Received via email 09/28/21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	R 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDEN OF NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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 an annual and follow-up survey from 08/31/21-09/01/21.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of deficiencies or Corrective ActionReport; the Plan of Correction is prepared solely as a matter of compliance with State law.	
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: Based on interviews and record reviews, the facility failed to ensure referral and follow up for 1 of 5 (Resident #4) sampled residents who did not have an appointment scheduled for an eye examination after receiving a referral from the resident's primary care provider (PCP) on 04/22/21. The findings are: Review of Resident #4's current FL2 dated 11/23/20 revealed diagnoses included diabetes, cerebrovascular disease, hematuria, hemiplegia and hemiparesis following cerebral infarction, essential hypertension, and pulmonary embolism. Review of Resident #4's subsequent PCP orders revealed there was a referral dated 04/22/21 for a diabetic eye examination. Review of Resident #4's record revealed there was no documentation related to Resident #4's diabetic eye examination. Interview with Resident #4's PCP on 09/01/21 at 11:18am revealed: -Resident #4's diabetic eye examination should	D 273	All residents shall have documentation to assure referral and follow up are being meet for the routine and acute health care needs of our residents. The RCC and Transport driver will document all appointments being scheduled. The RCC will follow up on all appointments and make sure they have been scheduled. The RCC and Transport driver will notify ED of missed or cancelled appointments. The RCC, Transport driver, and ED will discuss weekly during the at risk meeting the plan to reschedule appointments. The RCC will follow up and ensure the proper representatives and physicians have been notified of any missed or cancelled appointments. The RCC and Transport driver will meet weekly and review the scheduled appointments to ensure all appointments have been made.	10/07/2021 09/30/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roxanne Sills, TITLE: Executive Director, (X6) DATE: 9/28/2021

Received and acknowledged. 10/04/21 SM

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D 273	Continued From page 1 have been prioritized and followed-up by staff responsible for making appointments. -She thought the eye doctor's office should be contacted to see if Resident #4 could get an appointment sooner than October 2021. -She was going to monitor Resident #4's appointment schedule with the eye doctor. Interview with the receptionist/transportation staff on 09/01/21 at 3:08pm revealed: -She started this position less than one month ago. -Appointment calendars were on the computer system and at the front desk. -She was not responsible for making the residents' appointments with offsite healthcare providers. -The Resident Care Coordinator (RCC) or the resident's family members made appointments with offsite healthcare providers. -Family members provided transportation to offsite appointments "sometimes." -Family members informed staff when they would be providing transportation for an offsite appointment. -Resident #4 had an eye doctor appointment scheduled for 08/10/21. -Resident #4's family member was supposed to provide transportation for the 08/10/21 appointment but had called the eye doctor's office and cancelled the appointment. -The calendar did not indicate Resident #4's family member was going to provide transportation for the eye doctor appointment on 08/10/21. -She called the eye doctor's office and rescheduled Resident #4's appointment for 10/15/21. -There was a green highlighted calendar entry for 07/01/21 for Resident #4, but she did not know	D 273	MD appointments will continue to be monitored weekly by the RCC, transport driver and ED. RCC and Transport driver in-serviced on each of their roles and responsibilities related to appointments and follow up on resident appointments. This in-service was conducted by the ED. The ED and RCC will monitor and review documentation with chart audits.	10/15/2021 09/08/2021 10/15/2021

