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 _____	C 11/02/2022

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 an annual survey and complaint investigation on 11/01/22 - 11/02/22.	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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications prescribed by a licensed prescriber were administered as ordered for 2 of 5 sampled residents (#2 and #3) related to a medication that treats high blood glucose (#2) and a medication for sleep (#3). The findings are: 1. Review of Resident #2's current FL2 dated 10/04/22 revealed a diagnosis of type 2 diabetes (high blood glucose). Review of Resident #2's physician's orders dated 10/04/22 revealed Novolog 100u/ml, (reduces blood glucose), 44 units every morning and 38 units every evening before dinner.	D 358		

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D 358	Continued From page 1 Review of Resident #2's physician's orders dated 10/25/22 revealed increase Novolog to 48 units every morning and continue Novolog 38 units every evening before dinner. Review of Resident #2's electronic Medication Administration Record (eMAR) for 10/01/22 - 11/01/22 revealed: -There was an entry for Novolog 44 units every morning at 8:00am with a discontinued date of 10/25/22. -There was documentation the Novolog 44 units was administered 10/01/22 - 10/25/22 at 8:00am -There was no entry for Novolog 48 units every morning or documentation Novolog 48 units was administered 10/26/22 - 11/01/22. -There was an entry for Novolog 38 units every evening at 5:00pm with a discontinued date of 10/25/22. -There was documentation the Novolog 38 units had been administered 10/01/22 - 10/25/22 at 5:00pm. -There was no documentation the Novolog 38 units had been administered on 10/26/22 - 10/31/22. Review of Resident #2's finger stick blood sugars (FSBS) (a measure of blood glucose), for 10/26/22 - 11/01/22 revealed a range of 109 - 343. Review of Resident #2's medications available for administration on 11/01/22 at 3:00pm revealed there was one Novolog 100u/ml flex pen available for administration. Interview with the medication aide (MA) supervisor on 11/01/22 at 2:45pm revealed: -She knew the new Novolog orders were not on the eMAR for her to administer and administered	D 358		

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it anyway.
-She thought she had refaxed the Novolog order to the pharmacy but could not remember when.
-She did not think about telephoning the pharmacy about the missing Novolog orders.
-She was not responsible for auditing the new orders by comparing them to the eMAR and she thought the Executive Director (ED) was responsible for that.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/01/22 at 2:17pm revealed:
-The pharmacy had received a signed physician's order via fax to increase Novolog to 48 units every morning and to continue Novolog 38 units every evening before dinner on 10/25/22.
-Sometimes when the pharmacy entered new orders into the eMAR system the facility would not be able to view it and would then need to notify the pharmacy.
-The pharmacy had not received notification from the facility that the Novolog orders were not on the eMAR.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/01/22 at 2:55pm revealed:
-Resident #2 had been prescribed the Novolog due to diabetes.
-Not receiving the Novolog insulin as ordered put Resident #2 at risk of uncontrolled diabetic ketoacidosis (a serious medical condition that can cause confusion, lethargy, and altered mental status requiring hospitalization).

Interview with Resident #2 on 11/01/22 at 3:00pm revealed sometimes he did not receive all his insulin because he had been told it was not on the eMAR to administer.

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D 358	Continued From page 3 Interview with the ED on 11/02/22 at 7:30am revealed: -All new medication orders were to be faxed by the MA to the pharmacy. -The pharmacy entered the new orders into the eMAR system. -The MA supervisor was responsible for auditing new orders by comparing them to the eMAR. -The MA supervisor approved the new orders via the eMAR once the medications arrived in the facility. -The MAR supervisor should have contacted the pharmacy if the medication orders were not in the eMAR. -She instructed the MAs to write medication orders on a paper medication administration record if there was an issue with the eMAR. -She did not know if Resident #2 had received the Novolog insulin or not. 2. Review of Resident #3's current FL2 dated 07/12/22 revealed: -Diagnoses included insomnia, depression, type 2 diabetes, and chronic fatigue syndrome. -There was an order for trazadone (used to treat insomnia) 150mg 1 tablet daily at bedtime. Interview with Resident #3 during the initial tour on 11/01/22 at 9:21am revealed: -He had not received his "sleeping medicine" for the "last couple weeks." -He did not know the name of the medication. -When he did not receive the medication, he was "up all night." -It made him tired the next day when he was unable to sleep the previous night. Review of Resident #3's Nurse Practitioner (NP) order dated 09/27/22 revealed:	D 358		

