Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Gardens of Trent
Address: 2915 Brunswick Avenue, New Bern NC 28562
County: Craven
License Number: HAL-025-035
II. Date(s) of Visit(s): 02/17/2025, 02/21/2025, 02/26/2025, 03/04/2025, 03/05/2025, 03/18/2025, 03/19/2025, 03/20/2025, 04/04/2025, 04/07/2025, 04/11/2025, 04/15/2025.
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 04/15/2025

In column III (b) please provide a plan of correction to address *each of the rules* which were violated and cited in column III (a). The plan must describe the steps the facility will take to achieve and maintain compliance. In column III (c), indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within 15 working days from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .1004 (a)	☒ POC Accepted EH *DSS Initials*	—
Rule/Statutory Reference: (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.	Responces to all deficiencies do not constitute an admission or agreement by the facility to the facts alleged or conclusions set forth in the statement of deficiency or correction is soley as a matter of compliance with State law.	
Level of Non-Compliance: Type A1 Violation		
Findings: This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#1) for a medication used to treat seizures.		

The finding(s) are: Review of Resident #1's FL2 dated 08/13/2024, revealed: -Diagnoses of Alzheimer's Dementia, Subarachnoid Hemorrhage, Acute Subdural Hematoma, Temporal Bone Fracture, Altered Mental Status. -There was no orientation status documented. -There was no order for Depakote 500 MG twice a day on Resident #1's FL2. Review of Resident #1's Physician Order Report dated 08/13/2024 revealed an order for Depakote capsule delayed rel. sprinkle; 125 MG oral, take 2 capsules once daily (may open and sprinkle). (Depakote is a medication used to treat seizure disorder.) Review of Resident #1's hospitalizations due to seizure activity revealed: -Resident #1 was hospitalized from 01/28/2025-02/07/2025. -Resident #1 was hospitalized again from 02/18/2025-02/21/2025. -Resident #1 was hospitalized again from 02/27/2025-03/05/2025, then transferred to a hospital with a Neuro Critical Care Unit where Resident #1 remained until 04/03/2025. Review of Resident #1's hospital records from 01/28/2025-02/07/2025 revealed: -Resident #1 was diagnosed with Sepsis, Acute Cystitis with Hematuria, Acute Metabolic Encephalopathy, Acute Kidney Injury, Traumatic Brain Injury, Cerebrovascular Disease, Hypertension, Seizures, and Dysphagia. -Resident #1's hospital course included treatment for Sepsis, Acute Encephalopathy, Acute Stroke, Carotid Artery Stenosis, Seizure Disorder, and Acute Kidney Injury. -Resident #1 had low home valproic acid levels at 16.7 on 1/31/2025. (Valproic acid levels show the amount of Depakote in the blood. Therapeutic range is 50-100 for a person prescribed Depakote.) -Valproic acid level on 2/7/2025 continued to remain low at 38.3. -The Attending hospitalist recommended continuing current dose of 500mg of Depakote twice daily and close outpatient follow-up with neurology in 1-2 weeks. -The Attending hospitalist sent orders to the pharmacy for Depakote 500 MG EC, take 1 tablet in the morning and 1 tablet before bedtime.	The ED, SCC, or designee will complete a MAR to cart audit weekly X 4 weeks, then monthly to ensure medications on hand have directions as written per the PCP. If there are any discrepancies, the ED or designee will notify the SCC, who will clarify the order with the PCP. Clinical Nurse Consultant re-educated Med Aides and SCC on the 6 rights of medication administration with, medication policies and procedures, 3 time checks and procedures for residents returning from the hospital.	4/7/25 and ongoing 5/9/25

Review of Resident #1's hospital discharge summary dated 2/7/2025 revealed: -Resident #1 had a discharge order for Depakote 500 MG EC, take 1 tablet in the morning and 1 tablet before bedtime. -Next to the order for Depakote 500 MG EC, an undated, handwritten entry to discontinue and change to previous order. -It was also written to continue Depakote 125 MG DR Sprinkles- take 2 capsules every day. -The discharge summary was electronically signed by the hospital provider. -The discharge summary was not signed by Resident #1's primary care provider. Review of a medication order clarification form for Resident #1 dated on 02/11/2025 revealed: -The order for Depakote 500 MG DR twice a day was marked no. -The order for Depakote 125 MG Sprinkles daily was left blank. -The order clarification form had a stamp at the top stating it was faxed to the pharmacy on 02/07/2025. -The order clarification form was not signed by Resident #1's primary care provider until 2/11/2025 after it had been sent to the pharmacy. Review of Resident #1's February 2025 medication administration record revealed: -There was an entry for Depakote 500 MG, take 1 tablet twice daily. -Depakote 500 MG was not documented as administered from 02/07/2025-02/18/2025. Review of Resident #1's hospital records from 02/18/2025-02/21/2025 revealed: -Resident #1 was brought into the hospital for unresponsiveness. -Resident #1 was diagnosed with Altered Mental Status, Acute Metabolic Encephalopathy, Acute Renal Failure, Hypernatremia, and Breakthrough Seizures. -Resident #1's Valproic Acid level was 35.3 on 02/19/2025. (Valproic acid levels show the amount of Depakote in the blood. Therapeutic range is 50-100 for a person prescribed Depakote.) -Resident #1's Depakote level was low, and he was loaded with IV Depakote. -The Attending Hospitalist recommended Resident #1 continue the current dose of 500MG of Depakote twice daily.		

