STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031017	A. BUILDING: _____ B. WING _____	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYSPRING OF WALLACE	4026 HIGHWAY 11 SOUTH WALLACE, NC 28466

(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 and the Duplin County Department of Social Services conducted an annual survey on June 16 - 17, 2022.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 6 sampled residents (#6) who was ordered medications used to treat anxiety and depression. The findings are: Review of Resident #6's current FL-2 dated 03/20/2022 revealed: -Diagnoses included cerebral vascular accident (CVA), diabetes Type II, hypertension, vascular dementia and frequent falls. -The resident's recommended level of care was documented as Special Care Unit (SCU) -The resident was constantly disoriented, incontinent of bowel and bladder, non-ambulatory, and could verbally communicate her needs. Review of Resident #6's care plan dated 03/23/22	D 358		

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revealed:
-The resident wandered, was always disoriented, had significant memory loss requiring direction, and had a history of mental illness.
-The resident was ambulatory with the assistance of a walker.
-The resident required limited staff assistance with eating, ambulation, dressing, grooming, and transferring.
-The resident required extensive staff assistance with bathing and toileting.

Review of Resident #6's Primary Care Provider's (PCP) visit note dated 05/26/22 revealed:
-The resident was being seen because of medication changes.
-The resident was alert to name, month, and date.
-The resident was under the care of a psychiatrist.
-The family requested the resident to be taken off all psychiatric medications because of over sedation.
-Orders were written on 05/23/22 to slowly decrease the resident's medications.
-The medication names and/or dosages were not documented.
-The resident had not displayed side effects of missed doses of medications.
-The visit note was electronically signed by the PCP on 05/26/22 at 2:41pm.

a. Review of Resident #6's physician order sheet dated 03/23/22 revealed there was an order for Depakote (used to treat seizures and bipolar disorder) delayed release 125mg twice daily for dementia.

Review of Resident #6's Primary Care Provider (PCP) visit note dated 05/26/22 revealed there

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was an order to stop Depakote 125mg take one capsule twice daily.

Review of Resident #6's May 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Depakote delayed release 125mg take one capsule twice daily for dementia to be administered at 8:00am and 5:00pm.
-There was documentation Depakote was not administered from 05/23/22 to 05/24/22 at 8:00am and 5:00pm because the family refused.
-There was documentation Depakote was not administered at 5:00pm on 05/25/22 and 05/26/22 per the family request.

Review of Resident #6's PCP visit note dated 05/26/22 revealed:
-On 05/23/22, the resident's family member decided to decrease the resident from Depakote while still in the facility by having staff hold the evening dose of Depakote.
-On 05/23/22, the resident was only being administered the 8:00am dose of Depakote.
-Staff had not administered the resident the ordered 8:00pm dose of Depakote per family request.
-There was an order to stop Depakote 125mg take one capsule twice daily.

Interview with the SCU coordinator on 06/17/22 at 3:50pm revealed:
-She attempted to administer Depakote to Resident #6 when the family member was at the facility (the end of May 2022) but the family member stopped her.
-She did not administer Depakote to Resident #6 because the resident's family member told her the other MAs were not administering the

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medication to the resident.
-Resident #6's family did not want the resident to be administered Depakote because they thought the resident was over medicated.
-The SCU coordinator thought Resident #6's PCP ordered the Depakote to be held or discontinued even though the Depakote was still active on May 2022's eMAR because the family member told her the other MAs were not administering the Depakote.

Interview with a MA/Supervisor on 06/17/22 at 4:30pm revealed Resident #6's family member stopped staff from administering Depakote to the resident.

Telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm revealed:
-Neither she nor the resident's psychiatrist were comfortable discontinuing Depakote abruptly due to adverse side effects.
-Abruptly discontinuing Depakote could cause increased agitation, seizures, twitches, agitation, nausea/vomiting, and withdrawal.
-The resident did not display symptoms of abruptly discontinuing Depakote.
-She and the resident's psychiatrist decided to gradually lower the doses of Depakote to prevent side effects and withdrawal instead of abruptly discontinuing them.

Telephone interview with a pharmacy technician at Resident #6's pharmacy on 06/17/22 at 5:41pm revealed the resident had an order for Depakote 125mg take one tablet twice daily to be administered at 8:00am and 5:00pm; 60 tablets for a 30-day supply was dispensed on 05/02/22.

