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 04/09/2025

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on April 8, 2025 through April 9, 2025.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#1) related to weekly weight checks. The findings are: Review of Resident #1's FL-2 dated 02/12/25 revealed diagnoses included chronic kidney disease, class 1 obesity, hyperlipidemia and hypertension. Review of Resident #1's physician's orders dated 02/12/25 revealed there was an order to check weight weekly scheduled for 8:00am. Review of the Vital Signs Book revealed: -There was 1 weight check entry for February 2025. -There was 1 weight check entry for March 2025. -There was 1 weight check entry for April 2025. -There was no day of the month or time	D 276		

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D 276	Continued From page 1	D 276		

documented for any of the weight entries.

Review of Resident #1's February 2025 MAR and electronic medication administration record (eMAR) revealed:
-There was an entry for weight check once weekly scheduled for 8:00am.
-Weight checks were documented as completed on 02/07/25 and 02/21/25 with the MAs initials.
-There were no weight results documented on 02/07/25 and 02/21/25.
-There was no documentation of weight checks at 8:00am on 02/14/25 or 02/28/25.

Review of Resident #1's March 2025 MAR and eMAR revealed:
-There was an entry for weight check once weekly scheduled for 8:00am.
-A weight check was documented as completed on 03/20/25 with the MAs initials.
-There was no weight result documented on 03/20/25.
-There was no documentation of weight checks at 8:00am on 03/07/25, 03/14/25 or 03/28/25.

Review of Resident #1's April 2025 MAR and eMAR revealed:
-There was an entry for weight check once weekly scheduled for 8:00am.
-There was no documentation of weight checks at 8:00am on 04/04/25.

Interview with the medication aide (MA) on 04/09/25 at 10:55am revealed:
-She did not know how often Resident #1 was supposed to receive weight checks.
-She used the eMAR to determine how often weight checks were to be done.
-She checked Resident #1's weight weekly and documented it on the eMAR.

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D 276	Continued From page 2	D 276		

-Monthly weights were documented in the Vital Signs book.
-She did not know why weekly weights were not documented for Resident #1.
-The eMAR system did not work properly sometimes.
-MAs were told to document on paper MARs, by the Resident Care Coordinator (RCC), if they were unable to document on the eMARs.
-Weekly weights should have been documented on the eMAR or paper MAR.

Interview with the Resident Care Coordinator (RCC) on 04/09/25 at 1:57pm revealed:
-She was aware Resident #1's weight was to be checked weekly.
-Monthly weight checks were done on all residents.
-Weekly weight checks were ordered by the primary care provider (PCP) for Resident #1.
-The weight check order showed up on the eMAR daily to alert the MA.
-She expected the MAs to follow the eMAR orders.
-She was not aware weekly weight checks were not being done on Resident #1 until yesterday, 04/10/25.
-She tried to do MAR audits monthly but was unable to do so due to being short staffed, which caused her to have to work on the floor sometimes.
-She did not know why weekly weight checks were not done on Resident #1.
-There were times when the MAs had difficulty documenting in the eMAR system due to system issues.
-She told the staff to use paper MARs until the issues with the eMAR system were fixed.

Interview with the Administrator on 04/09/25 at

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	HAL031016	A. BUILDING: _____ B. WING _____	R 04/09/2025

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 276	Continued From page 3 2:36pm revealed: -She was not aware Resident #1 had an order for weekly weights. -The weekly weight order should have shown up on the eMAR to alert the MA to check the weight. -The RCC was responsible for making sure the weekly weights were monitored. -The RCC had been doing audits, but the computer system did not work properly sometimes. -The MARs and resident records were compared during audits. -She did not know why weekly weights were not done on Resident #1. -There were times when the MAs had difficulty documenting on the eMAR system due to system issues. -The staff were told to use paper MARs until the issues with the eMAR system were fixed. -Weekly weights should have been documented on paper MARs if the computer system was down. Attempted telephone interview with Resident #1's PCP on 04/09/25 at 3:02pm was unsuccessful.	D 276		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 4	D 358		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) including a medication used to lower blood pressure and heart rate.

The findings are:

Review of Resident #5's current FL2 dated 01/07/25 revealed:
-Diagnoses included left bundle branch block, Parkinson's disease, syncope, and elevated troponin.
-There was an order for Metoprolol Succinate Extended-Release (ER) 25mg take ½ tablet (12.5mg) every day, hold for heart rate below 60 (Metoprolol Succinate ER is an extended-release medication used to lower blood pressure and/or heart rate).

Review of Resident #5's February 2025 medication administration record (MAR) and electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Succinate ER 25mg take ½ tablet (12.5mg) every day, hold for heart rate below 60 scheduled for 7:00am.
-Metoprolol Succinate ER 12.5mg was documented as administered daily at 7:00am on 23 of 28 days from 02/01/25 to 02/28/25.
-Resident #5's heart rate was documented at 7:00am on 23 of 28 days from 02/01/25 to 02/28/25.
-On 02/19/25, Metoprolol Succinate ER 12.5mg was documented as administered at 7:00am.
-There was no documentation of Resident #5's heart rate at 7:00am on 02/19/25.
-There was no documentation Resident #5's Metoprolol Succinate 25mg ER 12.5mg was

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	HAL031016	A. BUILDING: _____ B. WING _____	R 04/09/2025

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D 358	Continued From page 5	D 358		

administered on 02/11/25, 02/14/25, 02/19/25, 02/26/25, and 02/27/25.
-There was no documentation of Resident #5's heart rate at 7:00am on 02/11/25, 02/14/25, 02/19/25, 02/26/25, and 02/27/25.