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D 273	Continued From page 2 what it meant. Interview with the RCC on 09/01/21 at 3:57pm revealed: -She started this position in May 2021. -She received referrals from the PCP, and the receptionist/transportation staff was responsible for scheduling the residents' appointments. -Referral appointments were to be scheduled as soon as the referral orders were received. -She reviewed the appointment calendar every day. -The facility provided transportation to the eye doctor's office. -This was the first time she was informed about Resident #4's eye doctor appointment. -On the computer calendar, it appeared Resident #4 had attended the appointment with the eye doctor that had been scheduled for 07/01/21. -Resident #4's family member made the eye doctor appointment scheduled for 07/01/21. -Resident #4's family member cancelled the appointment scheduled for 07/01/21. -The facility transport van previously had been broken down for one week. -The receptionist/transportation staff had rescheduled Resident #4's 08/20/21 appointment with the eye doctor. Telephone interview with Resident #4's family member on 09/01/21 at 4:31pm revealed: -Resident #4 had a previous appointment with the eye doctor scheduled for 07/01/21. -She did not know why the 07/01/21 appointment was cancelled. -She "never" made or cancelled any appointments for Resident #4. -She "never" informed facility staff she was going to transport Resident #4 to his appointments. -She was asked to transport Resident #4 to his	D 273		

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D 273	Continued From page 3 08/20/21 eye doctor appointment because the facility van was out of service. -Her car was not large enough to transport Resident #4 and his wheelchair. -She informed staff she could not transport Resident #4 to his appointment with the eye doctor. Interview with the Administrator on 09/01/21 at 4:49pm revealed: -She did not know who scheduled Resident #4's 07/01/21 appointment with the eye doctor. -She did not know if it was the first available appointment at the eye doctor's office. -The RCC or the receptionist/transportation staff scheduled Resident #4's 08/20/21 appointment with the eye doctor. -The facility van was out of service on 08/17/21; the wheelchair lift was inoperable. -Resident #4's family member was unable to provide transportation, so the 08/20/21 appointment with the eye doctor was cancelled. -The receptionist/transportation staff scheduled Resident #4's 10/15/21 appointment with the eye doctor. -She expected referral appointments to be scheduled within the first twenty-four hours of receiving the referral. -She expected documentation indicating who scheduled the appointment and when the appointment was scheduled to be in the residents' records. -She did not know if the PCP had been informed that Resident #4 had not seen the eye doctor. -The RCC was responsible for informing the PCP of missed appointments. -She expected the RCC to document communication with Resident #4's PCP. -The RCC was new to the position. -When the facility van was inoperable in August	D 273		

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D 273	Continued From page 4 2021, she did not know Resident #4's appointment with the eye doctor was a referral from April 2021. -"Someone" did not follow the procedure for referral orders. Attempted interview with Resident #4 on 09/01/21 at 11:54am was unsuccessful. Attempted interview with staff from the eye doctor's office on 09/01/21 at 2:14pm was unsuccessful.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 5 sampled residents (Resident #3) who had a diet order for no added table salt (NATS). The findings are: Review of Resident #3's current FL2 dated 03/12/21 revealed: -Diagnoses included cerebral infarction, essential	D 310	The dietary manager and dietary aides are to make sure the residents are getting the appropiate diets as ordered by the Physician. The dietary manager will make sure that she receives an updated diet list every Monday (Tuesday if Monday falls on a holiday) from the RCC.The RCC will make sure that she gives the dietary manager an updated diet list every Monday (Tuesday if Monday falls on a holiday). In the case that the RCC is out the ED is responsible for making sure the diet list is given to the dietary manager. The RCC is also responsible for making sure the dietary manager gets a diet order on all admissions the day of that resident's admission and any changed diet orders the day they are changed. The dietary manager is to keep an updatedbinder available for facility staff at all times.	09/30/2021

