STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 and complaint investigations on 09/24/24 - 09/26/24. A complaint investigation was initiated by the Nash County Department of Social Services on 08/23/24.	D 000	In response to the cited defeciencies 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 Defenciencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	Type tex
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that a call bell system was working properly to alert the staff through their pager system for assisted living residents who resided in the facility and failed to ensure that shared bathroom sink plumbing equipment was operating in good condition. The findings are: Review of the facility's license on 09/24/24 revealed: -The facility was licensed for a capacity of 62 residents. -The facility was licensed for assisted living (AL) residents only. Review of the facility's census on 09/24/24 revealed 55 residents resided in AL. 1. Observations of a resident's room on 09/24/24 from 9:55am to 10:23am revealed:	D 105	10A NCAC 13F .0311(a) The Gardens of Nashville will ensure that all mechanical and plumbing equipment shall be maintained in a safe operating condition. Facility staff have been in-serviced on ensuring all residents have a working electronic call bell system, is answered timely and within reach in their room at all times. The Maintenance Tech will inspect the electronic call light system during weekly room inspections. Any electronic call bell not functioning properly will be reported to the Executive Director and the impending issue will be resolved by Maintenance or by an outside approved vendor. The facility managers will discuss any impending plumbing issues within the facility to include any resident bathroom. Any plumbing issue that cannot be resolved by facility maintenance will immediately be reported to be resolved by an outside approved vendor. Facility Maintenance will check water temps weekly and report any variance to the Executive Director. Any variance to water temps not resolved by facility maltenance will be reported to an	10/15/24 10/1/24 10/1/24 10/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 11/11/24

Reviewed and Acknowledged. WW 11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 105	Continued From page 1 -At 10:03am, the surveyor pulled the call bell in the bathroom. -There was no audible sound heard but the call bell did light up. -There was no response from staff. -The surveyor was in the resident room from 9:55am to 10:25am. Observations of a second resident's room on 09/24/24 from 10:32am to 10:42am revealed: -At 10:32am, the surveyor pulled the call bell in the bathroom. -There was no audible sound heard but the call bell did light up. -There was no response from staff after 10 minutes. -The surveyor heard a staff member in the hall say hello to the resident as they passed by the room. Observations of a third resident's room on 09/24/24 from 11:05am to 11:35am revealed: -At 11:14am, the resident pulled the bathroom call bell. -There was no audible sound heard but the call bell did light up. -There was no response from staff for 21 minutes. -The surveyor was in the resident's room from 11:05am to 11:35am. Interview with a resident on 09/24/24 at 9:55am revealed: -She pushed the call bell a few minutes earlier that morning and no one came to see what she needed. -The call bell system had not worked for days but she could not recall the exact date. -When the system did work, she had to push the call bell in her bathroom because she did not	D 105	outside vendor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 105	Continued From page 2 have a call bell in her bedroom. -She had gotten weaker and needed help with getting her clothes on. Interview with a second resident on 09/24/24 at 10:58am revealed: -The call bell in her bedroom worked a couple of times and then stopped since she had been living at the facility, nine months earlier. -She told the facility's maintenance person who fixed it five times then it worked for a little while before it stopped again. -The red light turned on both in the bedroom and bathroom, but it did not sound to notify staff that she needed help. -Staff knew that the call bell was not working. Interview with a third resident on 09/24/24 at 11:05am revealed: -A personal care aide (PCA), she could not recall the name, told her on Saturday, (09/21/24) that the call bells were out for everyone. -She could not do anything for herself including transfers without help, "I need help with everything." -Another resident who visited her regularly would go to find a PCA when she needed help. A second interview with the third resident on 09/26/24 at 11:00am revealed: -She was incontinent with bladder and needed staff to help with toileting needs. -On 09/24/24, no PCA came into her room every thirty minutes to check on her to see if she needed assistance with anything. -On 09/25/24, no PCA came into her room every thirty minutes to check on her to see if she needed assistance with anything. -On 09/26/24, no PCA came into her room every thirty minutes to check on her to see if she	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 105	Continued From page 3 needed assistance with anything. Interview with a PCA on 09/26/24 at 11:15am revealed: -On Tuesday (09/24/24), a resident found her and said that the fourth resident needed help. -She walked to the fourth resident's room and assisted her. -She was not assigned to the resident and the PCA who was assigned had been pulled to the front to assist in the reception area. Interview with a facility maintenance technician manager on 09/24/24 at 4:09pm revealed: -He was not aware that the call bell system was not working properly until today. -He contacted his supervisor about the issue around 10:47am and was told he would follow up. -He was aware that a resident was missing her bedroom call bell a couple of weeks ago and he told the Administrator who would notify the Maintenance Director, but no one followed up about the call bell. -When the call bell was pushed, it went to a panel at the nursing station and to the medication aides' (MAs) pagers who then alerted the PCAs on their walkie talkies that a resident needed assistance. Interview with the Administrator on 09/24/24 at 4:34pm revealed: -She was not aware that the call bell system was not working properly because it was working last night. -She reached out to the Maintenance Director regarding the issue, and he contacted the company who serviced the call bell. -They were to come out today to look at the system. -She was not aware that a resident was missing her bedroom call bell.	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 105	Continued From page 4 Interview with the Maintenance person on 09/25/24 at 4:20pm revealed: -The call bell software was wiped completely out, therefore the system did not work properly. -He had to reset the computer system in April or May 2024 to get it working again. -The entire system was replaced about a month ago because the software had been wiped cleaned. -The call bell software was wiped out at least three times in the last five months. -His company covered a wide range of facilities using the call bell system, and he had never seen where the call bell system went out completely. Telephone interview with the facility's contracted primary care provider (PCP) on 09/26/24 at 3:43pm revealed she had concerns if there was no active call bell in the bathroom for a resident if they needed assistance due to a fall and no one knew to come to assist. 2. Observation of bathroom sink shared by resident rooms 201 and 203 on 09/26/24 at 10:44am revealed: -The hot water faucet knob was turned, and no water came out. -The hot water valve under the sink was turned and water did come out. -The hot water valve was turned off under the sink to stop the water from coming out. Interview with a resident on 09/24/24 at 9:37am revealed: -The hot water handle on the bathroom sink in her room did not work unless the hot water shut off valve under the sink was turned on. -She had to turn the valve under the sink every time she wanted to use hot water in the sink.	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 105	Continued From page 5 -She was unsure how long the hot water handle had been broken, -She moved to the room about two weeks ago. Interview with a second resident on 09/26/24 at 10:44am revealed: -She had lived in that room for over one year and the bathroom sink was broken when she came, -She must go under the sink and turn on the hot water valve to get hot water. -No one told her how to turn on the hot water, she figured it out on her own when the water faucet would not turn on. -She reported the faucet issue during a resident rights meeting when she first came to the facility about a year ago. -She reported it to maintenance and the Administrator almost every other month and she was told they were waiting for parts to fix the sink. -She got tired of asking about when the sink would be fixed, and she stopped asking about two months ago. Interview with a facility maintenance technician manager on 09/24/24 at 3:40pm revealed: -He was aware that the bathroom sink hot water faucet was broken in between bedrooms 201 and 203. -To turn on the hot water in that room, one must go under the sink and turn on the hot water valve to get hot water then turn it off to stop the hot water. -He told his supervisor in May 2024 and again in August 2024 about the sink. -He went to a store to purchase a faucet knob, but they were out, and he could not go elsewhere because it was the only store who took payments over the phone. Interview with the Administrator on 09/26/24 at	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 105	Continued From page 6 5:47pm revealed: -She was not aware that the bathroom shared between room 201 and 203 hot water faucet did not turn on properly. -She was not aware the two residents must go under their sink to turn on the hot water valve and then turn off the hot water valve to get hot running water.	D 105		Type text h
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain the water temperatures at the required minimum of 110 degrees Fahrenheit (°F) and a maximum of 116°F for 9 of 13 water fixtures in the shared and common bathrooms used by residents. The findings are: Review of the Environmental Health Report dated 06/11/24 revealed that hot water in residents' rooms and common restrooms ranged between 117 degrees Fahrenheit (°F) and 125°F. Observation of the hot water temperature in a resident's room on 09/24/24 at 9:47am revealed	D 113	10A NCAC 13F .0311(d) The Gardens of Nashville will ensure that there is an adequate supply of hot water and that all resident rooms will maintain a temperature at minimum of 100 degrees F and will not exceed 116 degrees F. The Maintenance Tech was in-serviced by Executive Director on the importance of an adequate supply of hot water to include the maintaining of a required minimum and maximum degrees F per State Regulation. The Maintenance Tech will continue weekly water temp checks as required, will document water temps, and report any variance outside of minimum or maximum range to the Executive Director. Any variance that cannot resolved by facility maintenance will be resolved by an outside vendor. Facility managers will discuss any impending water variances noted during Maintenance Tech water temperature checks during daily stand up. All issues not resolved by facility maintenance will be resolved by an approved outside vendor.	10/1/24 10/1/24 10/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27868

