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 _____	C 06/13/2016

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 survey, a follow-up survey and a complaint investigation on June 08-10 and June 13th, 2016.	D 000		
D 127	10A NCAC 13F .0403(c) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff performing Medication Aide duties had met the requirements to administer medications for 2 of 2 sampled staff (Staff B and E) who had not completed 6 hours of annual medication aide training. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired as a Medication Aide on 12/19/14. -Staff B passed the written Medication Aide test on 10/14/13. -There was no documentation that Staff B completed any Medication Administration continuing education in 2015. Interview with Staff B on 6/10/16 at 11:15am	D 127		

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 _____	C 06/13/2016

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

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D 127	Continued From page 1	D 127		

revealed:
-She had been employed at the facility before the current company took over.
-She had completed continuing education in Infection Control, Diabetes, and Coumadin, but she did not recall how many hours she had completed or when the trainings were.
-All of the training certificates would be in the personnel files in the Business Office Manager's office.

Refer to Interview with the Business Office Manager on 6/13/16 at 5:00pm.

Refer to Interview with the Administrator on 6/13/16 at 6:35pm.

2. Review of Staff E's personnel file revealed:
-Staff E was hired as a Medication Aide on 2/4/15.
-Staff E passed the written Medication Aide test on 1/25/05.
-There was no documentation that Staff E completed any continuing education related to Medication Administration in 2015.

Interview with Staff E on 6/13/16 at 4:35pm revealed:
-Staff E attended trainings at the facility as scheduled by the Business Office Manager.
-She had taken Cardio Pulmonary Resuscitation last year, but could not recall any other trainings completed.
-Management kept a record of all the training certificates.

Refer to Interview with the Business Office Manager on 6/13/16 at 5:00pm.

Refer to Interview with the Administrator on

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 _____	C 06/13/2016

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 127	Continued From page 2 6/13/16 at 6:35pm. _____ Interview with the Business Office Manager on 6/3/16 at 5:00pm revealed: -When the new company bought out the facility, the old company wiped out the personnel files. (This was at the end of 2014.) -These staff had taken several required courses for Dementia training, but she did not think those courses included medication training. -The pharmacy does trainings if needed, so she would schedule classes in medication administration for the Medication Aides. Interview with the Administrator on 6/13/16 at 6:35pm revealed: -The Business Office Manager was responsible for keeping personnel files in order. -The Business Office Manager would put reminders on the pay check stubs for the staff, and if something was not completed on time, that staff was taken off the schedule. -She would ensure that the Medication Aides received their required trainings each year.	D 127		
D 210	10A NCAC 13F .0604 (3) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (3) In addition to the staffing required for management and aide duties, there shall be sufficient personnel employed to perform housekeeping and food service duties. (f) Information on required staffing shall be posted in the facility according to G.S.	D 210		

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 _____	C 06/13/2016

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 210	Continued From page 3 131D-4.3(a)(5). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure Personal Care Aides (PCA) were not assigned the housekeeping duty of washing, drying, folding/hanging and delivering residents' laundry during the hours of 9:00am and 7:00pm. The findings are: A confidential staff interview revealed: -The staff on all shifts are responsible for doing the residents' laundry. -The staff wash, dry, fold or place on hangers and deliver the residents' clothes to their room. -We try to get it done in between taking care of the residents. Another confidential staff interview revealed: -We usually have 4 aides (Personal Care Aides/PCA) and 2 med techs (Medication Aides/MA) on day shift. -Sometimes there is an extra person assigned to laundry and that person will help the aides on the floor in between loads. -If there is no extra person, one of the PCAs will be assigned laundry in addition to their resident assignment. Observations on 6/10/16 at 9:35am revealed: -There were 2 large barrels in each of the common bathrooms on both halls. -One of the barrels contained the residents' soiled clothing; the other one contained soiled incontinent briefs, pads and towels. Confidential staff interview revealed: -One of the barrels in the common bathroom is used for soiled linens and the other is used for the resident's soiled clothing.	D 210		

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 _____	C 06/13/2016

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

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D 210	Continued From page 4	D 210		

-When the barrels are full, the staff take them to the laundry room, sort it, and load it in the washer to be washed.
-If the staff have time, they will go back to the laundry room, place the washed clothes in the dryer and load another load in the washer.

Observations of the laundry room on 6/10/16 at 9:50am revealed:
-There were clothes in the washer and clothes in the dryer,
-There were clothes hanging on a rack inside the room with the washer and dryer.
-There were clothes hanging on a rack in the entry area to the laundry room.
-There were clothes piled on shelves in the cabinet to the right in the entry area.
-There was a pile of clothes in a basket waiting to be washed.
-Some of the clothing were labeled with residents' names; some were not.

Interview with the personal care aide in the laundry room at this time revealed:
-When the clothes were done drying, the staff will place them on hangers and take them to the residents' rooms.
-If the clothes are not labeled, they leave them in the laundry room to be identified by other staff who may have seen the residents wearing the clothing.
-If no one can identify the owner of the clothing, the Administrator donates them to other residents.
-The clothes piled in the cabinet may be clothes donated by family members.

Confidential resident interview revealed:
-The resident's clothes get "missing".
-The resident's clothing gets "tangled up" with

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 _____	C 06/13/2016

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

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D 210	Continued From page 5	D 210		

other residents' clothing.
-The resident has seen another resident wearing clothes that belonged to the resident being interviewed.

Confidential interview with a resident's family member revealed:
-The resident's clothes do not come back from the laundry.
-The staff do not communicate with each about what one staff person started but did not complete.

Confidential interview with another resident's family member revealed:
-The resident's clothes get lost in the laundry.
-The staff give the resident anybody's clothing, and give the resident's clothing to other residents.
-The family member bought the resident diabetic socks that went to the laundry and never came back.
Observation of two residents in Room #212 revealed the residents were labeling clothes.

Interview with the Business Office Manager on 6/10/16 at 8:45am revealed:
-The facility had receive complaints about clothes being missing.
-The Business Office Manager had purchased stickers for staff to label the residents' clothes.
-Families would bring in clothes without the staff knowing about, so those clothes would not be labeled.
-Some residents would go in other residents' rooms and "shop."
-The facility had made a rack with each resident's name and room number, so the clothes would be hung on the rack to be passed out when the laundry was done.
-There had been times when residents would

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 _____	C 06/13/2016

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 210	Continued From page 6	D 210		

grab clothes off the rack.
-Staff did laundry on each shift.
-Yesterday, 6/9/16, one resident put on another resident's clothes and would not take them off.
-There are locks on the closet doors in the resident bedrooms.

Observation on 6/10/16 at 10:28am revealed a resident was wearing white socks with another resident's name.

Interview with a Personal Care Aide (PCA) on 6/10/16 at 11:15 am revealed:
-Extra clothes were in the laundry room that family members had returned because the clothing did not belong to certain residents.
-The clothes were usually donated to the facility.
-The PCA would come on shift and check the assignment; someone was assigned laundry every shift.

