STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031017	A. BUILDING: _____ B. WING _____	01/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted a annual survey, follow up survey and a complaint investigation on January 21, 2025 and January 27-28, 2025. The complaint investigation was initiated by the Duplin County Department of Social Services on January 6, 2025.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment in an orderly manner and good repair. The findings are: Interview with a resident on 01/21/25 at 9:19am revealed: -He resided in room 312 and his bedroom toilet got stopped up one to two times a week and it happened mostly in the evening time. -The toilet overflowed about two weeks ago, but he could not recall the exact date. -He told the staff about the toilet stopping up and the maintenance staff tried to fix it but could not get it unclogged.	D 079		

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-The Resident Care Coordinator (RCC) told him and his roommate to use the community bathroom down the hall until his bathroom could be fixed.
-He asked the RCC if he could move, and she said she would see but she never followed back up with him.

Observation of the proximity of the community bathroom on 01/27/25 at 10:30am revealed there were 5 bedrooms to pass to get to the community bathroom from Resident #4's bedroom down a long hall.

Second interview with a resident on 01/27/25 at 10:15am revealed:
-He would pull the call bell to get assistance with walking down to the community bathroom.
-Sometimes staff would walk with him to the bathroom and sometimes he would walk to the bathroom alone and the staff would meet him at the community bathroom.
-He used his rollator to walk to the community bathroom.

Interview with the resident's family member on 01/28/25 at 9:15am revealed he was not notified about the resident's toilet being out of order for several days.

Interview with the resident's roommate on 01/28/25 at 8:40am revealed:
-He had to use the community bathroom when his toilet was not working.
-No one had offered to move him to a new room with running water.
-In the middle of the night he would get up and put on his T-shirt, and pants and then he would walk down the hall to the bathroom, and he did not care to do all of that to use the bathroom.

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D 079	Continued From page 2 Interview with a personal care aide (PCA) on 01/21/25 at 11:15am revealed: -The residents in room 312 would place too much toilet paper in the toilet and it would clog. -She had unclogged the toilet a time or two. -The Maintenance or housekeeping would often unclog toilet. -The toilet clogged around Christmas, but she could not give an exact date. -She was unaware of any issues with the toilet in the month of January 2025. -To her knowledge the resident and his roommate were not removed from their room due to the toilet being clogged at any time. -When the toilet was clogged, and she could not unclog it she would let the medication aide (MA) know about the toilet. Interview with the housekeeper on 01/27/25 at 12:40pm revealed: -She was responsible for cleaning every bedroom which included sweeping and mopping the bathroom floor, cleaning the toilet, and taking out all of the trash. -On Saturday 01/04/25 she went into room 312, and saw a trash bag placed over the toilet, a wet floor sign, and blankets on the floor soaked with water but she did not smell any order of feces or urine. -Every other day she had to take the plunger to unclog the resident's toilet, but it had never gotten this bad. Interview with the facility's primary care provider (PCP) on 01/28/25 at 11:20am revealed: -She was not aware the resident could not use his bathroom for several days. -The resident was a high fall risk and used a walker for mobility.	D 079		

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D 079	Continued From page 3 -He had a urinary Foley catheter which made mobility more difficult in the middle of the night walking to a bathroom which was a risk due to his physical and mental decline. -She expected staff to relocate him to another bedroom with a working bathroom. Interview with the RCC on 01/21/25 at 11:35am revealed: -She was not aware the resident had any issues with his toilet before January 2025. -On Friday, 01/03/25 the bathroom overflowed, and the PCA tried unclogging the toilet using a plunger, but it did not unclog. -The maintenance staff tried to unclog it using a toilet snake, but it did not unclog. -The maintenance staff from cooperate was called on 01/03/25, but he could not come out until Monday, 01/06/25. -The running water to the resident's bathroom was turned off and a plastic bag was placed over the toilet. -The residents in room 312 were told to use the community bathroom down the hall. -She did not offer to relocate either resident to a room with running water because it was the weekend, and she did not have the staff to help with relocating the residents. -She did not call an outside plumber to look at the toilet. -The cooperate maintenance came out on Monday, 01/06/25 and was able to unclog the toilet. Second interview with the RCC on 01/21/25 at 12:04pm revealed: -She did not recall offering to relocate the residents to another bedroom. -At that time, the facility did have unoccupied bedrooms that the residents could have relocated	D 079		

