STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 1-4, 2015.	D 000		
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 observation, interview and record review, the facility failed to assure hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 1 of 32 fixtures (1 sink) located in the resident shared bathrooms, and 2 of 2 fixtures (1 sink and 1 shower) located in one community shower room. The findings are: Observations during the tour of the facility from 10:00am to 12:00pm on 9/1/15 revealed the following hot water temperatures: -At 11:15am, the sink in the community shower room to the left of the Housekeeping Closet on the 200 side of the facility was 124 degrees F. -At 11:20am, the shower in the community shower room to the left of the Housekeeping	D 113		

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D 113	Continued From page 1	D 113		

Closet on the 200 side of the facility was 118 degrees F.
-At 11:30am, the sink in room 210 was 120 degrees F.

Neither of the two residents of Room 210 were interviewable, due to diagnoses of dementia.

Interview at 11:40am on 9/1/15 with a resident who lived in Room #208 revealed:
-The water was hot in the community shower rooms, staff went with him when he used the community shower room.
-Staff checked water temperatures with their hands and knew to add cold water when assisting him in using the community shower room.
-He knew to add cold water when the water temperature felt too warm for him in his bathroom's sink.
-He had never been burned by the hot water.

Interview at 12noon on 9/1/15 with the Administrator revealed:
-She had an instant-read dial food probe thermometer to use when spot-checking water temperatures.
-The facility did not have a Maintenance Worker on a daily basis.
-The facility's corporate Maintenance Worker came to the facility once a week to check water temperatures.
-The facility's corporate Maintenance Worker had a more precise thermometer to check water temperatures, as it gave readings to one-tenth of a degree.
-The facility's corporate Maintenance Worker kept a log of facility water temperatures.

Surveyor calibrated facility instant-read dial food probe thermometer and surveyor's Fisher

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D 113	Continued From page 2 Scientific liquid-in-glass thermometer in 8 ounces of slushy ice water at 12:15pm on 9/1/15. The surveyor's thermometer read 32 degrees F, the instant read thermometer read 28 degrees F. Hot water temperatures were taken at 12:20pm on 9/1/15 using the facility instant-read dial food probe thermometer and the surveyor's Fisher Scientific liquid-in-glass thermometer: -Community bath sink was 124 degrees F with surveyor thermometer, facility instant-read dial thermometer measured temperature at 110 degrees F. -Community bath shower was 118 degrees F with surveyor thermometer, facility instant-read thermometer measured temperature at 108 degrees F. -Room 210 bathroom sink was 120 degrees F with surveyor thermometer, facility instant-read thermometer measured temperature at 108 degrees. The facility Administrator posted "Caution: Hot water. Do not use" signs on the walls next to fixtures found to have temperatures greater than 116 degrees Fahrenheit by 12:45pm on 9/1/15. Interview with the corporate Maintenance Worker at 3:15pm on 9/1/15 revealed: -He used an air gun digital non-contact thermometer to measure the air temperature around a running faucet. -He had been told the air gun digital non-contact thermometer was extremely reliable. -He did not calibrate the air gun digital non-contact thermometer. -He had a digital probe thermometer that measured the temperature to a tenth of degree, but preferred to use the air gun digital non-contact thermometer as it was faster.	D 113		

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-He did not use a probe thermometer and have hot water flow over the probe.
-He stated the air gun digital non-contact thermometer was more accurate than the facility's instant-read dial food probe thermometer.
-He came to the facility once a week and took water temperatures of the kitchen, at least 3 individual resident room bathrooms on the 100 hall and at least 3 individual resident room bathrooms on the 200 hall with the air gun thermometer.
-He occasionally checked the employee bathroom, the activity room sink, and a community bathroom.
-He knew 116 degrees F was the upper limit for hot water temperatures, and set the hot water tanks' temperatures at 116 degrees F to assure the facility had plenty of hot water.
-He planned to bring his digital probe thermometer to the facility for their use, as their dial thermometer was inaccurate.