-The Attending Hospitalist recommended Resident #1 add Keppra 500 MG twice daily. (Keppra is a medication used to treat certain types of seizures.) -The Attending Hospitalist recommended Resident #1 follow up with outpatient neurology. -The Attending Hospitalist signed off on orders for Keppra 500 MG twice per day, and Depakote 500MG twice per day. Review of Resident #1's hospital discharge summary dated 2/19/2025 revealed: -There was an order for Depakote 500 MG EC Tablet, take one tablet in the morning and one tablet at bedtime. -The Attending Hospitalist noted that Resident #1 was given IV Depakote and that it appeared Resident #1's dose was not increased from the previous hospitalization. -It was documented 3 times on the note that Resident #1 was diagnosed with seizure disorder. -Handwritten next to Depakote 500 MG EC Tablet was "D/C, cont. Sprinkles as prior to hospital visit 125mg take 2 QD." For Resident #1. -Resident #1's primary care provider signed off on the first page of the document on 02/25/2025. Review of Resident #1's February medication administration record revealed: -There was an entry for Depakote 500 MG, take 1 tablet by mouth twice daily. -Depakote 500 MG was not documented as administered from 02/21/2025-02/27/2025. -There was an entry for Keppra 500 MG take 1 tablet twice daily. -Keppra 500 MG was documented as administered twice a day from 02/25/2025-02/27/2025. Review of Resident #1's hospital records from 02/27/2025-03/05/2025 revealed: -Resident #1 was admitted for altered mental status with intermittent level of consciousness. -Resident #1 became lethargic during his admission and experienced hypoxic respiratory failure resulting in the need for mechanical ventilation and intubation. -Resident #1's Valproic Acid level was 24.0 on 02/28/2025 (Normal therapeutic level is 50-100) -Resident #1's electroencephalogram (a test that measures electrical activity in the brain to help diagnose epilepsy) showed generalized onset seizures.		

-Resident #1 experienced upward gaze, mouth movement, body tensing, followed by chewing movements and rightward eye gaze.
-Resident #1 was transferred to a neuro-ICU on 03/05/2025 due to having little improvement and continued seizure episodes.

Interview with the Special Care Coordinator (SCC) on 3/18/2025 at 2:15 PM revealed:
-The facility continued Resident #1's orders prior to hospitalization upon Resident #1's return from the hospital.
-Resident #1 was not having behaviors so she did not understand why they were increasing Resident #1's Depakote.
-Resident #1 could not take pills by mouth and required medications to be crushed.
-Depakote 500 MG Delayed Release could not be crushed so they could not administer it.
-She was not aware that Resident #1 had a stroke at the hospital.
-She was not aware that Depakote 500 MG Delayed Release was being prescribed to Resident #1 for seizure disorder.

Interview with the Manager on 3/18/2025 at 2:48 PM revealed:
-She was not informed that Resident #1 had seizures.
-She called 911 on 01/28/2025 when she was made aware Resident #1 was not at baseline.
-She was not involved in Resident #1's February hospitalizations.

Interview with SCC on 03/19/2025 at 2:30 PM revealed:
-The facility never received Depakote 500 MG DR for Resident #1.
-She thought 250 MG VS 1000 MG of Depakote would not cause Resident #1's current hospitalization, and the reason Resident #1 was hospitalized was because he aspirated.
-The facility did not change Resident #1's orders, but the facility primary care provider did on 02/11/2025 via medication order clarification form.

Telephone interview with the facility contracted pharmacist for Resident #1 on 03/20/2025 at 9:05AM revealed:
-Depakote was used primarily to treat seizures.
-The pharmacy received an order for Depakote 500 MG twice a day on 02/05/2025 for Resident #1.
-The pharmacy dispensed Depakote 500 MG twice a day on 02/05/2025, 02/10/2025, 02/17/2025, and 02/26/2025.
-Depakote 500 MG twice a day was dispensed in a multidose pack.