(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 113	Continued From page 7 the hot water temperature in the bathroom sink was 99.7°F. Observation of the hot water temperature in a second resident's room on 09/24/24 at 9:55am revealed: -The hot water temperature in the bathroom sink was 96.4°F. -The hot water temperature in the bathroom shower was 91.9°F. Observation of the spa bathroom across from room 201, on 9/24/24 at 9:56am revealed the hot water temperature in the sink was 96.4°F. Observation of the hot water temperature in a third resident's room on 09/24/24 at 10:27am revealed the hot water temperature in the bathroom sink was 123.1°F. Observation of the hot water temperature in a fourth resident's room on 09/24/24 at 11:05am revealed the hot water temperature in the bathroom sink was 124.7°F. Observation of the hot water temperature in a fifth resident's room on 09/24/24 at 11:42am revealed the hot water temperature in the bathroom sink was 82°F. Observation of the hot water temperature in a sixth resident's room on 09/26/24 at 10:44am revealed: -The hot water temperature in the bathroom sink was 97.5°F. -The hot water temperature in the bathroom shower was 93°F. Review of the facility's August 2024 water temperature log revealed:	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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-113	Continued From page 8 -There was documentation on the water temperature log that the water temperature must be between 100°F and 116°F. -There was documentation on the log to notify the district manager if staff could not adjust the water temperature within range of the required temperature. -On 08/01/24, the 100 hall had three water fixtures that were 97°F. -On 08/02/24, the 100 hall had three water fixtures that were 97°F. -On 08/02/24, the 200 hall had three water fixtures which ranged between 93°F to 97°F. -On 08/09/24, the 100 hall had four water fixtures that were 95°F. -On 08/09/24, the 200 hall had three water fixtures which ranged between 95°F to 97°F. -On 08/14/24, the 100 hall had three water fixtures which ranged between 96°F and 97°F. -On 08/14/24, the 200 hall had three water fixtures which ranged between 95°F to 97°F. -On 08/23/24, the 100 hall had one water fixture which was 85°F. -On 08/01/24, the 100 hall had two water fixtures which ranged between 120°F and 121°F. -On 08/01/24, the 300 hall had three water fixtures which ranged between 118°F to 120°F. -On 08/02/24, the 100 hall had eleven water fixtures which ranged between 118°F to 123°F. -On 08/09/24, the 100 hall had five water fixtures which ranged 117°F and 118°F. -On 08/14/24, the 100 hall had one water fixture that was 118°F. -On 08/23/24, the 100 hall had one water fixture that was 120°F. Interview with a resident on 09/24/24 at 9:47am revealed: -Her water was lukewarm and had been like that for a couple of months.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 113	Continued From page 9 -She told the staff, and they were waiting on a part to fix the water heater. Interview with a second resident on 09/24/24 at 9:55am revealed: -The hot water in the shower was always too cold and she was unable to take a shower at times. -She had told the staff some time ago (could not give exact date) but no one had fixed it. Interview with a third resident on 09/24/24 at 10:27am revealed: -The hot water, "gets really hot", and she had to add cold water to not burn herself. -The hot water had been like that since she came to the facility one year and five months ago. -Staff knew about the hot water, but no one had done anything about it. Interview with a fourth resident on 09/24/24 at 11:05am revealed: -The hot water had been really hot for the last six months. -Staff knew about the hot water but it had not been fixed. Interview with a fifth resident on 09/26/24 at 10:40am revealed: -The shower had been cool since she moved into the room one year and nine months ago. -The water would get lukewarm sometimes but not hot. -If the water did not get lukewarm, she did not get in the shower. -In the winter months the water got worse because it never heated up so she could take a shower. -She told the maintenance staff and the Administrator about her water not getting hot and she was told that they would fix it, but it had not	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 113	Continued From page 10 been fixed. -She got tired of asking and about two months ago she stopped asking. Interview with a facility maintenance technician manager on 09/24/24 at 4:09pm revealed: -He was aware that the hot water temperature in some resident's rooms was below 100°F and above 116°F. -He routinely checked the hot water temperatures within the facility about once a week and would choose six resident's rooms each time to see if the water temperatures were in compliance. -He kept a log of all water temperature to keep track of which rooms had issues with water temperature. -He adjusted the hot water heater to ensure the maximum hot water temperature was less than 116°F. -He informed his supervisor that the water temperature in some rooms were below 100°F while others were above 116°F. -In August 2024, the plumber came out and confirmed an element part burned out and a mixing valve (adds cold water to the hot water in the water heater) needed to be replaced. -The mixing valve had been ordered but had not come in. Interview with the Administrator on 09/24/24 at 4:34pm revealed: -She was aware of the water temperature issues in the building. -In August 2024, the plumber was called (could not remember the exact date) to service the water heater and found a mixing valve was needed. -She was still waiting for the mixing valve to come in.	D 113	Type text here	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 113	Continued From page 11 Second interview with the Administrator on 09/26/24 at 5:47pm revealed she could not recall the Environmental Health report dated 08/11/24 reporting the hot water in resident's rooms and common restrooms reached 117°F-125°F and that the water heater issues started in August 2024.	D 113	Type text here	
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, interviews, and record reviews, the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 5 sampled residents (#5) with a therapeutic diet order. The findings are: Review of Resident #5's current FL-2 dated 04/05/24 revealed: -Diagnoses included Parkinson's disease, age related physical debility, spinal stenosis, and weakness. -Diet order was mechanical soft with ground meats. Review of the facility's posted menu for lunch on 09/25/24 revealed it included turkey sandwich, California blend, white poke cake, and milk. Review of the facility's diet chart on 09/24/24	D 310	10A NCAC 13F .0904(e)(4) The Gardens of Nashville shall assure that all residents shall be served a therapeutic diet as ordered by the primary care physician. The Executive Director in-serviced the Dietary Manager and all staff on therapeutic diets and the importance of reporting any issues regarding food and nutrition. Facility managers will ensure that therapeutic diets are served as ordered by physician during weekly audits and walk through's during meal time. Any concerns identified will be addressed immediately. Facility managers will discuss any new resident diet orders to include therapeutic diets and any resident diet changes made by a physician during daily stand up and ensure dietary staff and facility care staff is aware of changes.	10/10/24 10/10/24 10/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 310	Continued From page 12 revealed Resident #5 should be served a mechanical soft diet. Review of the facility's special diet instructions for the turkey sandwich on 09/25/24 revealed there was a listing for mechanical soft with instructions to "Grind meat to 1/8-inch diced and moisten with condiments. Moisten soft white bread and cut into bite sized pieces. Shred cheese." Review of the facility's special diet instructions for the white poke cake on 09/25/24 revealed there was a listing for mechanical soft with instructions to "Cut into bite-sized pieces and moisten with milk as needed." Observation of Resident #5 during meal service on 09/25/24 from 12:00pm-12:52pm revealed: -A dietary aide (DA) served the resident a turkey sandwich, California blend, white poke cake and 2 glasses of juice. -The turkey she was served was not ground, the cheese was not shredded, and the bread was not moistened. -The white poke cake she was served was not cut into bite-sized pieces and was not moistened with milk. -Resident #5 ate half of the turkey sandwich, using one piece of bread, and half of the white poke cake. Interview with the Cook on 09/26/24 at 10:42am revealed: -She had been the Cook for over a year. -She knew what diet each resident was supposed to have because the diets were listed on the board in the kitchen. -Someone from the front office provided the information on residents' diets from their records. -Either she or the Dietary Manager (DM) updated	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 310	Continued From page 13 the diets on the board when received. -She knew how to prepare therapeutic diets because she had been cooking at facilities for 24 years. -She followed the special diet instructions provided on the recipes for each individual item on the menu. -She was aware Resident #5's food should have been of a certain consistency. -She was not aware Resident #5 received a whole turkey sandwich and whole piece of white poke cake. -A DA must have given Resident #5 the wrong plate. -The concern with Resident #5 getting the wrong plate was she could have choked.. -She fixed Resident #5's plate according to the special diet instructions listed on the recipes for each individual item. -She did not know why Resident #5 received a whole turkey sandwich and whole piece of white poke cake. Interview with the DM on 09/26/24 at 11:06am revealed: -She had been the DM for 2 and a half years. -She had been in the dietary field for over 20 years. -She knew what diet each resident was supposed to have because she received diet order updates every morning. -She knew how to prepare each diet because she followed the special diet instructions on the recipe sheets. -The mechanical soft turkey had to be ground. -The concern with a resident that had a mechanical soft diet order receiving a whole turkey sandwich would be choking. -She did assist with cooking but did not cook lunch on 09/25/24.