Observation of residents' closets on 6/10/16 from 10:15am-10:55am revealed:
-One closet had 1 coat, 2 sweatshirts, 1 long sleeve shirt, and 1 pair of jeans; there was one pair of socks lying on the dresser.
-24 closets were filled with clothes; some were labeled with the resident ' s name and others were not labeled.
-5 closets were locked.
-3 residents' closets had a sign on the door that "family did laundry."

Interview with the Administrator on 6/13/16 at 6:35pm revealed:
-Families had complained of missing clothes for the residents.
-The residents complained about their closets being locked or that another resident had gotten their clothes.

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	HAL071015	A. BUILDING: _____ B. WING _____	C 06/13/2016

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

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D 210	Continued From page 7 -There was no reason a resident should be wearing socks with another resident's name on them.	D 210		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure that 1 of 13 (Resident #1) residents was tested for tuberculosis (TB) upon admission. The findings are: Review of Resident #1's Resident's Register revealed: -Resident #1 was admitted on 12/09/15. -Documentation of TB was not found in Resident #1's record. Interview with the facility's Administrator on 06/13/16 at 11:40am revealed: -She was not aware that the TB testing documentation was missing from Resident #1's record. -The Administrator would contact the local hospital to see if TB testing was done prior to	D 234		

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	HAL071015	A. BUILDING: _____ B. WING _____	C 06/13/2016

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

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D 234	Continued From page 8 admission to the facility. Documentation of TB testing for Resident #1 was not available before the survey team exited. Resident #1 was not in the facility during the survey, due to being hospitalized.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that 1 of 6 residents (#9) received referral to the wound clinic as ordered for evaluation of a lower leg lesion. The findings are: Review of Resident #9's current FL2 dated 3/11/16 revealed: -Diagnoses included Alzheimer's type dementia, encephalopathy, sepsis due to anterior abdominal wall soft tissue infection, headache, fever, diarrhea, diabetes, mild dementia, pyuria, and hypokalemia. -Resident #9 was intermittently disoriented. Review of an Accident/Injury Report dated 4/14/16 revealed: -The description of the incident was that Resident #9 had a blister on top of left lower leg, inflamed with a possible skin tear and yellowish drainage. -Resident #9 was sent to the emergency room and returned with orders for home health.	D 273		

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 _____	C 06/13/2016

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

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D 273	Continued From page 9 Review of the Care Notes for Resident #9 revealed: -On 4/14/16, Resident #9 was admitted for skilled nursing for wound care due to what the resident referred to as a spider bite. -From 4/14/16-6/10/16, bactroban ointment was applied to the wound twice daily by the facility staff. (Bactroban is an antibiotic ointment used to treat infections of the skin.) -On 6/10/16, the home health nurse discharged Resident #9 due to "wounds healing well." Review of the Nurse Practitioner's (NP) Patient Encounter dated 4/20/16 revealed: -Resident #9 "may have been bitten by a spider while in bed." -Resident #9 was sent to the hospital and diagnosed with cellulitis. -Upon evaluation by the NP, Resident #9 had two lesions on her shin, one a half dollar in size and the second the size of a quarter. -Resident #9 to follow up with wound clinic for lower leg lesions. Review of a physician's order dated 4/27/16 revealed an order to follow up with wound clinic for evaluation and assist of left lower leg lesions. Review of the NP's Patient Encounter dated 5/4/16 revealed: -Home health and wound clinic were actively involved in the treatment of the lesions to Resident #9's lower leg. -The NP documented for Resident #9 to follow up with wound clinic for lower leg lesions. Review of the Home Health Nurse's (HHN) Care Notes in Resident #9's record revealed: -The HHN admitted the resident to home health	D 273		

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 _____	C 06/13/2016

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 273	Continued From page 10	D 273		

services on 4/16/16 for assessment and treatment of wounds to the left leg.
-Bactroban ointment and non-adherent dressing was applied to the wounds twice daily by the staff when the HHN did not visit Resident #9.
-The HHN discharged the resident from home health care on 6/10/16 due to wounds healed.

Interview with Resident #9 on 6/10/16 at 10:15am revealed:
-She had been bitten by a spider or bug on several occasions.
-Resident #9 had been treated for wounds on her left leg.
-Resident #9 went to the hospital and received antibiotics.
-The nurse from home health had applied ointment to the wounds until they healed.
-Resident #9 had never been to the wound clinic for the wounds on her leg.

Interview with a Medication Aide (MA) on 6/10/16 at 1:10pm revealed:
-She could not remember if Resident #9 had been to the wound clinic.
-If a resident was receiving wound care, the notes would be in the resident's record.

Interview with a second MA on 6/10/16 at 3:00pm revealed staff from the wound clinic came to the facility to provide wound care to Resident #9.

Interview with the Administrator on 6/13/16 at 6:35pm revealed:
-When Resident #9 told the staff that she had been bitten by a spider, the staff moved furniture, stripped the bed, and deep cleaned Resident #9's room.
-The Administrator did not know if the exterminator had sprayed the room.

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 _____	C 06/13/2016

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 273	Continued From page 11 -Resident #9 was sent to the hospital and was seen by home health. -The home health nurse was unable to determine what the areas were on Resident #9's leg. -Resident #9 never went to the wound clinic, because the home health nurse treated the wounds until they were healed. Attempted interview with the NP was unsuccessful at the time of exit.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain weights as ordered by the physician for 1 of 6 sampled residents (#3) and failed to obtain accuchecks as ordered for 1 of 6 sampled residents (#3). The findings are: Review of Resident #3's FL2 dated 12/17/15 revealed: -Diagnoses included vascular dementia, recurrent falls with evidence of loss of consciousness, gait disturbance, stroke, hypertension, congestive	D 276		

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 _____	C 06/13/2016

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 276	Continued From page 12	D 276		

heart failure, and lymphoma.
-Resident #3 was semi-ambulatory and required the use of a wheelchair.

Review of the Resident Register for Resident #3 revealed an admission date of 12/18/15.

A. Review of a physician's order dated 1/6/16 revealed an order to obtain weekly weights on Tuesday.

Interview with a Personal Care Aide (PCA) on 6/9/16 at 10:00am revealed:
-Most residents were weighed monthly unless they had a physician's order to weigh more often.
-The Medication Aide (MA) would let the PCA know of any weights that were ordered daily or weekly.
-The weight logs were kept in a notebook at the nurse's station.

Interview with a second PCA on 6/9/16 at 2:40pm revealed:
-The PCA worked first shift.
-She recalled Resident #3, but did not recall ever weighing Resident #3.
-The weights would be in the notebook at the nurse's station.

Review of the Monthly Weight and Vital Signs log for Resident #3 revealed:
-Resident #3 was weighed in January 2016 and the result was 130 pounds.
-Resident #3 was weighed in February and March 2016 and the result was documented as 127 pounds each time.

Interview with a family member for Resident #3 on 6/10/16 at 9:25am revealed:
-Resident #3 was discharged from the facility on

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 _____	C 06/13/2016

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 276	Continued From page 13	D 276		

4/14/16 and taken home with the family member.
-She did not recall Resident #3 ever being weighed when she visited.
-Resident #3 had lost weight, but she did not know how much weight.

