STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 000	Initial Comments The Adult Care Licensure Section and the Pender County Department of Social Services conducted an annual survey, a follow up survey and a complaint investigation from 09/17/19 through 09/20/19 and 09/23/19 through 09/24/19. The Pender County Department of social services initiated 6 of 7 complaint investigations on 07/01/19, 07/05/19, 07/19/19, 08/06/19, 08/16/19, and 09/05/19.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the facility was free of hazards related to opened pre-moistened packs of washcloths left in the resident rooms and hallway and assessable to all the residents on the special care unit. The findings are: Observations on 09/24/19 from 9:30am to 9:55am revealed: -There was an opened pack of premoistened disposable wipes on the bedside table in resident	D 079		

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D 079	Continued From page 1	D 079		

room #109. The resident was sitting in a recliner across from the beside table and was asleep.
- There was an opened pack of pre-moistened disposable wipes on the bedside table in resident room #106. The resident was not in the room.
-There was an opened pack of pre-moistened disposable wipes on the bedside table in resident room #100. The resident was in bed with eyes opened.
-There was an opened pack of pre-moistened disposable wipes sitting on a chair rail on the 200 hall next to room #207.

Review of Resident #19's FL-2 dated 11/29/18 revealed:
- Diagnoses included dementia, pain, and generalized weakness.
-The resident's level of care was domiciliary/special care unit

Review of Resident #19's care plan dated 01/25/19 revealed:
-The resident had a history of wandering and ambulated with aide or a device.
-The resident was forgetful and sometimes disoriented.

Review of an Accident/Incident report for Resident #19 dated 08/01/19 revealed:
-On 08/01/19 at 8:00am, Resident #19's eyes were red and swollen and the resident complained of eye pain of both eyes.
-Cold compresses were applied to both eyes and the resident's primary care provider (PCP) was notified.
-The resident was sent to the local emergency room (ER) and returned with diagnoses of periorbital cellulitis (inflammation and infection of the eyelid and portions of skin around the eye anterior to the orbital septum) and conjunctivitis

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D 079	Continued From page 2	D 079		

(inflammation of the outermost layer of the eye and the inner surface of the eyelids).

Review of a local hospital ER report for Resident #19 dated 08/01/19 revealed:
-Resident #19 arrived at the ER via ambulance at 08:32am.
-The resident presented with eye problems. She had been rubbing her eyes with baby wipes and had used 1 pack of wipes since last night.
-The resident had bilateral eye redness and swelling.
-The resident was diagnosed with bilateral periorbital cellulitis and bilateral conjunctivitis.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 revealed:
-He was aware Resident #19 was transported to the hospital on 08/01/19 and was diagnosed with conjunctivitis and periorbital cellulitis.
-He was aware the resident had wiped her face/eyes with multiple pre-moistened wipes.
-He was not aware the staff left the packs of wipes in the residents' rooms and hallway.
-The wipes should not be left where the resident had access to them.
-The packs of wipes were stored in the locked community bathrooms
-He did not instruct the staff to remove the wipes from the residents' rooms and did not know if the former ED instructed staff to remove the wipes from the residents' rooms.

Interview with a first shift personal care aide (PCA) on 09/24/19 at 9:15am revealed:
-Resident #19 was confused and required assistance with activities of daily living (ADLs).
-The resident used a wheelchair to ambulate but could ambulate short distances.

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D 079	Continued From page 3	D 079		

-Around the last week of July 2019, the resident started using the disposable pre-moistened disposable wipes, which were left in the residents' rooms, to clean her face.
-The PCA observed the resident using multiple disposable wipes to wipe her face on multiple occasions.
-She did not think the wipes would harm the resident since staff used the wipes to clean the residents' "bottoms".
-She thought the resident was only using the wipes, but later observed the resident rinsing the wipes under running water at her bathroom sink and pumping the antibacterial soap from the dispenser on the wipes to wash her face and her perineal/vaginal area.
-The resident's face was observed with a red rash and the area around both eyes were red and swollen.
-The resident complained of her eyes were hurting and observed her using the wipes to scrub her face near her eyes.
-The PCA told the resident not to use the wipes or soap in the dispenser to clean her skin but the resident was confused and did not understand.
-The resident was sent to the ER and treated for eye infection and yeast infection.
-The staff was instructed by the former Executive Director (ED) to remove the wipes from Resident #19's room (but on other residents' rooms) and the hand soap was replaced with a milder soap after Resident #19 came back from the ER on 08/02/19.
-The wipes should not be left where the residents have access to them.
-The wipes should be stored out of the residents reach or taken out of the room and locked in the community bathrooms.

