STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET 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 Duplin County Department of Social Services conducted an annual, and follow-up survey and a complaint investigation on January 7, 2025, through January 9, 2025. The complaint investigation was initiated by the Duplin County Department of Social Services on December 2, 2024.	D 000	Hot Water heater motor Replaced and Serviced	1/10/2025
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 14 of 14 fixtures located in resident's rooms and 3 spa rooms used by the residents. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed with a capacity of 64 beds. Review of the facility's census reports provided	D 113		

Reviewed and Acknowledged SC 2/21/25

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D 113	Continued From page 1 on 01/07/25 revealed the facility's in-house census was 39 residents. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed: -A water temperature of 127.4 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. -A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. Observation of the hot water temperature at the shower in the North Hall Spa room 1 on 01/07/25 at 8:50am revealed the hot water temperature was 90.0 degrees F. Observation of the hot water temperature at the shower in the North Hall Spa room 2 on 01/07/25 at 9:00am revealed the shower hot water temperature was 88.0 degrees F, observation of the hot water temperature at the tub was 88.0 degrees F, and observation of the hot water temperature at the sink was 90.0 degrees F. Observation of the hot water temperature at the sink in resident room 18 and 19 (shared) on 01/07/25 at 9:11am revealed the sink hot water temperature was 80.0 degrees F and the tub was 88.0 degrees F. Interview with a resident who resided in room 18 on 01/07/25 at 9:30am revealed that the shower water was always cold. Interview with a resident who resided in room 19 on 01/07/25 at 9:10am revealed that he preferred to bathe at night but the water was always cold and he had to bathe in the morning when it was a	D 113		

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D 113	Continued From page 2 little warmer but it was always cold. Observation of the hot water temperature at the sink in resident room 3 on 01/07/25 at 9:18am revealed the hot water temperature was 86.0 degrees F. Interview with a resident who resided in room 3 on 01/07/25 at 9:15am revealed that the North Spa showers were always cold in the Spa rooms, the room sink was never warm, and he washed off with a cloth instead of showering. Interview with a second resident who resided in room 3 on 01/07/25 at 9:17am revealed the North Spa showers water was always cold and he was unable to shower due to the cold water and the room sink was always cold. Observation of the hot water temperature on the South Hall in the shared bathroom of resident rooms 16 and 17 on 01/07/25 at 9:08am revealed the hot water temperature in the bathroom sink was 95.2 degrees F. Interview with the resident who resided in room 17 on 01/07/25 at 9:08am revealed: -The shower water did not get hot and she took cold showers at least two times a week. -She could not recall how long the shower water had been cold. -She told the Resident Care Coordinator (RCC) and the Administrator, and they said that they were trying to fix the issue. Interview with the resident who resided in room 16 on 01/07/25 at 9:12am revealed: -The water was sometimes very cold. -She could not recall how long the water issue had been going on but knew it had been a long	D 113		

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D 113	Continued From page 3 while. -At one time the water was very hot then someone came out to regulate it and now it was too cold but she could not recall when or who came out to fix the water. -She told the Maintenance Director (MD) about the cold water before the New Year, and he said that he would check the water and then fix it, but it had not been fixed. Observation of the hot water temperature on the South Hall in resident room 15 on 01/07/25 at 9:20am revealed, the hot water temperature in the bathroom sink was 98.1 degrees F. Interview with the resident who resided in room 15 on 01/07/25 at 9:20am revealed: -A personal care aide (PCA) told her that the shower water was cold today and she decided to take a bath at the sink. -She could not recall how long the cold water issue had been going on, but she became accustomed to taking sink baths when the water was too cold. Observation of the hot water temperature on the South Hall in resident room 12 on 01/07/25 at 9:30am revealed, the hot water temperature at the bathroom sink was 91.9 degrees F. Interview with the resident who resided in room 12 on 01/07/25 at 9:40am revealed: -The water was cold depending on the time of the day. -He began taking his baths in the evenings because the water was warmer. Observation of the hot water temperature in the South Hall Spa room on 01/07/25 at 9:58am revealed:	D 113		

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D 113	Continued From page 4 -The hot water temperature in the bathroom sink was 91 degrees F. -The hot water temperature in the bathroom shower was 89.1 degrees F. Observation of the bathroom sink fixture between rooms 26 and 27 on 01/07/25 from 9:19am to 9:22am revealed: -The water temperature was 122.8 degrees F at 9:20am. -There was an immediate drop in the hot water temperature to 116.4 degrees F at the sink fixture at 9:21am. -At 9:22am, the hot water temperature at the sink fixture was 108.6 degrees F. -There was no caution sign posted at the sink fixture notifying residents and staff of the fluctuation in hot water temperatures. Observation of the bathroom sink fixture between rooms 32 and 33 on 01/07/25 at 3:50pm revealed the hot water temperature was 129.2 degrees F at 3:50pm. Interview with a resident in room 32 on 01/07/25 at 9:55am revealed the sink hot water temperatures got "pretty warm" depending on the time of day. Interview with a resident who resided in room 23 on 01/07/25 at 9:22am revealed that the North Hall Spa room showers were always cold. Interview with a second resident who resided in room 23 on 01/07/25 at 9:25am revealed that the North Hall Spa room showers were always cold. Interview with a PCA on 01/07/25 at 9:50am revealed: -She was aware that the water ran cold.	D 113		

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D 113	Continued From page 5 -She checked the water temperature by placing her hands under the running water before bringing a resident in for a shower. -The water ran cold today, and she helped the resident who resided in room 15 with a sink bath. -The water ran cold at least two times a week. -She told the RCC and the Administrator about the cold water about three months ago and she was told they were working on fixing it. Interview with the Maintenance Director (MD) on 01/07/25 at 4:00pm revealed: -He had worked at the facility for one year. -He performed daily water temperature checks. -The facility water temperatures had fluctuated since he started to work at the facility. -He notified the Administrator when any water temperatures were out of required temperature range. -He had never adjusted the thermostat on the hot water heater. -The facility plumber was the only person who adjusted the thermostat on the hot water heater. -The facility's plumber was here today because the Administrator called him about the water temperatures. -The facility's plumber did not adjust the hot water heater thermostat. -The facility's plumber requested that an electrician evaluate the motor on the hot water heater. -He thought the hot water temperature reading of 129.2 degrees F at the bathroom sink fixture between rooms 32 and 33 on 01/07/25 at 3:52pm was "probably" the hot water running out of the system. -He had not checked hot water temperatures since the plumber left the facility. -He would get his thermometer for water temperature checks but was unable to locate it.	D 113		

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D 113	Continued From page 6 Second observation of the hot water temperature on the South Hall in the shared bathroom of resident rooms 17 and 16 on 01/08/25 at 7:35am revealed the hot water temperature in the bathroom sink was 140.5 degrees F. Second observation of the hot water temperature on the South Hall in resident room 15 on 01/08/25 at 7:40am revealed the hot water temperature in the bathroom sink was 136.4 degrees F. Second observation of the hot water temperature on the South Hall in resident room 12 on 01/08/25 at 7:45am revealed the hot water temperature in the bathroom sink was 130.5 degrees F. Second observation of the hot water temperature on the South Hall in the Spa room on 01/08/25 at 5:44pm revealed: -The hot water temperature in the bathroom sink was 98.2 degrees F. -The hot water temperature in the bathroom shower was 89.2 degrees F. Second observation of the hot water temperatures in the bathroom between rooms 32 and 33 on 01/08/25 at 8:52am revealed: -The hot water temperature at the sink fixture was 96.6 degrees F. -The hot water temperature at the tub/shower fixture was 118.2 degrees F. Second observation of the hot water temperature at the shower in the North Hall Spa 1 room on 01/08/25 at 7:42am revealed the hot water temperature at the shower was 90.0 degrees F and the sink was 92.0 degrees F. Second observation of the hot water temperature	D 113		

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D 113	Continued From page 7 in the North Hall Spa room 2 on 01/08/25 at 7:50am revealed the shower hot water temperature was 100.0 degrees F, the tub was 100.0 degrees F, and the sink was 118.0 degrees F. Second observation of the hot water temperature in resident rooms 18 and 19 (shared) on 01/08/25 at 8:05am revealed the hot water temperature the sink was 130.0 degrees F and the tub was 120.0 degrees F. Second observation of the hot water temperature at the sink in resident room 3 on 01/08/25 at 8:00am revealed the hot water temperature was 120.0 degrees F. Third observation of the hot water temperature on the South Hall in the shared bathroom of resident rooms 16 and 17 on 01/09/25 at 9:33am revealed the hot water temperature in the bathroom sink was 95.5 degrees F. Third observation of the hot water temperature on the South Hall in resident room 15 on 01/09/25 at 9:35am revealed the hot water temperature in the bathroom sink was 101.7 degrees F. Third observation of the hot water temperature on the South Hall in resident room 12 on 01/09/25 at 9:38am revealed the hot water temperature in the bathroom sink was 101.8 degrees F. Third observation of the hot water temperature on the South Hall in the Spa room on the South Hall 01/09/25 at 9:40am revealed: -The hot water temperature in the bathroom sink was 99.7 degrees F. -The hot water temperature in the bathroom shower was 98.1 degrees F.	D 113		

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D 113	Continued From page 8 Third observation of the bathroom sink fixture between rooms 26 and 27 on 01/08/25 at 8:40am revealed the water temperature was 124.1 degrees F. Third observation of the hot water temperature in the North Hall Spa 1 room on 01/08/25 at 5:35pm revealed the hot water temperature at the shower was 92.0 degrees F and the sink was 94.0 degrees F. Third observation of the hot water temperature in the North Hall Spa room 2 on 01/08/25 at 5:40pm revealed the hot water temperature at the shower was 100.0 degrees F, the tub was 100.0 degrees F, and the sink was 100.0 degrees F. Third observation of the hot water temperature in resident room #18 and 19 (shared) on 01/08/25 at 5:50pm revealed the hot water temperature at the sink was 122.0 degrees F and at the tub was 120.0 degrees F. Third observation of the hot water temperature in resident room #3 on 01/08/25 at 5:45pm revealed the sink hot water temperature was 110.0 degrees F. Third observation of the bathroom tub/shower fixture between rooms 32 and 33 on 01/08/25 at 5:42pm revealed: -The hot water temperature was 105.4 degrees F. -There was no caution sign posted at the bathroom sink fixture. Fourth observation of the hot water temperature in the North Hall Spa room 1 on 01/09/25 at 9:15am revealed the hot water temperature at the shower was 80.0 degrees F and the sink was	D 113		

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D 113	Continued From page 9 82.0 degrees F. Fourth observation of the hot water temperature in the North Hall Spa room 2 on 01/09/25 at 9:22am revealed the hot water temperature at the shower was 80.0 degrees F, the tub was 80.0 degrees F, and the sink was 80.0 degrees F. Fourth observation of the hot water temperature in resident rooms 18 and 19 (shared) on 01/09/25 at 9:35am revealed the hot water temperature at the sink was 90.0 degrees F and the tub was 94.0 degrees F. Fourth observation of the hot water temperature in resident room 3 on 01/09/25 at 9:30am revealed the hot water temperature at the sink was 86.0 degrees F. Fourth observation of the bathroom sink fixture between rooms 26 and 27 on 01/08/25 at 8:44am with the Administrator present (without facility thermometer) revealed the water temperature was 123.2 degrees F. Fifth observation of the bathroom sink fixture between rooms 26 and 27 on 01/08/25 at 5:48pm revealed: -The hot water temperature was 109.7 degrees F. -There was no caution sign posted at the bathroom sink fixture. Interview with the Administrator on 01/08/25 at 5:49pm revealed: -The caution signs were removed (no date provided) when the hot water temperatures were adjusted by the plumber. -She would repost hot water caution signs until the fluctuating hot water issue was fixed.	D 113		

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D 113	Continued From page 10 Interview with the Administrator on 01/08/25 at 8:05am revealed: -The water temperatures had been fluctuating over the past month. -The water temperatures were running high during the previous week. -The MD performed daily hot water temperature checks. -The MD had informed her on 01/07/25 that the hot water temperatures were running low. -She called the facility's plumber on 01/07/25. -The facility's plumber told her that the hot water heater motor was the problem and she called the facility's Electrician on 01/07/25 and he was coming to check the hot water heater motor 01/08/25. -If it was determined that the motor was not working the Plummer would replace the motor. -She did not have any previous water temperature logs except for a few from December 2024 because they were thrown away except for, 12/09/24, 12/10/24, 12/11/24, 12/12/24, 12/13/25, 12/16/24, 12/17/24, 12/18/24, 12/19/24, 12/20/24, 12/23/24, 12/24/25, 12/27/24, 12/30/24 all the documented water temperatures were within the required temperature range. -She had two temperature logs from 01/06/25 and 01/08/25. -She did not know that she was supposed to keep the temperature logs. -She was unable to provide any invoices from the plumber. -She would go to the MD's office to get the facility thermometer to check water temperatures. -She would post signs at the water fixtures to caution residents and staff of the fluctuating hot water temperatures. Review of the facility's water temperature log dated 01/06/24 revealed 100 degrees (F) in large	D 113		