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D 310	Continued From page 5 hypertension, hyperlipidemia, muscle weakness, abnormalities of gait and mobility, and other lack of coordination -There was a diet order for NATS. Observation of a bulletin board in the facility kitchen listing the residents' diets on 08/31/21 at 9:50am revealed there was a yellow index card indicating Resident #3's diet was a regular NATS diet. Review of the lunch menu for 08/31/21 revealed the lunch meal was fish sticks with tartar sauce, dill new potatoes, green salad, milk, and sherbet. Observation of the lunch meal service on 08/31/21 from 12:25pm-1:12pm revealed: -Resident #3's lunch meal served on 08/31/21 at 12:30pm revealed Resident #3 was served the lunch meal as listed on the menu. -A medication aide (MA) sprinkled a package of salt on Resident #3's lunch meal at 12:40pm. Interview with the Dietary Manager (DM) on 08/31/21 at 9:52am revealed: -Regular diets and NATS diets were served to the residents the facility. -Staff "knew" the residents' diets. -Diets were listed on the bulletin board. Interview with the MA on 09/01/21 at 11:17am revealed: -Resident #3 asked for salt, so she gave it to him. -She did not know Resident #3's diet order was NATS. -She did not ask dietary staff about Resident #3's diet order before providing salt to him. Interview with Resident #3's primary care provider (PCP) on 09/01/21 at 11:18am revealed she	D 310	All diet orders and diet changes will be discussed daily at stand up with the dietary manager and the RCC. The dietary manager will ensure all new diet orders the dietary board and the binder be kept up to date. The RCC and ED will review diet orders with monthly chart audits. An in-service was conducted with all facility staff. The responsibilities of the dietary manager and dietary staff were discussed with the facility staff. In regards to Therapeutic diets and what does NATS (no added table salt) mean. The facility staff was instructed that the dietary staff is responsible for serving the meals. In the case that the care staff does assist no condiments including but not limited to salt and pepper shall be given to any resident until that resident's diet is verified by the dietary manager or dietary staff. This in-service was conducted by the ED. The ED, BOC, RCC, LEC, and Dietary managers along with dietary aides will rotate monitoring meal times to ensure dietary staff and care staff are following the resident's diets and that proper staff is serving the meals. And if care staff is assisting they are following the instruction on verification of resident's diet orders.	10/15/2021 09/07/2021 10/15/2021

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D 310	Continued From page 6 would "watch" Resident #3's blood pressure results for the next few days. Interview with Resident #3 on 09/01/21 at 3:48pm revealed: -He did not know his PCP had ordered a NATS diet for him. -He asked staff for salt when he "need[ed] it." -Sometimes the food tasted "plain," and he wanted salt on it. Interview with the Resident Care Coordinator (RCC) on 09/01/21 at 3:57pm revealed: -She or the Administrator were responsible for informing the DM of the residents' diet orders. -There was a bulletin board in the kitchen listing the residents' diet orders. -When non-dietary staff were assisting with the meal service, dietary staff informed them of the residents' diet orders. -Residents with a NATS order should not receive salt "at all." -Staff should not be giving the residents with NATS diet order salt at the table. -Staff "should be following [the] order." -There were small bowls with salt and other meal needs on each table in the dining room. -The small bowls would not contain salt if the residents seated at the table were not supposed to have salt. -She "wished" dietary staff would have noticed the MA sprinkling salt on Resident #3's lunch meal. -She observed breakfast or lunch service daily. Interview with the Administrator on 09/01/21 at 4:49pm revealed: -The DM should receive copies of the residents' diet orders from the RCC. -The facility served regular and NATS diets to the residents.	D 310		

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D 310	Continued From page 7 -Staff should "not give anything" to a resident without checking with the cook. -Dietary staff and the MAs should know the residents' diet orders. -NATS meant a resident was not to be served salt. -One small bowl containing meal items was set on each table. -Dietary staff placed the containers on the tables and should know which resident could receive salt on the table. -The MA should have reviewed Resident #3's diet order before providing salt to him. -Diet orders were listed in the residents' electronic record which could be accessed by the MAs. -The MA must not have asked the cook about Resident #3's diet order. -She varied her meal observations throughout the week but routinely observed meals seven days each week. -She held the cook responsible for ensuring meals were served as ordered. -Dietary staff were responsible for what was served to the residents. -Dietary staff were responsible for instructing non-dietary staff to serve the residents' meals according to the residents' diet orders. -The MA was responsible for not serving Resident #3 his diet as ordered.	D 310		