Observations made on 09/24/19 at 9:30am

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D 079	Continued From page 4 revealed there was a pack of pre-moistened disposable wipes on the hand rails on the 200 hall was one door down (across the hall) from Resident #19's room. Interview with the current ED on 09/24/19 at 5:25pm revealed: -She was not aware of the incident with the wipes because she had only been working at the facility since last week. -The former ED should have assured all of the wipes were removed from all of the residents' rooms due to the wipes could be a hazard if not used properly since the residents were confused and had dementia. -There should not be any wipes left in residents' rooms or in the hallway. -All of the disposable wipes would be removed from the residents' rooms and stored in a locked room.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 270		

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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 270	Continued From page 5 Based on observations, interviews, and record reviews, the facility failed to provide supervision to 6 of 12 sampled residents (#1, #2, #3, #7, #8, #19) in accordance with their current symptoms and assessed needs resulting in Residents (#1, #2, #3, #7, #8,) having multiple falls, being found on the floor, and sustaining multiple injuries to include fractures and facial and head injuries (#1, #2, #3, #7, and #8) and a resident (#19) having access to wipes when unsupervised causing an eye injury. The findings are: Observation during the initial tour on 09/17/19 from 8:30am to 10:15am revealed some resident room doors had gold stars on the name plates. Review of the facility's Fall Management Program revealed: -The "Fall Risk Assessment Tool" was completed "for all residents admitted" to determine factors that may contribute to possible falls. -Staff completed an Incident Report in its entirety for any fall. Staff were to contact the family/responsible party and physician. -The Executive Director &/or Care Manager should determine any immediate interventions required based on circumstances of the fall. -Staff completed a 72 hour follow up on residents' falls to investigate possible circumstances contributing to the fall and documented observations of the resident 72 hours after the fall. Interview with the previous Resident Care Coordinator (RCC) on 07/19/19 at 9:45am revealed: -The facility's fall policy consisted of assessing	D 270		

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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D 270	Continued From page 6	D 270		

the vital signs and contacting the primary care physician (PCP), emergency medical system (EMS), and family of the resident.
-The fall policy did not include increased supervision.

Interview with a personal care aide (PCA) on 07/19/19 at 10:44am revealed:
-If a resident fell, she would go get a medication aide (MA).
-Residents were checked on every 2 hours.
-After a fall, residents were not checked on more frequently.
-Residents were not checked on every 15 or 30 minutes unless the Executive Director (ED) instructed staff to do so.

Interview with a MA on 07/19/19 11:01am revealed:
-After a resident had a fall, the MAs were responsible for placing the resident on 72-hour monitoring.
-The 72-hour monitoring meant the resident's vital signs were checked and the resident was checked for bruising or injuries for 72 hours.
-The 72-hour monitoring did not include increased monitoring such as 15 or 30 minute checks.

Telephone interview with another MA on 08/16/19 at 9:05am revealed the ED or RCC were responsible for assuring the fall program or additional supervision needs were implemented.

Interview with the Director of Resident Care / Licensed Practical Nurse (DRC/LPN) on 08/20/19 at 10:50am revealed he was not aware of a Fall Risk Assessment Tool being used at the facility.

A second interview with the DRC/LPN on 09/17/19 at 3:30pm revealed:

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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D 270	Continued From page 7 -Fall risk assessments were completed on the computer after each fall for all residents by the DRC/LPN, RCC or the MAs. -He did not know if any fall risk assessments had been completed per the policy prior to his hire date of 07/15/19. -The fall risk assessments had been completed on all falls since he started (on 07/15/19). -After each fall, the fall prevention program was to be initiated which consisted of 72-hour monitoring. -Monitoring consisted of checking vital signs and checking for changes in mental status/condition, pain, or other injuries related to the fall every shift for 72 hours. -The 72 hour fall monitoring was documented on the electronic medication administration record (eMAR). Interview with MA on 09/18/19 at 3:14pm revealed: -The fall prevention plan meant staff would monitor and document vital signs for 72 hours. -The documentation would be on the eMAR. 1. Review of Resident #2's current FL-2 dated 06/03/19 revealed: -Diagnoses included Alzheimer's disease with late onset, Type II diabetes, other long-term drug therapy, frequency of micturition, muscle weakness, other abnormalities of gait and mobility, dysphagia, and unspecified dementia with behavioral disturbance. -There was documentation Resident #2 was semi-ambulatory with the aid of a wheelchair. -There was documentation Resident #2 needed assistance with toileting, bathing and dressing. Review of Resident #2's Resident Register revealed:	D 270		

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D 270	Continued From page 8 -Resident #2 was admitted to the facility on 04/19/18 from a rehabilitation (rehab) facility. -Resident #2 had significant memory loss and required re-direction. -Resident #2 required assistance from staff with dressing, bathing, nail care, toileting, hair/grooming, mouth care and scheduling appointments. Review of Resident #2's Resident Service Plan (care plan) dated 01/27/19 revealed: -There was documentation the resident was sometimes disoriented and was forgetful and needed reminders. -There was documentation the resident was ambulatory. -There was documentation the resident needed limited assistance with bathing and eating and was independent for toileting and ambulation/transfers and needed supervised assistance with dressing. -The Resident Service Plan was signed by Resident #2's Primary Care Provider (PCP) and dated on 01/28/19. Review of a fall risk assessment for Resident #2 dated 09/01/19 revealed: -There was documentation of a history of falls. -There was documentation the resident had an unsteady gait and balance. -There was documentation the resident had visual impairment. -There was documentation the resident had use of an assistive device. -There was documentation the resident memory impairment and poor problem solving capability -There was documentation the resident had urinary incontinence. -There was documentation the resident was noncompliant with safety needs or reminders.	D 270		