Review of Resident #6's PCP orders for May 2022 revealed there were no discontinuation

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orders dated 05/23/22 or 05/24/22 to include Depakote.
Refer to telephone interview with Resident #6's Primary Care Provider (PCP) on 06/17/2022 at 11:36am.

Refer to interview with a MA on 06/17/22 at 3:45pm.

Refer to interview with the SCU coordinator on 06/17/22 at 3:50pm.

Refer to interview with a MA/Supervisor on 06/17/22 at 4:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/17/22 at 4:39pm.

Refer to the second telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm.

Refer to interview with the Administrator on 06/17/22 at 5:59pm.

b. Review of Resident #6's physician order sheet dated 03/23/22 revealed:
-There was an order for Ativan 0.5mg twice daily (used to treat seizures and anxiety).
-There was an order for Ativan 0.5mg once daily as needed for anxiety.

Review of Resident #6's Primary Care Provider (PCP) visit note dated 05/26/22 revealed:
-Staff had not administered the resident the ordered Ativan per family request (the last administered date was not documented).
-There was an order to stop Ativan 0.25mg twice daily effective 05/26/22.
-There was an order to start Ativan 0.25mg twice daily as needed for agitation effective 05/26/22.

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D 358	Continued From page 5 Review of Resident #6's May 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Ativan 0.5mg one tablet twice daily to be administered at 8:00am and 8:00pm. -There was documentation Ativan was not administered on 05/03/22, 05/04/22, and 05/06/22 at 8:00am because the medication was refused. -There was documentation Ativan was not administered on 05/23/22 to 05/24/22 at 8:00am because the resident's family refused. -There was documentation Ativan Lorazepam was not administered on 05/04/22 at 8:00pm because of a refusal. -There was documentation Ativan was not administered on 05/23/22, 05/24/22, and 05/26/22 at 8:00am because the family refused. -There was documentation Ativan was not administered from 05/23/22 to 05/26/22 at 8:00pm because the family refused. Telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm revealed: -She nor the resident's psychiatrist wanted to discontinue Ativan abruptly due to adverse side effects. -Side effects of abruptly discontinuing Ativan could cause increased agitation, seizures, twitches, agitation, nausea/vomiting, and withdrawal. -She and the resident's psychiatrist decided to gradually decrease Ativan to prevent side effects and withdrawal instead of abruptly discontinuing the Ativan. Telephone interview with a pharmacy technician at Resident #6's pharmacy on 06/17/22 at	D 358		

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5:41pm revealed the resident had an order for Ativan 0.5mg take one twice daily; 60 tablets, a 30-day supply, were dispensed on 05/02/22.

Review of Resident #6's PCP orders for May 2022 revealed there were no orders, to include Ativan, dated 05/23/22 or 05/24/22.

Refer to telephone interview with Resident #6's Primary Care Provider (PCP) on 06/17/2022 at 11:36am.

Refer to interview with a MA on 06/17/22 at 3:45pm.

Refer to interview with the SCU coordinator on 06/17/22 at 3:50pm.

Refer to interview with a MA/Supervisor on 06/17/22 at 4:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/17/22 at 4:39pm.

Refer to the second telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm.

Refer to interview with the Administrator on 06/17/22 at 5:59pm.

c. Review of Resident #6's physician order sheet dated 03/23/22 revealed there was an order for Zoloft 75mg once daily for mood (used to treat depression and anxiety).

Review of Resident #6's Primary Care Provider (PCP) visit note dated 05/26/22 revealed there was an order to stop Zoloft 50mg tablet: take 25mg daily for seven days, then discontinue.

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Review of Resident #6's May 2022 eMAR revealed:
-There was an electronic entry for Zoloft 75mg one tablet daily for mood to be administered at 8:00am.
-There was documentation Zoloft 75mg was not administered on 05/23/22 because the family refused.
-There was an electronic entry for Zoloft 50mg one tablet daily to be administered at 8:00am.
-There was documentation Zoloft 50mg was not administered from 05/24/22 to 05/26/22 at 8:00am because the family refused.

Review of Resident #6's PCP visit note dated 05/26/22 revealed staff had not administered the resident the ordered Zoloft per family request.
Telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm revealed:
-She nor the resident's psychiatrist wanted to discontinue Zoloft abruptly due to adverse side effects.
-Side effects of abruptly discontinuing Zoloft could cause increased agitation, seizures, twitches, agitation, nausea/vomiting, and withdrawal.
-She and the resident's psychiatrist decided to gradually decrease Zoloft to prevent side effects and withdrawal instead of abruptly discontinuing.