A work order dated 9/1/15 by the corporate Maintenance Worker revealed he got the water temperatures down to 112 degrees F that afternoon and planned to return the next day to recheck hot water temperatures.

Recheck of hot water temperatures at 4:30pm on 9/1/15 revealed:
-The sink in the community shower room to the left of the Housekeeping Closet on the 200 side of the facility was 112 degrees F.
-The shower in the community shower room to the left of the Housekeeping Closet on the 200 side of the facility was 110 degrees F.
-The sink in room 210 was 112 degrees F.

A work order dated 9/2/15 by the corporate Maintenance worker revealed water temperatures

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D 113	Continued From page 4 were rechecked at 107 - 108 degrees F. Recheck of hot water temperatures at 2:30pm on 9/2/15 revealed: -The sink in the community shower room to the left of the Housekeeping Closet on the 200 side of the facility was 108 degrees F. -The shower in the community shower room to the left of the Housekeeping Closet on the 200 side of the facility was 106 degrees F. -The sink in room 210 was 108 degrees F. Interview with the corporate Maintenance Worker on 9/2/15 at 10:45am revealed he planned to check water temperatures using an instant-read digital probe thermometer inserted in the stream of hot water from faucets. Interview with the Administrator on 9/2/15 at 11:00am revealed she will use the corporate Maintenance Worker's instant-read digital probe thermometer inserted in the stream of hot water from faucets to spot-check water temperatures. She will no longer use the facility' dial instant-read thermometer, as it read 10-14 degrees below the surveyor's thermometer. Review of water temperature logs taken once weekly from 6//29/15 to 9/2/15 revealed the water temperatures recorded by the facility were greater than 116 degrees F on the following dates: -7/13/15 - Room 110 sink measured 116.3 degrees F. -8/10/15 - Room 200 measured 119.6 degrees F. There was no documentation of the type of thermometer used, the time of day, or action taken by the facility in response to the high temperatures. Interviews on 9/2/15 at 10:30am with two	D 113		

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personal care assistants who worked on 200 hall revealed:
-They checked water temperatures in the community bathroom sink and shower with their hands before helping residents use the sink and shower.
-They adjusted water temperatures by adding cold water if it felt hot to the touch or if the hot water was steaming.
-No residents had complained about the water temperatures.
-They asked residents if they wanted their hot water hot, lukewarm, or cooler.

Interview on 9/2/15 at 12:15pm with a family member of the resident of room 208 stated she had not noticed the water being too hot, and the resident stated the water temperature was fine.

Interview with a resident of Room 217 at 1:15pm on 9/2/15 revealed:
-"No problems with water being too hot."
-The resident sometimes needed help when using the bathrooms.
-A facility aide added cold water when assisting her in using her bathroom's sink and the community shower rooms.
-She had never been burned by the hot water.

A work order dated 9/3/15 by the corporate Maintenance worker revealed water temperatures were rechecked at 107 degrees F.

Recheck of hot water temperatures at 2:30pm on 9/3/15 revealed:
-The sink in the community shower room to the left of the Housekeeping Closet on the 200 side of the facility was 106 degrees F.
-The shower in the community shower room to the left of the Housekeeping Closet on the 200

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D 113	Continued From page 6 side of the facility was 106 degrees F. -The sink in room 210 was 106 degrees F.	D 113		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner (Prednisolone ophthalmic eye drops, Calcium tablet) and in accordance with the facility's policies and procedures for 7 of 14 residents (#3, #6, #7, #8, #9, #10, and #11) observed during the medication pass which included errors with the time of medication administration for medications such as Calcium, Lorazepam, Bethanechol, Dilantin, and Artificial Tears. The findings are: The medication error rate was 28% as evidenced by the observation of 8 errors out of 28 opportunites during the 4:00pm medication pass on 09/01/2015 and the 12:00pm medication pass on 09/02/2015. 1.Review of Resident #3's current FL-2 dated	D 358		