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D 270	Continued From page 9 Observation of Resident #2's door to her room on 09/18/19 at 7:31am revealed there were no gold star or half circle stickers on the a name plate which indicated her room number and her name. Interview with a personal care aide (PCA) on 09/18/19 at 7:31am revealed there was no way to tell by looking at the resident's doors if they are a fall risk. Observation of Resident #2 on 08/06/19 at 2:15pm revealed: -She was in the activity room in a wheelchair with her chair alarm intact. -She was awake, pleasantly confused, and neatly groomed. Observation of Resident #2 on 09/17/19 at 9:04am revealed: -The resident was in bed. -There was a fall mat placed on the floor by her bed. -The bed alarm was in place. Interview with personal care aide (PCA) on 09/18/19 at 7:31am revealed: -Resident #2 could not walk. -Resident #2 could stand with assistance to transfer but could not do it without staff assistance. -Resident #2 was checked on about every 30 minutes when she was not at the nurse's desk. -Resident #2 was kept at the nurses' desk during the day because she tried to get out of her wheelchair. -Resident #2 had to be monitored more frequently because she had tried to get up and fell. -Resident #2 had broken her hip from a fall. -Resident #2 required toileting assistance every 2	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 10	D 270		

hours, and staff assistance with bathing, dressing, and transferring.
-In June 2019, Resident #2 got a fall mat and bed/chair alarm and they were initiated.
-The fall mat and bed alarm were used every time Resident #2 was in the bed.
-The chair alarm was used when Resident #2 was in the wheelchair because she tried to get up and walk.
-If the alarms did not work, the staff were to notify hospice.
-There had been an issue with the chair alarm not working about a month ago, but it was fixed now.

a. Review of an Accident/Incident report for Resident #2 dated 04/28/19 at 8:38pm revealed:
-Resident #2 had a fall with injury to the hip and leg area.
-Resident #2 was admitted to hospital for a hip fracture.

Interview with the medication aide (MA) who documented Resident #2's Accident/Incident Report dated 04/28/19 on 08/08/19 at 6:45pm revealed:
-Resident #2 was walking in the front lobby and had an unwitnessed fall.
-Resident #2 was evaluated, emergency medical services (EMS) was contacted, and she was sent out to emergency department for evaluation.

Review of an EMS call report dated 04/28/19 at 5:21pm revealed:
-Facility staff reported Resident #2 fell from a couch, landing on her right hip.
-Resident #2 complained of right hip pain.

Review of a hospital emergency room encounter for Resident #2 dated 04/28/19 at 6:29pm revealed:

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D 270	Continued From page 11 -Resident #2 was complaining of right hip pain after a fall. -The radiology report showed a right hip fracture. -The resident would proceed to the operating room on 04/29/19. Review of a Care Note for Resident #2 dated 04/29/19 at 7:22am revealed the resident was admitted to the hospital for a right femur fracture. Review of Resident #2's fall risk assessments revealed there was no fall risk assessments dated prior to the 04/28/19 fall. Review of Resident #2's hospital discharge records revealed she was discharged to a rehabilitation (rehab) facility on 05/03/19. Based on interviews and record reviews Resident #2 admitted back into the facility from rehab on 06/03/19. Review of Resident #2's fall risk assessments revealed there was no fall risk assessment for dated June 2019 upon her re-admission to the facility from rehab. Review of a physician's order for Resident #2 dated 06/06/19 revealed there was an order for hospice to evaluate and assist if appropriate. Review of a physician's order for Resident #2 dated 06/10/19 revealed there was an order for a wheelchair. Review of hospice notes for Resident #2 dated 06/11/19 revealed there was a wheelchair delivered to the facility and signed for by staff. Review of a physician's order for Resident #2	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 12 dated 06/18/19 revealed there was an order for a chair/bed alarm, hospital bed, and fall mat. Review of hospice notes for Resident #2 dated 06/20/19 revealed there was a chair/bed alarm, hospital bed and a fall mat delivered to the facility and signed for by staff. Review of another physician's order for Resident #2 dated 06/27/19 revealed there was an order for a chair/bed alarm and a wheelchair. (This was the second chair/bed alarm and wheelchair order for the resident). Review of hospice notes for Resident #2 dated 06/27/19 revealed there was a chair/bed alarm and a wheelchair delivered and signed for by staff. Interview with Resident #2's hospice registered nurse (RN) on 09/19/19 at 12:43pm revealed: -Resident #2 was ordered a wheelchair on 06/10/19 which was delivered to the facility on 06/11/19 but was given to another resident. -Resident #2 was ordered a hospital bed, fall mat and chair alarm on 06/18/19; the items were delivered to another resident at the facility on 06/20/19. -Resident #2 was using another resident's wheelchair and did not have a chair alarm on during her visit on 06/18/19. -She had been to the facility to see Resident #2 on 06/25/19 and the resident did not have a chair alarm activated or in place. -She reordered the wheelchair and chair alarm for Resident #2 on 06/27/19 and it was delivered to the facility on 06/27/19. -The staff kept the resident near the nurses' station in the daytime.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 13	D 270		

b. Review of a second Accident/Incident report for Resident #2 dated 07/05/19 at 6:59pm revealed Resident #2 had a fall.