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 310	Continued From page 14 -She was aware Resident #5 had a mechanical soft diet order. -She was not aware Resident #5 received a whole turkey sandwich and whole piece of white poke cake for lunch until surveyor pointed it out to her yesterday. -She did not know why Resident #5 did not receive a mechanical soft meal. -The DA passed out the plates. -DAs were aware of all residents' diets because the diets are posted on the board in the kitchen. Telephone interview with Resident #5's primary care provider (PCP) on 09/26/24 at 3:43pm revealed: -She was not aware Resident #5 was not provided with the diet as ordered. -If Resident #5 had a diet order for mechanical soft with ground meats; she should have been getting what was ordered. -A mechanical soft diet was ordered to make sure the resident was getting foods that were easy to chew and swallow. -Her concern was the possibility of Resident #5 choking. -Her expectation was the staff follow the diet order. Interview with the Administrator on 09/26/24 at 3:58pm revealed: -Diet changes were addressed in a meeting every morning with the management team; the DM was included in that meeting. -Diet orders were logged in the electronic computer system and the DM had access to that system. -Dietary orders were printed every Monday and given to the DM to keep in the kitchen. -The DM had all diet orders posted on a board in the kitchen.	D 310	Type text here	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 310	Continued From page 15 -Dietary staff had a recipe book that contained detailed instructions on all therapeutic diets. -She expected the DM and the Cook to follow the facility's therapeutic diet menu and PCP diet orders for residents. -She was not aware Resident #5 did not receive a mechanical soft meal for lunch. -Resident #5 not receiving a mechanical soft meal was a big concern due to the possibility of choking.	D 310	Type text here	dddd
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 were administered as ordered for 3 of 3 residents (#5, #6, #7) observed during the medication pass including errors with a controlled substance for moderate to severe pain and a topical gel for arthritis pain (#5); medication for depression, prevention of heart disease, gastrointestinal health, immune health, seasonal allergies, and dry eyes (#6); medication for constipation (#7), and acid reflux (#6, #7); and for 1 of 6 sampled residents (#8) who did not receive nine oral	D 358	10A NCAC 13F .1004(a) The Gardens of Nashville will assure that the adminsitration of resident medications are administered as ordered by the physician. The Clinical Nurse Consultant, RN, in-serviced Med Techs on high risk medications, Medication Administration, the 6 rights to medications and the Order Processing System. The Clinical Nurse Consultant, RN, in-serviced Med Techs on cart audits and the importance of ensuring accurate meds are on hand. Med Techs will complete Physician orders to emar to cart audits per facility schedule to ensure availability and accuracy of medication orders and supplies on medication carts. The audits will be reviewed by the Executive Director and Resident Care Coordinator for compliance and to ensure accurate medications on hand.	10/3/24 10/3/24 11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 16 morning medications on 09/25/24 due to the medications being unavailable for administration including medications for a viral infection, anxiety, depression, prevention of heart disease, high blood pressure, seasonal allergies, and Vitamin D deficiency (#8). The findings are: 1. The medication error rate was 29% as evidenced by 11 errors out of 37 opportunities during the 8:00am medication pass on 09/25/24. a. Review of Resident #5's current FL-2 dated 04/05/24 revealed: -Diagnoses included Parkinson's disease, spinal stenosis, osteoarthritis, weakness, and age-related physical debility. -There was an order for Oxycodone 5mg 1 tablet every 12 hours as needed (prn) for pain. (Oxycodone is a controlled substance used for moderate to severe pain.) Review of Resident #5's primary care provider (PCP) visit note dated 09/06/24 revealed: -The resident had chronic low back pain and took Oxycodone prn for the pain. -There was an order for Oxycodone 5mg 1 tablet every 8 hours prn for pain. Review of Resident #5's physician's order sheets dated 09/20/24 revealed an order for Oxycodone 5mg 1 tablet every 8 hours prn for pain. Review of Resident #5's physician's order dated 09/16/24 revealed an order for Oxycodone 5mg 1 tablet every 8 hours prn for pain. Observation of the 8:00am medication pass on 09/25/24 revealed:	D 358	The Clinical Nurse Consultant, RN, will perform random med pass observations to ensure Med Techs are performing medication administration appropriately. Any concerns identified will be discussed with the Executive Director and Resident Care Coordinator for follow up and additional training. The Resident Care Coordinator will conduct at minimum 2 resident chart audits weekly to ensure all orders have been processed properly to allow for accurate med administration.	11/8/24 11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 17 -Resident #5's medications were packed in multi-dose packs (MDPs) and the labeling included the date and time of day printed on the MDP. -The medication aide (MA) pulled Resident #5's MDP that was labeled, "morning 09/25/24". -The MA peeled the label off the MDP. -The MA opened the controlled substance locked drawer and added one prn Oxycodone 5mg tablet to the scheduled morning MDP for Resident #5. -The MA administered the morning medications including one prn Oxycodone 5mg tablet to Resident #5 at 8:32am. -The MA did not ask the resident if she was in pain and needed the prn Oxycodone tablet. -The MA did not notify the resident that she had put a prn Oxycodone tablet in the MDP. -The resident did not complain of pain or ask the MA for a prn Oxycodone. -Oxycodone was administered as a scheduled medication instead of prn as ordered. Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 5mg 1 tablet every 8 hours prn for pain. -Oxycodone was listed as prn on the eMAR. -Oxycodone was documented as administered on a prn basis on 28 occasions from 09/01/24 - 09/25/24. -The last two documented doses administered were on 09/24/24 at 8:55pm and 09/25/24 at 8:35am. Observation of Resident #5's medications on hand on 09/25/24 at 8:30am revealed: -There was a supply of Oxycodone in a bubble card stored in the controlled substance locked drawer.	D 358	Type text here	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 18 -There were 5 Oxycodone 5mg tablets remaining in the bubble card with instructions to take 1 tablet every 8 hours prn pain. Interview with the MA on 09/25/24 at 1:16pm revealed: -She usually administered Resident #5's prn Oxycodone with the resident's scheduled morning medications. -If the resident looked in the medication cup and did not see the Oxycodone, the resident usually asked for it. -The resident would ask for the Oxycodone every day for about a week and sometimes she would skip a week and not ask for the Oxycodone. Interview with Resident #5 on 09/25/24 at 1:23pm revealed: -She took Oxycodone because of pain related to spinal surgery, arthritis, and Parkinson's disease. -She used to have to ask for the Oxycodone but now the MAs were just putting it in her medication cup without her asking for it. -She was not sure why the MAs were putting the Oxycodone in the cup with her scheduled medications unless it was because she had asked for the Oxycodone frequently. -The Oxycodone helped some with her pain. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -She was currently overseeing the MAs since the Resident Care Coordinator (RCC) position was vacant. -The MAs should administer prn medications when a resident asked for it if it was within the correct timeframe. -Prn medications should not be administered as scheduled medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 19 Telephone interview with the on-call triage provider at Resident #5's primary care provider's (PCP) office on 09/26/24 at 3:57pm revealed: -If a resident was capable of asking for a prn medication when it was needed, the MAs should only administer the prn medication when the resident requested it for pain. -She was concerned that if the Oxycodone was administered too often or too close together, it could cause sedation. b. Review of Resident #5's primary care provider (PCP) visit note dated 08/02/24 revealed: -The resident had bilateral primary osteoarthritis of the knees. -The resident requested a prescription for Diclofenac 1% gel for pain management. -There was an order Diclofenac 1% gel apply a liberal amount topically to both knees 4 times a day for chronic knee pain. (Diclofenac gel is a topical medication used to relieve arthritis pain.) Observation of the 8:00am medication pass on 09/25/24 revealed: -The medication aide (MA) prepared and administered Resident #5's morning oral medications at 8:32am. -The MA did not prepare or offer to administer Resident #5's Diclofenac 1% gel. -Diclofenac 1% gel was not administered as ordered. Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Diclofenac 1% gel apply a liberal amount topically to both knees 4 times a day for chronic knee pain. -Diclofenac 1% gel was scheduled for administration at 8:00am, 12:00pm, 4:00pm, and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 20 8:00pm. -Diclofenac 1% gel was documented as administered from 09/01/24 - 09/25/24 (8:00am). Observation of Resident #5's medications on hand on 09/25/24 at 1:22pm revealed: -There was a 100-gram (gm) tube of Diclofenac 1% gel dispensed on 08/02/24. -The instructions were to apply a liberal amount topically to both knees 4 times a day for chronic knee pain. -The tube was approximately half full. Interview with Resident #5 on 09/25/24 at 1:23pm revealed: -She used Diclofenac gel for her chronic knee pain. -The MA usually asked the resident if she wanted to use the Diclofenac gel but the MA that morning, 09/25/24, did not ask or offer the Diclofenac gel. -The Diclofenac gel helped "somewhat" with her knee pain. Interview with the MA on 09/25/24 at 1:16pm revealed: -The resident usually received Diclofenac 1% gel on both knees when the resident received her other morning medications. -She did not apply the Diclofenac 1% gel to Resident #5 that morning, 09/25/24, because the resident was still in bed. -She had not administered any Diclofenac 1% gel to the resident today, but it was time for the 12:00pm dosage to be administered. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -She was currently overseeing the MAs since the Resident Care Coordinator (RCC) position was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 21 vacant. -The MA should have administered Diclofenac gel to Resident #5's knees that morning, 09/25/24. -The MAs should administer medications according to the orders on the eMARs. Telephone interview with the on-call triage provider at Resident #5's PCP's office on 09/26/24 at 3:57pm revealed: -Resident #5's Diclofenac gel should be administered as ordered 4 times a day. -Not receiving Diclofenac gel as ordered could cause the resident to have breakthrough pain. c. Review of Resident #6's current FL-2 dated 02/21/24 revealed: -Diagnoses included mild cognitive impairment, spinal stenosis, essential hypertension, occlusion and stenosis of right carotid artery, seasonal allergic rhinitis, gastroesophageal reflux disease, irritable bowel syndrome, constipation, osteoarthritis, essential thrombocytopenia, dysphagia, chronic kidney disease, anxiety disorder, and repeated falls. -There was an order for Paxil 10mg 1 tablet once daily. (Paxil is an antidepressant.) Review of Resident #6's primary care provider (PCP) prescription dated 09/11/24 revealed an order for Paxil 20mg 1 tablet every day at noon. Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The labeling on the MDPs included the time of day printed on the MDPs. -The medication aide (MA) pulled Resident #6's MDP that was labeled, "noon" and included one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 22 Paxil 20mg tablet. -The MA administered the resident's medications, including the Paxil 20mg, to Resident #6 at 8:41am. -Paxil 20mg was administered during the 8:00am medication pass instead of 12:00 noon as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Paxil 10mg 1 tablet once daily scheduled at 8:00am. -Paxil 10mg was documented as administered daily from 09/01/24 - 09/25/24. -There was no entry for Paxil 20mg, and none was documented as administered. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP contained one Paxil 20mg tablet with instructions to take 1 tablet every day at noon. -The Paxil 20mg tablet was packaged in the MDP for 12:00 noon. Interview with the MA on 09/25/24 at 1:25pm revealed: -Resident #6 used an outside pharmacy provider. -She had not noticed the eMAR had Paxil 10mg and the medication on hand was Paxil 20mg. -The outside pharmacy provider packaged the resident's morning medications in a MDP labeled noon. -She did not know why they were labeled noon and she had not contacted the pharmacy to ask why. -The medications in the noon MDP were scheduled on the eMAR at 8:00am so that was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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-358	Continued From page 23 why she administered those medications, including the Paxil, during the morning medication pass. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for Paxil 20mg prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -The only order they had ever had on file for Resident #6 was Paxil 20mg 1 tablet at noon. -They packaged Paxil 20mg in the noon MDP because that was how it was ordered. -They did not have any orders for Paxil 10mg on file. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs should let her or the Resident Care Coordinator (RCC) know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies. -The RCC position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Paxil. Attempted telephone interview with Resident #6's primary care provider (PCP) on 09/26/24 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 24 3:45pm was unsuccessful. d. Review of Resident #8's physician's order dated 08/20/24 revealed an order for Pepcid 20mg 1 tablet twice daily as needed (prn). (Pepcid is used for heartburn and acid reflux.) Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The labeling on the MDPs included the time of day printed on the MDPs. -The medication aide (MA) pulled Resident #6's MDP that was labeled "noon" and included one Pepcid 20mg tablet. -The MA administered the resident's medications, including the Pepcid 20mg to Resident #6 at 8:41am. -The resident did not request Pepcid or complain of heartburn or acid reflux. -Pepcid 20mg was administered as a scheduled medication during the 8:00am medication pass instead of prn as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed there was no entry for Pepcid, and none was documented as administered. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP contained one Pepcid 20mg tablet with instructions to take 1 tablet twice daily. Interview with Resident #6 on 09/25/24 at 12:43pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 25 -She thought she started taking Pepcid about a week ago. -She denied any current symptoms of heartburn or acid reflux. Interview with the MA on 09/25/24 at 1:25pm revealed: -Resident #6 used an outside pharmacy provider. -The outside pharmacy provider packaged the resident's morning medications in a MDP labeled noon. -The medications in the noon MDP were scheduled on the eMAR at 8:00am so that was why she administered those medications, including the Pepcid, during the morning medication pass. -She had not noticed there was Pepcid in the MDP, but Pepcid was not listed on the eMAR. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for Pepcid prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They had an order for pm Pepcid on file for Resident #6. -They packaged the Pepcid in the noon MDP because that was how they were instructed to package it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 26 -She did not know if the facility staff or if the resident instructed them to package Pepcid with the noon MDP. -They dispensed Pepcid in the MDPs for 08/22/24 and 09/20/22. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs should let her or the Resident Care Coordinator (RCC) know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies. -The RCC position was currently vacant so the MAs should have notified her that Pepcid was in the MDP but not listed on the eMAR. Attempted telephone interview with Resident #6's primary care provider (PCP) on 09/26/24 at 3:45pm was unsuccessful. e. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Aspirin EC 81mg 1 table once daily. (Aspirin is used to prevent heart disease.) Review of Resident #6's primary care provider (PCP) prescription dated 08/22/24 revealed an order for Aspirin 81 mg 1 tablet every day at noon. Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The labeling on the MDP included the time of day printed on the MDP. -The medication aide (MA) pulled Resident #6's MDP that was labeled, "noon" and included one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 27 Aspirin EC 81mg tablet. -The MA administered the resident's medications, including the Aspirin EC 81mg tablet to Resident #6 at 8:41am. -Aspirin EC 81mg was administered during the 8:00am medication pass instead of 12:00 noon as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin EC 81mg 1 tablet once daily scheduled at 8:00am. -Aspirin EC 81mg was documented as administered at 8:00am from 09/01/24 - 09/25/24, instead of 12:00pm as ordered. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP contained one Aspirin EC 81mg tablet with instructions to take 1 tablet every day at noon. -The Aspirin EC 81mg tablet was packaged in the MDP for 12:00 noon. Interview with the MA on 09/25/24 at 1:25pm revealed: -Resident #6 used an outside pharmacy provider. -The outside pharmacy provider packaged the resident's morning medications in a MDP labeled noon. -The medications in the noon MDP were scheduled on the eMAR at 8:00am so that was why she administered those medications, including the Aspirin, during the morning medication pass. Telephone interview with a pharmacy technician	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 28 at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for Aspirin to be administered at noon prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -The only order they had ever had on file for Resident #6 was Aspirin 81mg 1 tablet at noon. -They packaged Aspirin 81mg in the noon MDP because that was how it was ordered. -They did not have any orders for Aspirin to be administered in the morning. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs should let her or the Resident Care Coordinator (RCC) know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies. -The RCC position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Aspirin administration time. Attempted telephone interview with Resident #6's primary care provider (PCP) on 09/26/24 at 3:45pm was unsuccessful. f. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Artificial Tears	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 29 instill 1 drop in both eyes 4 times daily as needed (prn) for irritative symptoms and dryness. (Artificial Tears eye drops are used to treat and prevent dry, irritated eyes.) Review of Resident #6's hospice provider orders dated 03/20/24 revealed: -There was an order to discontinue Artificial Tears 1 drop in each eye 4 times a day as needed for irritative symptoms and dryness. -There was an order for Artificial Tears 1 drop in each eye 4 times daily. Review of Resident #6's primary care provider (PCP) prescription dated 04/16/24 revealed an order for Artificial Tears place 1 drop in each eye 4 times daily as needed (prn). Review of Resident #6's eye care provider prescription dated 04/29/24 revealed: -There was an order for Artificial Tears 1 to 2 drops in both eyes 3 times a day prn. -There was no order for Artificial Tears to be administered on a scheduled basis. Observation of the 8:00am medication pass on 09/25/24 revealed the medication aide (MA) prepared and administered oral medications to Resident #6 at 8:41am. Interview with the MA on 09/25/24 at 8:50am revealed: -Resident #6 was supposed to receive Artificial Tears at 8:00am but the resident ran out yesterday and there was none available for administration. -She had ordered the Artificial Tears and was going to pick them up soon. Observation on 09/25/24 at 9:30am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 30 -The MA prepared and administered Artificial Tears eye drops to Resident #6 at 9:30am. -The MA did not ask the resident if she needed the eye drops prior to administering them. -The resident did not complain of dry, irritated eyes to the MA and the resident did not ask for the eye drops to be administered. -Artificial Tears eye drops were administered as a scheduled medication instead of prn as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Artificial Tears instill 1 drop in both