Telephone interview with a pharmacy technician at Resident #6's pharmacy on 06/17/22 at 5:41pm revealed the resident had an order for Zoloft 50mg take 1.5 tablets daily; 45 tablets for a 30-day supply was dispensed on 05/02/22.

Review of Resident #6's PCP orders for May 2022 revealed there were no orders dated 05/23/22 or 05/24/22, to include Zoloft.

Refer to telephone interview with Resident #6's

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D 358	Continued From page 8 Primary Care Provider (PCP) on 06/17/2022 at 11:36am. Refer to interview with a MA on 06/17/22 at 3:45pm. Refer to interview with the SCU coordinator on 06/17/22 at 3:50pm. Refer to interview with a MA/Supervisor on 06/17/22 at 4:30pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/17/22 at 4:39pm. Refer to the second telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm. Refer to interview with the Administrator on 06/17/22 at 5:59pm. d. Review of Resident #6's physician order sheet dated 03/23/22 revealed there was an order for Trazodone 100mg at bedtime (used to depression). Review of Resident #6's Primary Care Provider (PCP) visit note dated 05/26/22 revealed there was an order to stop Trazodone 100mg tablet: take 0.5 tablet at bedtime. Review of Resident #6's May 2022 eMAR revealed: -There was an electronic entry for Trazodone 100mg one tablet at bedtime to be administered at 8:00pm. -There was documentation Trazodone was not administered from 05/23/22 to 05/26/22 at 8:00pm because the family refused.	D 358		

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Telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm revealed:
-Neither she nor the resident's psychiatrist wanted to discontinue Trazodone abruptly due to adverse side effects.
-Side effects of abruptly discontinuing Trazodone could cause increased agitation, seizures, twitches, agitation, nausea/vomiting, and withdrawal.
-She and the resident's psychiatrist decided to gradually decrease Trazodone to prevent side effects and withdrawal instead of abruptly discontinuing.

Telephone interview with a pharmacy technician at Resident #6's pharmacy on 06/17/22 at 5:41pm revealed the resident had an order for Trazadone 100mg take 1 tablet at bedtime; 30 tablets for a 30-day supply was dispensed on 05/02/22.

Review of Resident #6's PCP orders for May 2022 revealed there were no orders dated 05/23/22 or 05/24/22, to include Trazadone.

Refer to telephone interview with Resident #6's Primary Care Provider (PCP) on 06/17/2022 at 11:36am.

Refer to interview with a MA on 06/17/22 at 3:45pm.

Refer to interview with the SCU coordinator on 06/17/22 at 3:50pm.

Refer to interview with a MA/Supervisor on 06/17/22 at 4:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/17/22 at 4:39pm.

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D 358	Continued From page 10 Refer to the second telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm. Refer to interview with the Administrator on 06/17/22 at 5:59pm. _____ Telephone interview with Resident #6's Primary Care Provider (PCP) on 06/17/2022 at 11:36am revealed: -Resident #6's family expressed concern to staff that the resident was overly sedated by anti-depressants. -Staff notified her of the family's concern of the resident being over medicated. -She consulted with the resident's mental health provider to formulate a new care plan for the resident. -The new care plan included slowly decreasing the anti-depressants over a two-week period because it was dangerous for the resident to discontinue the medications abruptly. -Potential side effects of stopping the anti-depressants abruptly could mean discomfort, increased agitation, changes in mood, twitching, seizure, stroke and/or other withdraw symptoms. -Staff notified her that the resident's family member was staying with the resident at bedside and telling the MAs what medications could or could not be administered to the resident. -Staff questioned her about discontinuing the resident's ordered anti-depressants. -She told facility staff that the anti-depressants would not be discontinued due to the potentially dangerous side effects to the resident. -She told facility staff to document if the resident or resident's family member refused the anti-depressants -She spoke directly with the resident's family member who expressed that she wanted the	D 358		

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anti-depressants discontinued.
-The resident was discharged from the facility by family two days after the family member requested to discontinue anti-depressants was not fulfilled.

