STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045129	A. BUILDING: _____ B. WING _____	R 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 05/07/19 and 05/08/19.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #3) related to a medication ordered for sleep. The findings are:	{D 358}		

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{D 358}	Continued From page 1 Review of Resident #3's current FL2 dated 02/01/19 revealed diagnosis included generalized anxiety disorder and pain. Review of a signed physician's order dated 04/23/19 revealed trazadone 25mg one tablet at bedtime for insomnia. Review of Resident #3's Medication Administration Record (MAR) for April 2019 revealed: -There was a handwritten entry for trazadone 25mg every day at bedtime with a start date of 04/24/19 and adminstration time of 8:00pm. -There was documentation that the trazadone had been administered 04/24/19 - 04/26/19, and 04/28/19 - 04/29/19. -There was documentation that the trazadone had not been administered 04/27/19 and 04/30/19. -There was no documentation why the trazadone had not been administered. Review of Resident #3's MAR for May 2019 revealed the trazadone 25mg was not listed on the MAR. Interview with the Regional Clinical Director on 05/07/19 at 2:15pm revealed: -The medication aides (MA) transcribed new orders onto the MAR. -The new orders were faxed to the pharmacy. -The Resident Care Coordinator was responsible for ensuring medications were on the MAR. Telephone interview with a representative with the facility's contracted pharmacy on 05/07/19 at 2:30pm revealed: -The pharmacy had not received an order for	{D 358}		

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{D 358}	Continued From page 2 trazadone for Resident #3. -The pharmacy had not dispensed any trazadone for Resident #3. Telephone interview with Resident #3's physician's Nurse Practitioner (NP) on 05/07/19 at 2:40pm revealed: -She had ordered the trazadone because the Resident had reported not sleeping well. -She would expect Resident #3 to complain of insomnia due to not receiving the ordered trazadone. Interview with Resident #3 on 05/08/19 at 8:09am revealed: -The Resident had not had any problems sleeping at night. -The Resident did not know anything about the trazadone. Interview with the Resident Care Coordinator (RCC) on 05/08/19 at 8:15am revealed: -The MAs transcribed new orders onto the MAR and faxed the orders to the pharmacy. -The orders were then put in the pharmacy book. -Charts were audited monthly for new orders. -She did not know why the MAs had documented they had administered the trazadone for Resident #3.	{D 358}		