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D 358	Continued From page 4 -There was an order to discontinue trazadone. -There was an order to start temazepam (used to treat insomnia) 7.5mg 1 capsule daily at bedtime. Review of Resident #3's NP order dated 10/11/22 revealed there was an order to increase temazepam 15mg daily at bedtime. Review of Resident #3's September 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for trazodone 150mg 1 tablet daily at bedtime scheduled at 9:00pm. -The trazodone was documented as administered as ordered from 09/01/22 to 09/26/22. -There was an entry for temazepam 7.5mg 1 capsule daily at bedtime scheduled at 8:00pm. -The temazepam was documented as not administered on 09/28/22 due to "waiting on pharmacy." -There was no documentation for the temazepam 7.5 mg on 09/27/22 and 09/29/22. -The temazepam 7.5mg was documented as administered on 09/30/22. Review of Resident #3's October 2022 eMAR revealed: -There was an entry for temazepam 7.5mg 1 capsule daily at bedtime scheduled at 9:00pm. -The temazepam 7.5mg was documented as administered as ordered from 10/01/22 to 10/13/22. -There was an entry for temazepam 15mg 1 capsule daily at bedtime with a note to give 2 capsules to equal 15mg until pharmacy delivery. -The temazepam 15mg was documented as administered as ordered from 10/13/22 to 10/15/22, and 10/17/22 to 10/24/22. -On 10/16/22 and 10/25/22 to 10/31/22, the temazepam was documented as not	D 358		

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administered due to "waiting on pharmacy."

Review of Resident #3's November 2022 eMAR revealed:
-There was an entry for temazepam 7.5mg 2 capsules (15mg) daily at bedtime scheduled at 8:00pm.
-The temazepam was documented as not administered on 11/01/22 due to "waiting on pharmacy."

Observation of Resident #3's available medications on 11/02/22 at 1:47pm revealed there was no temazepam.

Telephone interview with the contracted facility pharmacy on 11/02/22 at 10:20am revealed:
-They dispensed a 30-day supply (30 capsules) of temazepam 7.5mg tablets for Resident #3 on 09/29/22.
-They received an electronic prescription from Resident #3's NP to increase the temazepam to 15mg daily at bedtime on 10/11/22.
-The did not dispense temazepam 15mg capsules to the facility when they received the new order on 10/11/22, because the facility still had a supply of temazepam 7.5mg tablets to use.
-The pharmacy's expectation was the facility would contact them and request the temazepam 15mg capsules be sent to the facility when a new supply of temazepam was needed.

Review of Resident #3's record revealed:
-The pharmacy dispensed temazepam 7.5mg 30 capsules for Resident #3 on 09/29/22.
-There was no documentation additional temazepam was sent to the facility for Resident #3.
-The temazepam 7.5mg capsules would have supplied the medication per the 10/11/22 order

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until 10/19/22.
-Resident #3's temazepam was not available to administered as ordered for 13 days (from 10/20/22 to 11/01/22).

Interview with Resident #3's NP on 11/02/22 at 1:51pm revealed:
-Resident #3 did not sleep well when he did not receive the temazepam as ordered.
-Resident #3 would be "tired" the next day when he did not receive the temazepam as ordered.
-She sent an electronic prescription to increase Resident #3's temazepam dosage to 15mg daily at bedtime to the contracted facility pharmacy on 10/11/22.
-She found out through facility staff on 10/25/22 the pharmacy required a hard script to fill the order for temazepam 15mg capsules.
-She sent another prescription for the temazepam 15mg daily at bedtime to the pharmacy on 10/25/22.
-The facility staff then contacted her on 10/28/22 and told her they still had not received the temazepam 15mg capsules from the pharmacy.
-She called the pharmacy and the pharmacy could not explain to her why they did not send Resident #3's temazepam after they received the new prescription on 10/25/22.

Interview with the ED on 11/02/22 at 2:15pm revealed:
-The MAs were responsible for calling the pharmacy when a medication was not available to administer.
-She found out on 10/28/22 Resident #3 did not have temazepam available.
-She called the pharmacy and discovered insurance denied payment for temazepam prescribed for two 7.5mg capsules to equal a 15mg daily dose.

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D 358	Continued From page 7 -She sent a text message to Resident #3's NP on 10/28/22 to inform the NP a new order was needed for Resident #3's temazepam. -She was able to reach the NP and another order was sent to the pharmacy. -The temazepam would arrive from the pharmacy tonight (11/02/22). _____ The facility's failure to administer Novolog insulin to Resident #2 as ordered put the resident at an increased risk of uncontrolled diabetic ketoacidosis. This failure is detrimental to the health of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 17, 2022.	D 358		