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D 358	Continued From page 7 07/17/2015 revealed: -Diagnoses included dementia, diabetes, hypertension, chronic kidney disease, urinary tract infection, and hyperlipidemia. -A physician's order for Calcium 600mg plus Vitamin D tablet (dietary supplement) two times daily. Review of subsequent Physician's Orders sheet dated 07/31/2015 revealed a physician's order for Calcium/D 600-400 tablet take one tablet twice a day with food. Observation of the 4:00pm medication pass on 09/01/2015 revealed: -Resident #3 was administered Calcium 600/400 one tablet at 4:50pm with water only. -The Medication Aide (MA) did not offer any food with the resident's medication. Interview with the MA on 09/01/2015 at 4:50pm revealed Resident #3 would be eating supper around 5:30pm. Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #3 revealed printed instructions for Calcium/D 600-400 tablet take one tablet twice a day with food and scheduled for administration at 8am and 6pm. Observation of Resident #3 on 09/01/2015 at 6:15pm revealed the resident was in the dining room eating her supper meal. Interview with the Regional Director on 09/02/2015 at 4:15pm revealed: -The contract pharmacy packaged multiple medications together using a bubble pack system.	D 358		

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-The pharmacy method of packaging medications would have to be reviewed, especially those medications with specific instructions like with food and with meals, unless a cracker or some food item was given at the time the medication was administered.
-The facility would need to talk to the physician about medication times or have certain medications packaged in separate bubble packs.

Interview with the contract pharmacy provider Pharmacist on 09/04/2015 at 4:00pm revealed:
-Resident #3's Calcium/D 600-400mg tablet was ordered to be administered with food.
-the Calcium could be administered with or without food.
-Instructions were noted in the emar directions when a medication was ordered to be given with food.

Following record review and observation of Resident #3 on the Special Care Unit, the resident was determined not to be interviewable.

2. Review of Resident #6's current FL-2 dated 03/18/2015 revealed:
-Diagnoses included alzheimer's, fluid overload, chronic renal failure 1, obesity, osteoarthrosis, schizophrenic, and hyperlipidemia.
a. A physician's order for Lorazepam (used to treat anxiety disorders) 1mg three times daily.
Review of a subsequent Physician's Orders sheet dated 07/29/2015 revealed a physician's order for Lorazepam 1mg take one tablet three times a day.

b. A physician's order for Bethanechol (used to treat disorders of the urinary tract) 50mg three times daily.
Review of a subsequent Physician's Orders sheet

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D 358	Continued From page 9 dated 07/29/2015 revealed a physician's order for Bethanechol 50mg take one tablet three times a day. Observation of the medication pass on 09/02/2015 at 1:25pm revealed Resident #6 was administered four pills from a pharmacy dispensed bubble pack which included Bethanechol 50mg one tablet, and Lorazepam 1mg tablet. Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #6 revealed: -Printed instructions for Bethanechol 50mg tablet take one tablet three times a day and scheduled for administration at 8:00am, 12:00pm and 8:00pm. -Printed instructions for Lorazepam 1mg tablet take one tablet three times a day and scheduled for administration at 8:00am, 12:00pm and 8:00pm. Interview with the MA on 09/02/2015 at 1:31pm revealed: -The 12:00pm medications were just being administered. -The 12:00pm medications were late because "everybody needs stuff" from the MA and "it's been like that way all day". -The physician had visited earlier in the morning and the MA had gotten a little behind. Interview with the Regional Director on 09/02/2015 at 4:15pm revealed: -The contract pharmacy packaged multiple medications together using a bubble pack system. -The pharmacy method of packaging medications would have to be reviewed.	D 358		