Interview with a medication aide (MA) on 06/17/22 at 3:45pm revealed:
-Resident #6's family member visited her every day from 8:00am to 5:00pm during the end of May 2022.
-Resident #6's family member refused to allow staff to administer the resident certain ordered medications the end of May 2022 because she thought they made the resident sleepy.
-She did not remember all the names of the medications.
-Resident #6's family member told her, before leaving the facility, to not administer the named medications to the resident.
-She was trained to always attempt to administer an ordered medication to the resident.
-She did not attempt to administer the specific medications to Resident #4 because the family member told her not to.
-Resident #6's medications still populated on the electronic medication administration record (eMAR) for administration.
-Resident #6 did not have an order from her PCP to hold or discontinue the medications during the times she did not attempt to administer the ordered medications to the resident.
-She discussed with the Special Care Unit (SCU) Coordinator (SCU) and the Resident Care Coordinator (RCC) that Resident #6's family member refused to allow her to administer ordered medications to the resident.
-She did not remember what the SCU Coordinator or RCC told her to do.
-She had never been in a situation where a

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D 358	Continued From page 12 resident's family member would not allow the resident to be administered medications. Interview with the SCU coordinator on 06/17/22 at 3:50pm revealed: -Resident #6's family member stayed with her the last week she was in the facility (May 2022). -Resident #6's family member would not allow staff to administer the resident certain medications. -Resident #6's PCP did not want the resident's medications abruptly discontinued because she felt the resident could have adverse reactions. -She never spoke with Resident #6's PCP regarding the resident's family member refusing staff to administer the resident medications because she knew the RCC had spoken to the PCP. Interview with a MA/Supervisor on 06/17/22 at 4:30pm revealed: -Resident #6's family member would not let her, or any other MA administer the resident medications. -Resident #6's family member told her the resident's medications were discontinued. -Resident #6's family member was present for all medication passes that were due for the resident. -Resident #6's family member told staff before she left to not administer any medications to the resident after she left. -Resident #6's PCP did not give an order to hold medications. -Resident #6's PCP was notified the resident's family member would not allow staff to administer the resident certain medications. -It was a tossup between not administering Resident #6 her ordered medications per family's directive or doing the right thing which was to administer the medications due.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Interview with the RCC on 06/17/22 at 4:39pm revealed: -She was also the facility's Licensed Practical Nurse (LPN). -Resident #6's family wanted all medications stopped without tapering them down during the last week she was in the facility in May 2022. -Resident #6's PCP stated she did not want the resident's medications discontinued abruptly. -Resident #6's PCP told her she wanted to speak with the resident's psychiatrist prior to altering her medications. -Resident #6's PCP did not give an order to hold or discontinue the resident's medications until her facility visit on 05/26/22. -Resident #6 was discharged from the facility on 05/27/22. -She thought Resident #6's family member was present in the facility during all medication passes. -She expected the MAs to attempt to administer Resident #6's medications to the resident when the family member was not present because they would not refuse the medications administered to the resident. A second telephone interview with Resident #6's PCP on 06/20/22 at 5:06pm revealed: -Resident #6 was severely cognitively impaired and could not make decisions for herself. -She was told by the facility the resident's family member would not allow staff to administer medication to the resident because she thought the resident was over medicated (the dated was not provided). -The resident was ordered medications to treat dementia, and psychiatric conditions, and help her to sleep. -The resident's family member wanted all the	D 358		

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	HAL031017	A. BUILDING: _____ B. WING _____	06/17/2022

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D 358	Continued From page 14	D 358		

resident's medication used to treat sleep, dementia, and psychiatric conditions discontinued.
-She told the RCC she wanted to speak with the resident's psychiatrist before altering or discontinuing the resident's medications.
-She and the resident's psychiatrist discussed the resident and developed a plan of care regarding her medications.
-She expected facility staff to have attempted to administer the medications to the resident when the family was there and were not during medication passes.
-She thought she wrote new orders around 05/24/22 to taper the resident's medications.
-She could not remember the exact date, but the facility should have her orders on file.

Interview with the Administrator on 06/17/22 at 5:59pm revealed:
-Resident #6's family member felt the resident was overmedicated and reviewed the resident's medication list.
-Resident #6's family member wanted all the resident's medications discontinued at first, but then later, Resident #6's family member wanted specific medications discontinued.
-The RCC did not state which medications were to be discontinued.
-Resident #6's PCP was notified by the facility, and the PCP originally discontinued medications then changed her mind because she wanted to discuss the resident's medications with her psychiatrist (the date was not provided).
-Resident #6 was examined by her PCP on 05/26/22 and medication orders written.
-Resident #6's family member told her she was the resident's healthcare power of attorney (POA).
-She reviewed Resident #6's healthcare