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D 113	Continued From page 11 print but no rooms were identified. Review of the facility's water temperature log dated 01/08/24 revealed: -The water temperature for Room 30 was recorded as 117 degrees F. -The water temperature for Room 31 was recorded as 117 degrees F. -The water temperature for Room 32 was recorded as 123 degrees F. -The water temperature for Room 33 was recorded as 123 degrees F. Interview with the facility's electrician on 01/08/25 at 9:18am revealed: -The Administrator called him to check the hot water heater motor. -The hot water heater motor was not working. -There was voltage to the motor but the motor was not working. -He had never checked the facility's hot water heater prior to today (01/08/25). Interview with the facility's plumber on 01/08/25 at 10:47am revealed: -He was contacted by the Administrator on 01/07/25 to come to the facility to check the hot water heater related to fluctuating room temperatures. -This was the first time (01/07/25) he had been called related to fluctuating hot water temperatures. -He did not adjust anything on the facility's hot water heater yesterday (01/07/25). -The hot water heater motor took the cold water and circulated it in the hot water heater to warm the cold water before it left the hot water heater. -He adjusted the cold water in the mixing valve today to decrease the water temperature to the resident's rooms.	D 113	Warning signs for fluctuating hot water temperatures was left posted. Maintenance and housekeeping was in-serviced on 1/9/2025. Until hot water motor is replaced each day housekeeping along with maintenance will check hot water temperatures to keep residents safe until new hot water heater motor is replaced. Plumber replaced hot water heater motor on 1/10/2025. Plumber came back out to facility on 1/11/2025 to recheck hot water heater motor. Hot water heater motor was working properly and temperatures came up to meet facility codes. Since hot water heater motor has been replaced and holding correct temperatures	1/10/2025

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D 113	Continued From page 12 -It would take several days to get a hot water heater motor and replace it. -He had worked on the hot water heater in the past because of a part that was leaking but it was not related to the water temperature. The facility failed to ensure hot water temperatures for 14 of 14 fixtures sampled in the facility were maintained between 100 - 116 degrees Fahrenheit (F). The water temperatures for 5 fixtures ranged from 129.2 degrees F to 140.5 degrees F. A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. The water temperatures for 12 fixtures ranged from 80.0 degrees F to 98.1 degrees F which resulted in residents not bathing or only washing off with a cloth due to the cold water temperatures. This failure of the facility was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/09/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 23, 2025.	D 113	Maintenance staff will check hot water temperatures Weekly and record them in hot water temperature book. At anytime hot water temperature are not in range maintenance staff will immediately inform Administrater and she will call the plumber to come out for service. Administrator monthly will check water temperature logs, common bathrooms and resident rooms for accurate temperatures. Plumber will come out annual to check and service hot water heater to make sure hot water heater is holding temp. and working properly.	
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of	D 271		

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D 271	Continued From page 13 an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure immediate response and intervention by staff for 1 of 6 sampled residents (6) for a resident who was found unresponsive, not breathing, and pulseless. The findings are: Review of the facility's Emergency Operation Plans page 25 dated 03/21/24 revealed: -Actions and procedures, treat life threating emergencies and call 911 for assistance. -The average person will die in six minutes or less if the oxygen supply is cut off, remove any obstructions to the airway and apply mouth-to-mouth resuscitation. -Start cardiopulmonary resuscitation (CPR) procedures for heart failure, get trained help and work as a team. Review of Resident #6's current FL-2 dated 03/27/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) with acute lower respiratory infection and adjustment disorder. -She was semi-ambulatory.	D 271	Immediately response to life saving emergencies. upon finding patient unresponsive check pulse look upon at the top of the resident bed to see if DNR is posted if not staff is to start CPR immediately. All staff is to be present in the room until patient is postion and starting CPR. At that time depend on what shift 1st or 2nd two people will assist with CPR 3rd Shift the one person will Continue CPR and the other staff will immediately call 911, RCC or Administrator and	11/6/2025

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 271	Continued From page 14 Review of Resident #6's current care plan dated 03/27/24 revealed: -Resident #6's care plan was completed by the Resident Care Coordinator (RCC) and signed by her primary care provider (PCP). -She required supervision with ambulation, toileting, dressing, and transferring. -She required extensive assistance with bathing. -She was totally dependent with eating and personal hygiene. Review of Resident #6's record on 01/07/25 revealed Resident #6 did not have a Do Not Resuscitate (DNR) order. Review of the Report of Death to Department of Health and Human Services (DHHS) dated 11/15/24 at 10:30am revealed: -The document was completed by the RCC. -Resident #6 rang her call bell. -The personal care aide (PCA) answered the call bell and Resident #6 requested her nebulizer treatment. -The PCA informed the Medication Aide (MA) that Resident #6 was requesting her nebulizer treatment. -The MA went to Resident #6's room with nebulizer medication and found her not breathing. -Emergency Medical Services (EMS) was called immediately. -CPR was started by EMS. -Resident #6 was pronounced deceased at 5:09am. Telephone interview with a County Communications 911 operator on 12/02/24 at 2:03pm revealed a call came into the 911 center on 11/15/24 at 4:34am regarding a female unresponsive at the facility.	D 271	Unlock the main entrance door. If police get to facility before EMT staff will still continue to do CPR and after EMT arrive's get in the room they will take over. The person performed CPR will stay in room until EMT determine if resident will go out to hospital or has expired. The other staff will then get all necessary paper work for EMT. All emergency situation will be handle on all shifts as life threatening. Reports will be filled out after RCC + Administrator Review Staff.	

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D 271	Continued From page 15 Review of the local 911 emergency services communication report dated 11/15/24 revealed: -A call was received at 4:34am for an unresponsive and not breathing resident. -A police officer arrived at the facility at 4:40am. -EMS arrived on the scene at 4:39am. Telephone interview with a police officer on 12/02/24 at 2:31pm revealed: -When the police officer arrived, the MA came to the door and let him in. -When he entered Resident #6's room on 11/15/24 another facility staff member was in the room and stated she was trying to do CPR but did not know what to do. -Resident #6's back was on the bed with her legs hanging off the bed. -He asked the staff member that was in the room for help lowering Resident #6 to the floor. -He notified dispatch that he was starting CPR on Resident #6 at 4:40am. -The police officer started CPR and EMS arrived a couple of minutes later. -EMS responded from the station which was located next to the police department. Second telephone interview with the police officer on 12/17/24 at 7:52pm revealed he would have to view his body camera footage to see if facility staff was administering CPR when he arrived at Resident #6's room. Third telephone interview with the police officer on 12/20/24 at 2:40pm revealed: -He reviewed his body camera footage from 11/15/24 at the facility. -Another staff member was up front and opened the facility door for the officer. -When he arrived the staff member was inside	D 271	All nursing staff was in-serviced on January 10, 2025 on immediate response to emergencies and unlocking main door on 2nd and 3rd Shift for police department and EMT arriving at the facility. RCC will review monthly each shift on peformance to responding to emergencies. All emergency situation will be handle as life threatening. On January 13, 2025 RCC made copies of all resident with DNR's and put them at the head of the resident bed. DNR's will be monitored by RCC weekly for changes and new resident coming in. Also ~~corrected~~ EMT will be given orginal when patient goes out to hospital. CPR was reviewed	

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D 271	Continued From page 16 Resident #6's room looking out of the room door. -When he walked into Resident #6's room the facility staff member was just standing there. -The facility staff member said something along the lines of she did not know what she was doing. -The facility staff member was not administering CPR when he arrived. -When he was trying to get his gloves on the facility staff member started administering CPR. -When he asked the facility staff member how long she had been doing CPR she said 10 to 15 minutes. Telephone interview with EMS Shift Supervisor on 12/02/24 at 1:12pm revealed the police officer started CPR until EMS arrived. Review of the EMS report dated 11/15/24 revealed: -EMS arrived at the facility at 4:39am, and the facility door was locked. -Upon arrival at the facility a police officer was noted to be on the scene. -EMS arrived at Resident #6's bedside at 4:42am. -It was noted that there was a 3 minute delay in resident contact due to facility doors being locked and having to wait for staff to let EMS into the facility. -The estimated time of collapse to CPR was 15 minutes. -Resident #6 was lying on her back on the floor and the police officer was performing CPR. -Staff reported the resident pulled her call bell around 4:30am. -The resident usually requested her albuterol treatment during the night and staff found her unresponsive in the bed. (Albuterol is used to treat wheezing and shortness of breath). -Staff reported they called 911 and waited for EMS arrival.	D 271	by Diane Giddeons AHA Instructor on January 16, 2025 for all nursing staff, Administrator RCC and transportation driver. ~~At this time~~ all nursing staff is CPR certified. Administrator will keep up with CPR training when needed. Nursing staff will be reviewed on CPR every 6 months. On January 29, 2025 hHPS nurse in-serviced nursing staff on infection control and any significant changes with residents. Monthly hHPS nurse will review significant changes. Infection control will be done annually or when needed by hHPS nurse. Administrator will oversee all training for facility compliance.	

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D 271	Continued From page 17 -The police officer reported he moved the resident off the bed and began CPR. -Resident #6 was found unresponsive, not breathing, and pulseless. -Resident #6 was warm to the touch with no signs of lividity (lividity is a postmortem sign of death that occurs when blood settles in the lower parts of the body due to gravity and usually begins to appear 30 minutes to 4 hours after death) nor rigor mortis (rigor mortis is the stiffening of muscles after death). -CPR was discontinued and the resident was pronounced deceased at 5:09am. Telephone interview with the PCA on 12/03/24 at 5:12am revealed: -About 5 minutes after she conducted 30 to 45 minutes rounds 2 or 3 call bells sounded at the same time on 11/15/24. -One of the call bells was for Resident #6. -Typically, when Resident #6 rang the call bell, it was to request a nebulizer breathing treatment. -She went to check Resident #6 first. -She noticed that Resident #6 was pale but warm and appeared unresponsive. -She told the MA that Resident #6 was not breathing, her mouth was open, and she had no pulse. -She left Resident #6 alone in her room and went to the nurses' station and called 911. -She returned to Resident #6's room. -Resident #6 was a 2-person assist and she could not move the resident to the floor alone. -When the police officer arrived, he helped move the resident to the floor and he helped with CPR. -She never heard Resident #6 ask for a breathing treatment because the resident was not responsive. Second interview with the PCA on 12/04/24 at	D 271		

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D 271	Continued From page 18 4:30am revealed: -Resident #6's call bell was responded to immediately on 11/15/24. -She did not recall informing the MA that Resident #6 needed a nebulizer breathing treatment. Third telephone interview with the PCA on 01/08/25 at 11:34pm revealed: -She was near the laundry area when she heard the call bells ringing on 11/15/24. -She went to answer the call bells and found Resident #6 around 4:15am-4:30am. -Resident #6 was lying on her back and her mouth was open she was unresponsive, not breathing, and pulseless. -Her head was at the head of the bed and her legs were on the bed. -She panicked and screamed for help and the MA did not come to help her. -She was not able to move Resident #6 to the floor by herself and she started to perform chest compressions and gave breaths. -She stopped performing CPR and told the MA she was going to call 911. -She returned to Resident #6's room and started CPR. -The police officer was the first to arrive and the two of them moved Resident #6 to the floor and he started CPR. Telephone interview with the MA on 12/11/24 at 9:28am revealed: -She was at the medication cart preparing medication for another resident when Resident #6's call bell sounded on the morning of 11/15/24. -She thought Resident #6 probably wanted a breathing treatment. -She told the PCA to go check Resident #6's call bell and ask Resident #6 if she wanted a breathing treatment.	D 271		

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D 271	Continued From page 19 -The PCA told her when she returned Resident #6 was just lying there. -She told the PCA to call 911. -She did not know if the PCA started CPR or not. -Police arrived first but she did not know if the police performed CPR. -She was not in the room. -She was going back and forth getting paperwork. -The PCA responded to Resident #6's call bell within 1 to 2 minutes. -She showed the police to Resident #6's room. Second telephone interview with the MA on 01/08/25 at 8:57am revealed: -She was the MA on third shift on 11/15/24, hours were 11:00pm-7:00am. -There were only two staff working on the night shift on 11/15/24 herself and a PCA. -Two staff on night shift was the normal staffing assignment. -Resident #6 pulled her call bell around 4:00am. -She was at the medication cart preparing medications for another resident. -The PCA was coming from the laundry room area and she informed her that Resident #6 had pulled her call bell and asked her to let her know that she would bring her nebulizer medication when she took the other resident who was requesting medications his medications. -When she entered Resident #6's room she was lying on her bed with her mouth open, her head was at the head of the bed and her legs were on the bed. -She shook Resident #6 and there was not any response. -She did not check Resident #6 for a pulse or respirations or start CPR. -She told the PCA to call 911 and the PCA left Resident #6's room to go to the nurses' station to call 911.	D 271		