eyes 4 times a day. -The start date for Artificial Tears was listed as 03/23/24. -Artificial Tears was documented as administered as a scheduled medication 4 times a day from 09/01/24 - 09/25/24 (8:00am). -There was no entry for prn Artificial Tears. Observation of Resident #6's medications on hand on 09/25/24 at 9:28am revealed: -There was a bottle of Artificial Tears eye drops dispensed on 09/20/24. -The instructions were to place 1 drop in each eye 4 times daily as needed. Interview with Resident #6 on 09/25/24 at 12:43pm revealed: -She received Artificial Tears every day for dry eyes. -She did not have to ask for Artificial Tears; the MAs administered the eye drops to her without her asking for them. Interview with the MA on 09/25/24 at 1:25pm revealed: -She was not aware the Resident's most current	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 31 order for Artificial Tears was for prn dosing. -She administered the Artificial Tears as a scheduled medication at 8:00am because that was when the Artificial Tears "popped up" on the eMAR to be administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for prn Artificial Tears prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They had an order for prn Artificial Tears for Resident #6, as indicated on the medication label. -They did not have an order for Artificial Tears to be administered scheduled 4 times a day. Interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm revealed: -The MAs should administer prn medications when a resident asked for it if it was within the correct timeframe. -Prn medications should not be administered as scheduled medications. -The MAs should let her or the Resident Care Coordinator (RCC) know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies. -The MAs were responsible for auditing the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 32 eMARs weekly. -The RCC position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Artificial Tears. Attempted telephone interview with Resident #6's primary care provider (PCP) on 09/26/24 at 3:45pm was unsuccessful. g. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Elderberry 1000mg 1 capsule once daily. (Elderberry is a supplement that may boost the immune system.) Review of Resident #6's primary care provider (PCP) order dated 06/07/24 revealed an order for Elderberry 1000mg 1 capsule once daily. Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) prepared and administered medications in a MDP to Resident #6 at 8:41am. -The MDP did not include Elderberry capsule. -Elderberry capsule was not administered as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Elderberry 1000mg 1 capsule once daily scheduled at 8:00am. -Elderberry 1000mg capsules were documented as administered daily from 09/01/24 - 09/25/24. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 33 -The resident's oral medications were packaged in MDPs. -The MDP did not contain any Elderberry capsules. -There was no supply of any Elderberry capsules available for administration for Resident #6. Interview with the MA on 09/25/24 at 1:25pm revealed: -She administered Resident #6's medications based on what was in the MDPs. -She had not noticed there was no Elderberry capsule in the resident's MDP administered in the mornings. -She thought there used to be Elderberry capsules in the resident's MDP, but she could not recall the last time she saw Elderberry capsules in the MDP. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They had not dispensed any Elderberry capsules for Resident #6. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not have an order for Elderberry capsules for Resident #6. -They had not dispensed any Elderberry capsules for Resident #6. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs were responsible for sending orders to Resident #6's pharmacy provider and the facility's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 34 contracted pharmacy provider. -The MAs should let her or the Resident Care Coordinator (RCC) know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies. -The RCC position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Elderberry capsules. Attempted telephone interview with Resident #6's PCP on 09/26/24 at 3:45pm was unsuccessful. h. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order Probiotic Formula 1 capsule once daily. (Probiotic Formula is used for gastrointestinal health and may be used to help prevent infections.) Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) prepared and administered medications in a MDP to Resident #6 at 8:41am. -The MDP did not include Probiotic Formula capsule. -Probiotic Formula capsule was not administered as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Probiotic Formula 1 capsule once daily scheduled at 8:00am. -Probiotic Formula was documented as administered once daily at 8:00am from 09/01/24	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 35 - 09/25/24. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP did not contain any Probiotic Formula capsules. -There was no supply of any Probiotic Formula capsules available for administration for Resident #6. Interview with the MA on 09/25/24 at 1:25pm revealed: -She administered Resident #6's medications based on what was in the MDPs. -She had not noticed there was no Probiotic Formula capsule in the resident's MDP administered in the mornings. -She thought there used to be Probiotic Formula capsules in the resident's MDP, but she could not recall the last time she saw Probiotic Formula capsules in the MDP. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They had not dispensed any Probiotic Formula capsules for Resident #6. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not have an order for Probiotic Formula capsules for Resident #6. -They had not dispensed any Probiotic Formula capsules for Resident #6.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 36 Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs were responsible for sending orders to Resident #6's pharmacy provider and the facility's contracted pharmacy provider. -The MAs should let her or the Resident Care Coordinator (RCC) know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies. -The RCC position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Probiotic Formula capsules. Attempted telephone interview with Resident #6's primary care provider (PCP) on 09/26/24 at 3:45pm was unsuccessful. I. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Flonase 50mcg Nasal Spray Instill 1 spray in each nostril once daily. (Flonase is used to treat and prevent seasonal allergy symptoms.) Review of Resident #6's primary care provider (PCP) prescription dated 06/07/24 revealed an order for Flonase 50mcg Nasal Spray Instill 1 spray in each nostril once daily. Observation of the 8:00am medication pass on 09/25/24 revealed: -The medication aide (MA) prepared and administered oral medications to Resident #6 at 8:41am. -The MA did not offer or administer Flonase Nasal Spray to Resident #6 when she received her other medications scheduled for 8:00am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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
D358	Continued From page 37 Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase Nasal Spray Instill 1 spray in each nostril once daily scheduled at 8:00am. -Flonase Nasal Spray was documented as administered daily from 09/01/24 - 09/25/24. Observation of Resident #6's medications on hand on 09/25/24 at 1:35pm revealed: -There was a bottle of Flonase 50mcg Nasal Spray dispensed on 12/08/23. -The instructions on the bottle were to use 1 spray in each nostril daily. Interview with the MA on 09/25/24 at 1:25pm revealed: -The resident would sometimes use the Flonase Nasal Spray and sometimes the resident did not want to use it. -She forgot to ask the resident that morning, 09/25/24, if the resident wanted to use the Flonase Nasal Spray. Interview with Resident #6 on 09/25/24 at 12:43pm revealed: -She should receive Flonase Nasal Spray every day, but she did not always receive it every day. -She did not get her Flonase Nasal Spray that morning, 09/25/24. -She did not know why she did not receive Flonase every day. -Her allergy symptoms were about the same today, 09/25/24. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -She was currently overseeing the MAs since the Resident Care Coordinator (RCC) position was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 38 vacant. -The MA should have administered Flonase Nasal Spray to Resident #6's that morning, 09/25/24. -The MAs should administer medications according to the orders on the eMARs. Attempted telephone interview with Resident #6's PCP on 09/26/24 at 3:45pm was unsuccessful. j. Review of Resident #7's current FL-2 dated 04/11/24 revealed: -Diagnoses included syncope and collapse, hypertensive chronic kidney disease, macular degeneration, atrial fibrillation, iron deficiency anemia, hypothyroidism, and abnormalities of gait and mobility. -There was an order for Miralax Powder 17 grams (gm) once a day. (Miralax is a laxative for constipation.) Review of Resident #7's physician's orders dated 09/20/24 revealed an order for Miralax Powder, mix 1 capful to the indicated line (17gm) in 8 ounces fluid and take daily. Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #7's medications were packaged in multi-dose packs (MDPs). -The medication aide (MA) prepared and administered medications packaged in a MDP labeled "morning 09/25/24" to Resident #7 at 8:41am. -The MA did not prepare or offer Miralax to Resident #7. -Miralax was not administered as ordered. Review of Resident #7's September 2024 electronic medication administration record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 39 (eMAR) revealed: -There was an entry for Miralax mix 1 capful to the indicated line (17gm) in 8 ounces fluid and take daily. -Miralax was scheduled for administration at 8:00am. -Miralax was documented as administered daily from 09/01/24 - 09/24/24. -Documentation for Miralax administration on 09/25/24 was blank with no reason documented. Observation of Resident #7's medications on hand on 09/25/24 at 1:47pm revealed there was no Miralax Powder available for administration to the resident. Interview with the MA on 09/25/24 at 1:42pm revealed she did not administer Miralax to Resident #7 because the resident would not take it unless the resident asked for it. Interview with Resident #7 on 09/25/24 at 12:56pm revealed: -She sometimes received Miralax every day and had loose stools. -She did not have loose stools today, 09/25/24, but she did not receive any Miralax. -She usually had to ask for Miralax if she wanted to get any. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -She was currently overseeing the MAs since the Resident Care Coordinator (RCC) position was vacant. -The MA should have administered Miralax to Resident #7 that morning, 09/25/24. -The MAs should administer medications according to the orders on the eMARs.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 40 Attempted telephone interview with Resident #7's primary care provider (PCP) on 09/26/24 at 4:54pm was unsuccessful. k. Review of Resident #7's current FL-2 dated 04/11/24 revealed an order for Protonix 40mg 1 tablet once a day. (Protonix is used to treat and prevent acid reflux.) Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #7's medications were packaged in multi-dose packs (MDPs). -The medication aide (MA) prepared and administered medications packaged in a MDP labeled "morning 09/25/24" to Resident #7 at 8:41am. -The MDP did not include Protonix. -Protonix was not administered as ordered. Review of Resident #7's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Protonix 40mg 1 tablet once daily scheduled at 8:00am. -Protonix was documented as administered daily from 09/01/24 - 09/24/24. -Documentation for Protonix administration on 09/25/24 was blank with no reason documented. Observation of Resident #7's medications on hand on 09/25/24 at 1:47pm revealed: -The resident oral morning medications were packaged in a MDP. -There were no Protonix 40mg tablets packaged in the morning MDPs. -There was a supply of Protonix 40mg packaged in a bubble card that was dispensed on 08/05/24. -The instructions on the label for the bubble card were to take 1 tablet once daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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