Interview with a MA on 6/13/16 at 11:45am revealed:
-The MA recalled Resident #3.
-She did not recall Resident #3 being a weekly weight.
-Most of the time, weekly or daily weights would be on the Medication Administration Record (MAR) so the MAs could document the weights when obtained.
-The log at the nurse's station was for the residents who were weighed monthly.
-All residents were weighed monthly if they did not have an order to do more often.
-Facility policy was to weigh all residents every month unless the physician gave a specific order to weigh more frequently.

Review of Resident #3's MAR for January-April 2016 revealed no entry for weekly weights, on Tuesdays.

Refer to telephone interview with the former Memory Care Manager (MCM) on 6/13/16 at 3:30pm.

Interview with the Administrator on 6/13/16 at 6:35 pm revealed:
-The MA or the MCM was responsible for processing new orders.
-The facility did not have an MCM at the present time, but was in the process of hiring someone.
-There were several orders found in the MCM's office that had not been filed in the record.
-The monthly weight and vital sign log for

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 _____	C 06/13/2016

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 276	Continued From page 14 Resident #3 was the only documentation she had found regarding weights. B. Review of a physician's order dated 1/31/16 revealed; -There was an order to obtain accuchecks before meals and at bedtime for 7 days, and notify with blood glucose less than 80 or greater than 300. -If blood glucose within normal limits, start blood glucose checks daily and document. -If blood glucose remained elevated, continue with before meals and at bed time and document. Review of Resident #3's Medication Administration Record (MAR) for February 2016 revealed: -There was a computer generated entry for accuchecks before each meal and at bedtime, document, and notify physician if blood sugar is less than 80 or greater than 300. -The scheduled times on the MAR to obtain the accuchecks was at 6:00am and 8:00pm. -The first accucheck result documented was on 2/23/16 at 8:00pm. -The results documented ranged from 88 to 144. -There was no entry or documentation for accuchecks to be obtained for 7 days beginning 1/31/16 per the physician's order. Review of Resident #3's MAR for March 2016 revealed: -There was an entry for accucheck before each meal and at bedtime and document; notify physician if blood sugar is less than 80 or greater than 300. -The accuchecks were scheduled to be obtained at 6:00am and 8:00pm. -The results ranged from 88-177.	D 276		

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 _____	C 06/13/2016

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 276	Continued From page 15 Review of Resident #3's MAR for April 2016 revealed: -There was an entry for accucheck before each meal and at bedtime and document; notify physician if blood sugar is less than 80 or greater than 300. -The accuchecks were scheduled to be obtained at 6:00am and 8:00pm. -The results ranged from 96-162. Interview with a MA on 6/13/16 at 11:45am revealed: -The MA recalled Resident #3. -Accuchecks ordered before each meal and at bedtime would be obtained at 7:30am, 11:30am, 4:30pm, and 8:00pm. -She did not know why the blood sugars were not obtained daily for 7 days nor why the blood sugars were not obtained until 2/23/16 of the order was written on 1/31/16. Refer to telephone interview with the former Memory Care Manager (MCM) on 6/13/16 at 3:30pm. Interview with the Administrator on 6/13/16 at 6:35 pm revealed: -The MA or the MCM was responsible for processing new orders. -The facility did not have an MCM at the present time, but was in the process of hiring someone. -There were several orders found in the MCM's office that had not been filed in the chart. -The Administrator could not find any documentation or communication with the physician as to why the accuchecks were not started until 2/23/16. _____	D 276		

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 _____	C 06/13/2016

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 276	Continued From page 16 Telephone interview with the former Memory Care Manager (MCM) on 6/13/16 at 3:30pm revealed: -She had not been working at the facility for about 2 weeks. -She recalled Resident #3, but did recall specific orders. -The MCM or the MA was responsible for faxing orders to the pharmacy and making follow-up appointments with the physician. -Usually, if a resident was to be weighed more often than monthly, the order was faxed to the pharmacy so it could be put on the MAR. -The MCM was responsible for ensuring that physician orders were carried out, MARs were accurate, and that the staff knew of any new orders or changes.	D 276		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that residents, who did not come to the dining room during snack times of 10:00am and 3:00pm, received a snack. The findings are: Observation on 6/8/16 at 10:21 am revealed: -Sixteen residents were observed in the dining room eating peaches. -Twelve residents were in their bedrooms down	D 298		

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 _____	C 06/13/2016

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 298	Continued From page 17	D 298		

the 200 hall during this time.
-Four residents were in their bedrooms down the 100 hall during snack time.
-No snacks were provided to residents who were in their bedrooms.

Observations on 6/10/16 at 10:15am revealed:
-19 residents were in the dining room for snack.
-Resident #4 and Resident #5 were not in the dining room.

Observations on 6/10/16 at 10:28am revealed:
-Resident #5 and his roommate were in their room.
-Both residents who resided in room 115 were in their room.
-One of the residents who resided in room 109 was in her room lying down.
-Resident #4 was in his room.
-The resident who resided in room 201 was in his room.

Interview with Resident #5 on 6/10/16 at 10:20am revealed he wanted a snack.

Confidential staff interview revealed residents come to the dining room for snacks. "We serve them snacks in the dining room."

Another confidential staff interview revealed the residents come to the dining room for snack. "I've never been told to take snacks to the residents' rooms."

A third confidential staff interview revealed residents are served snacks in the dining room.

Interview with the Administrator on 6/10/16 at 10:30am revealed residents in their rooms are supposed to get snacks.

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 _____	C 06/13/2016

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 298	Continued From page 18 Observations on 6/10/16 at 10:35am revealed staff were serving snacks to the residents who were in their rooms.	D 298		
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: Type B Violation Based on observation, interviews and record reviews, the facility failed to serve nutritional supplements and thickened liquids to 2 of 3 residents sampled who had a physician's order for honey thick liquids (Resident #11) and who was ordered 2 different nutritional supplements (Resident #6). The findings are: 1. Review of Resident #11's current FL2 dated 2/17/16 revealed: -Diagnoses included Alzheimer's disease, Hypertension, Arthritis and Degenerative Joint Disease. -The resident was non-ambulatory and intermittently disoriented. -There was no information regarding the resident's diet. Review of the resident's diet order dated 11/18/15 revealed the resident was ordered a mechanical	D 310		

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 _____	C 06/13/2016

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 310	Continued From page 19	D 310		

soft diet with honey thick liquids. (Thickened liquids are used to help prevent choking and fluid from entering the lungs when thin liquids are difficult to swallow.)

Observations on 6/9/16 at 3:15pm revealed:
-Resident #11 was in the dining room while snacks were being served.
-The resident was drinking an orange colored liquid that had not been thickened.
-The resident drank all of the liquid and was given more.
-The resident began to clear his throat but did not choke.
-Upon notification, the Business Office Manager (BOM) removed the cup with the remaining liquid.

Observations during meal service on 6/8/16 at 12:22pm and 5:25pm and on 6/9/16 at 7:45am and 5:45pm, the resident was served thickened water and tea.

Interview with the BOM on 6/9/16 at 3:15pm revealed:
-The facility orders the pre-thickened water and tea for Resident #11.
-The BOM would look to see if they could order some thickened juice or other thickened liquids for snack time.