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D 358	Continued From page 10 -The facility would need to talk to the physician about medication times or have certain medications packaged in separate bubble packs. Interview with the contract pharmacy provider Pharmacist on 09/04/2015 at 4:05pm revealed there was no clinical issue with the 12:00pm Lorazepam and Bethanechol being administered at 1:25pm because the next scheduled dose was at 8:00pm for both medications, however, there was a process issue with the medications being administered late. Following record review and observation of Resident #6 on the Special Care Unit, the resident was determined not to be interviewable. 3. Review of Resident #7's current FL-2 dated 05/14/2015 revealed diagnoses included alzheimer's, hypothyroidism, and seizure. Review of a subsequent Physician's Order Request dated 05/20/2015 revealed a physician's order for Calcium Carbonate/Vit D 600/400 unit (a dietary supplement) tablet take one tablet two times a day. Review of a subsequent Physician's Orders sheet dated 07/29/2015 revealed a physician's order for Calcium/D 600-400 tablet take one tablet two times a day. Observation of the medication pass on 09/02/2015 at 1:30pm revealed Resident #7 was administered one Calcium 600-400 tablet crushed and mixed with yogurt. Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #7 revealed printed instructions for	D 358		

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D 358	Continued From page 11 Calcium/D 600-400 tablet take one tablet two times a day and scheduled for administration at12:00pm and 8:00pm. An interview with the MA on 09/02/2015 at 1:31pm revealed: -The 12:00pm medications were just being administered. -The 12:00pm medications were late because "everybody needs stuff" from the MA and "it's been like that way all day". -The physician had visited earlier in the morning and the MA had gotten a little behind. Interview with the Regional Director on 09/02/2015 at 4:15pm revealed: -The contract pharmacy packaged multiple medications together using a bubble pack system. -The pharmacy method of packaging medications would have to be reviewed. -The facility would need to talk to the physician about medication times or have certain medications packaged in separate bubble packs. Interview with the contract pharmacy provider Pharmacist on 09/04/2015 at 4:15pm revealed there was no clinical issue with the 12:00pm Calcium being crushed and administered at 1:30pm because the next scheduled dose was at 8:00pm, but there was a process issue with the medication being administered late. Observation of the 12:00pm medication pass on 09/03/2015 at 11:42am revealed: -The MA administered Calcium 600-400 one tablet to Resident #7. -The MA gave Resident #7 two sips of water and asked the Resident if she had swallowed the medicine.	D 358		

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-Resident #7 shook her head up and down, but did not speak.
-At 12:05pm, Resident #7 came to room 108 with two halves of a white capsule in her hand.
-The MA retrieved the two halves of the white tablet from Resident #7 and disposed of them in the trash.
-The MA stated Resident #7 can usually chew if she does not swallow, the MA did not see Resident #7 chew so the MA thought Resident #7 had swallowed the medication when the medication was administered. The MA stated she usually did not have any problem with Resident #7 taking her medication.

Following record review and observation of Resident #7 on the Special Care Unit, the resident was determined not to be interviewable.

4. Review of Resident #8's current FL-2 dated 06/22/2015 revealed diagnoses included alzheimer's disease, hypertension, thyroid disease, arthritis, osteoarthritis, and anemia.

Review of a Physician's Orders sheet dated 07/29/2015 revealed a physician's order for Calcium/D 600-400 tablet take one tablet two times a day.

Observation of the medication pass on 09/02/2015 at 1:33pm revealed Resident #8 was administered three pills crushed and mixed in yogurt, from a pharmacy dispensed bubble pack, which included one Calcium 600-400 tablet.

Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #8 revealed:
-Printed instructions for Calcium/D 600-400 tablet take one tablet two times a day and scheduled for

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administration at12:00pm and 4:00pm.
-The other two pills, according to the emar, were scheduled to be administered at 2:00pm.

A previous interview with the MA on 09/02/2015 at 1:31pm revealed:
-The 12:00pm medications were just being administered.
-The 12:00pm medications were late because "everybody needs stuff" from the MA and "it's been like that way all day".
-The physician had visited earlier in the morning and the MA had gotten a little behind.

Interview with the Regional Director on 09/02/2015 at 4:15pm revealed:
-The contract pharmacy packaged multiple medications together using a bubble pack system.
-The pharmacy method of packaging medications would have to be reviewed.
-The facility would need to talk to the physician about medication times or have certain medications packaged in separate bubble packs.

Interview with the contract pharmacy provider Pharmacist on 09/04/2015 at 4:15pm revealed there was no clinical issue with the 12:00pm Calcium being crushed, but there was a process issue with the medication being administered late.