D358	Continued From page 41 -There were 14 of 28 tablets remaining. Interview with the MA on 09/25/24 at 1:42pm revealed: -Resident #7's Protonix was not packaged in a MDP. -The Protonix was packaged in a bubble card. -She did not administer Resident #7's Protonix because she thought it might be administered before breakfast by third shift staff. -She had not noticed Protonix was not documented as administered on 09/25/24. Interview with Resident #7 on 09/25/24 at 12:56pm revealed: -She usually received a pill for acid reflux. -She did not usually have a problem with acid reflux if she received that medication and ate small bites of food slowly. -She denied any current symptoms of acid reflux. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -She was currently overseeing the MAs since the Resident Care Coordinator (RCC) position was vacant. -The MA should have administered Protonix to Resident #7 that morning, 09/25/24. -The MAs should administer medications according to the orders on the eMARs. Attempted telephone interview with Resident #7's primary care provider (PCP) on 09/26/24 at 4:54pm was unsuccessful. 2. Review of Resident #8's current FL-2 dated 05/10/24 revealed: -Diagnoses included type 2 diabetes mellitus, bipolar disorder, a viral infection, hypertension, hypertensive retinopathy, aortocoronary bypass	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 42 graft, atherosclerotic heart disease, protein-calorie malnutrition, gastroesophageal reflux disease, and hyperlipidemia. -There was an order for Acyclovir 400mg 1 tablet twice daily. (Acyclovir is used to treat viral infections.) -There was an order for Aspirin EC 81mg 1 tablet once daily. (Aspirin is used to prevent heart disease.) -There was an order for Buspirone 7.5mg 1 tablet 3 times daily. (Buspirone is used to treat depression and anxiety.) -There was an order for Cetirizine 10mg 1 tablet once daily. (Cetirizine is used for seasonal allergies.) -There was an order for Vitamin D3 5000 units 1 capsule once daily. (Vitamin D3 is used to treat Vitamin D deficiency.) -There was an order for Duloxetine 60mg 1 capsule once daily. (Duloxetine is an antidepressant.) -There was an order for Lamotrigine 25mg 1 tablet once daily. (Lamotrigine is used to treat mood disorders.) -There was an order for Lisinopril 2.5mg 1 tablet once daily. (Lisinopril is used to lower blood pressure.) -There was an order for Metoprolol Tartrate 50mg 1 tablet twice daily. (Metoprolol Tartrate is used to lower blood pressure.) Review of Resident #8's physician's order dated 07/13/24 revealed an order change for Vitamin D3 2000 units 1 tablet once daily. Review of Resident #8's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Acyclovir 400mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 43 -There was an entry for Aspirin EC 81mg 1 tablet once daily scheduled at 9:00am. -There was an entry for Buspirone 7.5mg 1 tablet 3 times daily scheduled at 9:00am, 3:00pm, and 9:00pm. -There was an entry for Cetirizine 10mg 1 tablet once daily scheduled at 9:00am. -There was an entry for Vitamin D3 2000 units 1 tablet once daily scheduled at 9:00am. -There was an entry for Duloxetine 60mg 1 capsule once daily scheduled at 9:00am. -There was an entry for Lamotrigine 25mg 1 tablet once daily scheduled at 9:00am. -There was an entry for Lisinopril 2.5mg 1 tablet once daily scheduled at 9:00am. -There was an entry for Metoprolol Tartrate 50mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Acyclovir, Aspirin, Buspirone, Cetirizine, Vitamin D3, Duloxetine, Lamotrigine, Lisinopril, and Metoprolol Tartrate were documented as not administered on 09/25/24 due to the medications being unavailable. Observation of the morning medication pass on 09/25/24 from 8:20am - 8:49am revealed: -Resident #8 approached the medication cart and asked the medication aide (MA) for her morning medications. -The MA told the resident that she would get her medications to her. -The resident walked away from the medication cart and went back down the hallway. -The MA continued preparing medications for other residents. Interview with the MA on 09/25/24 at 10:42am revealed: -She had not administered Resident #8's oral morning medications today, 09/25/24, because	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C* 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 44 the resident's oral morning medications were not in the medication cart. -Resident #8's medications came from an outside pharmacy provider. -Resident #8's pharmacy provider did not send automatic cycle fills; the resident's medications had to be ordered and picked up at the pharmacy. -She usually tried to call in the resident's refills when the resident was on the last pack. -She realized a few minutes ago that Resident #8's morning oral medications were not in the medication cart. -She had to go to the outside pharmacy to pick up the resident's medications. Second interview with the MA on 09/25/24 at 12:26pm revealed: -She went to the Resident #8's pharmacy that morning to pick up the resident's medications but the pharmacy staff would not allow her to get the medications because she did not know the resident's date of birth. -The Administrator was going to send someone else to pick up the resident's medications. -Resident #8 did not receive her oral morning medications today, 09/25/24. Observation on 09/25/24 at 1:16pm revealed: -Resident #8 walked up to the MA at the medication cart and said she needed her medications. -The resident reported she was sweating and not feeling good at all. Observation of Resident #8 on 09/25/24 at 1:53pm revealed: -The resident was lying in bed, staring toward the window. -The resident had a sad expression on her face.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 45 Interview with Resident #8 on 09/25/24 at 1:53pm revealed: -She did not receive her oral medications that morning, 09/25/24. -The MA said they were going to get her medications. -This was the first time she had not received her morning medications. -She usually got medication to help with her pain and medications for her bipolar disorder. -She had a headache, and she was hurting all over. -She was worried because she did not get her morning medications. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -She was not aware Resident #8 had not received her morning medications today, 09/25/24. -The MAs should notify her if medications were not available in the facility. A second interview with the Administrator on 09/25/24 at 2:53pm revealed the facility's Business Office Manager (BOM) had gone now to pick up Resident #8's medications from the pharmacy. Telephone interview with a pharmacy technician at Resident #8's outside pharmacy provider on 09/26/24 at 4:59pm revealed: -Resident #8's oral medications were packaged in multi-dose packs (MDPs). -The resident's medications were dispensed on 09/19/24 and had been ready for pick up since that time. -The facility was notified the medication was ready for pick up on 09/20/24 via automated message to a phone linked to the facility's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 358	Continued From page 46 Administrator. -On 09/25/24, the MA at the facility called the pharmacy and she was told the medication had been ready for pick up for 6 days -The facility was supposed to notify the pharmacy when there was 1 to 1 ½ weeks of medication remaining. -They had offered to deliver medications to the facility in the past but the facility declined (not sure what date). -The first facility staff that came yesterday, 09/25/24, could not give the name or date of birth of the resident per pharmacy policy, so that staff did not get the medications. -Another staff picked up Resident #8's medications sometime later on 09/25/24 but she could not recall the time. A third interview with the Administrator on 09/26/24 at 6:41pm revealed: -Resident #8 received her medications from an outside pharmacy provider. -The outside pharmacy provider did not send automatic cycle fills. -The MAs were responsible for ordering Resident #8's medications a couple of days before the resident ran out of medication. -One of the facility's office phones had been set up to receive automatic voice messages from the outside pharmacy provider when medications were ready to be picked up. -When the MAs received the message, they were supposed to let her know so she could make arrangements for the medication to be picked up. -No one had notified her that Resident #8's medications were ready and needed to be picked up until yesterday, 09/25/24. Telephone interview with Resident #8's mental health provider (MHP) on 09/26/24 at 4:40pm	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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-358	Continued From page 47 revealed: -She prescribed Buspirone, Lamotrigine, and Duloxetine for the resident. -She ordered all those medications on 04/11/24 with 10 refills so the resident should not have run out of those medications. -It was important for Resident #8 to receive those medications as ordered to keep her mood stable. -The resident was on a low dose of Lamotrigine. -If the resident had been on a higher dose of Lamotrigine and it was stopped abruptly, it could cause the resident to develop Stevens-Johnson syndrome (a rare, serious disorder of the skin and mucous membranes). Attempted telephone interview with Resident #8's primary care provider (PCP) on 09/26/24 at 3:57pm was unsuccessful. The facility failed to administer medications as ordered for 3 of 3 residents observed during the 8:00am medication pass on 09/25/24. Resident #5 did not receive a controlled substance for moderate to severe pain as ordered putting the resident at risk of sedation and did not receive a topical pain medication, putting the resident at risk of having breakthrough knee pain. There were 7 errors observed with Resident #6's medications administered on 09/25/24. Resident #6 did not receive a medication used to prevent constipation and a medication used for acid reflux. Resident #8 did not receive nine oral morning medications on 09/25/24 due to the medications being unavailable for administration, including missing doses of three medications used to treat mood disorders, anxiety and depression that need to be administered as ordered to keep the resident's mood stable. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 368	Continued From page 48 welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2024.	D 368		Type text h