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D 271	Continued From page 20 -She left Resident #6's room and went to prepare the paperwork for EMS. -She just wanted to get Resident #6 out of the facility. -She was not sure why she had not checked for a pulse or respirations. -She was unable to explain why CPR was not started. -The PCA was standing at Resident #6's room door waiting for EMS to arrive. -A police officer arrived first. -She did not see the PCA perform CPR. Interview with the RCC on 12/02/24 at 2:54pm revealed: -She got the call from staff before day shift on 11/15/24. -When she arrived, EMS met her at the door. -When she arrived at the facility Resident #6 was already deceased. Second interview with the RCC on 01/08/25 at 2:08pm revealed: -Resident #6 was not a DNR, she was a full code. -Facility doors were locked around 6:30pm-7:00pm and unlocked at 6:30am-7:00am. -In an emergency one staff member should wait at the door to unlock it. -The facility door should not be unlocked until the EMS arrived. -Both staff on night shift were responsible for performing CPR. Interview with the Administrator on 12/13/24 2:08pm revealed the PCA started CPR on Resident #6 and the police helped with CPR when they arrived. Second interview with the Administrator on 01/08/25 at 2:33pm revealed:	D 271		

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D 271	Continued From page 21 -She was not in the facility when Resident #6 passed away. -The RCC notified her between 5:30am and 6:30am. -She arrived at the facility about 9:00am on 11/15/24. -The RCC completed the death report. -There was at least one CPR trained staff on each shift. Third interview with the Administrator on 01/09/25 at 4:48pm revealed: -EMS should have been let into the facility immediately upon arrival on 11/15/24. -When staff found a resident unresponsive, not breathing, and pulseless they should yell for help and never leave the resident alone. -One person should call 911 while the other was working with the resident then someone should monitor the door. -The facility doors were locked at night. Telephone interview with Resident #6's PCP on 12/02/24 at 2:06pm revealed: -Resident #6 was started on medications for management of chronic obstructive pulmonary disease (COPD) exacerbation in April 2024. -The resident continued to smoke. -On 05/01/24 she discussed medications, shortness of breath, and wheezing with Resident #6 and the resident had no desire to quit smoking. -On 05/01/24 a nebulizer was ordered for Resident #6. -Resident #6 was seen on 10/02/24 for COPD exacerbation and was non-compliant with quitting smoking. -Resident #6 was seen by the PCP on 10/23/24 for an ongoing cough, mucous production, and continuing to smoke.	D 271		

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D 271	Continued From page 22 Second interview with Resident #6's PCP on 01/08/25 at 10:02am revealed: -Resident #6 was a full code. -She was never hypoxic and did not require oxygen. -CPR should be started immediately upon finding a resident unresponsive, not breathing, and pulseless. -A person would die quickly without CPR being started. The facility failed to provide immediate life saving intervention in accordance with their facility policy for a resident who was a full code. Resident #6 rang her call bell and was found by facility staff to be unresponsive, not breathing, and pulseless. When the police officer arrived, the facility staff was not performing Cardiopulmonary Resuscitation and he initiated until EMS arrived once they were able to gain access to the locked facility which delayed treatment to the resident. The resident died. This failure resulted in neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/18/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED February 8, 2025.	D 271	Corrected	1/16/2025
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and	D 316		

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D 316	Continued From page 23 updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post a current, monthly activity calendar on the first day of the month for the 39 residents residing in the facility. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed with a	D 316		

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D 316	Continued From page 24 capacity of 64 beds. Review of the facility's census reports provided on 01/07/25 revealed the facility's in-house census was 39 residents. Observation of the main hallways and common areas of the facility on 01/07/25 revealed there was no activity calendar posted dated January 2025. Interview with a resident on 01/07/25 at 9:22am revealed they did not like the activities provided, it was mainly coloring. Interview with second resident on 01/07/25 at 9:25am revealed they did not attend activities because they did not know what the activities were or when they were held. Interview with third resident on 01/07/25 at 9:30am revealed: -There was not an activity calendar. -He never knew when the activities were held. -No one had ever come to his room and invited him to an activity. Interview with the Activity Director on 01/07/25 at 9:49am revealed the Administrator had the activity calendar and she was working on completing it. Second interview with the Activity Director on 01/08/2025 at 11:50am revealed: -She had been in the Activity Director role for 4-5 months. -She did not have any official training related to the Activity Director position. -She had not been oriented to her position of Activity Director at the facility.	D 316		

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D 316	Continued From page 25 -She knew that she was supposed to post a monthly calendar. -She did not know that there was a requirement for the calendar to be posted by a certain date or that the activities required the number of hours. -The facility did have a van to transport residents but she had not had any outings for residents. Interview with the Administrator on 01/08/25 at 12:00pm revealed: -She was trying to get the Activity Director trained but she had other priorities that took precedence. -She knew that the activity calendar was to be completed and posted by the first of the month. -It was the Activity Director's responsibility to complete and post the monthly activity calendar. -She was ultimately responsible to ensure that an activity calendar was completed correctly and posted by the first of the month.	D 316		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of a variety of group activities were provided each week for the residents. The findings are: Review of the facility's current license effective	D 317		

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D 317	Continued From page 26 01/01/25 revealed the facility was licensed with a capacity of 64 beds. Review of the facility's census reports provided on 01/07/25 revealed the facility's in-house census was 39 residents. Observation of the main hallways and common areas of the facility on 01/07/25 revealed there was no activity calendar posted dated January 2025. Observation of the facility on 01/07/25 between 8:30am-5:00pm there were no activities provided for the residents. Observation of the facility on 01/08/25 revealed there was an exercise class held at 9:00am-9:30am. Observation of the facility on 01/09/25 revealed someone sang for the residents from 3:00pm-4:00pm. Interview with the Activity Director on 01/08/2025 at 11:50am revealed: -She had been in the Activity Director role for 4-5 months. -She did not have any official training related to the Activity Director position. -She had not been oriented to her position of Activity Director at the facility. Interview with the Administrator on 01/08/25 at 12:00pm revealed: -She was trying to get the Activity Director trained but she had other priorities that took precedence. -She knew that the requirement was 14 hours of activities per week. -She was ultimately responsible to ensure that	D 317	Administrator in-serviced interim activity personnel on January 14, 2025. Review policy for activity program was discussed and understood. Each Week the resident have to have 14 hours of a variety of planned group activities per week with all resident that would like to participate. Plan outing monthly for resident that would like to participate. Activity personnel was asked to prepare calendar for activities the last week in every month to be posted on 1st day of each month. Administrator will review activity calendar and resident activities monthly Evaluation will be done every six months with input of residents.	1/14/2025

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D 317	Continued From page 27 there was 14 hours of activities per week.	D 317	Paper MAR's Resolving Glitch Medication Administration Review and Documentation RCC in-serviced Med Tech. on January 10, 2025. Paper MAR's was put in place to assure meds was given accurately. All Med Tech. will continue to pass meds on computer	11/10/2025 11/14/2025 11/29/2025
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 5 of 5 sampled residents (#1, #2, #3, #4, and #5) had accurate medication administration records. The findings are: Review of the facility's administration of	D 367		

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D 367	Continued From page 28 medications policy revealed: -The staff person administering medication is responsible for charting the drug immediately after administration on the resident's medication administration record (MAR). -The medication doses will be recorded in accordance with instructions for completing the MAR. -PRN (as needed) medications administered shall be recorded on the face of the MAR indicating time given, reason, or indication and follow up for results, and the results should be recorded in 2-hour periods after administering the PRN until the next dose or need is due. -The dose not given shall be noted as circle at the appropriate time slot on all MARs with an explanation given on the back of the MAR of why the dose was omitted. 1. Review of Resident #4's current FL-2 dated 01/07/25 revealed: -Diagnoses included left bundle branch block, Parkinson's disease, syncope, and elevated troponin. -There was an order for Acetaminophen 325mg 2 tablets every 8 hours (used to treat pain), Aquaphor ointment apply to affected area 2 times a day (used to treat drying skin), Aspirin 81mg 1 tablet daily (a blood thinner medication used to prevent heart attacks and strokes), Atorvastatin 10mg 1 tablet at bedtime daily (used to lower cholesterol), Donepezil 5mg 1 tablet at bedtime (used to treat memory loss), Ezetimibe 10mg 1 tablet daily (used to lower cholesterol), Famotidine 20 mg 1 tablet daily (used to treat gastroesophageal reflux disease), Jardiance 10mg 1 tablet daily (used to lower blood sugar), Magnesium Oxide 400mg 1 tablet 2 times daily (used to treat heartburn), Metformin HCL ER 500mg 2 tablets 2 times daily (used to treat high	D 367	After each Med pass Med Tech will go back Check for glitches on Computer MAR at this time if Med Tech can't fix or resolve they will inital on paper MAR. This will be done until all issue is resolved. RCC will check paper MAR's monthly and file in patient Charts. Med Tech was in-serviced on January 14, 2025 on resolving the issue with glitches durning medpass. Spoke with pharmacy he instructed RCC how to resolve problem with computer glitches. Med Tech at this time using	

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D 367	Continued From page 29 blood sugar levels), Metoprolol SUCC ER 25mg, ½ tablet 12.5mg daily (used to treat heart disease), Paroxetine HCL 20mg 1 tablet at bedtime (used to treat depression), Myrbetriq ER 50mg 1 tablet daily (used to treat overactive bladder), Pregabalin 75mg 1 capsule 2 times daily (used to treat pain), Tamsulosin HCL 0.4mg 1 capsule daily (used to treat enlarged prostate), and Tresiba Flextouch 100 units/ml inject 24 units under the skin at bedtime and hold for glucose less than 120 daily (used to control blood sugar level). Review of Resident #4's Resident Register revealed an admission date of 04/06/23. Review of Resident #4's November 2024 electronic mediation administration record (eMAR) revealed: -There was an entry for Acetaminophen 325mg, take 2 tablets every 8 hours (6:00am, 2:00pm, and 10:00pm). -Acetaminophen 325mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 6:00am on 11/04/24, 11/19/24, 11/20/24, and 11/25/24. -Acetaminophen 325mg was documented as a "/" symbol at 2:00pm on 11/16/24, 11/17/24, and 11/26/24. -Acetaminophen 325mg was documented as a "/" symbol at 10:00pm on 11/01/24, 11/15/24, 11/22/24, 11/25/24, 11/26/24, and 11/29/24. -There was an entry for Aquaphor ointment apply to affected area 2 times daily (9:00am and 9:00pm). -Aquaphor ointment was documented as a "/" symbol at 9:00am on 11/03/24. -Aquaphor ointment was documented as a "/" symbol at 9:00pm on 11/01/24, 11/15/24, 11/22/24, and 11/29/24.	D 367	Computers on Med Pass is to check their meds after each hall before going to the next hall to see if any arrow sign is shown on that hall. Med Tech will immediately go back look at each medication with arrow to see if med was given and fix arrow on MAR. RCC + Administrator will check weekly for glitches on Computers On January 29, 2025 LHPS nurse in-serviced on Medication Administration Review + Documentation for all Med Techs. All Med Tech. was reviewed on giving meds correctly	

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D 367	Continued From page 30 -There was an entry for Aspirin 81mg, take 1 tablet daily (7:00am). -Aspirin 81mg was documented as a "/" symbol at 7:00pm on 11/04/24, 11/06/24, 11/11/24, and 11/22/24 -There was an entry for Atorvastatin 10mg, take 1 tablet at bedtime (7:00pm). - Atorvastatin 10mg was documented as a "/" symbol at 7:00pm on 11/01/24 through 11/03/24, 11/15/24 through 11/18/24, and 11/20/24 through 11/22/24, 11/24/24, and 11/29/24. -There was an entry for Donepezil 5mg, take 1 tablet at bedtime (7:00pm). -Donepezil 5mg was documented as a "/" symbol at 7:00pm on 11/01/24 through 11/03/24, 11/15/24 through 11/18/24, 11/20/24 through 11/22/24, 11/24/24, and 11/29/24. -There was an entry for Ezetimibe 10mg, take 1 tablet daily (9:00am). -Ezetimibe 10mg was documented as a "/" symbol at 9:00am on 11/03/24. -There was an entry for Famotidine 20 mg, take 1 tablet daily (7:00am). -Famotidine 20 mg was documented as a "/" symbol at 7:00am on 11/04/24, 11/06/24, 11/11/24, and 11/22/24. -There was an entry for Jardiance 10mg, take 1 tablet daily (7:00am). -Jardiance 10mg was documented as a "/" symbol at 7:00am on 11/04/24, 11/06/24, 11/11/24, and 11/22/24. -There was an entry for Magnesium Oxide 400mg, take 1 tablet 2 times daily (7:00am and 7:00pm). -Magnesium Oxide 400mg was documented as a "/" symbol at 7:00am on 11/04/24, 11/06/24, 11/11/24, and 11/22/24. -Magnesium Oxide 400mg was documented as a "/" symbol at 7:00pm on 11/01/24 through 11/03/24, 11/15/24 through 11/18/24, 11/20/24	D 367	and signing MAR's during Med pass. HHPS nurse will in-service Med Techs on Medication Administration + Documentation every six months for Medication Compliance.	