Following record review and observation of Resident #8 on the Special Care Unit, the resident was determined not to be interviewable.

5. Review of Resident #9's current FL-2 dated 07/01/2015 revealed:
-Diagnoses included alzheimers-dementia, metabolic encephalopathy, hypotension, diabetes mellitus type II, and muscle weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

(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 14 -A physician's order for Artificial Tears instill one drop into right eye four times daily. Review of a Physician's Orders sheet dated 07/29/2015 revealed a physician's order for Artificial Tears Opthalmic Solution instill one drop into right eye four times a day. Observation of the medication pass on 09/02/2015 at 1:45pm revealed Resident #9 was administered Artificial Tears one drop in the right eye. Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #9 revealed: -Printed instructions for Artificial Tears Opthalmic Solution instill one drop into right eye four times a day for burning/itchy eyes. -The Artificial Tear drops were scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. A previous interview with the MA on 09/02/2015 at 1:31pm revealed: -The 12:00pm medications were just being administered. -The 12:00pm medications were late because "everybody needs stuff" from the MA and "it's been like that way all day". -The physician had visited earlier in the morning and the MA had gotten a little behind. Following record review and observation of Resident #9 on the Special Care Unit, the resident was determined not to be interviewable. 6. Review of Resident #10's current FL-2 dated 08/19/2015 revealed diagnoses included vascular dementia, cachexia, and history of prostate	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 358	Continued From page 15 cancer. Review of a hospital discharge medication list dated 08/21/2015 revealed a physician's order for Phenytoin (used in treatment of seizure disorders) 100mg ER capsule take one tablet three times daily. Observation of the medication pass on 09/02/2015 at 1:50pm revealed Resident #10 was administered Phenytoin EX 100mg one capsule mixed in yogurt. Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #10 revealed printed instructions for Phenytoin EX 100mg capsule take one capsule three times a day and scheduled for administration at 8:00am, 12:00pm and 4:00pm. A previous interview with the MA on 09/02/2015 at 1:31pm revealed: -The 12:00pm medications were just being administered. -The 12:00pm medications were late because "everybody needs stuff" from the MA and "it's been like that way all day". -The physician had visited earlier in the morning and the MA had gotten a little behind. Interview with the contract pharmacy provider Pharmacist on 09/04/2015 at 4:15pm revealed administration of the next scheduled dose at 4:00pm was close, clinically no issue, but procedurally there was an issue with the medication being administered late. Following record review and observation of Resident #10 on the Special Care Unit, the resident was determined not to be interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 358	Continued From page 16 7. Review of Resident 11's current FL-2 dated 08/19/2015 revealed: -Diagnoses included alzheimers-dementia, brain neoplasm, intracerebral hemorrhage, and depressive disorder. -A physician's order for Prednisolone (used to treat eye inflammation) 1% in left eye four times daily. Review of a Physician's Orders sheet dated 07/29/2015 revealed: -A physician's order for Prednisolone 1% ophthalmic suspension instill one drop in the left eye four times a day. -There were no subsequent orders for the Prednisolone 1% ophthalmic suspension from 07/29/2015. Observation of the medication pass on 09/03/2015 at 11:55am revealed Resident #11 was administered Prednisolone 1% ophthalmic suspension one drop in both eyes. Review of the September 2015 Electronic Medication Administration Records (emar) for Resident #11 revealed: -Printed instructions for Prednisolone 1% Opthalmic Suspension instill one drop in the left eye four times a day for burning/itchy eyes. -The Prednisolone 1% ophthalmic suspension drops were scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Interview with the MA on 09/03/2015 at 12:00pm revealed: -The MA should have administered the eye drops in the left eye only. -The MA had forgotten the Prednisolone 1% ophthalmic suspension was only to be	D 358		

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D 358	Continued From page 17 administered in Resident #11's left eye only. Following record review and observation of Resident #11 on the Special Care Unit, the resident was determined not to be interviewable.	D 358		