Observations on 6/10/16 at 10:17am revealed:
-Resident #11 was in the dining room while snacks were being served.
-The resident was drinking an orange colored liquid which had not been thickened.
-The resident drank over half the liquid.
-No staff attempted to stop the resident from drinking the unthickened liquid.
-Upon notification, the Administrator requested the cup from the resident and attempted to

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 _____	C 06/13/2016

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 310	Continued From page 20	D 310		

remove the cup of liquid but the resident would not let her have it.
-The resident drank the remaining liquid.

On 6/10/16 at 10:22am, the Administrator and a Personal Care Aide (PCA) provided the following information:
-The PCA did not serve the unthickened liquid to Resident #11.
-The PCA placed the drink on the table for another resident and Resident #11 grabbed the drink and began drinking it.

2. Review of Resident #1's current FL-2 revealed: diagnoses included vascular dementia, impaired mobility and inability to perform activities of daily living (routine personal care, toileting and food preparation).

Review of a physician's order dated 01/12/16 revealed:
-Resident #1 was to have a Mighty Shake (a calorie dense supplement) three times per day and at bedtime.
-Resident #1 was to also have a Magic Cup (a calorie dense supplement) three times per day.

Review of Resident #1's Medication Administration Record (MAR) revealed:
-Resident #1 was given his first Mighty Shake on 05/04/16 at 4pm.
-The original order date listed on the MAR for the Mighty Shakes was 05/04/16.
-The order for Magic Cups was not on the MAR.

Interview with a medication aide (MA) on 06/13/16 at 1:20pm revealed:
-The documentation for ordered dietary supplements was done on the MAR.
-The MA was not aware that Magic Cups had

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 _____	C 06/13/2016

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 310	Continued From page 21 been ordered for Resident #1. Interview with the Administrator on 06/13/16 at 2:45pm revealed: -The Administrator could not explain the lapse of time between the Mighty Shake order and when Resident #1 began receiving the supplement. -The Administrator could not explain why the order for Magic Cups was never listed on the MAR. Resident #1 was in the hospital and was not available for interview. Review of the facility's Plan of Protection dated 6/10/16 revealed: -A staff member will immediately be assigned to the resident's table who is on thickened liquid to ensure he is served his beverage first. -The resident will be provided a sufficient amount of liquids to prevent him from attempting to obtain other residents' drinks during meals and snacks. -A "SIC" [supervisor-in-charge] or department head will supervise meals and snacks. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 28, 2016.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's	D 312		

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 _____	C 06/13/2016

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 312	Continued From page 22 dignity and respect. This Rule is not met as evidenced by: Type B Violation Based on observation, record review and interviews, the facility failed to provide feeding assistance with eating during 5 of 5 meals observed. The findings are: Observations during the lunch meal on 6/8/16 revealed: -At 12:00pm, most residents were seated in the dining room. -Two Medication Aides (MA) and 4 Personal Care Aides (PCA) were serving plates of food to the residents. -At 12:05pm, Resident #5 was rolled in the wheelchair to a small room (the Chapel) across the hall from the dining room. -At 12:09pm, Resident #2, who was seated at a table in the dining room in her wheelchair, was served pureed peas, macaroni and cheese, fish, tea and water. -At 12:11pm, Resident #2 attempted to eat the pureed food with her fingers. -At 12:25pm, staff attempted to assist the resident to eat but the resident ate only 10% of the meal. -Resident #4 was being fed by a family member. -Flies were landing on residents and their food throughout the meal. Interview with the Administrator on 6/8/16 at 6:15pm revealed the exterminator had been in the facility earlier in the day. Observations during the breakfast meal on 6/9/16 between 7:38am and 8:30am revealed: -Most residents were seated in the dining room.	D 312		

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 _____	C 06/13/2016

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 312	Continued From page 23	D 312		

-The PCAs were serving breakfast plates to the residents.
-The residents were served one pancake, one sausage link and a small bowl of fruit.
-One resident was observed with flies landing on her and her food. No staff intervened to shew the flies from the resident and her food.
-Resident #12 was eating with the fingers of her right hand and holding a fork and spoon in her lap in her left hand while flies landed on her and her food. No staff intervened to assist the resident or cue the resident.
-Resident #4 was holding and eating a dry pancake, no syrup, with his hand. No staff intervened to assist the resident to eat.
-At 8:14am, Resident #2 was brought to the dining room and served applesauce and pureed sausage and pancake. The resident ate less than 25% of the meal. No assistance was provided.
-A PCA pulled a resident, who was trying to grab another resident's food, up out of the chair by the resident's wrist.

Observations of the lunch meal on 6/9/16 between 12:15pm and 12:35pm revealed:
-Most residents were seated in the dining room.
-The Business Office Manager (BOM), MAs and PCAs were serving lunch plates to the residents.
-The residents were served chicken fingers, mixed vegetables, collards, mashed potatoes, a roll, water, tea and banana pudding.
-Resident #5 was rolled in the wheelchair to the Chapel across the hall from the dining room. Another resident was brought in to the small table with Resident #5. When Resident #5's meal was served, the other resident immediately reached over to grab food from Resident #5's plate.
-Resident #12 was observed eating with her fingers. No staff intervened to assist or redirect

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 _____	C 06/13/2016

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 312	Continued From page 24	D 312		

the resident to use a utensil.
-Resident #13 was observed putting collards in her tea. No staff intervened to redirect the resident.
-Another resident was scraping the chopped chucked and mashed potatoes from her plate to the table. No staff intervened to assist or redirect the resident.
-Flies were landing on residents and their food throughout the meal.

Observations of the dinner meal on 6/9/16 between 5:15pm and 5:45pm revealed:
-Most residents were seated in the dining room.
-The PCAs were serving dinner plates to the residents.
-The residents were served mixed vegetables, beef stew and gravy over rice, a roll, tea and water.
-Resident #2 was served mixed vegetables, a roll, banana pudding and pureed beef and rice. The resident ate approximately 20% of the meal. No staff intervened to prompt the resident to eat more or assist the resident.
-Resident #4 was not in the dining room.
-Resident #12 was eating with her fingers, drank another resident's water and reached for another resident's roll.
-Resident #11 reached over and took a roll from another resident's plate and ate it.

Observations of the lunch meal on 6/10/16 between 11:50am and 12:15pm revealed:
-Most residents were seated in the dining room.
-The MAs and PCAs were serving dinner plates to the residents.
-The residents were served ham, potatoes, squash, green beans, corn bread, tea and water.
-A resident was observed scraping her food in a napkin on the table. No staff intervened to

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 _____	C 06/13/2016

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 312	Continued From page 25 redirect or assist the resident to eat. Observation on 6/13/16 at 8:05am revealed: -Ten residents were seated at a long table (several small tables placed side by side). -Two staff, one at each end of the table, were seated among the residents. -One staff was feeding two residents. -The second staff was assisting a third resident with breakfast. Review of the facility's Plan of Protection dated 6/10/16 revealed: -We will immediately group residents according to those needing assistance with feeding, those that need cueing. -Tables will be rearranged to accommodate these groups. -Staff will provide assistance with eating. -Staff will be trained on the new dining arrangement. Meals and snacks will be monitored by an "SIC" [supervisor-in-charge] or department head. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 28, 2016.	D 312		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record	D 338		

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 _____	C 06/13/2016

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 338	Continued From page 26	D 338		

review, the facility failed to ensure residents were treated with respect, and dignity by placing Resident #8's mattress directly on the floor.

