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 06/09/2023

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 on June 8, 2023 and June 9, 2023.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to contact the prescribing practioner for medication clarification for 1 of 6 sampled residents (#4) who was prescribed an insulin to treat high blood glucose (sugar) and missed three doses each week due to going to dialysis. The findings are: Review of Resident #4's current FL-2 dated 10/20/22 revealed diagnoses included end stage renal disease, atrial fibrillation, hypertension, type 2 diabetes mellitus, idiopathic epilepsy,	D 344	The Gardens of Nashville shall ensure contact with the Resident's provider for verification or clarification of orders for medications and treatments as appropriate. Verification/ Clarifications are to be documented in the Resident's record. Regional Director of Operations (RDO) will in-service the Resident Care Coordinator (RCC) and Med Techs on the 6 rights of medication administration, the importance of contacting the Provider to clarify orders that are incomplete or unclear, and the importance of following up on that clarification and ensuring documentation. Med Techs to be in-serviced on the importance of notifying the RCC when there is any delay in getting an order clarified and assistance is needed. 7/21/23 RCC will monitor order processing folders daily to ensure there are not medication orders awaiting clarification. If such orders are present, RCC will work to assist in expediting the process. 7/24/23	

SQS

Received via email 07/25/23
Reviewed and acknowledged 07/25/23

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D 344	Continued From page 1 atherosclerotic heart disease, gout, and paranoid schizophrenia. Review of Resident #4's medication order dated 02/24/23 revealed an order for Humalog KwikPen Insulin, inject 15 units three times a day. (Humalog is a fast-acting insulin, also called insulin lispro, used to treat high blood sugar). Review of Resident #4's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog KwikPen Insulin, inject 15 units three times a day at 8:00am, 3:00pm, and 9:00pm. -There was documentation that Humalog KwikPen Insulin, 15 units was not administered at 3:00pm on 04/04/23, 04/06/23, 04/08/23, 04/11/23, 04/13/23, 04/15/23, 04/18/23, 04/23/23, 04/22/23, 04/25/23, and 04/29/23 due to the resident being out of the facility for dialysis or unavailable. Review of Resident #4's May 2023 eMAR revealed: -There was an entry for Humalog KwikPen Insulin, inject 15 units three times a day at 8:00am, 3:00pm, and 9:00pm. -There was documentation that Humalog KwikPen Insulin, 15 units was not administered at 3:00pm on 05/02/23, 05/04/23, 05/09/23, 05/16/23, 05/18/23, 05/23/23, 05/25/23, and 05/30/23 due to resident being out at dialysis or unavailable. Review of Resident #4's June 2023 eMAR revealed: -There was an entry for Humalog KwikPen Insulin, inject 15 units three times a day at 8:00am, 3:00pm, and 9:00pm.	D 344	RCC will pull EMAR compliance reports daily to review for accuracy and compliance. The report will be reviewed and discussed daily with the ED during management meeting for any needed follow-up.	7/24/23

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-There was documentation that Humalog KwikPen Insulin, 15 units was not administered at 3:00pm on 06/01/23, 06/03/23, and 06/06/23 due to being unavailable or at dialysis.

Observation of Resident #4's medications on hand on 06/09/23 at 10:30am revealed there were five (5) KwikPen Insulin with a dispensing date of 02/23/23 and an expiration date of 03/22/24.

Interview with Resident #4 on 06/09/23 at 11:00am revealed:
-He went to dialysis on Tuesday, Thursday, and Saturday.
-He left the facility "around" 11:30am and came back to the facility "around" 4:30pm.
-He was a "diabetic" and received insulin three times a day.
-He did not receive his 3:00pm insulin on the days he went to dialysis.

Interview with the medication aide (MA) on 06/09/23 at 11:30am revealed:
-Resident #4 went to dialysis on Tuesday, Thursday, and Saturday.
-He left the facility going to dialysis between 11:00am and 11:45am.
-He usually came back to the facility between 4:00pm and 5:00pm.
-On dialysis days, he did not receive his 3:00pm insulin.
-The primary care provider (PCP) was aware he went to dialysis.
-She thought the PCP was aware the resident was not administered his 3:00pm insulin on dialysis days.
-When the resident went to dialysis and did not receive his 3:00pm Humalog, she would enter on the eMAR "out to dialysis" or "unavailable."

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Interview with the Resident Care Coordinator (RCC) on 06/09/23 at 2:45pm revealed:
-She was aware Resident #4 went to dialysis on Tuesday, Thursday, and Saturday.
-She was aware the resident was diagnosed with diabetes and received insulin.
-She was not aware of the time the resident went to dialysis.
-She was aware the resident was not administered his 3:00pm Humalog on dialysis days.
-She was not sure if the PCP was aware Resident #4 did not receive his 3:00pm Humalog on dialysis days.
-She had not mentioned or reached out to the PCP for clarification regarding the 3:00pm scheduled Humalog for Resident #4 on dialysis days.