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D 367	Continued From page 31 through 11/22/24, 11/24/24, and 11/29/24. -There was an entry for Metformin HCL ER 500mg, take 2 tablets 2 times daily (7:00am and 7:00pm). -Metformin HCL ER 500mg was documented as a "/" symbol at 7:00am on 11/04/24 through 11/06/24, 11/11/24, and 11/22/24. -Metformin HCL ER 500mg was documented as a "/" symbol at 7:00pm on 11/01/24 through 11/03/24, 11/15/24 through 11/18/24, 11/20/24 through 11/22/24, 11/24/24, and 11/29/24. -There was an entry for Metoprolol SUCC ER 25mg, take ½ tablet 12.5mg daily (7:00am). -Metoprolol SUCC ER 25mg was documented as a "/" symbol at 7:00am on 11/04/24 through 11/06/24, 11/11/24, 11/22/24, and 11/24/24. -There was an entry for Paroxetine HCL 20mg, take 1 tablet at bedtime (7:00pm). -Paroxetine HCL 20mg was documented as a "/" symbol at 7:00pm on 11/01/24 through 11/03/24, 11/15/24 through 11/18/24, 11/20/24 through 11/22/24, 11/24/24, and 11/29/24. -There was an order for Myrbetriq ER 50mg, take 1 tablet daily (7:00am). -Myrbetriq ER 50mg was documented as a "/" symbol at 7:00am on 11/04/24, 11/06/24, 11/11/24, 11/16/24, and 11/22/24. -There was an entry for Pregabalin 75mg, take 1 capsule 2 times daily (9:00am and 9:00pm). -Pregabalin 75mg was documented as a "/" symbol at 9:00am on 11/03/24. -Pregabalin 75mg was documented as a "/" symbol at 9:00pm on 11/01/24, 11/15/24, 11/22/24, and 11/29/24. -There was an order for Tamsulosin HCL 0.4mg, take 1 capsule daily (7:00pm). -Tamsulosin HCL 0.4mg was documented as a "/" symbol at 7:00pm on 11/01/24 through 11/03/24, 11/15/24 through 11/18/24, 11/20/24 through 11/22/24, 11/24/24, and 11/29/24.	D 367		

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D 367	Continued From page 32 -There was an order for Tresiba Flextouch 100 units/ml inject 24 units under the skin at bedtime (8:00pm). -Tresiba Flextouch 100 units/ml inject 24 units was documented as a "/" symbol at 8:00pm on 11/01/24, 11/15/24, 11/22/24, and 11/29/24. -There were 16 medications documented as missed dose on 12 out of 30 days. Review of Resident #4's December 2024 eMAR revealed: -There was an entry for Acetaminophen 325mg, take 2 tablets every 8 hours (6:00am, 2:00pm, and 10:00pm). -Acetaminophen 325mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 6:00am on 12/06/24, 12/09/24 through 12/12/24, 12/14/24, 12/15/24, 12/17/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, 12/27/24, and 12/30/24. -Acetaminophen 325mg was documented as a "/" symbol at 2:00pm on 12/03/24, 12/13/24 through 12/15/24, and 12/25/24. -Acetaminophen 325mg was documented as a "/" symbol at 10:00pm on 12/09/24, 12/10/24, 12/13/24, 12/30/24, and 12/31/24. -There was an entry for Aquaphor ointment apply to affected area 2 times daily (9:00am and 9:00pm). -Aquaphor ointment was documented as a "/" symbol at 9:00am on 12/01/24, 12/14/24, 12/15/24, 12/22/24, and 12/31/24 -Aquaphor ointment was documented as a "/" symbol at 9:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an entry for Aspirin 81mg, take 1 tablet daily (7:00am). -Aspirin 81mg was documented as a "/" symbol at 7:00pm on 12/02/24, 12/09/24, 12/12/24, 12/14/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24,	D 367		

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D 367	Continued From page 33 12/26/24, and 12/30/24. -There was an entry for Atorvastatin 10mg, take 1 tablet at bedtime (7:00pm). - Atorvastatin 10mg was documented as a "/" symbol at 7:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an entry for Donepezil 5mg, take 1 tablet at bedtime (7:00pm). -Donepezil 5mg was documented as a "/" symbol at 7:00pm on 12/13/24, 12/30/24 and 12/31/24. -There was an entry for Ezetimibe 10mg, take 1 tablet daily (9:00am). -Ezetimibe 10mg was documented as a "/" symbol at 9:00am on 12/01/24, 12/14/24, 12/15/24, 12/22/24, 12/24/24, and 12/31/24. -There was an entry for Famotidine 20 mg, take 1 tablet daily (7:00am). -Famotidine 20 mg was documented as a "/" symbol at 7:00am on 12/02/24, 12/09/24, 12/12/24, 12/14/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, and 12/30/24. -There was an entry for Jardiance 10mg, take 1 tablet daily (7:00am). -Jardiance 10mg was documented as a "/" symbol at 7:00am on 12/02/24, 12/09/24, 12/12/24, 12/14/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, and 12/30/24. -There was an entry for Magnesium Oxide 400mg, take 1 tablet 2 times daily (7:00am and 7:00pm). -Magnesium Oxide 400mg was documented as a "/" symbol at 7:00am on 12/02/24, 12/09/24, 12/12/24, 12/14/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, and 12/30/24. -Magnesium Oxide 400mg was documented as a "/" symbol at 7:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an entry for Metformin HCL ER 500mg, take 2 tablets 2 times daily (7:00am and 7:00pm).	D 367		

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D 367	Continued From page 34 -Metformin HCL ER 500mg was documented as a "/" symbol at 7:00am on 12/02/24, 12/09/24, 12/12/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, and 12/30/24. -Metformin HCL ER 500mg was documented as a "/" symbol at 7:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an entry for Metoprolol SUCC ER 25mg, take ½ tablet 12.5mg daily (7:00am). -Metoprolol SUCC ER 25mg ½ tablet was documented as a "/" symbol at 7:00am on 12/02/24, 12/09/24, 12/12/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, and 12/30/24. -There was an entry for Paroxetine HCL 20mg, take 1 tablet at bedtime (7:00pm). -Paroxetine HCL 20mg was documented as a "/" symbol at 7:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an order for Myrbetriq ER 50mg, take 1 tablet daily (7:00am). -Myrbetriq ER 50mg was documented as a "/" symbol at 7:00am on 12/02/24, 12/09/24, 12/12/24, 12/15/24, 12/18/24, 12/22/24, 12/23/24, 12/26/24, and 12/30/24. -There was an entry for Pregabalin 75mg, take 1 capsule 2 times daily (9:00am and 9:00pm). -Pregabalin 75mg was documented as a "/" symbol at 9:00am on 12/01/24, 12/14/24, 12/15/24, 12/22/24, 12/24/24, and 12/31/24. -Pregabalin 75mg was documented as a "/" symbol at 9:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an order for Tamsulosin HCL 0.4mg, take 1 capsule daily (7:00pm). -Tamsulosin HCL 0.4mg was documented as a "/" symbol at 7:00pm on 12/13/24, 12/30/24, and 12/31/24. -There was an order for Tresiba Flextouch 100 units/ml inject 24 units under the skin at bedtime (8:00pm).	D 367		

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D 367	Continued From page 35 -Tresiba Flextouch 100 units/ml inject 24 units was documented as a "/" symbol at 8:00pm on 12/13/24, 12/30/24, and 12/31/24. -There were 16 medications documented as missed dose on 10 out of 31 days. Review of Resident #4's January 2025 eMAR revealed: -There was an entry for Acetaminophen 325mg, take 2 tablets every 8 hours (6:00am, 2:00pm, and 10:00pm). -Acetaminophen 325mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 6:00am on 01/01/25, 01/03/25, and 01/06/25. -Acetaminophen 325mg was documented as a "/" symbol at 2:00pm on 01/05/25. -Acetaminophen 325mg was documented as a "/" symbol at 10:00pm on 01/03/25, and 01/05/25. -There was an entry for Aquaphor ointment apply to affected area 2 times daily (9:00am and 9:00pm). -Aquaphor ointment was documented as a "/" symbol at 9:00am on 01/03/25. -Aquaphor ointment was documented as a "/" symbol at 9:00pm on 01/03/25, and 01/05/25. -There was an entry for Aspirin 81mg, take 1 tablet daily (7:00am). -Aspirin 81mg was documented as a "/" symbol at 7:00pm on 01/01/25, and 01/03/25. -There was an entry for Atorvastatin 10mg, take 1 tablet at bedtime (7:00pm). - Atorvastatin 10mg was documented as a "/" symbol at 7:00pm on 01/02/25, and 01/06/25. -There was an entry for Donepezil 5mg, take 1 tablet at bedtime (7:00pm). -Donepezil 5mg was documented as a "/" symbol at 7:00pm on01/02/25, and 01/06/25. -There was an entry for Ezetimibe 10mg, take 1 tablet daily (9:00am).	D 367		

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D 367	Continued From page 36 -Ezetimibe 10mg was documented as a "/" symbol at 9:00am on 01/03/25. -There was an entry for Famotidine 20 mg, take 1 tablet daily (7:00am). -Famotidine 20 mg was documented as a "/" symbol at 7:00am on 01/01/25, and 01/03/25. -There was an entry for Jardiance 10mg, take 1 tablet daily (7:00am). -Jardiance 10mg was documented as a "/" symbol at 7:00am on 01/01/25, and 01/03/25. -There was an entry for Magnesium Oxide 400mg, take 1 tablet 2 times daily (7:00am and 7:00pm). -Magnesium Oxide 400mg was documented as a "/" symbol at 7:00am on 01/01/25, and 01/03/25. -Magnesium Oxide 400mg was documented as a "/" symbol at 7:00pm on 01/02/25, and 01/06/25. -There was an entry for Metformin HCL ER 500mg, take 2 tablets 2 times daily (7:00am and 7:00pm). -Metformin HCL ER 500mg was documented as a "/" symbol at 7:00am on 01/01/25, and 01/03/25. -Metformin HCL ER 500mg was documented as a "/" symbol at 7:00pm on 01/02/25, and 01/06/25. -There was an entry for Metoprolol SUCC ER 25mg, take ½ tablet 12.5mg daily (7:00am). -Metoprolol SUCC ER 25mg ½ tablet was documented as a "/" symbol at 7:00am on 01/01/25 and 01/03/25 through 01/04/25. -There was an entry for Paroxetine HCL 20mg, take 1 tablet at bedtime (7:00pm). -Paroxetine HCL 20mg was documented as a "/" symbol at 7:00pm on 01/02/25, and 01/06/25. -There was an order for Myrbetriq ER 50mg, take 1 tablet daily (7:00am). -Myrbetriq ER 50mg was documented as a "/" symbol at 7:00am on 01/01/25, and 01/03/25. -There was an entry for Pregabalin 75mg, take 1	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 37 capsule 2 times daily (9:00am and 9:00pm). -Pregabalin 75mg was documented as a "/" symbol at 9:00am on 01/03/25. -Pregabalin 75mg was documented as a "/" symbol at 9:00pm on 01/03/25, and 01/05/25. -There was an order for Tamsulosin HCL 0.4mg, take 1 capsule daily (7:00pm). -Tamsulosin HCL 0.4mg was documented as a "/" symbol at 7:00pm on 01/02/25 and 01/06/25. -There was an order for Tresiba Flextouch 100 units/ml inject 24 units under the skin at bedtime (8:00pm). -Tresiba Flextouch 100 units/ml inject 24 units was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/05/25. -There were 16 medications documented as missed dose on 4 out of 6 days. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/09/25 at 2:55pm revealed: -Resident #4 was prescribed medications through their pharmacy. -On 11/08/24, Acetaminophen 325mg 2 tablets every 8 hours, was dispensed with a quantity of 180. -On 05/28/24 and on 01/09/25, Aquaphor ointment, applied to affected area 2 times a day, was dispensed for 1 jar 596 grams. -On 12/11/24 and on 01/09/25, Aspirin 81mg, 1 tablet daily, was dispensed with a quantity of 31. -On 12/11/24 and on 01/09/25, Atorvastatin 10mg, 1 tablet at bedtime daily, was dispensed with a quantity of 31. -On 12/11/24 and on01/09/25, Donepezil 5mg, 1 tablet at bedtime, was dispensed with a quantity of 31. -On 12/11/24 and on01/09/25, Ezetimibe 10mg, 1 tablet daily, was dispensed with a quantity of 31. -On11/09/24 and on 12/11/24, Famotidine 20 mg,	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 38 1 tablet daily, was dispensed with a quantity of 31. -On 12/11/24 and on 01/09/25, Jardiance 10mg, 1 tablet daily, was dispensed with a quantity of 31. -On 12/11/24 and on 01/09/25, Magnesium Oxide 400mg, 1 tablet 2 times daily, was dispensed with a quantity of 62. -On 12/11/24 and on 01/09/25, Metformin HCL ER 500mg, 2 tablets 2 times daily, was dispensed with a quantity of 124. -On 12/11/24 and on 01/09/25, Metoprolol SUCC ER 12.5mg, ½ tablet daily, was dispensed with a quantity of 16. -On 12/11/24 and on 01/09/25, Paroxetine HCL 20mg, 1 tablet at bedtime, was dispensed with a quantity of 31. -On 12/11/24 and on 01/09/25, Myrbetriq ER 50mg, 1 tablet daily, was dispensed with a quantity of 31. -On 01/09/25, Pregabalin 75mg, 1 capsule 2 times daily, was dispensed with a quantity of 72. -On 12/11/24 and on 01/09/25, Tamsulosin HCL 0.4mg, 1 capsule daily, was dispensed with a quantity of 31. -On 10/30/24, Tresiba Flextouch 100 units/ml, inject 24 units under the skin at bedtime, was dispensed with a quantity of 15ml. -She could not say for sure that any medications were returned because when medications were returned they destroyed them and did not keep a record. Refer to the interview with the medication aide (MA) on 01/08/25 at 7:53am. Refer to the second interview with the MA on 01/09/25 at 11:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 2:30pm	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 39 revealed. Refer to the second interview with the RCC on 01/09/25 at 12:00pm revealed. Refer to the second telephone interview with a pharmacist at the facility's contracted pharmacy on 01/08/25 at 4:13pm. Refer to the interview with the Administrator on 01/09/25 at 12:30pm. 2. Review of Resident #5's current FL-2 dated 01/03/24 revealed diagnoses included brain trauma, dementia behavioral disturbances, and benign prostatic hyperplasia. Review of Resident #5's Resident Register revealed an admission date of 08/01/07. Review of Resident #5's current Physician orders dated 01/01/25 revealed: -There was an order for Amlodipine Besylate 10mg 1 tablet daily (used to treat high blood pressure), Calcium Antacid 500mg 2 and ½ tablets daily (used to treat heartburn), Combivent Respimat 20-100mcg inhale 1 puff four times daily (used to treat chronic obstructive pulmonary disease), Depakote 125mg 1 capsule 2 times daily (used to treat mood), Colace 100mg 2 capsules at bedtime (used to treat constipation), Melatonin 5mg 1 tablet at bedtime (used to treat insomnia), Miralax powder 3350 17 grams in 8 ounces of water daily (used to treat constipation), Prazosin 1mg 1 capsule at bedtime (used to treat high blood pressure), Refresh Classic Eye Drop instill 1 drop to left eye socket 2 times a day (used to treat dry eyes), Senna Plus 17.2mg 1 tablet daily (used to treat constipation), Sertraline 20mg 5ml 1 tablet daily (used to treat	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 40	D 367		