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D 358	Continued From page 15 documents to confirm. -The facility had to follow the orders of Resident #6's family member because she was the resident's healthcare POA. -Resident #6's PCP told her the resident's healthcare POA could refuse the staff to administer medications to the resident. -She currently did not have Resident #6's healthcare POA documentation because the resident's entire facility record was missing. -Resident #6's PCP was adamant to not abruptly discontinue the resident's medications even if the resident's family member wanted the medications discontinued because the PCP was concerned of how it would affect the resident. -Resident #6's family was in control of the resident's medications during the residents stay at the facility the end of May 2022. -She expected the SCU and MAs to administer Resident #6's ordered medications to the resident when the resident's family member was not in the facility when the ordered medications were due.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the 7:00am to 8:00am mediation pass observed on	D 371		

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D 371	Continued From page 16 06/17/22 for 1 of 2 medication aides observed who failed to perform hand hygiene before preparing and after administering oral medications to three residents. The findings are: Review of the facility's infection control policy dated September 2021 revealed: -Hand hygiene consisted of handwashing and/or alcohol-based hand rubs. -Hand hygiene was to be performed by staff before, between, and after each time resident care was performed. -Hand hygiene was to be performed by staff after touching or around body fluid or mucus membranes. -The policy was not specific regarding infection control during medication administration. Observation of the nurses' station of the Special Care Unit (SCU) on 06/17/22 at 7:28am revealed: -The medication cart was located at the nurses' station. -There was a bottle of alcohol-based hand sanitizer approximately three fourths full located on the top left of the medication cart. -There was a room to the left of the nurses' station that contained a sink. Observation of a SCU medication aide (MA) administering medications during the 7:00am to 8:00am medication pass on 06/17/22 revealed: -At 7:28am, the MA prepared the first resident's medications at the medication cart and poured water from the water pitcher into a cup. -The MA took the resident his medications and a cup of water to the resident in his room. -At 7:31am, the MA placed the medication cup containing the resident's medications to his	D 371		

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D 371	Continued From page 17 mouth, and the MAs finger touched his lips. -The resident opened his mouth and the MA poured the mediations from the cup into the resident's mouth. -The MA placed the cup of water to the resident's mouth and he swallowed the water and medications. -The MA was not wearing gloves. -The MA returned to the medication cart. -The MA did not wash her hands or use an alcohol-based sanitizer when she returned to the medication cart before she began preparing mediations for the next resident. -The MA unlocked the medication cart with the keys, opened the drawer, touched the computer mouse, removed medications from inside the medication cart drawer for the second resident, touched the water pitcher, poured water into a water cup, and prepared the second resident's medications. -At 7:40am the MA placed the second resident's medication cup to the resident's mouth. -The MA placed a water cup to the resident's mouth and the resident swallowed the water and medications. -The MA was not wearing gloves. -The MA returned to the medication cart. -The MA did not wash her hands or use an alcohol-based sanitizer when she returned to the medication cart or before she began preparing mediations for the third resident. -The MA unlocked the medication cart, opened the drawer, touched the computer mouse, pulled medication packs for the third resident, touched the water pitcher and poured water into a water cup. -The MA popped medications into a medication cup for the third resident. -At 7:48am, the MA administered medications to the third resident in the dining room.	D 371		

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D 371	Continued From page 18 -The MA returned to the medication cart and did not perform hand hygiene in between three residents during the 7:00am to 8:00am medication pass on 06/17/22. Interview with the MA on 06/17/22 at 11:00am revealed: -She should have performed hand hygiene before and after, administering medications today (06/17/22). -She should have performed hand hygiene every time after she touched a resident or their mouth during the medication pass today (06/17/22). -There was a sink located at the nurses' station she could have used to wash her hands. -There was a bottle of hand sanitizer on the medication cart she could have used to sanitize her hands during the medication pass today, 06/17/22. -She failed to wash her hands or use hand sanitizer during the medication pass because she was nervous. Interview with the SCU Coordinator on 06/17/22 at 11:30am revealed: -MAs were supposed to wash their hands or use hand sanitizer before, after, and in between residents during the medication pass. -MAs were supposed to use hand sanitizer before and after every medication pass to decrease the spread of germs between residents. Interview with the Administrator on 06/17/22 at 11:40am revealed MAs were trained to perform hand hygiene using hand sanitizer after each medication pass before preparing other residents medications to decrease infection control.	D 371		