) 5mg tablet daily for two weeks and week three increase dose to two (2) tablets daily, quantity of 54 tablets to be dispensed for a 30-day supply.
-The order was sent to a mail service pharmacy on 06/18/26.
-The order was stamped as being faxed to the facility provider pharmacy on 06/23/26.

Review of a MHP order for Resident #3 dated

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{D 358}	Continued From page 2 08/04/26 revealed: -There was an order for Lexapro 10mg tablet daily, quantity of 30 tablets to be dispensed for a 30-day supply. -The order was sent to a mail service pharmacy on 08/04/26. -The order was stamped as being faxed to the facility provider pharmacy on 08/06/26. Review of the primary care provider (PCP) physician orders for Resident #3 dated 07/07/26 revealed: -There was an order for Escitalopram (generic for Lexapro) 5mg tablet every day for two (2) weeks, prescribed by the MHP. The original date of the order was documented as 06/18/26, the diagnosis was documented as "MAR PURPOSE", and the date written was documented as 06/24/26. -There was an order for Lexapro 5mg tablet take two tablets (=10mg) once daily in the morning, prescribed by the MHP. The original date of the order was documented as 06/18/26, the diagnosis was documented as "MAR PURPOSE", and the date written was documented as 06/24/26. -There was no date ordered for discontinuing the Lexapro. Review of Resident #3's June 2026 electronic medication administration records (eMARs) revealed: -There was a printed entry for Lexapro 5mg tablet every day for two weeks and scheduled for 8:00am. -There was a stop date for the Lexapro 5mg tablet of 07/07/26 printed on the eMAR. -There was documentation for administration of the Lexapro 5mg tablet at 8:00am beginning 06/24/26 through 06/30/26.	{D 358}		

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{D 358}	Continued From page 3 Review of Resident #3's July 2026 eMARs revealed: -There was a printed entry for Lexapro 5mg tablet every day for two weeks and scheduled for 8:00am. -There was a stop date for the Lexapro 5mg tablet of 07/07/26 printed on the eMAR. -There was documentation for administration of the Lexapro 5mg tablet at 8:00am beginning 07/01/26 through 07/06/26. -There was a printed entry on the July 2026 eMAR of "DC'd" (discontinued) next to the area of instructions for administration of the Lexapro. -There was a second printed entry for Lexapro 5mg take two tablets (=10mg) once daily in the morning and scheduled for 8:00am. -There was a stop date for the Lexapro 5mg two tablets once daily of 07/14/26 printed on the eMAR. -There was documentation for administration of the Lexapro 5mg two tablets at 8:00am beginning 07/08/26 through 07/14/26. -There was a printed entry on the July 2026 eMAR of discontinued next to the area of instructions for administration of the Lexapro. -There was no documentation for administration of Lexapro from 07/15/26 through 07/31/26. Review of Resident #3's August 2026 eMARs revealed: -There was no printed entry with instructions for administration of Lexapro. -There was no documentation for administration of Lexapro. Observation of Resident #3's medication on hand on 08/06/26 at 1:35pm revealed there was a pharmacy labeled bottle for Lexapro 10mg tablet daily on the medication cart, dispense date of	{D 358}		

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{D 358}	Continued From page 4 08/02/26, quantity of 30 tablets. Interview with Resident #3 on 08/06/26 at 9:10am revealed: -She did not feel like her Lexapro was being administered correctly. -The MHP prescribed the Lexapro. -She had not been getting the Lexapro administered to her and had not been administered the Lexapro since last month (July 2026). -She was supposed to be administered Lexapro in the mornings. -She was told by a medication aide (MA) that the Lexapro had been discontinued. -She did not know when the Lexapro was supposed to have been discontinued, and nobody had informed her about it. -She confirmed with her MHP on 08/05/26 that the MHP wrote a prescription in June 2026 for a 30-day supply of Lexapro. -When she was without her medication, she was without her treatment. -She got "short sometimes". Second interview with Resident #3 on 08/06/26 at 5:55pm revealed: -She could tell when she was not being administered the Lexapro because she felt angry. -She knew she could not do what she wanted to do to anyone when she felt angry. Interview with Resident #3's mental health peer worker on 08/06/26 at 5:31pm revealed: -Resident #3 would let you know what she wanted or did not want. -Resident #3 had been without her Lexapro for about one month. -The resident had been a little angrier and she would have to calm Resident #3 down when the	{D 358}		

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{D 358}	Continued From page 5 resident spoke about people at the facility. -Resident #3 informed her about two weeks ago that she was feeling more anger, had asked a MA if she was being administered the Lexapro, and was informed she did not have any Lexapro. Interview with the Administrator on 08/06/26 at 9:25am revealed: -Resident #3's MHP did not make visits to the facility. -Resident #3's mental health peer worker transported her to MHP appointments because that was the resident' choice. -When Resident #3 was ordered new medications, the facility became aware of the new medications when the medications arrived via mail. -She had been in contact with the outside MHP practice about the facility needing copies of MHP notes and medication prescribed for Resident #3. Second interview with the Administrator on 08/06/26 between 1:30pm and 2:10pm revealed: -The Resident Care Coordinator (RCC) had oversight of the MAs and was responsible for ensuring resident medications were available for administration. -She was working as the MA on 08/06/26. -Lexapro for Resident #3 arrived at the facility on 08/05/26 via mail delivery. -Resident #3's Lexapro was added to the eMAR on 08/06/26. -According to Resident #3's eMAR, the Lexapro was discontinued and was stopped on 07/14/26. -She did not know why the Lexapro was stopped on 07/14/26. -She had not seen a physician's order to discontinue the Lexapro. Third interview with the Administrator on 08/06/26	{D 358}		

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{D 358}	Continued From page 6 at 3:55pm revealed: -The administration of the Lexapro to Resident #3 was missed. -She realized on 08/05/26 that Resident #3 had gone without the Lexapro. -She instructed the RCC to contact the MHP office to inquire about the Lexapro. Interview with the RCC on 08/06/26 at 2:16pm revealed: -The contracted provider pharmacy input orders to the eMARs. -She spoke to the contracted provider pharmacy who informed her that Resident #3's Lexapro was entered to the eMAR as a tapered dose which is why "DC'd" was entered on the eMAR. Second interview with the RCC on 08/06/26 at 5:08pm revealed: -Resident #3 was talkative and her mood was sometimes sad. -She did not know anything about Resident #3's Lexapro until 08/05/26 which was when a MA informed her that a new medication came to the facility. -She was not aware Resident #3 had physician orders for Lexapro to be administered. -Her main duties included ensuring medications on hand and medication orders were matching. -She approved new medication orders. -She had not been involved with the eMARs at that facility. -If there were any problems with medications at that facility, the MAs would let her know. Fourth interview with the Administrator on 08/06/26 at 6:00pm revealed: -She had not had any communication from Resident #3 about not being administered Lexapro as prescribed or any feelings Resident	{D 358}		

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{D 358}	Continued From page 7 #3 was experiencing. -She had not been informed by staff regarding any anger noted from Resident #3. -She expected the residents' medications to be administered accurately and on time based on physician orders. -If she had known Resident #3's Lexapro medication was not available for administration in the facility, she would have contacted the MHP and pharmacy to obtain the medication. Attempted telephone interview on 08/06/26 at 4:27pm with a MHP for Resident #3 was unsuccessful.	{D 358}		