The findings are:

Observation during the facility tour of Resident #8's room, #205, on 6/8/16 at 10:16am revealed:
-There was a mattress lying on the floor covered by a fitted sheet.
-The mattress was located to the right of the door and against the wall.
-There was a hospital bed on the opposite side of the room.
-Resident #8 was lying in the hospital bed.
-Resident #8's roommate was not in the room during the tour.

Interview with a Personal Care Aide (PCA) on 6/8/16 at 10:18am revealed:
-Resident #8 often got in her roommate's bed.
-Resident #8 was confused most of the time.
-The mattress on the floor in Room #205 was Resident #8's.
-It had been on the floor for "a long time."
-The mattress was on the floor because Resident #8 had a history of falls.
-Resident #8 had not fallen in several months that the PCA could recall.

Observation of Resident #8 on 6/9/16 at 7:45am revealed Resident #8 was lying on top of the mattress on the floor.

Review of Resident #8's current FL2 dated 10/30/15 revealed:
-Diagnoses included vascular dementia, Parkinson's disease, coronary artery disease, chronic obstructive pulmonary disease, and nausea/vomiting.

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 _____	C 06/13/2016

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 338	Continued From page 27	D 338		

-Resident #8 was intermittently disoriented.
-Resident #8 was semi-ambulatory, incontinent of bladder, and total care.

Review of physician's orders in Resident #8's record revealed no order for the mattress to be on the floor.

Review of Resident #8's Resident Service Plan dated 12/7/15 revealed:
-Resident #8 was totally dependent in all activities of daily living.
-There was no documentation that Resident #8's mattress was on the floor.

Review of the Interdisciplinary Notes for Resident #8 revealed no documentation that Resident #8 had a recent fall.

No incident reports were provided for Resident #8.

Interview with a second PCA on 6/10/16 at 3:00pm revealed:
-Resident #8 had a history of falls, but no recent falls that she "knew of."
-The reason for the mattress being on the floor was because Resident #8 had fallen several times.
-Resident #8 would get in her roommate's bed from time to time.
-The PCA did not know if Resident #8 had fallen out of the bed prior to the mattress being placed on the floor.

Observation of Resident #8 on 6/10/16 at 3:15pm revealed Resident #8 was lying on the mattress with her eyes closed.

Interview with the Administrator on 6/13/16 at

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 _____	C 06/13/2016

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 338	Continued From page 28 8:35am revealed: -Resident #8 had an order from the physician for the mattress to be on the floor. -The order was in place before the Administrator began working at the facility in December 2014. -Resident #8 had transitioned from hospice twice because she had improved significantly. -Resident #8 was falling prior to the mattress being in place, but since the mattress was ordered to be placed on the floor, Resident #8 has had no falls other than from sitting to standing from the wheelchair. -The staff had been talking to the physician about getting a low bed since Resident #8 had been doing so well. -The Administrator would locate the order from the physician to put the mattress on the floor. Review of a physician's order dated 4/15/15 and provided by the Administrator revealed "patient to have mattress on floor due to safety issues."	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed	D 358		

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 _____	C 06/13/2016

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 29	D 358		

prescribing practitioner for 3 of 7 residents (#2, #6, #7) including errors with a protein pump inhibitor (#2 and #7), errors with a benzodiazepine, a narcotic pain reliever (#6), errors with an anti-psychotic (#7) and errors with prn(as needed) medications for breathing difficulties (#6). The findings are:

1. Review of the current FL2 for Resident #7 dated 4/19/16 revealed:
-Diagnoses included dementia rule out dementia of the Alzheimer's type, coronary artery disease, hyperlipidemia, hearing loss, hypertension, and muscular degeneration.
-Medication orders included Nexium 20mg every morning with breakfast and Zyprexa 10mg every night.

A. Observation during the medication pass on 6/9/16 at 7:25am revealed:
-The resident did not receive the ordered Nexium.
-There was no Nexium on the medication cart to be administered.

Interview with the Medication Aide (MA) on 6/9/16 at 7:30am revealed:
-Resident #7 had not been receiving the ordered Nexium because his family had not brought the medication to the facility.
-The medication had not been administered since May 31, 2016.

Review of the Medication Administration Record (MAR) for June 2016 revealed:
-There was a computer generated entry for Nexium 20mg every morning before breakfast (family provides.)
-The scheduled time of administration was 6:30am.

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 _____	C 06/13/2016

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

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D 358	Continued From page 30 -From 06/01/16-06/07/16, the documentation on the MAR read "New Order" as the reason for not administering Nexium to Resident #7. -On 06/08/16, the Nexium was documented as administered to Resident #7. -On 06/09/16, the documentation on the MAR read "New Order" as the reason for not administering the Nexium. Interview with the MA on 6/9/16 at 10:00am revealed: -When documenting the reason for not giving a medication to a resident, "new order" meant that the medication was not available and the staff was waiting on the medication to be brought in to the facility. -The MA had not called Resident #7's family member herself regarding the medication, but she knew that the family member had been contacted by another staff. -They had been having difficulty getting Resident #7's medications on time, because the family member did not bring the medications to the facility in a timely manner. -The staff would notify the family member when the resident's medications had 7 days remaining to give the family time to get the medications refilled, picked up, and brought to the facility. Interview with the Administrator on 6/9/16 at 11:20am revealed: -Resident #7's family member came to the facility once a month to pay the bill and bring his medications since he used an outside pharmacy. -It had been an ongoing issue that the family member did not bring Resident #7's medications on time and it appeared as though the facility staff were not giving the medications. -The facility had discussed with the family member the possibility of making a referral to the	D 358		

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 _____	C 06/13/2016

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

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D 358	Continued From page 31	D 358		

county Adult Protective Services because she would not bring the medications in timely.
-The staff should be documenting on the care notes when the daughter had been contacted so that it was obvious the staff had been making efforts to obtain the medications.

Review of Resident #7's care notes revealed:
-On 5/20/16, the staff documented that the resident's family member was called for medication refills at 3:00pm, and the pharmacy was contacted who informed the staff that the family member would be notified when the medications were ready to be picked up.
-There was no additional documentation that the family member or the daughter had been contacted regarding medication refills.

