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 02/02/2023

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 completed a Follow-up survey on 02/01/23 and 02/02/23.	{D 000}		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to verify there were no substantial findings on the Health Care Personnel Record (HCPR) for 1 of 2 sampled staff (Staff A) prior to working at the facility. The findings are: Review of Staff A's personnel record revealed: -She was hired on 09/27/22. -She worked as a medication aide (MA). -There was no documentation a HCPR check was completed upon hire. -There was documentation a HCPR check was completed on 02/03/23 with no substantial findings. Interview on 02/03/23 at 12:10pm with the Business Office Manager (BOM) revealed: -She was responsible for checking the HCPR on all new staff members since January 2023. -The previous BOM would have been responsible for checking the HCPR prior to Staff A being hired.	D 137		

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D 137	Continued From page 1 -She could not locate a HCPR check for Staff A. -She checked the HCPR on Staff A on 02/03/23. Interview on 02/03/23 at 12:20pm with the Executive Director revealed: -The BOM was responsible for completing the HCPR checks on new employees prior to hire. -She was not aware Staff A had not a a HCPR check prior to her employment with the facility.	D 137		
{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 Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure a medication prescribed by a licensed prescriber was administered as ordered for 1 of 5 sampled residents (#1) related to a medication to treat low blood potassium. The findings are: Review of Resident #1's current FL2 dated	{D 358}		

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{D 358}	Continued From page 2 10/04/22 revealed diagnosis included hypertension (high blood pressure), hyponatremia (low sodium levels in the blood), and atherosclerotic heart disease (build up of fats and cholesterol in the artery walls). Review of physician's orders for Resident #1 dated 10/04/22 revealed: -Potassium chloride (supplement that treats low potassium in the body) 20mEq take 2 tablets (40mEq) twice daily. -Furosemide (diuretic that can cause low potassium levels) 40mg take 1 tablet daily for edema. Review of a physician's order for Resident #1 dated 12/06/22 revealed metolazone (diuretic that can cause low potassium levels) 5mg daily for weight gain. Review of Resident #1's December 2022, January 2023, and February 2023 electronic Medication Administration Records (eMAR) revealed from 12/17/22 to 02/01/23 there was not an entry for potassium chloride. Telephone interview a pharmacy technician at the facility's contracted pharmacy on 02/01/23 at 1:10pm revealed: -The pharmacy received a signed physician's order via fax on 10/04/22 for Resident #1 for potassium chloride 20mEq take 2 tablets twice daily. -The pharmacy received a signed physician's order via fax on 11/08/22 for Resident #1 for potassium chloride 20mEq reduce to 2 tablets daily. -The pharmacy had not received an order to discontinue the potassium chloride and it was still an active order and continued to be dispensed in	{D 358}		

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{D 358}	Continued From page 3	{D 358}		

the multi dose packs to the facility.
-The pharmacy entered orders electronically but were unable to view the facility's eMAR system.
-If a medication order was not listed on the eMAR the facility would need to notify the pharmacy of the discrepancy.

Observation of Resident #1's medications on hand for administration on 02/02/23 at 10:12am revealed:
-There was a multi dose pack of medications.
-Printed on the label was the name and directions for each medication including potassium chloride 20mEq take 2 tablets (40mEq) daily.
-There were two potassium chloride tablets in the multi dose pack of medications.
-Handwritten over the printed potassium chloride label was "D/C" (discontinue).

Review of a hospital discharge summary for Resident #1 dated 01/13/23 revealed:
-Resident #1 was admitted to the hospital on 01/10/23 with a syncopal (temporary loss of consciousness) episode.
-Resident #1 had a blood potassium level of 3.1.
-Resident #1 had multiple discharge diagnoses including hypokalemia (a below normal potassium level).
-Potassium chloride was not listed on Resident #1's medication list as a prior or current medication.

Review of a physician's clarification order for Resident #1 dated 01/13/23 revealed:
-Discontinue potassium chloride.
-The order was signed by the facility's contracted Nurse Practitioner (NP) with two hand written initials.

Telephone interview with the facility's contracted

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{D 358}	Continued From page 4 NP on 02/01/23 at 2:15pm revealed: -She did not know Resident #1 had not been administered the potassium chloride. -She did not remember writing an order on 01/13/23 to discontinue the potassium chloride. -Resident #1 was taking two diuretics and needed the potassium chloride supplement because the diuretics can deplete the body of potassium chloride. -Low potassium blood levels can cause cardiac problems possibly leading to hospitalization. Interview with the Administrator on 02/01/23 at 2:35pm revealed: -She was the Administrator in the facility for two weeks and did not know what transpired with the potassium chloride prior to that. -She administered the morning medications to the residents. -She knew Resident #1's potassium chloride had been discontinued in January 2023. -She did not know why the potassium chloride was not on the eMAR before the discontinue date. -The pharmacy continued to dispense the potassium chloride in the multi dose packs but she knew to take out the potassium chloride and not administer it. -She had faxed the order to discontinue the potassium chloride to the pharmacy but did not have a fax verification form. -The RCC was responsible for approving new orders and auditing the medication cart weekly. Interview with the Resident Care Coordinator (RCC) on 02/02/23 at 9:00am revealed: -She was responsible for faxing new orders to the pharmacy. -She was responsible for conducting medication cart audits weekly by comparing orders with the	{D 358}		

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{D 358}	Continued From page 5 medications in the cart. -She had conducted the last cart audit on 01/10/23 or 01/11/13. -She had been working in the facility for one month and did not know why the potassium chloride was not on Resident #1's eMAR. -She had not seen any orders for potassium chloride and knew nothing about it. -She had been told that the last couple of months had been "hectic" in the facility because there was not an RCC in the facility. _____ The facility failed to administer a medication as ordered related to a medication to treat low blood potassium levels which placed the resident at risk of cardiac problems which could lead to hospitalization (Resident #1). This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection on 02/01/23 for this violation in accordance with G.S. 131D-34.	{D 358}		