-A cancel order was received via e-scribe on 02/28/2025 at 10:10 AM.
-Depakote 500 MG twice a day was not dispensed after 02/26/2025.
-Resident #1 could have seizures if Resident #1 did not receive Depakote.
-Not receiving medication as prescribed can exacerbate an illness.

Interview with Resident #1's Primary care provider on 03/20/2025 at 8:12 AM revealed:
-She never contacted the hospital, but the facility received the discharge paperwork.
-Resident #1's FL2 never said anything about seizures or seizure disorder (FL2 completed by primary care provider).
-Resident #1 was on Keppra and all the studies show that if a patient is on Keppra it should replace other medications.
-She believed Resident #1 was on Keppra after the first hospitalization when Resident #1 discharged on 2/7/2025.
-She could not see in her system when Resident #1 started Keppra.
-The aftercare instructions from Resident #1's 2/7/2025 hospitalization did not state to increase Depakote and that there was nothing listed.
-She did not see Resident #1 immediately upon discharge from the hospital.
-Depakote 125 MG was initially started for Resident #1 for changes with his Traumatic Brain Injury and behaviors.
-Resident #1 had never had an electroencephalogram.
-Resident #1 "did not need to have a therapeutic level of Depakote for changes in traumatic brain injury or behaviors because that is not how it works.".
-The discontinue order for Depakote 500 MG DR should have been on a clarification form for Resident #1 signed on 02/11/2025.

Telephone interview with the Admitting Hospital Physician on 03/04/2025 at 12:54 PM revealed:
-Resident #1 was postictal each time he was admitted (Postictal is the recovery period that begins after a seizure ends and lasts until the patient returns to their normal state.)
-Resident #1's Depakote level was low on 01/28/2025 admission.
-Resident #1's Depakote was increased and the order for Depakote 500 MG twice a day was sent to the pharmacy.
-Medication reconciliation was completed for Resident #1 upon admission on 02/18/2025 hospitalization.

-Medication reconciliation revealed Resident #1's Depakote 500MG twice a day order was not continued by the facility. -She was not sure why Resident #1's Depakote order was discontinued as it was clearly stated on the summary when Resident #1 returned to the facility. -Resident #1 was having seizures and needed that medication. -If Resident #1 did not receive the ordered medication, he would have seizures. -Having seizures cause the killing of brain cells. -Resident #1 had a traumatic brain injury and stroke history, so having seizures on top of that could cause a lot of damage. Telephone interview with Resident #1's legal guardian on 04/02/2025 at 4:09 PM revealed: -Resident #1 had to be transferred to a Neuro Intensive Care Unit due to uncontrollable seizures. -Resident #1 required mechanical ventilation for most of his hospitalization. -Resident #1 had to have a percutaneous endoscopic gastrostomy tube placed for nutrition. -Resident #1's level of care has changed to skilled nursing. -Resident #1 is no longer verbally communicating. Review of Resident #1's hospital records from 03/05/2025-03/26/2025 revealed: -Resident #1 was transferred to Neuro Intensive Care Unit directly from hospitalization on 02/27/2025-03/05/2025. -Resident #1 was not consistently given anti-seizure medications at his facility evidenced by a subtherapeutic VPA level at the outside hospital. -Resident #1 was being treated for higher level of care and further management of status epilepticus. -Resident #1's status epilepticus' etiology was likely medication non-compliance. -Resident #1 was intubated from 03/03/2025-03/13/2025. -A G-tube was placed for Resident #1 to obtain nutrition.	The SCC or designee will complete a medication clarification for all medications ordered by the discharging physician at the hospital. The PCP will receive the medication clarification for review and signature. The discharge paperwork will be given to the PCP for review and signature.	5/15/26 and ongoing
The facility failed to administer Resident #1 their ordered medication used to treat and prevent seizures. Resident #1 was discharged from the hospital following an acute stroke on 02/07/2025 with orders to increase the dose of Depakote, this was not increased. The resident was sent back to the hospital on 02/18/2025 after being found unresponsive and was diagnosed with breakthrough seizures. Resident #1 was discharged back to the facility on 02/21/2025 with orders to continue previously increased dose of Depakote and a second medication to prevent seizures was added. The Depakote was	ED will monitor compliance by completing EHR review of the medication clarification and discharge paperwork within 1 week of residents return from the hospital	5/16/25