Telephone interview with Resident #7's family member/responsible party on 6/9/16 at 1:50pm revealed:
-Someone from the facility had just contacted the family member on the morning of 6/9/16 and informed the family member that the Nexium had been discontinued.
-The family member was told that a new medication was started, but she could not remember the name of the staff or medication that was ordered.
-The staff usually notified the family member when the medications were getting low, but there had been times when Resident #7 was completely out of a medication before the family member was notified.
-The pharmacy automatically refilled the medications once a month.
-The family member would pick up the medications from the pharmacy and take them to the facility every month.
-The facility had not notified the family member

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 _____	C 06/13/2016

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

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D 358	Continued From page 32 "in a while, not this month" about needing any refills. Interview with the Administrator on 6/9/16 at 4:00pm revealed the Nexium was in the medication room and the staff did not realize it was there. Observation of medications on hand on 6/13/16 at 11:35am revealed there was a bottle of over-the-counter Nexium (quantity 30 capsules) with 11 capsules on hand; there was no date indicating when the bottle was opened. B. Review of Resident #7's Medication Administration Record (MAR) for June 2016 revealed: -There was a computer generated entry for Zyprexa 10mg every night at bedtime (outside pharmacy.) -The scheduled administration time was 8:00pm. -From 06/01/16-06/08/16, the documentation on the MAR read "New Order" as the reason for not administering Zyprexa to Resident #7. Observation of medications on hand on 6/13/16 at 11:35am revealed: -There was a bottle of Zyprexa 2.5mg tablets that was filled on 5/20/16. -Ninety tablets were filled on 5/20/16 and 88 tablets remained on hand. -The label read Zyprexa 2.5mg tablet at bedtime. -There was a second bottle of Zyprexa 2.5mg tablets that was filled on 3/31/16. -Ninety tablets were filled on 3/31/16 and ninety tablets remained on hand. -The label read Zyprexa 2.5mg tablet at bedtime. Interview with a Medication Aide (MA) on 6/13/16	D 358		

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 _____	C 06/13/2016

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 33 at 5:05 pm revealed: -The order for Zyprexa was 10mg at bedtime. -The MA assumed Resident #7 was getting the correct dose even though the label on the bottle of Zyprexa was for 2.5mg. -Resident #7 should be getting 4 of the 2.5mg tablets. -The order must not have been faxed to the outside pharmacy that Resident #7 used because the facility ' s MAR had the correct order of Zyprexa 10mg take every night at bedtime. Telephone interview with Resident #7's Pharmacy Provider on 6/13/16 at 6:19pm revealed: -On 5/20/16, a prescription for Zyprexa 2.5mg, one tablet daily, was filled and 90 tablets were dispensed. -The medication was picked up on 6/1/16. -On 12/5/15, a prescription for Zyprexa 2.5mg, one tablet daily, was filled and 90 tablets were dispensed. -There was no order on file for Zyprexa 10mg tablets. -The only other order on file was for Zyprexa 5mg tablets that was dated 6/16/15. Interview with the Administrator on 6/13/16 at 6:35pm revealed: -"I would hope Resident #7 had a backup pharmacy." -The facility did not know what pharmacy the family member for Resident #7 used. -The facility had no communication with that pharmacy. -The family member would bring in medications that were still being filled, but the order had been discontinued. -If a new order was written for a new medication, the facility held on to the order until the family member came, and the order would then be	D 358		

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 _____	C 06/13/2016

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

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D 358	Continued From page 34	D 358		

given to the family to take to the pharmacy to get filled.
-When the medications got low, the MAs would call the family member so she could pick up the refills.
-Resident #7 did not use the facility's phamarcy because his family member preferred to use the local pharmacy.

Observation of Resident #7 throughout the survey revealed Resident #7 did not have any behaviors observed.

2. Review of Resident #2's current FL2 dated 11/16/15 revealed:
-Diagnoses included Alzheimer's type Dementia, Hypertension, weight loss, Anxiety/Depression, unsteady gait and Gastritis.
-Resident #2 was documented as constantly disoriented.
-The resident required personal care assistance (total care) with bathing, "feeding" and dressing.
-Medications included Protonix 40mg daily. (Protonix is used to decrease the amount of acid produced in the stomach.)

Review of a physician's order dated 1/16/16 revealed an order for Protonix 40mg daily.

Review of Resident #2's Medication Administration Records (MAR) for April 2016 and May 2016 revealed:
-Protonix 40mg was scheduled to be administered daily at 6:30am.
-The Medication Aide's initials had been documented and circled on 4/30/16, 5/1/16, 5/5/16, 5/6/16 and 5/7/16.
-The reason for not administering the Protonix, documented as " Exceptions for [Resident #2's name] " on both MARs was "New Order" .

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 _____	C 06/13/2016

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

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D 358	Continued From page 35 Interview with a Medication Aide on 6/13/16 at 5:30pm revealed the Medication Aides had been told by the previous Memory Care Coordinator to document " new order " anytime the medications were not in the facility, available for administration to the residents. Confidential interview with a representative from the pharmacy used by the resident revealed a 30-day supply of Protonix 40mg was dispensed to the facility on March 28, 2016, April 25, 2016 and May 26, 2016 and should have been available in the facility to be administered. Observations of Resident #2 during mealtime throughout the survey on 6/8-10/16 revealed the resident did not eat 50% of the meal served. 3. Review of Resident #6's FL-2 dated 03/26/16 revealed: -Diagnoses included vascular dementia and chronic opioid dependency. -Medications included Oxycodone (an opioid pain mediation) 15 milligrams (mg), 1 tablet four times a day and Duo Neb solution (used to treat shortness of breath and wheezing associated with chronic lung disorders) administer one vial via hand held nebulizer by mouth every four hours as needed for wheezing or shortness of breath. A. Review of Resident #6's electronic Medication Aministration Record (eMAR) for April 2016 revealed: -Eighteen doses of Oxycodone were not given per MD's orders. -Exceptions documented for the Oxycodone were	D 358		

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 _____	C 06/13/2016

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 36	D 358		

'new order' seventeen times and 'med not in facility' once.
-Dates of the missed doses were from 04/09/16 through 04/13/16.

Telephone interview with pharmacy staff revealed:
-The original prescription for the Oxycodone was dated 03/23/16 and was a fifteen day (60 tablets) supply.
-The 03/23/16 prescription would have lasted until 04/07/16.
-The first refill for Oxycodone was dated 04/13/16 and was for a thirty day (120 tablets) supply.
-Each refill for Oxycodone required a written prescription signed by the ordering physician.

Interview with a medication aide (MA) on 06/10/16 at 4:10pm revealed:
-The 'new order' documentation on the eMAR referred to a new prescription needed for the medication.
-The MA stated that non-controlled drugs were on automatic refills.
-The MA could not explain how controlled drugs, such as Oxycodone, were refilled.

Interview with the Administrator on 06/10/16 at 5:20pm revealed:
-Shecould not explain why so many doses of Resident #6's medication were not given.
-The Administrator stated that the facility was in the process of establishing a different medication re-ordering system with the pharmacy.

B. Review of physician's orders for Resident #6 revealed:
-An order dated 04/15/16 for alprazolam 0.5 mg tablet by mouth every four hours as needed for panic attacks and anxiety.

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 _____	C 06/13/2016

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 37	D 358		

-An order dated 04/25/16 for Proair HFA AER (used to treat acute shortness of breath and wheezing) 2 puffs by mouth four times as needed for wheezing.
-An order dated 03/24/16 for DuoNeb 1 vial by hand held nebulizer every four hours as needed for wheezing or shortness of breath.

Review of Care Notes for Resident #6 revealed:
-Resident#6 was sent to local emergency department (ER) on 05/25/16 at 4pm.
-Resident was in distress and was having a difficult time breathing.
-Resident returned at 9:30pm from the ER with [a] diagnoses of acute dyspnea (difficulty breathing), COPD, [and] unspecified COPD type, and anxiety.