Review of an EMS call report for Resident #2 dated 07/05/19 at 6:59pm revealed:
-Resident #2 was sitting on the floor in her room and scooting herself around the room.
-"Staff is sitting on the bed and in a chair in the room not helping the resident or comforting her, just watching her call for help and move herself around."
-Resident #2 told EMS that her buttocks hurt and pointed to her right buttock's cheek.
-"Staff reports that there is a bump on the side of her head and that is why they called EMS."
-EMS found a small maybe dime size bump on the side of Resident #2's head.

Review of a hospital emergency department encounter for Resident #2 dated 07/05/19 at 7:34pm revealed:
-Resident #2 was complaining of pain in the buttocks, right leg and right arm after falling from her wheelchair.
-Resident #2 had altered mental status and could not remember what happened to her.
-Radiology reports were negative for injuries.

Review of Care Note for Resident #2 dated 07/05/19 at 11:44pm revealed Resident #2 returned from the hospital to facility with no new orders.

Review of Resident #2's July 2019 electronic medication administration record (eMAR) revealed there was no documentation of the 72-hour monitoring following the 07/05/19 fall.

Review of Resident #2's fall risk assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 14	D 270		

revealed there was no fall risk assessments dated in July 2019 after the 07/05/19 fall.

c. Review of a third Accident/Incident report for Resident #2 dated 07/07/19 at 8:00pm revealed Resident #2 had a fall with no injury and was not sent to the emergency department.

Review of Care Note for Resident #2 dated 07/07/19 at 9:13pm revealed:
-Resident #2 fell out of the wheelchair. No injury known.
-Hospice and the family were notified.

Telephone interview with the MA who documented Resident #2's Care Note and Accident/Incident Report dated 07/07/19 on 08/08/19 at 6:45pm revealed:
-The MA did not recall the specifics of the incident.
-The MA did not recall any safety interventions put in place for Resident #2 after that incident.
-The MA did not recall if Resident #2's chair alarm was being used, as ordered, at the time of the fall on 07/07/19.

Review of Resident #2's July 2019 eMAR revealed there was no documentation of the 72 hour fall monitoring from 07/07/19-07/11/19.

Review of Resident #2's fall risk assessments revealed there was no fall risk assessments dated in July 2019 after the 07/07/19 fall.

d. Review of a fourth Accident/Incident report for Resident #2 dated 07/18/19 at 9:00pm revealed:
-Resident #2 was on the floor with injuries to the right arm and leg.
-Resident #2 said she fell out of the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 15 Attempted telephone interview with the MA who completed Resident #2's Accident /Incident report dated 07/18/19 on 09/19/19 at 4:15pm was unsuccessful. Review of a Care Note for Resident #2 dated 07/18/19 at 9:30pm revealed: -Resident #2 was found on the floor with skin tears and a laceration on the right arm and a skin tear on the right leg. -First aid was preformed to stop the bleeding. -The primary care provider (PCP), power of attorney (POA), and hospice were notified. Review of Resident #2's July 2019 eMAR revealed: -There was documentation of the 72-hour monitoring following the 07/18/19 fall starting on 07/19/19 and ending on 07/21/19. -The vital signs (blood pressure, pulse, respirations and temperature) for Resident #2 were documented each shift starting with 07/19/19 on 7:00am-3:00pm shift and ending on 07/21/19 during the 11:00pm-7:00am shift. -There was a second entry for fall documentation :monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall every shift document any changes or no changes starting on 07/19/19 and ending on 07/21/19. -There was documentation of no changes on each shift starting on 07/19/19 for the 7:00am-3:00pm shift through 07/21/19 on the 11:00pm -7:00am shift. Review of Resident #2's fall risk assessments revealed there was no fall risk assessments dated for July 2019 after the 07/18/19 fall. Observation of Resident #2 on 07/19/19 at	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 16 12:00pm revealed: -She was in her bed without a bed alarm in use. -A MA looked for the bed alarm but was only able to to find the cord to the bed alarm. e. Review of a fifth Accident/Incident report for Resident #2 dated 08/10/19 at 3:45am revealed: -Resident #2 was found on the floor and had a skin tear on the right arm by the elbow. -The MA left an "For Your Information" (FYI) message with the on-call provider for Resident #2's PCP and hospice. -The fall prevention program was initiated. -The resident would be monitored for 72 hours for bruising, change in mental status/condition, pain or other injuries related to the fall. Review of a Care Note for Resident #2 dated 08/10/19 at 4:05am revealed: -Resident #2 was found on the floor. -The PCP, hospice and the POA were notified. -Resident #2 had a skin tear on the right arm by the elbow and had no complaints of pain or discomfort. Review of Resident #2's August 2019 eMAR revealed: -There was documentation of 72-hour monitoring following the 08/10/19 fall starting on 08/10/19 and ending on 08/13/19. -The vital signs (blood pressure, pulse, respirations and temperature) for Resident #2 were documented each shift starting on 08/10/19 during the 7:00am-3:00pm shift and ending on 08/13/19 during the 11:00pm-7:00am shift. -There was a second entry for fall documentation :monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall every shift document any changes or no changes starting on 08/10/19 and ending on	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 17	D 270		