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D 079	Continued From page 4 to. -She did not call the responsible party to share the toilet issues. Interview with the Administrator on 01/21/25 at 11:50am revealed: -She was aware the resident had issues with his toilet clogging. -The maintenance staff notified her about the clogged toilet on Friday, 01/03/25. -The cooperate maintenance staff used a 90 feet toilet snake and was able to unclog the toilet on 01/06/25. -She did not relocate the residents to a room with running water because there was a community bathroom that they could use. -The RCC did offer the resident and his roommate to relocate to another room and both residents said that they were "good" and did not wish to leave their room. -The RCC notified the resident's responsible party to discuss the toileting issues.	D 079		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and	D 161		

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D 161	Continued From page 5 abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a licensed health professional evaluate and validate for Licensed Health Professional Support tasks. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -There was a hire date of 02/09/22. -There was no documentation of a licensed health professional evaluate and validate for Licensed Health Professional Support tasks (LHPS) evaluation. Interview with the Clinical Nurse Consultant (CNC) on 01/28/25 at 3:55pm revealed: -She was responsible for completing the LHPSs. -She was unable to locate a completed LHPS on Staff A. -A LHPS nurse was completing the LHPS when Staff A was hired. -She was notified by the Administrator when a LHPS was needed. -When the facility changed owners in 2022 a new LHPS should have been completed for the	D 161		

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D 161	Continued From page 6 required staff. Interview with the Business Office Manager (BOM) on 01/28/25 at 4:14pm revealed: -She had been working in the facility for about 2 years. -She had never been told the process of her role in managing personnel records for staff hired before her. -She had never reviewed the facility staff personnel records. -She followed a check list to ensure newly hired personnel records were complete. Interview with the Administrator on 01/28/25 at 4:10pm revealed: -She had worked at the facility for 3 months. -She was responsible for notifying the CNC when new staff were hired and needed the LHPS completed. -She was not aware the LHPS was not completed for Staff A until 01/28/25. -She performed 5 personnel record reviews per month. -She was responsible for ensuring all staff that needed an LHPS had one completed. -She was not sure why the LHPS had not been completed.	D 161		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 7 TYPE B VIOLATION Based on observations, interviews, and record reviews, and the facility failed to notify the primary care provider (PCP) of multiple medication refusals for 1 of 5 sampled residents (#5) including medications used. The findings are: Review of the facility's refusal of medication policy dated January 2018 revealed continuous medication refusal must be reported to the prescriber and there must be documentation of prescriber notification of such. Review of Resident #5's current FL-2 dated 07/30/24 revealed: -Diagnoses included hypertension, congestive heart failure, chronic kidney disease, anemia, varicose veins, and dilated cardiomyopathy. -The resident was ambulatory. -The resident was intermittently disoriented. -The resident's current level of care was Assisted Living (AL). -There was an order for Cholecalciferol Vitamin D3 50mcg/2000 units 1 tablet daily (used to treat vitamin D deficiency), Ferrous Sulfate 325mg 1tablet twice daily (used to treat iron deficiency), Review of Resident #5's current Resident Register revealed the resident's admission date was 06/26/24. Review of Resident #5's current signed physician's order dated 12/31/24 revealed there was an order for Ferrous Sulfate 325mg 1tablet twice daily, Entresto 24-26mg 1 tablet daily (used to treat chronic heart failure), Furosemide 40mg 1 tablet daily (used to treat fluid retention),	D 273		

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Carvedilol 3.125mg 1 tablet twice daily with meals (used to treat high blood pressure), Polyethylene Glycol 3350 powder 17 gram twice daily (used to treat constipation), Calcium Carbonate Vitamin D3 600mg -5mcg/200unit 1 tablet daily (used to treat low levels of calcium), and Cholecalciferol Vitamin D3 50mcg/2000 units 1 tablet daily.