depression), Metoprolol Tartrate 50mg 1 tablet 2 times daily (used to treat heart disease), and Levothyroxine 75mcg 1 tablet daily (used to treat an underactive thyroid gland).

Review of Resident #5's December 2024 electronic mediation administration record (eMAR) revealed:
-There was an entry for Amlodipine Besylate 10mg, take 1 tablet daily (8:00am).
- Amlodipine Besylate 10mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 8:00am on 12/27/24, and 12/28/24.
-There was an entry for Calcium Antacid 500mg, take 2 and ½ tablets daily (8:00am).
-Calcium Antacid 500mg 2 and ½ tablets was documented as a "/" symbol at 8:00am on 12/27/24, and 12/28/24.
-There was an entry for Combivent Respimat 20-100mcg, inhale 1 puff four times daily (8:00am, 12:00pm, 4:00pm, and 8:00pm).
-Combivent Respimat 20-100mcg was documented as a "/" symbol at 8:00am on 12/27/24, and 12/28/24.
-Combivent Respimat 20-100mcg was documented as a "/" symbol at 12:00pm on 12/11/24, 12/12/24, and 12/26/24.
-There was an entry for Depakote 125mg, take 1 capsule 2 times daily (8:00am and 8:00pm).
-Depakote 125mg was documented as a "/" symbol at 8:00am on 12/27/24, and 12/28/24.
-There was an entry for Miralax powder 3350 17 grams in 8 ounces of water daily (9:00am).
-Miralax powder 3350 17 grams was documented as a "/" symbol at 9:00am on 12/28/24.
-There was an entry for Refresh Classic Eye Drop instill 1 drop to left eye socket 2 times a day (8:00am and 8:00pm).
-Refresh Classic Eye Drop was documented as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 41 "/" symbol at 8:00am on 12/17/24, 12/27/24, and 12/28/24. -There was an entry for Metoprolol Tartrate 50mg, take 1 tablet 2 times daily (8:00am and 6:00pm). Metoprolol Tartrate 50mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/27/24, and 12/28/24. -There was an entry for Levothyroxine 75mcg, take 1 tablet daily(6:00am). -Levothyroxine 75mcg was documented as a "/" symbol at 6:00am on 12/11/24, 12/12/24, 12/17/24, and 12/24/24 through 12/28/24, and 12/31/24. -There were 8 medications documented as missed dose on 6 out of 31 days. Review of Resident #5's January 2025 eMAR revealed: -There was an entry for Amlodipine Besylate 10mg, take 1 tablet daily (8:00am). - Amlodipine Besylate 10mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 8:00am on 01/08/25. -There was an entry for Calcium Antacid 500mg, take 2 and ½ tablets daily (8:00am). -Calcium Antacid 500mg 2 and ½ tablets was documented as a "/" symbol at 8:00am on 01/08/25. -There was an entry for Combivent Respimat 20-100mcg, inhale 1 puff four times daily (8:00am, 12:00pm, 4:00pm, and 8:00pm). -Combivent Respimat 20-100mcg was documented as a "/" symbol at 8:00am on 01/08/25. -Combivent Respimat 20-100mcg was documented as a "/" symbol at 12:00pm on 01/02/25 and 01/03/25. -Combivent Respimat 20-100mcg was documented as a "/" symbol at 4:00pm on 01/07/25.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET 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 367	Continued From page 42 -Combivent Respimat 20-100mcg was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Depakote 125mg, take 1 capsule 2 times daily (8:00am and 8:00pm). -Depakote 125mg was documented as a "/" symbol at 8:00am on 01/08/25. -Depakote 125mg was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Colace 100mg, take 2 capsules at bedtime (6:00pm). -Colace 100mg was documented as a "/" symbol at 6:00pm on 01/04/25, 01/06/25 and 01/07/25. -There was an entry for Levothyroxine 75mcg, take 1 tablet daily(7:00am). -Levothyroxine 75mcg was documented as a "/" symbol at 7:00am on 01/05/25, 01/06/25, 01/08/25, and 01/09/25. -There was an entry for Melatonin 5mg, take 1 tablet at bedtime (8:00pm). -Melatonin 5mg was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Refresh Classic Eye Drop instill 1 drop to left eye socket 2 times a day (8:00am and 8:00pm). -Refresh Classic Eye Drop was documented as a "/" symbol at 8:00am on 01/08/25. -Refresh Classic Eye Drop was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Metoprolol Tartrate 50mg, take 1 tablet 2 times daily (8:00am and 6:00pm). -Metoprolol Tartrate 50mg was documented as a "/" symbol at 8:00am on 01/08/25. -Metoprolol Tartrate 50mg was documented as a "/" symbol at 6:00pm on 01/06/25 and 01/07/25. -There was an entry for Prazosin 1mg, take 1 capsule at bedtime (8:00pm). -Prazosin 1mg was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Senna Plus 17.2mg, take	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 43 1 tablet daily (8:00pm). -Senna Plus 17.2mg was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Sertraline 20mg 5ml, take 1 tablet daily (8:00pm). -Sertraline 20mg 5ml was documented as a "/" symbol at 8:00pm on 01/07/25. -There were 12 medications documented as missed dose on 4 out of 9 days. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/09/25 at 2:55pm revealed: -Resident #5 was prescribed medications through their pharmacy. -On 12/12/24 and on 01/09/25, Amlodipine Besylate 10mg, 1 tablet daily, was dispensed with a quantity of 31. -On 12/11/24 and on 01/09/25, Calcium Antacid 500mg, 2 and ½ tablets daily, was dispensed with a quantity of 31. -On 11/05/24 and on 12/18/24, Combivent Respimat 20-100mcg, inhale 1 puff four times daily, was dispensed. -On 12/11/24 and on 01/09/25, Depakote 125mg, 1 capsule 2 times daily, was dispensed with a quantity of 62. -On 12/16/24 and on 01/09/25, Colace 100mg, 2 capsules at bedtime, was dispensed with a quantity of 62. -On 09/25/24 Miralax powder 3350 17 grams, in 8 ounces of water daily, was dispensed with a quantity to last 60 days. -On 01/09/25, Refresh Classic Eye Drop instill 1 drop, to left eye socket 2 times a day, was dispensed. -On 11/20/24 and on 12/30/24, Metoprolol Tartrate 50mg, 1 tablet 2 times daily, was dispensed with a quantity of 30. -On 12/11/24 and on 01/09/25, Levothyroxine	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 44 75mcg, 1 tablet daily, was dispensed with a quantity of 31. -She could not say for sure that any medications were returned because when medications were returned they destroyed them and did not keep a record. Refer to the interview with the medication aide (MA) on 01/08/25 at 7:53am. Refer to the second interview with the MA on 01/09/25 at 11:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 2:30pm revealed. Refer to the second interview with the RCC on 01/09/25 at 12:00pm revealed. Refer to the second telephone interview with a pharmacist at the facility's contracted pharmacy on 01/08/25 at 4:13pm. Refer to the interview with the Administrator on 01/09/25 at 12:30pm. 3. Review of Resident #2's current FL-2 dated 11/06/2024 revealed: -Diagnoses included Cellulitis of Left Foot, Neuropathic Arthropathy, Fracture 2nd and 3rd Metatarsal Bone Left Foot, Thrombocytopenia, Hypertension, Schizophrenia. -There was an order for Acetaminophen 500mg 2 tablets 3 times daily (used to treat pain), Benztropine 1mg take 1 tablet twice daily (used to treat Parkinson's disease), Cetirizine 5-120mg take 1 tablet 2 times daily (used to treat allergies), Diltiazem 24hr ER 120mg 1 capsule daily (used to treat hypertension), Divalproex SOD ER	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 45 500mg take 3 tablets daily (used for mood), Duloxetine HCL DR 60mg take 1 capsule daily (used to treat mood), Fluticasone PROP 50mcg spray 1 spray into both nostrils once daily (used to treat allergies), Gabapentin 600mg take 2 tablets 3 times daily (used to treat neuropathy), Gemtesa 75mg take 1 tablet daily (used to treat benign prostatic hyperplasia), Lactulose 10gm/15mL take 15 ML's daily (used to treat constipation), Linzess 10mg take 1 capsule daily (used to treat constipation), Lisinopril 10mg tablet take 1 tablet daily (used to treat high blood pressure), Oxybutynin 5mg take 1 tablet at bedtime (used to treat nocturnal enuresis), Probiotic Gummy take 1 gummy daily (for supplement), Quetiapine ER 150mg take 1 tablet at bedtime (for mood), Quetiapine ER 50mg take 1 tablet at bedtime (for mood), Senna 8.6mg take 2 tablets twice daily (used to treat constipation), Sertraline HCL 25mg take 1 tablet daily (used to treat Dysthymic Disorder), Simvastatin 10mg take one tablet by mouth at bedtime (used to treat cholesterol), Thera Tablet take 1 tablet daily (for supplement), Tramadol HCL 50mg take 1 tablet four times daily (used to treat pain), Ziprasidone HCL 80mg take 1 capsule 2 times daily with meals (used to treat schizophrenia). -Review of Resident #2's Physician's order dated 11/13/24 revealed an order for Tramadol HCL 50mg take1 tablet two times daily (used to treat pain). Review of Resident #2's November 2024 electronic mediation administration record (eMAR) revealed: -There was an entry for Acetaminophen 500mg, take 2 tablets 3 times daily (8:00am, 2:00pm, and 8:00pm). -Acetaminophen 500mg was documented as a "/"	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET 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 367	Continued From page 46 symbol (used to indicate a missed dose of medication) at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/17/24, 11/25/24, 11/26/24, and 11/30/24. -Acetaminophen 500mg was documented as a "/" symbol at 2:00pm on 11/16/24, 11/17/24, and 11/26/24. -Acetaminophen 500mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Benztropine MES 1mg, take 1 tablet twice daily (8:00am and 8:00pm). -Benztropine MES 500mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/17/24, 11/25/24, 11/16/24, and 11/30/24. -Benztropine MES 500mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Cetirizine 5-120mg, take 1 tablet 2 times daily (8:00am and 8:00pm). -Cetirizine 5-120mg was documented as a "/" symbol at 8:00am on 11/04/24. -There was an entry for Diltiazem 24hr ER 120mg, take 1 capsule daily (8:00am). -Diltiazem 24hr ER 120mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Divalproex SOD ER 500mg, take 3 tablets daily (8:00pm). -Divalproex SOD ER 500mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was any entry for Duloxetine HCL DR 60mg, take 1 capsule daily (8:00am). -Duloxetine HCL DR 60mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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WALLACE GARDENS	1052 NE RAILROAD STREET 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 367	Continued From page 47 -There was an entry for Fluticasone PROP 50mcg Spray, spray into both nostrils once daily (8:00am). -Fluticasone PROP 50mcg Spray 500mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Gabapentin 600mg, take 2 tablets 3 times daily (8:00am, 2:00pm, and 8:00pm). -Gabapentin 600mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -Gabapentin 600mg was documented as a "/" symbol at 2:00pm on 11/16/24, 11/17/24, and 11/26/24. -Gabapentin 600mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Gemtesa 75mg take 1 tablet daily (8:00am). -Gemtesa 75mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Lactulose 10gm/15mL, take 15 ML's daily (8:00am). -Lactulose 10gm/15mL was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Linzess 10mg, take 1 capsule daily (8:00am). -Linzess 10mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Lisinopril 10mg tablet, take 1 tablet daily (8:00am).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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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 367	Continued From page 48 -Lisinopril 10mg tablet was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Oxybutynin 5mg, take 1 tablet at bedtime (8:00pm). - Oxybutynin 5mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Probiotic Gummy, take 1 gummy daily (8:00am). -Probiotic Gummy was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Quetiapine ER 150mg, take 1 tablet at bedtime (8:00pm). -Quetiapine ER 150mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Quetiapine ER 50mg, take 1 tablet at bedtime (8:00pm). -Quetiapine ER 50mg was documented as a "/" symbol at 8:00pm on 11/08/24 and 11/15/24. -There was an entry for Senna 8.6mg, take 2 tablets twice daily (8:00am and 8:00pm). -Senna 8.6mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -Senna 8.6mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Sertraline HCL 25mg take 1 tablet daily (8:00am). -Sertraline HCL 25mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Simvastatin 10mg, take	D 367		

