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 _____ *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.		
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.

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 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

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 05/07/2025.

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.

Level of Non-Compliance:

Standard Deficiency

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. THE CORRECTION DATE FOR THIS STANDARD DEFICIENCY SHALL NOT EXCEED:		

IV. Delivered Via:		Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)

Facility Name: The Gardens of Trent

☐ *POC Not Accepted*	By:	Date:
Comments:		

☐ *POC Accepted*	By:	Date:
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.*		