Review of Resident #5's incident and accident (I/A) report dated 01/17/25 revealed:
-The I/A occurred on 01/17/25 at 9:55am.
-He fell without injury in his bedroom.
-He reported that he became dizzy and fell.
-The primary care provider (PCP) was notified.
-Emergency Medical Services (EMS) was called.

Review of Resident #5's after visit summary (AVS) dated 01/17/25 revealed:
-The reason for the visit was hypertension.
-His diagnoses were elevated blood pressure (149/67) reading and essential hypertension
-His imaging consisted of an EKG 12 LEAD and X-ray chest single view.
-There was no documentation about a fall.
-He was discharged back to the facility.

Review of Resident #5's December 2024 electronic mediation administration record (eMAR) revealed:
-There was an entry for Ferrous Sulfate 325mg, take 1 tablet 2 times daily (8:00am and 8:00pm).
- Ferrous Sulfate 325mg was documented as a "()" symbol (used to indicate not administered: refused) at 8:00am on 12/09/24, 12/11/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24 and 12/29/24, and 12/31/24.
- Ferrous Sulfate 325mg was documented as a "()" symbol at 8:00pm on 12/10/24 through 12/31/24.
-There was an entry for Entresto 24-26mg, take 1

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tablet daily (8:00am).
-Entresto 24-26mg was documented as a "()" symbol at 8:00am on 12/09/24, 12/11/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24, 12/29/24, and 12/31/24.
-There was an entry for Furosemide 40mg, take 1 tablet daily (8:00am).
- Furosemide 40mg was documented as a "()" symbol at 8:00am on 12/09/24, 12/11/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24, 12/29/24, and 12/31/24.
-There was an entry for Carvedilol 3.125mg, take 1 tablet 2 times daily with meals (8:00am and 5:30pm).
-Carvedilol 3.125mg was documented as a "()" symbol at 8:00am on 12/09/24, 12/11/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24, 12/29/24, and 12/31/24.
-Carvedilol 3.125mg was documented as a "()" symbol at 5:30pm on 12/09/24, 12/10/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24, 12/29/24, and 12/30/24.
-There was an entry for Calcium Carbonate Vitamin D3 600mg -5mcg 200 unit, take 1 tablet daily (8:00am).
- Calcium Carbonate Vitamin D3 600mg -5mcg 200 unit was documented as a "()" symbol at 8:00am on 12/09/24, 12/11/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24, 12/29/24, and 12/31/24.
-There was an entry for Cholecalciferol Vitamin D3 50mcg 2000 unit, take 1 tablet daily (8:00am).
- Cholecalciferol Vitamin D3 50mcg 2000 unit was documented as a "()" symbol at 8:00am on 12/09/24, 12/11/24, 12/14/24 through 12/17/24, 12/21/24 through 12/24/24, 12/28/24, 12/29/24, and 12/31/24.

Review of Resident #5's January 2025 electronic mediation administration record (eMAR) revealed:

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D 273	Continued From page 10 -There was an entry for Ferrous Sulfate 325mg, take 1 tablet 2 times daily (8:00am and 8:00pm). - Ferrous Sulfate 325mg was documented as a "()" symbol (used to indicate not administered: refused) at 8:00am on 01/01/25, 01/02/25, 01/04/25 through 01/05/25, 01/07/25 through 01/09/25, 01/10/25, 01/12/25 through 01/17/25, 01/19/25 through 01/21/25. - Ferrous Sulfate 325mg was documented as a "()" symbol at 8:00pm on 01/01/25 through 01/05/25, 01/07/25 through 01/09/25, 01/11/25, 01/12/25 through 01/16/25, 01/18/25 through 01/20/25. -There was an entry for Entresto 24-26mg, take 1 tablet daily (8:00am). -Entresto 24-26mg was documented as a "()" symbol at 8:00am on 01/01/25, 01/02/25, 01/04/25 through 01/07/25, 01/09/25, 01/10/25, 01/12/25 through 01/17/25, 01/19/25 through 01/21/25. -There was an entry for Furosemide 40mg, take 1 tablet daily (8:00am). - Furosemide 40mg was documented as a "()" symbol at 8:00am on 01/01/25, 01/02/25, 01/04/25 through 01/07/25, 01/09/25 through 01/17/25, 01/19/25 through 01/21/25. -There was an entry for Carvedilol 3.125mg, take 1 tablet 2 times daily with meals (8:00am and 5:30pm). -Carvedilol 3.125mg was documented as a "()" symbol at 8:00am on 01/01/25, 01/02/25, 01/04/25 through 01/07/25, 01/09/25, 01/10/25, 01/12/25 through 01/17/25, 01/19/25 through 01/21/25. -Carvedilol 3.125mg was documented as a "()" symbol at 5:30pm on 01/04/25 through 01/09/25, and 01/11/25 through 01/20/25. -There was an entry for Calcium Carbonate Vitamin D3 600mg -5mcg 200 unit, take 1 tablet daily (8:00am).	D 273		