not administered as ordered and the resident was hospitalized again on 02/27/2025 with an intermittent level of consciousness ultimately resulting in the transfer to an intensive care hospital on 03/05/2025 in respiratory failure and required mechanical ventilation and intubation and feeding tube placement for nutrition prior to being discharged to a higher level of care. This failure resulted in serious physical harm and constitutes a TYPE A1 VIOLATION. -The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/07/2025 for this violation. -CORRECTION DATE FOR THE TYPE A VIOLATION SHALL NOT EXCEED 05/15/2025.		
Rule/Statute Number: 10A NCAC 13F .1212(a)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	The ED, SCC, or designee will send to DSS all incident reports resulting in the resident requiring a referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	5/15/25 and ongoing
Level of Non-Compliance: Standard Deficiency	The RVPO will re-educated the ED and SCC on the rule area 10A NCAC 13F .1212a.	4/29/25.
Findings: This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that incident reports were sent to the county department of social services within 48 hours for 1 out of 5 residents that required referral for emergency medical evaluation. The finding(s) are: Review of incident reports on file at the facility from 12/30/2025 through 02/28/2025 revealed: -There were 4 total incident reports for Resident #1. -The facility's incident report form has a "Notifications" section which showcases 4 check box options: "Spoke to", "Faxed to", "E-mailed to", and "N/A". Review of an incident report for Resident #1 dated 12/30/2024 at 5:28 PM revealed:		

-Resident #1's incident was marked as "medical".
-Next to medical- it was typed that Resident #1 was lethargic with altered mental status and had a high temperature of 101.1.
-The description of what was observed stated that Resident #1 was leaned over in his wheelchair.
-Resident #1's level of consciousness stated that he would arouse when his name was called.
-Resident #1 was sent to the Emergency Room on 12/30/2024 at 5:38 PM.
-Resident #1 was transported via Emergency Medical Service (EMS).
-There was a section of the report to record the status of the resident after the Emergency Room/Hospital visit.
-The recorded status of Resident #1 stated that he was admitted to the hospital with Pneumonia.
-The notification section for regulatory agency was left blank and unmarked.

Review of the County Department of Social Services records revealed:
-The Department of Social Services received 3 incident reports from the facility in the month of December 2024.
-The Department of Social Services did not receive the incident report for Resident #1 dated 12/30/2024.

Review of an incident report for Resident #1 dated 01/28/2025 at 9:06 AM revealed:
-Resident #1's incident was marked as "medical".
-Next to medical- it was typed that Resident #1 was lethargic.
-The description of what was observed stated that Resident #1 was sluggish and confused more than his baseline.
-Resident #1's level of consciousness stated that he would arouse when his name was called.
-Resident #1 was sent to the Emergency Room on 01/28/2025 at 9:25 AM.
-Resident #1 was transported via EMS.
-The recorded status of Resident #1 stated that he was admitted to the hospital for a Urinary Tract Infection (UTI).
-The notification section for regulatory agency was left blank and unmarked.

Review of the County Department of Social Services records revealed:
-The Department of Social Services received 4 incident reports from the facility in the month of January 2025.
-The Department of Social Services did not receive the incident report for Resident #1 dated 01/28/2025.

Review of an incident report for Resident #1 dated 02/18/2025 at 6:33 PM revealed: -Resident #1's incident was marked as "medical". -Next to medical- it was typed that Resident #1 was unresponsive. -The description of what was observed stated that Resident #1 was leaned over in the chair unresponsive. -Resident #1's level of consciousness stated that he was unresponsive. -Resident #1 was sent to the Emergency Room on 02/18/2025 at 6:30 PM. -Resident #1 was transported via EMS. -The recorded status of Resident #1 stated "N/A". -The notification section for regulatory agency was left blank and unmarked. Review of County Department of Social Services records revealed: -The Department of Social Services received 6 incident reports from the facility in the month of February 2025. -The Department of Social Services did not receive the incident report for Resident #1 dated 02/18/2025. The facility failed to notify the County Department of Social Services of 3 incidents resulting in the need for emergency medical evaluation or hospitalization for 1 of 5 sampled residents resulting in the potential detrimental risk to the safety and welfare of residents.		

IV. Delivered Via:	IN-PERSON	Date: 4/25/25
DSS Signature:		Return to DSS By: 5/10/25

V. CAR Received by:	Administrator/Designee (print name): Amber Brooke Marshburn	
	Signature:	Date: 4-25-25
	Title: LPN / Director of Resident Care	

VI. Plan of Correction Submitted by:	Administrator (print name): Kris Bolen	
	Signature:	Date: 5/6/25

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		

Facility Name: The Gardens of Trent

☒ *POC Accepted*	By: Emily Hamlin	Date: 6/19/2026
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*