08/13/19.
-There was documentation of no changes on each shift starting on 08/10/19 during the 7:00am -3:00pm shift through 08/13/19 on the 11:00pm -7:00am shift.

f. Review of an EMS call report dated 09/01/19 at 8:42am revealed:
-Resident #2 was found on the floor behind the door of her room.
-Resident #2 had a laceration on her left arm.

Review of a Care Note for Resident #2 dated 09/01/19 at 8:31am revealed the resident was found on the floor and sent to the emergency department.

Review of a hospital emergency department note dated 09/01/19 for Resident #2 revealed:
-Resident #2 had an unwitnessed fall.
-A computed tomography (CT) scan of the head showed no injury. (A CT scan provides a series of x-rays from different angles to provide images of bones, soft tissues, and blood vessels).

Review of Resident #2's September 2019 eMAR revealed:
-There was documentation of 72-hour monitoring following the 09/01/19 fall starting on 09/01/19 and ending on 09/04/19.
-The vital signs (blood pressure, pulse, respirations and temperature) for Resident #2 were documented each shift starting on 09/01/19 during the 3:00pm-11:00pm shift and ending on 09/04/19 on the 11:00pm-7:00am shift.
-There was a second entry for fall documentation :monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall every shift document any changes or no changes starting on 09/01/19 and ending 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 _____	R 09/24/2019

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 270	Continued From page 18	D 270		

09/04/19.
-There was documentation of no changes on each shift starting on 09/01/19 on the 3:00pm -11:00pm shift to 09/04/19 on the 1:00pm -7:00am shift.

Interview with a PCA on 09/18/19 at 12:20pm revealed:
-She did not remember anything about the fall Resident #2 had on 09/01/19.
-After Resident #2 fell on 09/01/19 she was placed on 72-hour monitoring.
-The 72-hour monitoring consisted of 15 minutes checks for a certain amount of time then 30-minute checks. She could not remember how long the 15- or 30-minute checks were performed.
-During the 15- or 30-minute checks staff had to note where the resident was located, and that they were safe.
-Resident #2 sat up at the nurses' desk most of the time because of her trying to get up and fall.
-The chair alarm was kept on Resident #2 when she was in the wheelchair.
-Resident #2 was on the 200 hall.
-Residents on the 200 hall were the heavier care residents.

Review of a physician order for Resident #2 dated 09/02/19 revealed there was an order to have the chair alarm on while up in the wheelchair and an order to have bed alarm on bed while in bed.

Observation of Resident #2 on 09/18/19 at 12:00pm revealed:
-Resident #2 was in front of the nurses' desk with other residents.
-The resident was trying to get up out of the wheelchair.
-The chair alarm sounded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 19 -A staff member came from behind the desk to assist Resident #2. Interview with a MA on 09/18/19 at 3:14pm revealed: -Resident #2 tried to stand up a lot so she must have her chair alarm on all the time. -She was aware Resident #2 had several falls but did not know anything about them. -She mostly worked on the 100 hall and Resident #2 was on the 200 hall. Interview with Resident #2's primary care provider (PCP) on 09/18/19 at 11:36 revealed: -Resident #2 needed a geri chair, but that was a restraint and restraints could not be used. -Resident #2 thought she could walk; this could cause her to fall. -The staff called him every time Resident #2 fell. -He did not remember the dates staff had called him about the residents falls. -He did not remember the date, but a few months ago Resident #2 had fractured her hip due to a fall. -When Resident #2 returned from rehab, he placed an order for hospice to see her. -Resident #2 received chair/bed alarm and a fall mat after returning from rehab to help prevent falls. -He expected the staff to keep Resident #2 at the nurses' station in the daytime because she required frequent monitoring. -He had not written an order to keep her at the nurses' station during the day. -When Resident #2 was at the nurses' station she could be monitored closer. -He expected the chair and bed alarms to be used all the time. Interview with Director Resident Care	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 20	D 270		

(DRC)/Licensed Practical Nurse (LPN) on 09/19/19 at 8:25am revealed:
-He was not aware the fall risk assessments for Resident #2 were not completed after her each of her falls.
-He thought he had completed the fall risk assessments after each of the resident's last 2 falls which were in August 2019 and September 2019.
-Resident #2 could walk without assistance at times, but she got weak or would lose her balance.
-Resident #2 required close monitoring because she would try and get up out of her wheelchair.
-Resident #2 was kept at the nurse's desk a lot during the day.