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- Calcium Carbonate Vitamin D3 600mg -5mcg 200 unit was documented as a "()" symbol at 8:00am on 01/01/25, 01/02/25, 01/04/25 through 01/07/25, 01/09/25 through 01/17/25 01/19/25 through 01/21/25.
-There was an entry for Cholecalciferol Vitamin D3 50mcg 2000 unit, take 1 tablet daily (8:00am).
- Cholecalciferol Vitamin D3 50mcg 2000 unit was documented as a "()" symbol at 8:00am on 01/01/25, 01/02/25, 01/04/25 through 01/07/25, 01/09/25 through 01/17/25, 01/19/25 through 01/21/25.

Interview with Resident #5 on 01/21/25 at 9:15am revealed he stopped taking his medication because he became sick and threw up about two weeks ago and he did not take his medication because of religious reasons.

Interview with the lead medication aide (MA) on 01/21/25 at 9:40am revealed:
-Resident #5 refused his medication about 3 weeks ago.
-The primary care provider (PCP) was aware of his refusal of medication, and the PCP spoke with him about refusing his medication.

Second interview with the lead MA 01/28/25 at 1:30pm revealed:
-Resident #5 told her that he refused his medication because of his religion called "Yoga".
-She verbally spoke with the PCP while the PCP was on her rounds Tuesday 2 weeks ago or it could have been one month ago, she could not recall the exact date.
-She did not document that she notified the PCP about the refusal of medications.
-She was responsible for notifying the Resident Care Coordinator (RCC) about the refusal after the 3rd or 4th day of refusal and the RCC was

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responsible for notifying the PCP.

Telephone interview with Resident #5's PCP on 01/28/25 at 11:25am at 2:35pm revealed:
-She was not aware that Resident #5 refused his medications.
-She became aware on 01/28/25 by the facility staff and spoke with him at that time.
-The facility should notify her after three days of medication refusals.
-Carvedilol 3.125mg was used to treat high blood pressure and if Resident #5 missed this medication he could have symptoms such as dizziness, shortness of breath (SOB), an increase in his blood pressure and it could lead to a stroke and kidney failure.
-Ferrous Sulfate 325mg was used to treat iron deficiency and if he missed this medication, he could have symptoms such as SOB and tiredness.
-Entresto 24-26mg was used to treat heart failure and if he missed this medication, he could have symptoms such as SOB and edema.
-Furosemide 40mg was used to treat fluid retention and if he missed this medication, he could have symptoms such as edema and swelling.
-She was notified that Resident #5 had fallen on 01/17/25 and was sent to the Emergency Department.
-Her concern was if he was not taking his blood pressure medication it could cause dizziness.
-She had ordered the daily blood pressure check, but no parameters because when he first came to the facility he did not have any medications with him, and she wanted to keep a close eye on him because his blood pressure being under control was significant for his health and well-being.

Interview with the RCC on 01/28/25 at 1:45pm

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	HAL031017	A. BUILDING: _____ B. WING _____	01/28/2025

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

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D 273	Continued From page 13	D 273		

revealed:
-She knew Resident #5 refused his medication two weeks ago.
-She verbally notified the PCP on 01/14/25 of his refusal of medications and the PCP spoke with the resident and explained the importance of taking his medications.
-She did not document the day or time that she notified the PCP.
-She was responsible for notifying the PCP after the resident refused medications for three days, then she completed the medication refusal form and placed it in the PCP's folder to review & sign.