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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 367	Continued From page 49 one tablet by mouth at bedtime (8:00pm). -Simvastatin 10mg was documented as a "/" symbol at 8:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Thera Tablet, take 1 tablet daily (8:00am). -Thera Tablet was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -There was an entry for Tramadol HCL 50mg, take 1 tablet four times daily (8:00am, 12:00pm, 4:00pm and 8:00pm). -Tramadol HCL 50mg was documented as a "/" symbol at 8:00am on 11/04/24, 11/08/24, 11/11/24, and 11/13/24. -Tramadol HCL 50mg was documented as a "/" symbol at 12:00pm on 11/03/24, 11/11/24, and 11/13/24. -Tramadol HCL 50mg was documented as a "/" symbol at 4:00pm on 11/08/24. -Tramadol HCL 50mg was documented as a "/" symbol at 8:00pm on 11/08/24. -There was an entry for Tramadol HCL 50mg, take 1 tablet two times daily (8:00am and 8:00pm). -Tramadol HCL 50mg was documented as a "/" symbol at 8:00am on 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -Tramadol HCL 50mg was documented as a "/" symbol at 8:00pm on 11/15/24, 11/22/24, and 11/29/24. -There was an entry for Ziprasidone HCL 80mg take 1 capsule 2 times daily with meals (8:00am and 5:00pm). -Ziprasidone HCL 80mg was documented as a "/" symbol at 8:00am on 11/03/24, 11/04/24, 11/08/24, 11/11/24, 11/13/24, 11/14/24, 11/16/24, 11/25/24, 11/26/24, and 11/30/24. -Ziprasidone HCL 80mg was documented as a "/"	D 367		

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WALLACE GARDENS	1052 NE RAILROAD STREET 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 367	Continued From page 50 symbol at 5:00pm on 11/08/24, 11/15/24, 11/22/24, and 11/29/24. -There were 21 medications documented as missed dose on 28 out of 30 days. Review of Resident #2's December 2024 eMAR revealed: -There was an entry for Acetaminophen 500mg, take 2 tablets 3 times daily (8:00am, 2:00pm, and 8:00pm). -Acetaminophen 500mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -Acetaminophen 500mg was documented as a "/" symbol at 2:00pm on 12/01/24, 12/03/24, 12/13/24 through 12/15/24, 12/25/24, and 12/28/24. -Acetaminophen 500mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Benztropine MES 1mg, take 1 tablet twice daily (8:00am and 8:00pm). -Benztropine MES 500mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -Benztropine MES 500mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Diltiazem 24hr ER 120mg, take 1 capsule daily (8:00am). -Diltiazem 24hr ER 120mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Divalproex SOD ER	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 367	Continued From page 51 500mg, take 3 tablets daily (8:00pm). -Divalproex SOD ER 500mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was any entry for Duloxetine HCL DR 60mg, take 1 capsule daily (8:00am). -Duloxetine HCL DR 60mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Fluticasone PROP 50mcg Spray, spray into both nostrils once daily (8:00am). -Fluticasone PROP 50mcg Spray 500mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Gabapentin 600mg, take 2 tablets 3 times daily (8:00am, 2:00pm, and 8:00pm). -Gabapentin 600mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -Gabapentin 600mg was documented as a "/" symbol at 2:00pm on 12/01/24, 12/03/24, 12/13/24 through 12/15/24, 12/25/24, and 12/28/24. -Gabapentin 600mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Gemtesa 75mg take 1 tablet daily (8:00am). -Gemtesa 75mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Lactulose 10gm/15mL,	D 367		

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D 367	Continued From page 52 take 15 ML's daily (8:00am). -Lactulose 10gm/15mL was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Linzess 10mg, take 1 capsule daily (8:00am). -Linzess 10mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Lisinopril 10mg tablet, take 1 tablet daily (8:00am). -Lisinopril 10mg tablet was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Oxybutynin 5mg, take 1 tablet at bedtime (8:00pm). -Oxybutynin 5mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Probiotic Gummy, take 1 gummy daily (8:00am). -Probiotic Gummy was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Quetiapine ER 150mg, take 1 tablet at bedtime. -Quetiapine ER 150mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Quetiapine ER 150mg, take 1 tablet at bedtime (8:00pm). -Quetiapine ER 50mg was documented as a "/" symbol at 8:00pm 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24,	D 367		

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D 367	Continued From page 53 and 12/31/24. -There was an entry for Senna 8.6mg, take 2 tablets twice daily (8:00am and 8:00pm). -Senna 8.6mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -Senna 8.6mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Sertraline HCL 25mg take 1 tablet daily (8:00am). -Sertraline HCL 25mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Simvastatin 10mg, take one tablet by mouth at bedtime (8:00pm). -Simvastatin 10mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24. -There was an entry for Thera Tablet, take 1 tablet daily (8:00am). -Thera Tablet was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -There was an entry for Tramadol HCL 50mg, take 1 tablet two times daily (8:00am and 8:00pm). -Tramadol HCL 50mg was documented as a "/" symbol at 8:00am on 12/02/24, 12/04/24, 12/11/24 through 12/16/24, 12/20/24, 12/22/24, 12/28/24, and 12/29/24. -Tramadol HCL 50mg was documented as a "/" symbol at 8:00pm on 12/13/24, 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, 12/30/24, and 12/31/24.	D 367		

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D 367	Continued From page 54 -There was an entry for Ziprasidone HCL 80mg take 1 capsule 2 times daily with meals (8:00am and 5:00pm). -Ziprasidone HCL 80mg was documented as a "/" symbol at 8:00am on 12/02/24. -There were 20 medications documented as missed dose on 12 out of 31 days. Review of Resident #2's January 2025 eMAR revealed: -There was an entry for Acetaminophen 500mg, take 2 tablets 3 times daily (8:00am, 2:00pm, and 8:00pm). -Acetaminophen 500mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 2:00pm on 01/03/25 and 01/05/25. -Acetaminophen 500mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Benztropine MES 1mg, take 1 tablet twice daily (8:00am and 8:00pm). -Benztropine MES 500mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Divalproex SOD ER 500mg, take 3 tablets daily (8:00pm). -Divalproex SOD ER 500mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Gabapentin 600mg, take 2 tablets 3 times daily (8:00am, 2:00pm, and 8:00pm). -Gabapentin 600mg was documented as a "/" symbol at 2:00pm on 01/03/25 and 01/05/25. -Gabapentin 600mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Oxybutynin 5mg, take 1 tablet at bedtime (8:00pm). -Oxybutynin 5mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Quetiapine ER 150mg, take 1 tablet at bedtime (8:00pm). -Quetiapine ER 150mg was documented as a "/"	D 367		

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D 367	Continued From page 55 symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Senna 8.6mg, take 2 tablets twice daily (8:00am and 8:00pm). -Senna 8.6mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Simvastatin 10mg, take one tablet by mouth at bedtime (8:00pm). -Simvastatin 10mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There was an entry for Tramadol HCL 50mg, take 1 tablet two times daily (8:00am and 8:00pm). -Tramadol HCL 50mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/07/25. -There were 9 medications documented as missed dosed on 2 out of 7 days. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/09/25 at 3:30pm revealed: -Resident #2 was prescribed medications through their pharmacy. -On 11/08/24, Acetaminophen 500mg 2 tablets 3 times daily, was dispensed with a quantity of 180. -On 12/11/24 and 01/09/25 Acetaminophen 500mg 2 tablets 3 times daily, was dispensed with a quantity of 186. -On 11/08/24 and 12/11/24 Benztropine 1mg 1 tablet twice daily, was dispensed with a quantity of 60. -On 01/09/25 Benztropine 1mg 1 tablet twice daily, was dispensed with a quantity of 62. -On 11/08/24 and 12/11/24 Diltiazem 24hr ER 120mg 1 capsule daily, was dispensed with a quantity of 30. -On 01/09/25 Diltiazem 24hr ER 120mg 1 capsule daily, was dispensed with a quantity of 31. -On 11/08/24 and 12/11/24 Divalproex SOD ER 500mg 3 tablets daily, was dispensed with a quantity of 90. -On 01/09/25 Divalproex SOD ER 500mg 3	D 367		

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D 367	Continued From page 56	D 367		