Interview with the Administrator on 06/09/23 at 3:15pm revealed:
-She was aware Resident #4 was diagnosed with diabetes, on insulin, and went to dialysis.
-She did not know if the PCP was aware the resident was not administered his 3:00pm Humalog on dialysis days.
-She had not reached out to the PCP for clarification regarding the 3:00pm scheduled Humalog for Resident #4 on dialysis days.
-She was aware the resident was not administered his 3:00pm Humalog on dialysis days.
-She will reach out to the PCP to look at changing the administration time of the resident's 3:00pm Humalog.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/09/23 at 11:30am was unsuccessful.

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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: Based on observation, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 2 residents observed (Resident #6) during a medication administration pass including medications for seasonal allergies, vitamin D supplement and a blood thinner (#6). The findings are: Review of the facility's Medication Services/Pharmaceutical Care Services date September 2021 revealed: -The Executive Director, Resident Care Coordinator or designee will ensure that medication administration services required for each resident are provided. -Medication may be given up to one hour before or up to one hour after the prescribed time unless the physician orders an exact time. The medication error rate was 16% as evidenced by 4 errors out of 25 opportunities during the 9:00am medication pass on 06/08/23. Review of Resident #6's current FL-2 dated	D 358	The Gardens of Nashville shall ensure the preparation and administration of medications and treatments by staff are according to Provider orders which are kept in the Resident's record, the facility's policies and procedures, and rule area .1004(a). RDO will in-service in Med Techs on 6 Rights of Med Admin, High Risk meds, the importance of having ordered medications on hand, and ensuring all medications are being administered per pysician orders and signed for after watching the Resident take the medication. 7/21/23 Med Techs will complete cart audits per facility schedule to account for medications on hand in the facility, available for Resident administration. RCC will follow-up on completed cart audits for compliance. 7/24/23 RCC will complete weekly QA cart audit to monitor for compliance of the medication cart. This will include ensuring items are dated upon opening as appropriate, no expired meds on cart, and meds are given appropriately. Results will be reviewed with the ED for any needed follow-up. 7/24/23 RCC will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance. 7/24/23	

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05/15/23 revealed diagnoses included osteoporosis, malnutrition and atrial fibrillation.

1. Resident #6's current FL-2 dated 05/15/23 revealed an order for Eliquis 5mg to be administered twice daily. (Eliquis is a medication used to prevent blood clots.)

Observation of the 9:00am medication administration pass on 06/08/23 revealed Eliquis 5mg was not administered to Resident #6.

Review of Resident #6's electronic medication administration record (eMAR) for June 2023 revealed:
-There was an entry for Eliquis 5 mg to be administered twice daily at 9:00am and 9:00pm.
-There was documentation Eliquis 5 mg was not administered at 9:00am on 06/08/23 because it was on hold.

Interview with the medication aide (MA) on 06/08/23 at 10:46am revealed Eliquis 5 mg was not available for administration.

Telephone interview with the Registered Nurse for Resident #6's primary care provider (PCP) on 06/09/23 at 3:30pm revealed Resident #6 was prescribed Eliquis to prevent stroke due to atrial fibrillation.

Telephone interview with the pharmacy technician at Resident #6's previous pharmacy on 06/09/23 at 10:20am revealed 30 tablets, a 15 day supply of Eliquis 5mg, was last dispensed on 05/08/23 and the prescription was transferred to another pharmacy.

Telephone interview with the Pharmacist at Resident #6's preferred pharmacy on 06/08/23 at

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3:59pm revealed:
-They became Resident #6's pharmacy on 05/26/23 and prescriptions were transferred from the previous pharmacy.
-They had not received the current FL-2 for Resident #6 and had not dispensed Eliquis 5mg since services began.
-There was a refill ready for pick-up and were waiting on the co-pay.

Second telephone interview with the Pharmacist at Resident #6's preferred pharmacy on 06/09/23 at 3:47pm revealed:
-Eliquis was an anticoagulant (blood thinner) that was prescribed because of a diagnosis of atrial fibrillation to decrease the risk of stroke or a heart attack.

Refer to interview with a second MA on 06/09/23 at 5:26pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/09/23 at 4:05pm.

Refer to interview with the Administrator and the Area Clinical Director (ACD) on 06/09/23 at 5:45pm.

2. Resident #6's current FL-2 dated 05/15/23 revealed an order for vitamin D 50mcg to be administered each day. (Vitamin D is used to supplement vitamin D levels that support immune health and calcium absorption.)

Observation of the 9:00am medication administration pass on 06/08/23 revealed vitamin D 50mcg was not administered to Resident #6.

Review of Resident #6's electronic medication administration record (eMAR) for June 2023

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revealed:
-There was an entry for vitamin D 50mcg to be administered each day at 9:00am.
-There was documentation vitamin D 50mcg was not administered at 9:00am on 06/08/23 because it was on hold.

Interview with the medication aide (MA) on 06/08/23 at 10:46am revealed vitamin D 50mcg was not available for administration.

Telephone interview with the Registered Nurse for Resident #6's primary care provider (PCP) on 06/09/23 at 3:30pm revealed Resident #6 was prescribed Vitamin D to treat osteoporosis.