Review of Resident #5's March 2025 MAR and eMAR revealed:
-There was an entry for Metoprolol Succinate ER 25mg take ½ tablet (12.5mg) every day, hold for heart rate below 60 scheduled for 7:00am.
-Metoprolol Succinate ER 12.5mg was documented as administered daily at 7:00am from 03/01/25 to 03/31/25.
-Resident #5's heart rate was documented at 7:00am on 23 of 31 days from 03/01/25 to 03/31/25.
-There was no documentation of Resident #5's heart rate at 7:00am on 03/07/25, 03/09/25, 03/17/25, 03/22/25, 03/23/25, 03/26/25, 03/28/25, and 03/31/25.

Review of Resident #5's April 2025 MAR and eMAR revealed:
-There was an entry for Metoprolol Succinate ER 25mg take ½ tablet (12.5mg) every day, hold for heart rate below 60 scheduled for 7:00am.
-Metoprolol Succinate ER 12.5mg was documented as administered daily at 7:00am from 04/01/25 to 04/08/25.
-Resident #5's heart rate was documented at 7:00am on 04/01/25, 04/03/25, 04/04/25, and 04/08/25.
-There was no documentation of Resident #5's heart rate at 7:00am on 04/02/25, 04/05/25, 04/06/25, and 04/07/25.

Interview with a medication aide (MA) on 04/09/25 at 10:18am revealed:
-The facility had an eMAR system but sometimes

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	HAL031016	A. BUILDING: _____ B. WING _____	R 04/09/2025

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D 358	Continued From page 6	D 358		

the eMAR system did not work properly.
-MAs were instructed by the Resident Care Coordinator (RCC) to document medications administered on the residents' paper MARs if they were unable to document on the eMARs.
-When she administered medications to residents, she followed the instructions on the MAR.
-If a resident had an order for their blood pressure or heart rate to be checked, the third shift (11:00pm-7:00am) staff usually checked the resident's blood pressure and heart rate.
-She was unsure what time the third shift staff completed the blood pressure and heart rate checks because the checks were completed before she arrived for her shift at 7:00am.
-The third shift staff recorded blood pressure and heart rate readings in a notebook.
-She did not check Resident #5's heart rate when she administered Metoprolol Succinate ER 12.5mg because his heart rate was checked on third shift.
-She was unsure why Resident #5's heart rate was not documented on the MARs on some dates.
-She was unsure why some doses of Resident #5's Metoprolol Succinate ER were not documented unless there were issues with his eMARs on those dates.
-Resident #5's heart rate should be checked before his Metoprolol Succinate ER was administered since there were instructions on his MAR to hold the medication if his heart rate was less than 60.

Interview with the RCC on 04/09/25 at 1:58pm revealed:
-The facility was having issues with their eMAR system, so the eMAR system was going to be replaced.

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WALLACE GARDENS	1052 NE RAILROAD STREET WALLACE, NC 28466

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D 358	Continued From page 7 -There were times when the MAs had difficulty documenting medications administered on the eMAR system. -She instructed the staff to use paper MARs until the issues with the eMAR system were resolved. -She was responsible for auditing the MARs and eMARs monthly. -She had been unable to perform the monthly audits recently due to other responsibilities and the issues with the eMAR system. -MAs should administer the residents' medications according to the instructions on the MAR. -MAs should document on the residents' MARs after medications were administered and document any refusals of medications. -The third shift staff checked vital signs for residents who had orders for their vital signs to be checked. -The third shift staff checked vital signs right before their shift ended at 7:00am. -If a resident had an order to for their heart rate to be checked, the MAs should check the heart rate before the medication was administered. -Resident #5's heart rate should be checked immediately before his Metoprolol Succinate ER 12.5mg was administered. -Resident #5's heart rate could vary between the time it was checked on third shift and the time his Metoprolol Succinate ER 12.5mg was scheduled to be administered, so the first shift MA should check his heart rate at the time the medication was scheduled -The administration of Resident #5's Metoprolol Succinate ER and his heart rate should both be documented on the MAR. -If medications were not documented, there may have been issues with the eMAR system on that date. -Any medications administered should have been	D 358		

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D 358	Continued From page 8	D 358		

documented on either the eMAR or the paper MAR.
-Any medication orders should be administered as ordered by the resident's primary care provider (PCP).

Interview with the Administrator on 04/09/25 at 2:37pm revealed:
-The facility was having issues with their current eMAR system.
-The facility's eMAR system was going to be replaced.
-The MAs were currently documenting on paper MARs until the system was replaced and all issues were resolved.
-The RCC was responsible for auditing the residents' MARs and eMARs.
-The RCC conducted audits of the eMARs and MARs monthly.
-MAs should follow the instructions on the residents' MARs when administering medications to residents.
-When a resident had an order for their heart rate to be checked with a medication, the heart rate should be checked before the medication was administered and documented on the resident's MAR.
-If a resident's heart rate was checked on another shift, the MA should not go by that heart rate reading and should check the heart rate immediately before administering the resident's medication.
-Medications that were not documented as administered may have been administered on days when there were glitches in the eMAR system.
-Medication administered to residents should be documented on the residents' paper MARs if the eMAR was not working properly.
-Resident #5's heart rate could become too low if

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D 358	Continued From page 9 Metoprolol Succinate ER was administered without checking his heart rate. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/09/25 at 10:29am revealed: -Metoprolol Succinate ER was an extended release medication used for blood pressure and heart rate regulation. -If Resident #5's PCP ordered his heart rate to be checked, the facility staff should check Resident #5's heart rate immediately before administering Metoprolol Succinate ER. -Metoprolol Succinate ER could lower the heart rate, so it was important to check the heart rate before administration. Attempted telephone interview with Resident #5's PCP on 04/09/25 at 10:53am was unsuccessful.	D 358		