Review of Resident #5's record revealed there were no medication refusal forms signed by the PCP.

Interview with the facility's Clinical Nurse Consultant (CNC) on 01/28/25 at 2:00pm revealed:
-On 01/17/25, she was in Resident #5's room to do an assessment, he stood up, got dizzy and fell.
-She took his blood pressure, and it was high, but she could not recall how high and she sent him to the hospital.
-She was not aware of his refusal of medications or of the ongoing issue with refusals of medications.
-She was not aware that there was no documentation from the facility staff of notifying the PCP of medication refusal.
-She expected the facility staff to document medication refusals and notify the PCP of the refusals.

Interview with the Administrator on 01/28/25 at 2:10pm revealed:
-She was not aware of Resident #5 refusing

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D 273	Continued From page 14 medications. -Refusal of medications were documented in the progress notes. -The RCC was responsible for notifying the PCP and documenting that she notified the PCP of medication refusals. _____ The facility failed to notify the primary care provider (PCP) of medication refusals for Resident #5 who refused five medications for 13 days in the month of December 2024 and 17 days in the month of January 2025. This failure placed the resident with a history of congestive heart failure, chronic kidney disease, dilated cardiomyopathy and hypertension with an increased risk of high blood pressure levels. This failure was detrimental to the health, safety, and welfare of the resident and constituted a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/28/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 14, 2025	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in	D 287		

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D 287	Continued From page 15 Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were maintained hot until residents were ready to eat their meals for 1 of 5 sampled residents (#2). The findings are: On 01/21/25 the weekly lunch menu revealed hamburger steak with gravy, baked potato, collard greens and California blend, dinner roll, strawberry ice cream, and beverage of choice. Observation of lunch meal on 01/21/25 at 12:45pm revealed Resident #2 was given pureed hamburger steak with gravy, mashed potatoes, pureed collard greens and pureed California blend, strawberry ice cream, and water. Observation of lunch meal on 01/21/25 at 12:46pm revealed: -Resident #2 placed a small portion of her mashed potatoes on a paper towel and it was very cold to touch. -Resident #2 placed a small portion of her pureed hamburger steak with gravy on a paper towel and it was cold to touch. Interview with Resident #2 on 01/21/25 at	D 287		

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D 287	Continued From page 16 12:45pm revealed: -Her food was always cold, and she often had to ask staff to warm up her plate, but it would take to long for them to return her plate. -She had mentioned the cold food to the kitchen staff and to the Administrator in the past, as recently as yesterday. -She did not want a new plate of warm food because she became accustomed to eating cold food. Second interview with Resident #2 on 01/27/25 at 8:05am revealed her breakfast food was warm and had been warm since 1/21/25. Interview with the DM on 01/21 25 at 1:00pm revealed: -She pureed Resident #2's food, placed it on the plate, then covered the plate and placed it on the cart. -She did not have a heating cart or another way to keep the food warm. -Resident #2 told her yesterday that her food was cold, and she asked for a sandwich. -She could not explain why the food was cold before getting to Resident #2's room. Interview with the Resident Care Coordinator (RCC) on 01/21 25 at 1:05pm revealed: -She was not aware Resident #2's lunch was cold. -Resident #2 usually asked for sandwiches and asked for the sandwich to be warm. -Dietary staff was responsible for making sure her food is warm. Interview with the primary care provider (PCP) on 01/28 25 at 11:30am revealed: -She was not aware Resident #2 was being served cold food.	D 287		

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D 287	Continued From page 17 -Cold food could upset her gastrointestinal (GI) track. -She expected the dietary staff to serve food at the appropriate temperature. Interview with the Administrator on 01/21/25 at 1:08pm revealed: -She was not aware Resident #2's lunch was cold. -She was not aware that she had been having issues with cold food being served to her. -She expected the dietary staff to serve food at the appropriate temperature. -She was not aware if the dietary staff used heating carts for the assisted living side when taking food to the rooms.	D 287		