Telephone interview with the Pharmacist at Resident #6's preferred pharmacy on 06/08/23 at 3:59pm revealed:
-They became Resident #6's pharmacy on 05/26/23 and prescriptions were transferred from the previous pharmacy.
-They had not received the current FL-2 for Resident #6 and there was no order for vitamin D in their system.

Telephone interview with the pharmacy technician at Resident #6's previous pharmacy on 06/09/23 at 10:20am revealed they did not have a prescription for vitamin D to be administered but could be obtained over the counter.

Refer to interview with a second MA on 06/09/23 at 5:26pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/09/23 at 4:05pm.

Refer to interview with the Administrator and the Area Clinical Director (ACD) on 06/09/23 at

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D 358	Continued From page 8 5:45pm. 3. Resident #6's current FL-2 dated 05/15/23 revealed an order for Loratidine 10mg to be administered each day. (Loratidine is a medication used to treat seasonal allergy symptoms.) Observation of the 9:00am medication administration pass on 06/08/23 revealed loratadine 10mg was not administered to Resident #6. Review of Resident #6's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for loratidine 10mg to be administered each day at 9:00am. -There was documentation loratidine 10mg was not administered at 9:00am on 06/08/23 because it was on hold. Interview with the medication aide (MA) on 06/08/23 at 10:46am revealed loratidine 10mg was not available for administration. Telephone interview with the Pharmacist at Resident #6's preferred pharmacy on 06/08/23 at 3:59pm revealed: -They became Resident #6's pharmacy on 05/26/23 and prescriptions were transferred from the previous pharmacy. -They had not received the current FL-2 for Resident #6 and had not dispensed loratidine 10mg since services began. -There was a refill of loratidine 10mg ready for pick-up and were waiting on the co-pay. Telephone interview with the pharmacy technician at Resident #6's previous pharmacy on 06/09/23	D 358		

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at 10:20am revealed 30 tablets, a 30 day supply of loratidine 10mg, was last dispensed on 05/03/23 and the prescription was transferred to another pharmacy.

Telephone interview with Resident #6's family member on 06/08/23 at 4:13pm revealed:
-Resident #6 was admitted from another facility in May 2023.
-Resident #6 was admitted with medications but he did not know what the medications were or how many doses.
-There was a problem with a large copay but he took care of it that morning and he thought the medication was ready to be picked up.

Refer to interview with a second MA on 06/09/23 at 5:26pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/09/23 at 4:05pm.

Refer to interview with the Administrator and the Area Clinical Director (ACD) on 06/09/23 at 5:45pm.

4. Resident #6's current FL-2 dated 05/15/23 revealed an order for fluticasone 1 spray to each nostril each day. (Fluticasone in a medication used to treat symptoms of seasonal allergies.)

Observation of the 9:00am medication administration pass on 06/08/23 revealed :
-The medication aide (MA) pulled the fluticasone nasal spray from the medication cart, shook the bottle and handed it to Resident #6.
-The MA did not give any instructions to Resident #6 for use of the nasal spray.
-Resident #6 sprayed 2 sprays into each nostril at 8:15am.

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-The MA retrieved the nasal spray and returned it to the cart.

Review of Resident #6's electronic medication administration record (eMAR) for June 2023 revealed:
-There was an entry for fluticasone 1 spray to each nostril to be administered each day at 9:00am.
-There was documentation fluticasone 1 spray to each nostril was administered on 06/08/23 at 9:00am.

Interview with the medication aide (MA) on 06/08/23 at 2:05pm revealed:
-Two sprays of fluticasone was always administered to each nostril for Resident #6.
-She thought the order was for two sprays to each nostril.
-She should have read the entire order prior to administration but she thought two sprays were always ordered.

Refer to interview with a second MA on 06/09/23 at 5:26pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/09/23 at 4:05pm.

Refer to interview with the Administrator and the Area Clinical Director (ACD) on 06/09/23 at 5:45pm.

Interview with a second MA on 06/09/23 at 5:26pm revealed:
-MAs were responsible for faxing new orders to the pharmacy and requesting refills through the online system.
-MAs should call the pharmacy to ensure they received the new order and refill requests.

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D 358	Continued From page 11 -MAs requested refills when there were 7-10 days left of a medication. -MAs conducted cart audits weekly to check for expiration and amount of medication on hand. Interview with the Resident Care Coordinator (RCC) on 06/09/23 at 4:05pm revealed: -The medication aides (MA) were responsible for requesting refills of medications when there were less than 10 days supply left on the cart through the online system. -New order medications and refill medications were typically received within 24-48 hours.] -New medications were entered onto the eMAR by the pharmacy and the RCC was responsible for ensuring the order was entered correctly and approved before administration. -MAs were responsible for weekly cart audits to ensure medications were available for administration and she reviewed the cart audit sheets. -She was supposed to pull compliance reports daily, but she was sometimes busy and did not. Interview with the Administrator and the Area Clinical Director (ACD) on 06/09/23 at 5:45pm revealed: -MAs were responsible for weekly cart audits and medication refills requested when there were about 7 days left. -The RCC is expected to complete audits and upload her audit to the drive for the corporation support center but she did not know if that was being done.	D 358		