tablets daily, was dispensed with a quantity of 93.
-On 11/08/24 and 12/11/24 Duloxetine HCL DR 60mg 1 capsule daily, was dispensed with a quantity of 30.
-On 01/09/25 Duloxetine HCL DR 60mg 1 capsule daily, was dispensed with a quantity of 31.
-On 10/09/24 and 12/23/24 Fluticasone PROP 50mcg 1 spray into both nostrils once daily was dispensed.
-On 11/08/24, 12/11/24, and 01/09/24 Gabapentin 600mg 2 tablets 3 times daily, was dispensed with a quantity of 180.
-On 11/08/24 and 12/11/24 Gemtesa 75mg 1 tablet daily, was dispensed with a quantity of 30.
-On 01/09/25 Gemtesa 75mg 1 tablet daily, was dispensed with a quantity of 31.
-On 10/05/24 and 12/12/24 Lactulose 10gm/15mL 15 ML's daily, was dispensed with a quantity of 473 ML.
-On 10/31/24, 11/27/24, and 12/26/24 Linzess 10mg 1 capsule daily, was dispensed with a quantity of 30.
-On 11/08/24 and 12/11/24 Lisinopril 10mg tablet 1 tablet daily, was dispensed with a quantity of 30.
-On 01/09/25 Lisinopril 10mg tablet 1 tablet daily, was dispensed with a quantity of 31.
-On 11/08/24 and 12/11/24 Oxybutynin 5mg 1 tablet at bedtime, was dispensed with a quantity of 30.
-On 01/09/25 Oxybutynin 5mg 1 tablet at bedtime, was dispensed with a quantity of 31.
-On 11/08/24 Probiotic Gummy 1 gummy daily, was dispensed with a quantity of 30.
-On 12/11/24 and 01/09/25 Probiotic Gummy 1 gummy daily, was dispensed with a quantity of 31.
-On 11/14/24 and 12/16/24 Quetiapine ER 150mg 1 tablet at bedtime, was dispensed with a quantity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET 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 367	Continued From page 57 of 30. -On 01/09/25 Quetiapine ER 150mg 1 tablet at bedtime, was dispensed with a quantity of 62. -On 11/08/24 Senna 8.6mg 2 tablets twice daily, was dispensed with a quantity of 120. - On 12/11/24 and 01/09/25 Senna 8.6mg 2 tablets twice daily, was dispensed with a quantity of 124. -On 11/12/24, 12/11/24, and 01/09/25 Sertraline HCL 25mg 1 tablet daily, was dispensed with a quantity of 30. -On 11/08/24 and 12/11/24 Simvastatin 10mg one tablet by mouth at bedtime, was dispensed with a quantity of 30. -On 01/09/25 Simvastatin 10mg one tablet by mouth at bedtime, was dispensed with a quantity of 31. -On 11/08/24 Thera Tablet 1 tablet daily, was dispensed with a quantity of 30. -On 12/11/24 and 01/09/25 Thera Tablet 1 tablet daily, was dispensed with a quantity of 31. -On 11/14/24 Tramadol HCL 50mg 2 times daily, was dispensed with a quantity of 70. -On 12/11/24 Tramadol HCL 50mg 2 times daily, was dispensed with a quantity of 60. Refer to the interview with the medication aide (MA) on 01/08/25 at 7:53am. Refer to the second interview with the MA on 01/09/25 at 11:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 2:30pm revealed. Refer to the second interview with the RCC on 01/09/25 at 12:00pm revealed. Refer to the second telephone interview with a	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 58 pharmacist at the facility's contracted pharmacy on 01/08/25 at 4:13pm. Refer to the interview with the Administrator on 01/09/25 at 12:30pm. 4. Review of Resident #1's current FL-2 dated 02/02/24 revealed diagnoses included hypertension, schizophrenia, and osteoarthritis. Review of the physician order sheet for Resident #1 dated 01/01/25 revealed there was an order for Acetaminophen 500mg twice daily (used to treat pain), Amlodipine Besylate 10mg daily (used to treat hypertension), Aspirin 81mg chewable daily (used to treat heart health), Benztropine Mes 1mg at bedtime (used to treat extrapyramidal involuntary muscle movements), Brimonidine 0.2% eye drops twice daily (used to treat glaucoma), Cetirizine 10mg daily (used to treat allergies), Colace 100mg twice daily (used to treat constipation), Lasix 20mg daily (used to treat edema), Lactulose 10gm/15ml daily (used to treat constipation), Lisinopril 40mg daily (used to treat hypertension), Lorazepam 0.5mg three times daily (used for mood stabilization), Lumigan 0.01% at bedtime (used to treat glaucoma), Melatonin 3mg at bedtime (used to treat insomnia), Mirtazapine 15mg at bedtime (used to treat depression), Myrbetriq ER 25mg every other day (used to treat urinary frequency), Nystatin 100,000 unit/gm twice daily (used to treat yeast infection), Olanzapine 5mg every evening (used to treat agitation), Scopolamine 1mg/3 day patch every 72 hours (used to treat nausea and vomiting), Valproic Acid 250mg/5ml twice daily (used to treat mood), Vitamin D3 1,000 unit daily (used for vitamin deficiency). Review of Resident #1's Resident Register	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 59 revealed an admission date of 09/03/13. Review of Resident #1's November 2024 electronic medication administration record (eMAR) revealed: -There was and entry for Lorazepam 0.5mg administer one tablet 3 times daily (9:00am, 2:00pm, and 9:00pm). -Lorazepam 0.5mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 2:00pm on 11/03/24.-There was an entry for Nystatin 100,000 unit/gm administer twice daily (8:00am and 8:00pm). -Nystatin 100,000 unit/gm was documented as a "/" symbol at 8:00am on 11/01/24, 11/07/24, and 11/16/24. Review of Resident #1's December 2024 (eMAR) revealed: -There was and entry for Lorazepam 0.5mg administer one tablet 3 times daily (9:00am, 2:00pm, and 9:00pm). -Lorazepam 0.5mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 2:00pm on 12/13/24, 12/15/24, and 12/20/24. -There was an entry for Nystatin 100,000 unit/gm administer twice daily (8:00am and 8:00pm). -Nystatin 100,000 unit/gm was documented as a "/" symbol at 2:00pm on 12/31/24). Review of Resident #1's January 2025 (eMAR) revealed: -There was an entry for Acetaminophen 500mg administer twice daily (9:00am and 6:00pm). -Acetaminophen 500mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 6:00pm on 01/07/25. -Acetaminophen 500mg was documented as a "/" symbol at 9:00am on 01/08/25.	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLACE GARDENS	1052 NE RAILROAD STREET 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 367	Continued From page 60 -There was an entry for Amlodipine Besylate 10mg administer daily (9:00am). -Amlodipine Besylate 10mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Aspirin 81mg chewable tablet administer daily (9:00am). -Aspirin 81mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Benztropine 1mg tablet administer daily at (9:00pm). -Benztropine Mes 1mg was documented as a "/" symbol at 9:00pm on 01/07/25. -There was an entry for Benztropine 2mg tablet administer daily at (9:00am). -Benztropine Mes 2mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Brimonidine 0.2% eye drop administer twice daily (9:00am and 9:00pm). -Brimonidine 0.2% was documented as a "/" symbol at 9:00pm on 01/07/25. -Brimonidine 0.2% was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Cetirizine 10mg administer daily (9:00am). -Cetirizine 10mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Colace 100mg administer twice daily (9:00am and 9:00pm). -Colace 100mg was documented as a "/" symbol at 9:00pm on 01/07/25. -Colace 100mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Lasix 20mg administer daily (9:00am). -Lasix 20mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Lactulose 10gm/15ml administer daily (9:00am). -Lactulose 10gm/15ml was documented as a "/" symbol at 9:00am on 01/08/25.	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 61 -There was an entry for Lisinopril 40mg administer daily (9:00am). -Lisinopril 40mg was documented as a "/" symbol at 9:00am on 01/08/24. -There was an entry for Lorazepam 0.5mg administer three times daily (9:00am, 2:00pm, and 9:00pm). -Lorazepam 0.5mg was documented as a "/" symbol at 2:00pm on 01/05/25. -Lorazepam 0.5mg was documented as a "/" symbol at 9:00pm on 01/07/25. -Lorazepam 0.5mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Lumigan 0.01% eye drops administer daily (9:00pm). -Lumigan 0.01% was documented as a "/" symbol at 9:00pm on 01/07/25. -There was an entry for Melatonin 3mg administer daily (9:00pm). -Melatonin 3mg was documented as a "/" symbol at 9:00pm on 01/07/25. -There was an entry for Mirtazapine 15mg administer at bedtime (9:00pm). -Mirtazapine 15mg was documented as a "/" symbol at 9:00pm on 01/07/25. -Nystatin 100,000 unit/gm was documented as a "/" symbol at 8:00am on 01/04/25, 01/07/25, and 01/08/25). -Nystatin 100,000 unit/gm was documented as a "/" symbol at 8:00pm on 01/07/25. -There was an entry for Olanzapine 5mg administer daily (9:00pm). -Olanzapine 5mg was documented as a "/" symbol at 9:00pm on 01/07/25. -There was an entry for Olanzapine 7.5mg administer daily (9:00am). -Olanzapine 7.5mg was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Scopolamine 1mg/3 day patch apply every 72 hours (9:00am).	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 62 -Scopolamine 1mg/3 day patch was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Valproic Acid 250mg/5ml administer twice daily (9:00am and 5:00pm). -Valproic Acid 250mg/5ml was documented as a "/" symbol at 9:00am on 01/08/25. -There was an entry for Vitamin D3 1,000 unit daily (9:00am). -Vitamin D3 1,000 unit was documented as a "/" symbol at 9:00am on 01/08/25. Telephone interview with the facility's contracted pharmacist on 01/09/25 at 3:30pm revealed: -Lorazepam 0.5mg was filled on 11/09/24 for 93 tablets and 12/11/24 for 93 tablets. -Nystatin 100,000 unit/gm was filled on 07/04/24 for 60 grams and 01/02/25 for 60 grams. -Acetaminophen 500mg was filled on 11/08/24 for 60 tablets, 12/11/24 for 62 tablets, and 01/09/25 for 62 tablets. -Amlodipine Besylate 10mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Aspirin 81mg chewable tablets was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Benztropine 1mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Benztropine 2mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Cetirizine 10mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Lasix 20mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Lactulose 10mg/15ml was filled on 10/21/24 for 473 ml and 12/12/24 for 473ml.	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 63 -Lisinopril 40mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Lumigan 0.01% was filled on 07/29/24 for 2.5ml. -Melatonin 3mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/24 for 31 tablets. -Mirtazapine 15mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/25 for 31 tablets. -Olanzapine 5mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/24 for 31 tablets. -Olanzapine 7.5mg was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/24 for 31 tablets. -Scopolamine 1mg/3 day patch was filled on 10/07/24 for 10, 11/13/24 for 10, and 01/06/25 for 10. -Valproic Acid 250mg/5ml was filled on 10/28/24 for 300ml, 12/02/24 for 300ml, and 12/30/24 for 300ml. -Vitamin D3 1,000 unit was filled on 11/08/24 for 30 tablets, 12/11/24 for 31 tablets, and 01/09/24 for 31 tablets. Refer to the interview with the medication aide (MA) on 01/08/25 at 7:53am. Refer to the second interview with the MA on 01/09/25 at 11:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 2:30pm revealed. Refer to the second interview with the RCC on 01/09/25 at 12:00pm revealed. Refer to the second telephone interview with a	D 367		

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D 367	Continued From page 64 pharmacist at the facility's contracted pharmacy on 01/08/25 at 4:13pm. Refer to the interview with the Administrator on 01/09/25 at 12:30pm. 5. Review of Resident #3's current FL-2 dated 08/06/24 revealed diagnoses included uncontrolled type 2 diabetes mellitus with hypoglycemia, essential hypertension, hyperlipidemia, history of cerebral vascular accident, and stage 3 chronic kidney disease. Review of Resident #3's physician orders dated 08/06/24 and 11/24/24 revealed: -There was an order for Amlodipine 10mg tablet every day (used to treat high blood pressure, Aspirin (ASA) 81mg tablet daily (used to treat pain and as a blood thinner), Atorvastatin 40mg tablet at bedtime (used to treat high cholesterol), Coreg 25mg tablet twice daily with meals (used to treat heart disorders), Docusate Sodium (DOK) 100mg capsule once daily (used to treat constipation), Dorzolamide-Timolol (Cosopt) eye drops instill one drop in both eyes two times daily (used to lower eye pressure in patients with glaucoma), Xalatan 0.005% eye drops instill one drop in both eyes at bedtime (used to treat increased eye pressure in patients with glaucoma), Cozaar 100mg tablet once daily (used to treat high blood pressure), Tradjenta 5mg tablet once daily (used to treat diabetes), Lantus Insulin 30 units subcutaneously every day (used to treat diabetes), Vitamin D3 capsule once daily (used to treat low levels of calcium), Plavix 75mg tablet once daily (used to prevent blood clots), and Humalog Insulin three times a day before meals per sliding scale: blood glucose less than 60 give orange juice and sugar and recheck in one hour, call with results; hold insulin if blood	D 367		