Review of Resident #6's electronic Medication Administration Record (eMAR) for May 2016 revealed:
-The ordered Duo Neb for shortness of breath and wheezing was not given prior to ER visit.
-The ordered alprazolam 0.5mg was not given for anxiety.

Observation of medications on hand on 06/10/16 at 4pm for Resident#6 medications revealed that both Duo Neb and alprazolam were available.

Interview with the Administrator on 06/10/16 at 5:20pm revealed;
-The Administrator could not explain why the ordered prn (as needed) medications were not given.
-She would contact the medication aide (MA) working that shift to see if further information could be obtained.

At 6pm on 06/10/16 the Administrator stated that

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 _____	C 06/13/2016

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 38 the MA working on 05/25/16 3pm-11pm recalled that Resident #6 had refused all offered prn medications and the MA had forgotten to document the refusal.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 42 of 45 shifts from 1/20/16-1/27/16 and 3/8/16-4/14/16; 8 of 15 shifts during the week of 4/19-23/16, and 10 of 15 shifts during the week of 5/26-30/16. The findings are: A confidential staff interview revealed: -The staff on all shifts are responsible for doing the residents' laundry. -The staff wash, dry, fold or place on hangers and deliver the residents' clothes to their room. -"We try to get it done in between taking care of the residents."	D 465		

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 _____	C 06/13/2016

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

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D 465	Continued From page 39	D 465		

Another confidential staff interview revealed:
-"We usually have 4 aides (Personal Care Aides/PCA) and 2 med techs (Medication Aides/MA) on day shift."
-Sometimes there is an extra person assigned to laundry and that person will help the aides on the floor in between loads.
-If there is no extra person, one of the PCAs will be assigned laundry in addition to their resident assignment.

A third confidential staff interview revealed:
-Now, we usually have 2 "med techs" and 4 "aides" on the 2nd shift.
-Sometimes we might have 5 aides on second shift and 1 "med tech".
-Up until a couple of months ago, "we had 4 aides and 1 med tech working on 2nd shift."

A fourth confidential interview revealed:
-Usually on 2nd shift, there are 4 aides and 2 "med techs". Sometimes, there is only 1 "med tech" on 2nd shift.
-There are usually 4 staff on 3rd shift, 3 aides and 1 "med tech". Sometimes, there are 3 staff total on 3rd shift, including the "med tech".

A fifth confidential staff interview revealed:
-Until recently, there was always 1 "med tech" and 4 aides on 2nd shift.
-Now, there are usually 2 "med techs" and 4 aides.

Review of the Special Care Unit (SCU) daily census for 1/20/16-1/27/16 revealed:
-The total census for the SCU from 1/20/16-1/27/16 was 54 residents except on 1/25/16, there were 53.
-The staffing requirements for the SCU with a census of 54 was 6 staff plus 6.0 additional staff

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 _____	C 06/13/2016

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 465	Continued From page 40	D 465		

hours for first and second shift, and 5 staff plus 3.2 additional staff hours for third shift.
-The staff requirements for the SCU with a census of 53 was 6 staff plus 5.0 additional staff hours for first and second shift, and 5 staff plus 2.4 additional staff hours for third shift.

Review of the staff schedule created by the Business Office Manager for January 2016 revealed:
-On 1/20/16, 8 staff were scheduled to work first shift, 6 staff were scheduled to work second shift, and 5 staff were scheduled to work third shift.
-On 1/21/16, 7 staff were scheduled to work first and second shift, and 5 staff were scheduled to work third shift.
-On 1/22/16, 6 staff were scheduled to work first and second shift, and 5 staff were scheduled to work third shift
-On 1/23/16, 9 staff were scheduled to work first shift, 6 staff were scheduled to work second shift, and 4 staff were scheduled to work third shift.
-On 1/24/16, 7 staff were scheduled to work first shift, 6 staff were schedule to work second shift, and 4 staff were scheduled to work third shift.
-On 1/25/16, 6 staff were scheduled to work first and second shift, and 5 were scheduled to work third shift.
-On 1/26/16, 9 staff were scheduled to work first shift, 8 staff were scheduled to work second shift, and 5 staff were scheduled to work third shift.
-On 1/27/16, 7 staff were scheduled to work first shift, 6 staff were scheduled to work second shift, and 5 staff were scheduled to work third shift.

Review of the Time & Attendance report for 1/20/16 revealed:
-Staffing for the SCU was less than the state requirements of 54 hours for first and second shift, and 43.2 hours for third shift.

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 _____	C 06/13/2016

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D 465	Continued From page 41	D 465		

-On first shift, the SCU had 8 staff clocked in for SCU assignments equal to 44.30 hours.
-The facility staffing was short by 9.7 hours for first shift.
-On second shift, the SCU had 6 staff clocked in for SCU assignments equal to 40.15 hours, with 8 of the hours carried over from first shift.
-The facility staffing was short 13.85 hours for second shift.
-On third shift, 5 staff clocked in for SCU assignments equal to 36.37 hours.
-The facility staffing was short 6.83 hours for third shift.

Review of the Time & Attendance report for 1/21/16 revealed:
-Staffing for the SCU was less than the state requirements of 54 hours for second shift and 43.2 hours for third shift.
-On second shift, the SCU had 8 staff clocked in for SCU assignments equal to 41.60 hours, with 12 of the hours carried over from first shift.
-The facility staffing was short 12.4 hours for second shift.
-On third shift, 5 staff clocked in for SCU assignments equal to 37.46 hours.
-The facility staffing was short 5.74 hours for third shift.

Review of the facility's daily census for 4/19/16 revealed the census was 50 requiring 50 hours of staff time on first and second shifts and 40 hours of staff time on third shift.

Review of the facility's Time and Attendance-Employee Punch history for 4/19/16 revealed the facility provided only 33.42 staff hours for 2nd shift.

Review of the facility's daily census for 4/20-23/16

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	HAL071015	A. BUILDING: _____ B. WING _____	C 06/13/2016

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D 465	Continued From page 42	D 465		

revealed the census was 51 requiring 51 hours of staff time on first and second shifts and 40.8 hours of staff time on third shift.

Review of the facility's Time and Attendance-Employee Punch history revealed:
- On 4/20/16, the facility provided only 36.93 staff hours for 2nd shift and only 35.7 for 3rd shift.
- On 4/21/16, the facility provided only 37.85 staff hours for 2nd shift.
- On 4/22/16, the facility provided only 37.83 staff hours for 2nd shift and only 31.44 for 3rd shift.
- On 4/23/16, the facility provided only 37.04 staff hours for 2nd shift and only 23.25 for 3rd shift.

Review of the facility's daily census for 5/26/16 revealed the census was 49 requiring 49 hours of staff time on first and second shifts and 39.2 hours of staff time on third shift.

Review of the facility's Time and Attendance-Employee Punch history for 5/26/16 revealed the facility provided only 44.87 staff hours for 2nd shift.

Review of the facility's daily census for 5/27-30/16 revealed the census was 50 requiring 50 hours of staff time on first and second shifts and 40 hours of staff time on third shift.