Interview with a family member of Resident #2 on 09/19/19 at 4:21pm revealed:
-Resident #2 had several falls.
-She fractured her hip and had to have surgery then went to rehab after one of her falls.
-Resident #2 would not stay in her wheelchair.
-She went to visit Resident #2 about a month ago and her chair alarm was not on/in use.
-She asked a staff member about the chair alarm, but she did not get an answer about why it was not being used.
-The chair alarm had been on the visits after that (no dates provided).
-Resident #2 also had a bed alarm.
-She knew there had been some falls since Resident #2 got the alarms but did not think it was as many as she had been having prior to the use of the alarms.

Telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm revealed:
-She could not say if Resident #2 had the chair alarm on every time she was in the chair or had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 270	Continued From page 21 fall. -Resident #2 was not considered a fall risk. Interview with current ED on 09/20/19 at 2:05pm revealed: -She was not working in the facility when Resident #2 had falls and sustained injuries. -She always expected the staff to use the chair and bed alarms. -Fall risk assessments should be completed on each resident on admission and if there was any significant change. -She did not know why fall risk assessments were not completed but would be completed from now on. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable. Additional fall risk assessments were requested for Resident #2 on 09/18/19; however, were not provided prior to survey exit. Refer to the observations of the 100-hall on 09/17/19 at 4:10pm. Refer to the second observation of the 100-hall on 09/20/19 at 11:40am. Refer to the interview with a personal care aide (PCA) on 09/17/19 at 09:03am. Refer to the interview with a second PCA on 09/17/19 at 03:58pm. Refer to interview with a third PCA on 09/17/19 at 4:15pm. Refer to the interview with a medication aide (MA)	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 22 on 09/17/19 at 4:38pm. Refer to the interview with a fourth PCA on 09/18/19 at 7:31am. Refer to the interview with a second MA on 09/20/19 at 11:49am. Refer to the interview with a fifth PCA on 09/20/19 at 11:57am. Refer to the telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm. Refer to the interview with the facility's Clinical Project Director on 09/22/19 at 1:45pm. 2. Review of Resident #1's current FL-2 dated 03/28/19 revealed: -Diagnoses included Alzheimer's dementia, metastatic breast cancer, major depression disorder, hernia prolapsed, and history of nephrolithiasis. -There was documentation the resident was constantly disoriented. -There was documentation the resident was ambulatory and had a rollator walker. -The recommended level of care was documented as domiciliary and "other"/special care unit (SCU). Review of Resident #1's Resident Register revealed: -Resident #1 was admitted to the facility on 08/09/18 from a memory care unit. -Resident #1 was forgetful and needed reminders. -Resident #1 required assistance from staff with dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, grooming, skin care, and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 23 mouth care. Review of Resident #1's Resident Service Plan (care plan) dated 02/04/19 revealed: -The resident was ambulatory with an aide or device -The resident was fully dependent upon staff for bathing, toileting, and mobility except for limited assistance with transfers to/from chair/bed and ambulation room to room and extensive assistance with dressing. -The Resident Service Plan was signed by Resident #1's Primary Care Provider (PCP) and dated 02/06/19. Based on record reviews and interviews, Resident #1 was discharged from the facility to home on 07/28/19. a. Review of an Accident/Incident Report for Resident #1 dated 04/23/19 revealed: -Resident #1 stated she tripped in the dining room. -Resident #1 had a 5 centimeter (cm) by 2 cm skin tear on the right forearm and the right knee was slightly bruised. -The fall prevention program was initiated;check vital signs for three days every shift with start date of 04/26/19. The previous Director of Resident Care (DRC) who documented Resident #1's Accident/Incident report dated 04/23/19 was no longer employed and was not available for interview during the survey. Review of Resident #1's April 2019 electronic medication administration record (eMAR) revealed: -There was an entry for the fall prevention	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 24	D 270		

program with start and end date of 04/26/19 with instructions to check vital signs for three days every shift.
-There was documentation on 04/26/19 for each shift of blood pressure, pulse, respirations, and temperature.
-There was no other documentation of the fall prevention program.

b. Review of an Emergency Medical Services (EMS) call report dated 05/19/19 at 10:56pm revealed:
-Resident #1 was laying on her left side in the floor by the bed.
-Resident #1 said she slipped and fell trying to get onto her bed.
-Resident #1 had a hematoma on the back of the head.

Review of a hospital emergency department encounter for Resident #1 dated 05/19/19 revealed:
-The resident was evaluated and discharged on 05/20/19.
-The diagnoses included head injury without loss of consciousness and fall.

Review of a Care Note for Resident #1 dated 05/20/19 revealed:
-The resident had a good day after being sent out to the emergency department on 05/19/19.
-Resident #1 had not complained of pain or discomfort throughout the shift.