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D 367	Continued From page 65 glucose less than 70; 100-149 =2 units, 150-199=4 units, 200-249=6 units, greater than 250-299=8 units, greater than 300=10 units (used to lower blood glucose levels in patients with diabetes). Review of a physician order for Resident #3 dated 09/03/24 revealed: -An order for Humalog Insulin three times a day before meals per sliding scale: blood glucose less than 60 give orange juice and sugar and recheck in one hour, call with results; hold insulin if blood glucose less than 70; 100-149 =2 units before meals, 150-199=4 units before meals, 200-249=6 units before meals, 250-299=8 units before meals, 300-350=10 units before meals, greater than 351=12 units before meals. Review of a physician order for Resident #3 date 11/24/24 revealed: -An order for Humalog Insulin three times a day before meals per sliding scale: blood glucose less than 60 give orange juice and sugar and recheck in one hour, call with results; hold insulin if blood glucose less than 70; 100-149 =2 units, 150-199=4 units, 200-249=6 units, 250-299=8 units, greater than 300=10 units. Observations for the 5:00pm medication pass on 01/07/25 between 4:08pm and 4:20pm revealed: -The medication aide (MA) prepared and administered Humalog insulin to a resident after checking the resident's fingerstick blood sugar (FSBS). -The MA attempted to document administration for the medication but was unable to log into the eMAR system. -The MA tried a second computerized eMAR and was able to log into the system. -The MA documented the FSBS and	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 367	Continued From page 66 administration for the medication she administered. Review of Resident #3's November 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Amlodipine Besylate 10mg, take 1 tablet daily (8:00am). -Amlodipine Besylate 10mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 8:00am on 11/04/24. -There was an entry for Aspirin (ASA) 81mg, take 1 tablet daily (8:00am). -Aspirin (ASA) 81mg was documented as a "/" symbol at on 11/04/24. -There was an entry for Coreg 25mg, take 1 tablet twice daily (8:00am and 8:00pm). -Coreg 25mg was documented as a "/" symbol at 8:00am on 11/04/24. -There was an entry for DOK 100mg, take 1 softgel capsule daily (8:00am). -DOK 100mg was documented as a "/" symbol at 8:00am on 11/04/24. -There was an entry for Dorzolamide-Timolol (Cosopt) eye drops, instill one drop in both eyes two times daily (8:00am and 8:00pm). - Dorzolamide-Timolol (Cosopt) eye drops was documented as a "/" symbol at 8:00am on 11/04/24. -There was an entry for Losartan Potassium (Cozaar) 100mg, take 1 tablet daily (8:00am). -Losartan Potassium (Cozaar) 100mg on was documented as a "/" symbol at 8:00am on 11/04/24. -There was an entry for Tradjenta 5mg, take 1 tablet daily (8:00am). -Tradjenta 5mg on was documented as a "/" symbol at 8:00am on 11/04/24 and 11/06/24. -There was an entry for Vitamin D3 1000 unit, take 1 softgel capsule daily (8:00am).	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 67 -Vitamin D3 1000 unit was documented as a "/" symbol at 8:00am on 11/04/24 and 11/06/24. -There was an entry for Clopidogrel (Plavix) 75mg, take 1 tablet daily (8:00). - Clopidogrel (Plavix) 75mg was documented as a "/" symbol at 8:00am on 11/04/24. -There was an entry for Humalog Kwikpen inject subcutaneously three times a day based on pre-meal glucose sliding daily (8:00am, 5:00pm and 12:00pm). -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 8:00am on 11/04/24 and 11/06/24. -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 12:00pm on 11/05/24. Review of Resident #3's December 2024 eMARs revealed: -There was an entry for Amlodipine Besylate 10mg, take 1 tablet daily (8:00am). -Amlodipine Besylate 10mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24 at 8:00am -There was an entry for Aspirin (ASA) 81mg, take 1 tablet daily (8:00am). -Aspirin (ASA) 81mg was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24. -There was an entry for Atorvastatin 40mg, take 1 tablet daily at bedtime (8:00pm). -Atorvastatin 40mg was documented as a "/" symbol at 8:00pm on 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, and 12/30/24 through 12/31/24. -There was an entry for Coreg 25mg, take 1 tablet twice daily (8:00am and 8:00pm). -Coreg 25mg was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24,	D 367		

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	HAL031016	A. BUILDING: _____ B. WING _____	R 01/09/2025

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D 367	Continued From page 68 12/16/24, 12/21/24, 12/27/24, and 12/31/24. -Coreg 25mg was documented as a "/" symbol at 8:00pm on 12/16/24, 12/17/24, 12/20/24, 12/23-25/24, and 12/30-31/24. -There was an entry for DOK 100mg, take 1 softgel capsule daily (8:00am). -DOK 100mg was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24. -There was an entry for Dorzolamide-Timolol (Cosopt) eye drops, instill one drop in both eyes two times daily (8:00am and 8:00pm). - Dorzolamide-Timolol (Cosopt) eye drops was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24. - Dorzolamide-Timolol (Cosopt) eye drops was documented as a "/" symbol at 8:00pm on 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, and 12/30/24 through 12/31/24. -There was an entry for Latanoprost (Xalatan) 0.005% eye drops, instill one drop into both eyes at bedtime (8:00pm). -Latanoprost (Xalatan) 0.005% eye drops was documented as a "/" symbol at 8:00pm on 12/16/24, 12/17/24, 12/20/24, 12/23 through 12/25/24, and 12/30/24 through 12/31/24. -There was an entry for Losartan Potassium (Cozaar) 100mg, take 1 tablet daily (8:00am). -Losartan Potassium (Cozaar) 100mg was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24. -There was an entry for Tradjenta 5mg, take 1 tablet daily (8:00am). -Tradjenta 5mg was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24. -There was an entry for Lantus Solostar inject 30 units subcutaneously, once daily (8:00pm).	D 367		

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D 367	Continued From page 69 -Lantus Solostar 30 units were documented as a "/" symbol at 8:00pm on 12/16/24, 12/17/24, 12/20/24, 12/23/24 through 12/25/24, and 12/30-31/24. -There was an entry for Clopidogrel (Plavix) 75mg, take 1 tablet daily (8:00am). - Clopidogrel (Plavix) 75mg was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, 12/16/24, and 12/27/24. -There was an entry for Humalog Kwikpen inject subcutaneously three times a day based on pre-meal glucose sliding daily (8:00am, 5:00pm and 12:00pm). -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 8:00am on 12/11/24, 12/12/24, 12/14/24, and 12/16/24. -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 12:00pm on 12/15/24, and 12/17/24. -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 5:00pm on 12/16/24, 12/17/24, 12/20/24, 12/24/24, 12/25/24, 12/30/24 and 12/31/24. Review of Resident #3's January 2025 eMARs revealed: -There was an entry for Amlodipine Besylate 10mg, take 1 tablet daily (8:00am). -Amlodipine Besylate 10mg was documented as a "/" symbol (used to indicate a missed dose of medication) at 8:00am on 01/04/25. -There was an entry for Aspirin (ASA) 81mg, take 1 tablet daily (8:00am). -Aspirin (ASA) 81mg was documented as a "/" symbol at 8:00am on 01/04/25. -There was an entry for Atorvastatin 40mg, take 1 tablet daily at bedtime (8:00pm). -Atorvastatin 40mg was documented as a "/" symbol on at 8:00am on 01/03/25 and 01/05/25. -There was an entry for Coreg 25mg, take 1	D 367		

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D 367	Continued From page 70 tablet twice daily (8:00am and 8:00pm). -Coreg 25mg was documented as a "/" symbol at 8:00am on 01/04/25. -Coreg 25mg was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/05/25. -There was an entry for DOK 100mg, take 1 softgel capsule daily (8:00am). -DOK 100mg was documented as a "/" symbol at 8:00am on 01/04/25. -There was an entry for Dorzolamide-Timolol (Cosopt) eye drops, instill one drop in both eyes two times daily (8:00am and 8:00pm). -Dorzolamide-Timolol (Cosopt) eye drops was documented as a "/" symbol at 8:00am on 01/04/25. -Dorzolamide-Timolol (Cosopt) eye drops was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/05/25. -There was an entry for Latanoprost (Xalatan) 0.005% eye drops, instill one drop into both eyes at bedtime (8:00pm). -Latanoprost (Xalatan) 0.005% eye drops was documented as a "/" symbol at 8:00pm on 01/03/25 and 01/05/25. -There was an entry for Losartan Potassium (Cozaar) 100mg, take 1 tablet daily (8:00am). -Losartan Potassium (Cozaar) 100mg on was documented as a "/" symbol at 8:00am on 01/04/25. -There was an entry for Tradjenta 5mg, take 1 tablet daily (8:00am). -Tradjenta 5mg on was documented as a "/" symbol at 8:00am on 11/04/25 and 01/06/25. -There was an entry for Lantus Solostar inject 30 units subcutaneously, once daily (8:00pm). -Lantus Solostar 30 units were documented as a "/" symbol at 8:00pm on 01/03/25 and 01/05/25. -There was an entry for Vitamin D3 1000 unit, take 1 softgel capsule daily (8:00am). -Vitamin D3 1000 unit was documented as a "/"	D 367		

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D 367	Continued From page 71 symbol at 8:00am on 01/04/25 -There was an entry for Clopidogrel (Plavix) 75mg, take 1 tablet daily (8:00). -Clopidogrel (Plavix) 75mg was documented as a "/" symbol at 8:00am on 01/04/25. -There was an entry for Humalog Kwikpen inject subcutaneously three times a day based on pre-meal glucose sliding daily (8:00am, 5:00pm and 12:00pm). -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 8:00am on 01/04/25. -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 12:00pm on 01/05/25. -Humalog Kwikpen inject subcutaneously was documented as a "/" symbol at 5:00pm on 01/07/25. Interview with the MA on 01/07/25 at 4:20pm revealed: -The second computerized eMAR was showing "error". -She would write the FSBS results and amount of Humalog insulin on a sheet of paper. -She would try to document the information in the eMAR once rounds were finished. Review of the eMAR for the observed resident's 5:00pm medication pass on 01/07/25 revealed the missed dose symbol was reflected on the eMAR for the 01/07/25 5:00pm FSBS and Humalog insulin administration. Interview with Resident #3's primary care provider (PCP) on 01/08/25 at 1:02am revealed: -She was not aware there was a glitch in the eMAR system. -She was not able to access the eMARs. -The internet at the facility was a major issue.	D 367		

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D 367	Continued From page 72 -She was not aware of any missed doses of medications for Resident #3 and was not aware if the documentation on the eMARs were truly missed doses of medication. -She visited the facility every week and had not seen anything that would indicate the resident was not getting medications. -Resident #3 was "fairly compliant" and did not refuse his medications. Interview with Resident #3 on 01/08/25 at 2:08pm revealed: -He did not know the names of his medications. -He was administered medications two to three times a day. -He was not aware of any missed medications. Refer to the interview with the medication aide (MA) on 01/08/25 at 7:53am. Refer to the second interview with the MA on 01/09/25 at 11:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 2:30pm revealed. Refer to the second interview with the RCC on 01/09/25 at 12:00pm revealed. Refer to the second telephone interview with a pharmacist at the facility's contracted pharmacy on 01/08/25 at 4:13pm. Refer to the interview with the Administrator on 01/09/25 at 12:30pm. _____ Interview with the medication aide (MA) on	D 367		

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D 367	Continued From page 73 01/08/25 at 7:53am revealed: -All the 8:00am medications on the eMAR for the resident she was preparing to administer medications were not populating on the eMAR. -She did not know why all the medications were not populating on the resident' eMAR. -The delay with the eMARs did not happen a lot, but when it happened, she waited a few minutes before administering medications. -The internet in the facility was not good and the computers were "very slow sometimes". -When she documented administration for medication, she selected the checkmark and once a pink color disappeared the medication was supposed to be signed off on the eMAR. -She did not know if documentation for medication administration showed on the eMAR once she went through the steps to document. Second interview with the MA on 01/09/25 at 11:30am revealed: -She was aware that the software had glitches because when she clicked on a resident name she would see a circle go around and around, and sometimes she would have to sign out then sign back in because it would stall. -After administering the medication to a resident, she went to her laptop and clicked on the resident name, the resident's picture popped up and she would click on the medication given on the eMAR, then she would see a check mark showing she clicked administered. -She told the Resident Care Coordinator (RCC) about the issue, and this had been going on for about four or five years. -She would call the pharmacy to assist her with signing off on medication administered when the software was having its glitches. Interview with the RCC on 01/07/25 at 2:30pm	D 367		

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D 367	Continued From page 74 revealed: -The slash mark "/" symbol in the section of the eMARs for documentation of administration of medications meant there was a "computer glitch". -The MA's administered medications as ordered. -She knew the MAs administered the medications because she watched the MAs. -When the MAs administered medication, the MAs clicked on the medication and signed the eMAR to document administration of the medication. -The MAs would not know there was no documentation for the administration of the medication until she reviewed the eMARs. Second interview with the RCC on 01/09/25 at 12:00pm revealed: -She was aware that there was a glitch with the eMAR program that they used. -This issue had been going on for at least four years. -She contacted the pharmacy when there was an issue, and a ticket would be placed for IT to assist, and IT would work on the system remotely. -She did not have a backup plan to ensure the medication was being recorded accurately. -She did audits monthly, but the last audit was in September 2024, and she did notice the backslashes on the eMARs. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/08/25 at 4:13pm revealed: -He was aware that the medication aid (MA) had trouble clicking off on the eMAR on the computer system. -The laptop was provided by the pharmacy for the MA to check off on their MAR. -The software was provided by another company.	D 367		

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D 367	Continued From page 75 -The software or the internet was the problem with not being able to click and check off on eMARs. -The facility staff would contact the pharmacy with the issue and the pharmacy would place a ticket into information technology (IT) to assist them with the problem. -He could not recall how long this issue with not being able to check off the eMARs had been going on. -He was not aware of any medication returns for Resident #3. Interview with the Administrator on 01/09/25 at 12:30pm revealed: -She was aware that the system had a glitch but could not recall how long it had been going on. -She had mentioned to the RCC that a paper trail was needed and to get in touch with pharmacy to utilize paper eMars but could not recall when she instructed her to do so -The RCC and pharmacy were responsible for taking care of the issue, but she should have followed up and did not. -She did not know that there were so many backslashes on the eMARs. -She was responsible for ensuring that the issue had been taken care of.	D 367		