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record	D 367	10A NCAC 13F .1004(j) The Gardens of Nashville will assure the Resident's EMAR is accurate for Med Administration. The Clinical Nurse Consultant, RN, In-serviced Med Techs on Medication Adminsitration to include to importance of accuracy of EMAR's and the 6 Right's to Medication Administration. The Clinical Nurse Consultant, RN, In-serviced the Med Techs on High Risk Medications, Medication Administration and the Order Processing System. The Med Techs will complete physician order to emar to cart audit per facility to ensure availability and accuracy of medications on med carts. The audits will be reviewed by the Executive Director and Resident Care Coordinator.	10/3/24 10/3/24 11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 49 reviews, the facility failed to ensure the medication administration records were accurate for 1 of 6 sampled residents (#6) including medications used to treat acid reflux, depression, prevention of heart disease, gastrointestinal health, immune health, seasonal allergies, and dry eyes. The findings are: Review of Resident #6's current FL-2 dated 02/21/24 revealed diagnoses included mild cognitive impairment, spinal stenosis, essential hypertension, occlusion and stenosis of right carotid artery, seasonal allergic rhinitis, gastroesophageal reflux disease, irritable bowel syndrome, constipation, osteoarthritis, essential thrombocytopenia, dysphagia, chronic kidney disease, anxiety disorder, and repeated falls. a. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Paxil 10mg 1 tablet once daily. (Paxil is an antidepressant.) Review of Resident #6's primary care provider (PCP) prescription dated 09/11/24 revealed an order for Paxil 20mg 1 tablet every day at noon. Observation of the 8:00am medication pass on 09/25//24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) pulled Resident #6's MDP that was labeled, "noon" and included one Paxil 20mg tablet. -The MA administered the resident's medications, including the Paxil 20mg, to Resident #6 at 8:41am.	D 367	Resident Care Coordinator will pull emar compliance reports daily and review during daily, weekly stand up meetings with Executive Director for compliance. Any noted areas of concern will have follow up as appropriate, including MD notifications and clarifications. Resident Care Coordinator will complete a minimum of 2 resident chart audits weekly to ensure that all orders have been processed properly to allow for accurate med administration. Completed chart audits will be reviewed with the Executive Director for compliance.	11/8/24 11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 50 Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Paxil 10mg 1 tablet once daily scheduled at 8:00am. -Paxil 10mg was documented as administered daily at 8:00am from 09/01/24 - 09/25/24. -The MA documented Paxil 10mg was administered during the 8:00am medication pass on 09/25/24, when Paxil 20mg was observed to be administered. -There was no entry for Paxil 20mg 1 tablet at noon and no Paxil 20mg documented as administered at any time. -The eMAR was not accurate. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in multi-dose packs (MDPs). -The MDP contained one Paxil 20mg tablet with instructions to take 1 tablet every day at noon. -The Paxil 20mg tablet was packaged in the MDP for 12:00 noon. -There was no Paxil 10mg tablets available for administration. Interview with the MA on 09/26/24 at 1:25pm revealed: -Resident #6 used an outside pharmacy provider. -She had not noticed the eMAR had Paxil 10mg and the medication on hand was Paxil 20mg. -The medications in the noon MDP were scheduled on the eMAR at 8:00am so that was why she administered those medications, including the Paxil, during the morning medication pass. -She documented the administration of Paxil on the eMAR without noticing the eMAR was Paxil 10mg, but the resident received Paxil 20mg.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 51 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for Paxil 20mg prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -The only order they had ever had on file for Resident #6 was Paxil 20mg 1 tablet at noon. -They packaged Paxil 20mg in the noon MDP because that was how it was ordered. -They did not have any orders for Paxil 10mg on file. Interview with the Administrator on 09/25/24 at 2:23pm revealed the Resident Care Coordinator (RCC) position was currently vacant so the MAs should have notified her about the eMAR and label discrepancies with Resident #6's Paxil. Refer to interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. b. Review of Resident #6's physician's order dated 08/20/24 revealed an order for Pepcid 20mg 1 tablet twice daily as needed (prn). (Pepcid is used for heartburn and acid reflux.) Observation of the 8:00am medication pass on 09/25//24 revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 52 -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) pulled Resident #6's MDP that was labeled "noon" and included one Pepcid 20mg tablet. -The MA administered the resident's medications, including the Pepcid 20mg to Resident #6 at 8:41am. -The resident did not request Pepcid or complain of heartburn or acid reflux. -Pepcid 20mg was administered as a scheduled medication during the 8:00am medication pass instead of pm as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed -There was no entry for Pepcid, and none was documented as administered. -The eMAR was not accurate. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP contained one Pepcid 20mg tablet with instructions to take 1 tablet twice daily. Interview with the MA on 09/25/24 at 1:25pm revealed: -Resident #6 used an outside pharmacy provider. -She had not noticed there was Pepcid in the MDP or that Pepcid was not listed on the eMAR and documented as administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 53 because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for Pepcid prior to today, 09/26/24, which was the reason Pepcid was not included on the eMAR. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not enter any orders into the facility's eMAR system. -They had an order for pm Pepcid on file for Resident #6. -They dispensed Pepcid in the MDPs for 08/22/24 and 09/20/22. Interview with the Administrator on 09/25/24 at 2:23pm revealed the Resident Care Coordinator (RCC) position was currently vacant so the MAs should have notified her that Pepcid was in the MDP but not listed on the eMAR. Refer to interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. c. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Aspirin EC 81mg 1 table once daily. (Aspirin is used to prevent heart disease.) Review of Resident #6's primary care provider (PCP) prescription dated 08/22/24 revealed an order for Aspirin 81 mg 1 tablet every day at noon. Observation of the 8:00am medication pass on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 54 09/25//24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) pulled Resident #6's MDP that was labeled, "noon" and included one Aspirin EC 81mg tablet. -The MA administered the resident's medications, including the Aspirin EC 81mg tablet to Resident #6 at 8:41am. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin EC 81mg 1 tablet once daily scheduled at 8:00am, instead of 12:00pm as ordered. -Aspirin EC 81mg was documented as administered at 8:00am from 09/01/24 - 09/25/24, instead of 12:00pm as ordered. -The eMAR was inaccurate and did not match the most current order for Aspirin EC 81mg 1 tablet at 12:00 noon. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP contained one Aspirin EC 81mg tablet with instructions to take 1 tablet every day at noon. -The Aspirin EC 81mg tablet was packaged in the MDP for 12:00 noon. Interview with the MA on 09/25/24 at 1:25pm revealed: -Resident #6 used an outside pharmacy provider. -The outside pharmacy provider packaged the resident's morning medications in a MDP labeled noon.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 55 -The medications in the noon MDP were scheduled on the eMAR at 8:00am so that was why she administered those medications, including the Aspirin, during the morning medication pass. -She had not thought to notify anyone about the scheduled time on the eMAR not matching the label. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for Aspirin to be administered at noon prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not enter orders into the facility's eMAR system. -The only order they had ever had on file for Resident #6 was Aspirin 81mg 1 tablet at noon. -They did not have any orders for Aspirin to be administered in the morning. Interview with the Administrator on 09/25/24 at 2:23pm revealed the Resident Care Coordinator (RCC) position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Aspirin administration time on the eMAR. Refer to interviews with the Administrator on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 387	Continued From page 56 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. d. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Artificial Tears instill 1 drop in both eyes 4 times daily as needed (prn) for irritative symptoms and dryness. (Artificial Tears eye drops are used to treat and prevent dry, irritated eyes.) Review of Resident #6's hospice provider orders dated 03/20/24 revealed: -There was an order to discontinue Artificial Tears 1 drop in each eye 4 times a day as needed for irritative symptoms and dryness. -There was an order for Artificial Tears 1 drop in each eye 4 times daily. Review of Resident #6's primary care provider (PCP) prescription dated 04/16/24 revealed an order for Artificial Tears place 1 drop in each eye 4 times daily prn. Review of Resident #6's eye care provider prescription dated 04/29/24 revealed: -There was an order for Artificial Tears 1 to 2 drops in both eyes 3 times a day prn. -There was no order for Artificial Tears to be administered on a scheduled basis. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Artificial Tears instill 1 drop in both eyes 4 times a day. -The start date for Artificial Tears was listed as 03/23/24. -Artificial Tears was documented as administered as a scheduled medication 4 times a day from 09/01/24 - 09/25/24 (8:00am). -There was no entry for prn Artificial Tears.	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 387	Continued From page 57 -The eMAR was not accurate and did not have an entry for the most current order for prn Artificial Tears. Observation during the 8:00am medication pass on 09/25/24 at 9:30am revealed: -The MA prepared and administered Artificial Tears eye drops to Resident #6 at 9:30am. -The MA did not ask the resident if she needed the eye drops prior to administering them. -The resident did not complain of dry, irritated eyes to the MA and the resident did not ask for the eye drops to be administered. -Artificial Tears eye drops were administered as a scheduled medication instead of prn as ordered. Observation of Resident #6's medications on hand on 09/25/24 at 9:28am revealed: -There was a bottle of Artificial Tears eye drops dispensed on 09/20/24. -The instructions were to place 1 drop in each eye 4 times daily prn. Interview with the MA on 09/25/24 at 1:25pm revealed: -She was not aware the resident's most current order for Artificial Tears was for prn dosing. -She administered the Artificial Tears as a scheduled medication at 8:00am because that was when the Artificial Tears "popped up" on the eMAR to be administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:18pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They entered medication orders into the eMAR system, and the facility staff were responsible for	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 58 reviewing and approving orders before the orders were active on the eMAR. -They had not received an order for prn Artificial Tears prior to today, 09/26/24. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not enter orders into the facility's eMAR system. -They had an order for prn Artificial Tears for Resident #6, as indicated on the medication label. -They did not have an order for Artificial Tears to be administered scheduled 4 times a day. Interview with the Administrator on 09/25/24 at 2:23pm revealed the Resident Care Coordinator (RCC) position was currently vacant so the MAs should have notified her about the discrepancies on the eMAR with Resident #6's Artificial Tears. Refer to interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. e. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Elderberry 1000mg 1 capsule once daily. (Elderberry is a supplement that may boost the immune system.) Review of Resident #6's primary care provider (PCP) order dated 08/07/24 revealed an order for Elderberry 1000mg 1 capsule once daily. Observation of the 8:00am medication pass on 09/25/24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) prepared and administered medications in a MDP to Resident	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 59 #6 at 8:41am. -The MDP did not include Elderberry capsule. -Elderberry capsule was not administered as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Elderberry 1000mg 1 capsule once daily scheduled at 8:00am. -Elderberry 1000mg capsules were documented as administered daily from 09/01/24 - 09/25/24. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed there was no supply of any Elderberry capsules available for administration for Resident #6. Interview with the MA on 09/25/24 at 1:25pm revealed: -She administered Resident #6's medications based on what was in the MDPs. -She had not noticed there was no Elderberry capsule in the resident's MDP administered in the mornings. -She thought there used to be Elderberry capsules in the resident's MDP, but she could not recall the last time she saw Elderberry capsules in the MDP. -She had not noticed there was an entry for Elderberry on the eMAR system that was being documented as administered even though Elderberry was not being administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 60 -They had not dispensed any Elderberry capsules for Resident #6. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not enter orders into the facility's eMAR system. -They did not have an order for Elderberry capsules for Resident #6. -They had not dispensed any Elderberry capsules for Resident #6. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs should not document Elderberry was being administered on the eMAR if there was none available for administration. -The Resident Care Coordinator (RCC) position was currently vacant, so the MAs should have notified her about the discrepancies with Resident #6's Elderberry capsules. Refer to interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. f. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order Probiotic Formula 1 capsule once daily. (Probiotic Formula is used for gastrointestinal health and may be used to help prevent infections.) Observation of the 8:00am medication pass on 09/25//24 revealed: -Resident #6's medications were packaged in multi-dose packs (MDPs) by an outside pharmacy provider. -The medication aide (MA) prepared and administered medications in a MDP to Resident #6 at 8:41am.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 61 -The MDP did not include Probiotic Formula capsule. -Probiotic Formula capsule was not administered as ordered. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Probiotic Formula 1 capsule once daily scheduled at 8:00am. -Probiotic Formula was documented as administered once daily at 8:00am from 09/01/24 - 09/25/24. Observation of Resident #6's medications on hand on 09/25/24 at 8:37am revealed: -The resident's oral medications were packaged in MDPs. -The MDP did not contain any Probiotic Formula capsules. -There was no supply of any Probiotic Formula capsules available for administration for Resident #6. Interview with the MA on 09/25/24 at 1:25pm revealed: -She administered Resident #6's medications based on what was in the MDPs. -She had not noticed there was no Probiotic Formula capsule in the resident's MDP administered in the mornings. -She thought there used to be Probiotic Formula capsules in the resident's MDP, but she could not recall the last time she saw Probiotic Formula capsules in the MDP. -She had not noticed there was an entry for Probiotic Formula on the eMAR system that was being documented as administered even though none was not being administered.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 62 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/24 at 5:16pm revealed: -Resident #6 was in their system as profile only because the resident's medications were dispensed by another pharmacy. -They had not dispensed any Probiotic Formula capsules for Resident #6. Telephone interview with a pharmacy technician at Resident #6's pharmacy provider on 09/26/24 at 4:59pm revealed: -They did not enter orders into the facility's eMAR system. -They did not have an order for Probiotic Formula capsules for Resident #6. -They had not dispensed any Probiotic Formula capsules for Resident #6. Interview with the Administrator on 09/25/24 at 2:23pm revealed: -The MAs should not document Probiotic Formula was being administered on the eMAR if there was none available for administration. -The RCC position was currently vacant so the MAs should have notified her about the discrepancies with Resident #6's Probiotic Formula capsules. Refer to interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. g. Review of Resident #6's current FL-2 dated 02/21/24 revealed an order for Flonase 50mcg Nasal Spray Instill 1 spray in each nostril once daily. (Flonase is used to treat and prevent seasonal allergy symptoms.) Review of Resident #6's primary care provider (PCP) prescription dated 06/07/24 revealed an	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 63 order for Flonase 50mcg Nasal Spray Instill 1 spray in each nostril once daily. Observation of the 8:00am medication pass on 09/25/24 revealed: -The medication aide (MA) prepared and administered oral medications to Resident #6 at 8:41am. -The MA did not offer or administer Flonase Nasal Spray to Resident #6 when she received her other medications scheduled for 8:00am. Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase Nasal Spray Instill 1 spray in each nostril once daily scheduled at 8:00am. -Flonase Nasal Spray was documented as administered daily from 09/01/24 - 09/25/24. Observation of Resident #6's medications on hand on 09/25/24 at 1:35pm revealed: -There was a bottle of Flonase 50mcg Nasal Spray dispensed on 12/08/23. -The instructions on the bottle were to use 1 spray in each nostril daily. Interview with Resident #6 on 09/25/24 at 12:43pm revealed: -She should receive Flonase Nasal Spray every day, but she did not always receive it every day. -She did not get her Flonase Nasal Spray that morning, 09/25/24. -She did not know why she did not receive Flonase every day. -Her allergy symptoms were about the same today, 09/25/24. Interview with the MA on 09/25/24 at 1:25pm	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064031	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS 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 367	Continued From page 64 revealed: -She forgot to ask the resident that morning, 09/25/24, if the resident wanted to use the Flonase Nasal Spray. -She could not explain why she documented the Flonase Nasal Spray as being administered on 09/25/24 at 8:00am when she failed to administer it. Interview with the Administrator on 09/25/24 at 2:23pm revealed the MA should not document a medication was administered on the eMAR if it was not administered. Refer to interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm. Interviews with the Administrator on 09/25/24 at 2:23pm and 09/26/24 at 6:41pm revealed: -She was currently overseeing the MAs since the Resident Care Coordinator (RCC) position was vacant. -The facility's contracted pharmacy usually entered the orders into the eMAR system. -Either she or the RCC were responsible for reviewing and approving the orders in the eMAR system before the orders became active. -The MAs were responsible for checking the eMARs for accuracy and doing medication cart audits weekly. -The MAs should let her or the RCC know if the eMARs and the medication labels did not match. -She or the RCC could contact the pharmacy to clarify any discrepancies.	D 367		