Review of the facility's Time and Attendance-Employee Punch history revealed:
- On 5/27/16, the facility provided 38.22 staff hours for 2nd shift and 30.14 for 3rd shift.
- On 5/28/16, the facility provided 36.17 staff hours for 2nd shift and 29.72 for 3rd shift.
- On 5/29/16, the facility provided 40.49 staff hours for 1st shift, 45.35 for 2nd shift, and 35.80 for 3rd shift.
- On 5/30/16, the facility provided 46.54 staff

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	HAL071015	A. BUILDING: _____ B. WING _____	C 06/13/2016

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D 465	Continued From page 43 hours for 2nd shift and 35.84 for 3rd shift. Telephone interview with the former Memory Care Coordinator (MCM) on 6/13/16 at 3:30pm revealed: -The Business Office Manager did the staffing schedule. -The MCM could not work all shifts, so some shifts went lacking for staff. -On first shift, there was no more than six staff, two MAs and 4 PCAs. -Second shift usually had 1 MA and 5 PCAs. -On third shift, there was supposed to be 1 MA and 4 PCAs, but there was usually just 1 MA and 2 PCAs. -The PCAs rotated personal care tasks with laundry duties. -Whoever was assigned laundry duty would come off the floor for one hour and then go back on the floor for personal care needs. Interview with a MA on 6/13/16 at 4:40pm revealed: -The facility was always short on staff, especially on second shift. -There would be times when there was only one MA on second shift. -Staff had to do laundry as well which took away from resident care. Interview with the Administrator on 6/13/16 at 6:35pm revealed: -Staffing assignments depended on the census. -The ratio on first and second shift was 1:8, and 1:10 on third. -The facility scheduled for seven total staff. -If the staff was working short, the Administrator was not aware of it. -The MCM had not been letting her know when	D 465		

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D 465	Continued From page 44 staff called in or holding staff accountable for calling in. -The facility had not always had 2 MAs on second shift, but there had been 2 scheduled for the past month. -Prior to that, second shift had 1 MA and 5 PCAs. -There were two housekeepers, but the company did not consider laundry to be a housekeeping duty. -Since 5/25/16, the company had given the facility 5 hours of laundry duty every day. -The facility liked to offer their current staff the extra hours rather than hiring from outside. -The facility would begin to do a separate schedule for laundry.	D 465		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the faciliy failed to assure each resident received care and services which were adequate and appropriate related to Nutrition and Food Service (Therepeutic Diets) and Nutrition and Food Service (Assistance with Eating). The findings are: 1. Based on observation, interviews and record reviews, the facility failed to serve nutritional supplements and thickened liquids to 2 of 3	D912		

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D912	Continued From page 45 residents sampled who had a physician's order for honey thick liquids (Resident #11) and who was ordered 2 different nutritional supplements (Resident #6). [Refer to Tag D310, 10A NCAC 13F.0904(e)(4) Nutrition and Food Service (Type B Violation)] 2. Based on observation, record review and interviews, the facility failed to provide feeding assistance with eating during 5 of 5 meals observed. [Refer to Tag D310, 10A NCAC 13F.0904(f)(2) Nutrition and Food Service (Type B Violation)]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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D935	Continued From page 46 (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 1 of 2 sampled staff (Staff B) who administered medications had completed the five and ten hour Medication Aide Training, and 1 of 2 sampled staff (Staff E) who administered medications had worked as a medication aide during the previous 24 months prior to October 1, 2013. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired as a Medication Aide (MA) on 12/19/14. -Staff B completed the Medication Administration Clinical Skills checklist on 8/12/13.	D935		

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D935	Continued From page 47 -Staff B passed the written Medication Aide test on 10/14/13. -There was a Medication Aide Verification Form that listed the most recent date of work as a MA was 12/18/14. -There was no documentation that Staff B had completed the five and ten hour Medication Aide training program. Interview with Staff B on 6/10/16 at 11:15am revealed: -She had been employed at the facility before the current company took over. -She had worked as a MA since 2013. Interview with the Business Office Manager on 6/3/16 at 5:00pm revealed: -When the new company bought out the facility, the old company wiped out the personnel files. (This was at the end of 2014.) -Staff B and Staff E had worked as MAs before being hired at the facility. -She thought the verification form only asked for the most recent date of work as a MA. -She did not realize you had to go back farther than 2014 when she completed the forms for the staff. 2. Review of Staff E's personnel file revealed: -Staff E was hired as a Medication Aide on 2/4/15. -Staff E completed the Medication Administration Clinical Skills checklist on 3/9/15. -Staff E passed the written Medication Aide test on 1/25/05. -There was a Medication Aide Verification Form that listed the most recent date of work as a MA was 2/6/14. -There was no verification that Staff E had worked as a MA prior to 2/6/14.	D935		

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D935	Continued From page 48 Interview with Staff E on 6/13/16 at 4:35pm revealed: -Staff E had been employed at the facility for two years. -She had worked as a MA for over 15 years. Interview with the Business Office Manager on 6/3/16 at 5:00pm revealed: -When the new company bought out the facility, the old company wiped out the personnel files. (This was at the end of 2014.) -Staff B and Staff E had worked as MAs before being hired at the facility. -She thought the verification form only asked for the most recent date of work as a MA. -She did not realize you had to go back farther than 2014 when she completed the forms for the staff.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled	D992		

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D992	Continued From page 49 substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 2 of 5 sampled staff (Staff A and C) hired after 10/1/13. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired on 12/10/15 as a Personal Care Aide. -There was a Urine Preliminary Drug Screen Result Form in Staff A's personnel file dated 12/10/15. -The section for Preliminary Test Results was not completed for controlled substances. -The form was signed by Staff A and the Memory Care Manager (MCM).	D992		

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D992	Continued From page 50 Interview with Staff A on 6/10/16 revealed: -He recalled submitting a specimen and signing a form to have a urine drug screen completed. -He did not recall seeing the results but knew the results should have been negative. The MCM was not available for interview. Refer to interview with the Administrator on 6/13/16 at 6:35pm. 2. Review of Staff C's personnel file revealed: -Staff C was hired on 2/5/16 as a Personal Care Aide. -There was a Urine Preliminary Drug Screen Result Form in Staff C's personnel file dated 2/5/16. -The section for Preliminary Test Results was not completed for controlled substances. -The form was signed by Staff C and the Business Office Manager. Staff C was not available for interview. Interview with the Business Office Manager on 6/10/16 at 3:10pm revealed: -She was responsible for ensuring the personnel files were complete and that the drug screening was done upon hire for new staff. -She recalled completing Staff C's drug screen, but did not know why the results for controlled substances was not completed. -The Business Office Manager knew that the results were negative. Review of the Urine Preliminary Drug Screen Result Form for Staff C on 6/10/16 at 3:10pm revealed the results for controlled substances were checked as negative for each drug name by	D992		

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D992	Continued From page 51 the Business Office Manager with the surveyor present. Refer to interview with the Administrator on 6/13/16 at 6:35pm. Interview with the Administrator on 6/13/16 at 6:35pm revealed: -The Business Office Manager was responsible for keeping personnel files in order. -The Administrator, Business Office Manager, or the MCM was responsible for controlled substance screening for new staff upon hire. -She was not aware that the staff's result form was incomplete.	D992		