Interview with the medication aide (MA) on duty on 05/19/19 when Resident #1 fell on 08/07/19 at 2:30pm revealed:
-Resident #1 had an unwitnessed fall when going to the bathroom.
-Resident #1 bumped her head and was sent out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 25 to the emergency department. Review of Resident #1's May 2019 eMAR revealed there was no documentation of 72-hour monitoring after the 05/19/19 fall. c. Review of an Accident/Incident report for Resident #1 dated 07/14/19 at 10:40am revealed Resident #1 had a fall with an injury. Interview with the MA who documented Resident #1's Accident/Incident Report dated 07/14/19 on 08/07/19 at 3:57pm revealed: -Resident #1 was walking into another resident's room, tripped, and knocked her teeth out. -Resident #1 was lying on the floor approximately 5 minutes before EMS arrived. -Resident #1's hospice nurse was notified and Resident #1 was not sent out to the emergency department per the hospice RN. Review of a Care Note for Resident #1 dated 07/15/19 at 1:35pm revealed: -Resident had a bruise on her top lip from a fall on 07/14/19 but had a good day. -The resident had not complained of pain or discomfort throughout the shift. Interview with Resident #1 family member on 09/19/19 at 4:54pm revealed: -The family member was concerned the residents falls. -Resident #1 last fell in July 2019 and had some bumps, bruising and broken teeth. -The hospice RN came out to assess Resident #1 after the fall. -The family was unaware of any safety interventions put in place for Resident #1. -The facility had not discussed any increased supervision needs or safety inventions with the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 26 family. Interview with Resident #1's Hospice Registered Nurse (RN) on 09/20/19 at 10:40am revealed: -Facility staff contacted her whenever Resident #1 had a fall. -Resident #1 had a fall on 07/14/19 that resulted in the resident knocking her teeth out. -Resident #1 was not sent out to emergency department. -She had no information on any safety interventions put into place for Resident #1 to prevent falls prior to this fall or after this fall. Review of Resident #1's July 2019 eMAR revealed there was no documentation of implementation of the fall prevention program or 72-hour monitoring after the 07/14/19 fall. Interview with Resident #1's Primary Care Provider (PCP) on 09/19/19 at 3:33pm revealed: -Resident #1 did not live in the facility for a long period of time. -She was aware of Resident #1's falls and ordered interventions after falls. -She wanted the resident moved closer to the nursing station for increased supervision Interview with current Executive Director (ED) on 09/20/19 at 2:05pm revealed: -Fall risk assessments should be completed on each resident on admission and if there was any significant change. -She did not know why fall risk assessments were not completed but would be completed from now on. Resident #1 was discharged from facility on 07/28/19 at family's request and was not available for interview.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 27 Fall risk assessments were requested for Resident #1 on 09/18/19; however, were not provided prior to survey exit. Refer to the observations of the 100-hall on 09/17/19 at 4:10pm. Refer to the second observation of the 100-hall on 09/20/19 at 11:40am. Refer to the interview with a personal care aide (PCA) on 09/17/19 at 09:03am. Refer to the interview with a second PCA on 09/17/19 at 03:58pm. Refer to interview with a third PCA on 09/17/19 at 4:15pm. Refer to the interview with a medication aide (MA) on 09/17/19 at 4:38pm. Refer to the interview with a fourth PCA on 09/18/19 at 7:31am. Refer to the interview with a second MA on 09/20/19 at 11:49am. Refer to the interview with a fifth PCA on 09/20/19 at 11:57am. Refer to the telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm. Refer to the interview with the facility's Clinical Project Director on 09/22/19 at 1:45pm. 3. Review of Resident #3's current FL-2 dated 11/29/18 revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 28 -Diagnoses included vascular dementia. -There was documentation the resident was constantly disoriented. -There was documentation the resident was semi-ambulatory. -The recommended level of care was documented as domiciliary and "other"/special care unit (SCU). Review of Resident #3's Resident Service Plan (care plan) dated 12/18/18 revealed: -Resident #3 wandered, was always disoriented and had significant memory loss. -The resident required extensive assistance from staff with bathing, dressing, mobility, and toileting. Observation of Resident #3's door to her room on 09/17/19 at 4:12pm revealed a name plate which indicated her room number, her name, a gold star sticker beside her name and a half orange circle sticker beside her name. Observation of Resident #3 room on 09/20/19 at 9:55am revealed: -There was fall mat observed under the resident's bed. -A chair alarm was attached to resident's wheelchair. Review of Resident #3's Care Notes, Accident/Injury Reports, and hospital records dated between 01/26/19 and 06/19/19 revealed Resident #3 fell or was found on the floor on at least 6 different occasions. a. Review of an Accident/Incident Report for Resident #3 dated 04/10/19 at 4:05pm revealed Resident # 3 fell forward out of the chair onto the floor.	D 270		

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

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D 270	Continued From page 29	D 270		

Review of an Emergency Medical Services (EMS) call record dated 04/10/19 at 4:11pm revealed:
-Resident #3 was in her wheelchair and fell forward onto the floor.
-Resident #3 denied pain; however, grimaced on palpation of the neck.

Review of a hospital Emergency Department Encounter for Resident #3 dated 04/10/19 at 4:40pm revealed:
-Resident #3 fell forward out of the wheelchair and struck her head on the floor.
-A CT scan showed no acute injury.
-Resident #3 was discharged back to the facility with a diagnosis of fall from a wheelchair.

Review of a Care Note for Resident #3 dated 04/11/19 dated 1:55am revealed:
-Resident #3 was resting well after returning from the emergency department due to a fall.
-72-hour monitoring was to be complete with increased supervision.

Telephone interview with the medication aide (MA) who documented Resident #3's Care Note and Accident/Incident Report dated 04/10/19 on 08/16/19 at 9:05am revealed:
-The MA did not recall the specifics of the incident.
-The MA did not recall any safety interventions being put into place for Resident #3 after the fall.

Interview with another MA on 09/20/19 at 10:11am revealed:
-She did not remember anything about Resident #3's fall on 04/10/19.
-She did not recall if anything was put in place as a safety intervention for the resident after the fall.

Fall risk assessments were requested 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 _____	R 09/24/2019

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 270	Continued From page 30	D 270		

Resident #3 on 09/18/19; however, were not provided prior to survey exit.

b. Review of a second Accident/Incident Report for Resident #3 dated 04/12/19 revealed:
-Resident #3 was leaning way over in the wheelchair and was sat back up.
-Resident #3 leaned over again and fell forward; staff was unable to catch her.

Review of an EMS call report dated 04/12/19 at 7:28pm revealed:
-Resident #3 was sitting in the wheelchair in the hallway and fell suddenly forward and onto her head.
-Staff stated Resident #3 initially complained of head pain but was not complaining anymore.

Review of a hospital Emergency Department Encounter for Resident #3 dated 04/12/19 at 10:08pm revealed:
-Resident #3 fell out of the wheelchair and hit her head.
-Resident #3 was complaining of pain on the left side of her head.
-Resident #3's CT scan of the head, neck and face were negative for any acute findings and the resident was diagnosed with fall.

The MA who documented Resident #3's Care Note and Accident/Incident Report dated 04/12/19 was not available for interview on 08/16/19.

Review of a Care Note for Resident #3 dated 04/13/19 at 2:22am revealed Resident #3 returned from the emergency department after a fall and was resting well.

Fall risk assessments were requested 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 _____	R 09/24/2019

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 270	Continued From page 31	D 270		

Resident #3 on 09/18/19; however, were not provided prior to survey exit.

c. Review of a third Accident/Incident Report for Resident #3 dated 04/26/19 at 4:45pm revealed:
-Resident #3 had a fall with injury.
-The fall prevention plan was initiated.

Review of an EMS call report dated 04/26/19 at 4:58pm revealed:
-Resident #3 was lying on the floor with a towel under her head.
-Resident #3 had a skin tear on the left forearm.

Review of a hospital Emergency Department Encounter dated 04/26/19 at 5:36pm revealed:
-Resident #3 had a witnessed fall from her wheelchair falling to the ground and striking her head.
-Skin tears were repaired with steri-strips.
-Resident #3 was stable for discharge back to the facility.
-Diagnoses included mild closed head injury and multiple skin tears from status post fall from wheelchair.

Interview with the MA who documented Resident #3's Accident/Incident report dated 04/26/19 on 08/15/19 at 4:14pm revealed:
-Resident #3 was leaning forward and fell out of the wheelchair.
-The MA sent Resident #3 out to emergency department for evaluation.

Fall risk assessments were requested for Resident #3 on 09/18/19; however, were not provided prior to survey exit.

d. Review of a fourth Accident/Incident Report for Resident #3 dated 04/29/19 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 32	D 270		

-Resident #3's alarm sounded, and the resident was observed on the fall mat next to the bed.
-Resident #3 had a fall with injury.
-Resident #3 complained of neck pain.
-The fall prevention plan was initiated.

Review of an EMS call report dated 04/29/19 at 2:55pm revealed:
-Resident #3 was laying on her back in the bed sleeping upon EMS arrival.
-Resident #3 had a history of several falls recently.
-Resident #3 had been sleeping and rolled out of bed and landed on the fall mat.
-Staff stated when they moved the resident back into bed, she complained of neck pain.
-Resident #3 was transported to the emergency department for evaluation

Review of a Care Note for Resident #3 dated 04/29/19 at 3:41am revealed:
-Resident #3's bed alarm sounded, and she was observed on the fall mat next to her bed.
-Resident #3 was observed holding her neck and complaining of neck pain.
-Resident #3 was sent to hospital via EMS.

Review of a hospital Emergency Department encounter for Resident #3 dated 04/29/19 at 03:43am revealed:
-Resident #3 apparently rolled out of bed and landed on a fall mat.
-Resident #3 was discharged back to the facility.
-Diagnoses included fall out of the bed and dementia.

The MA who documented Resident #3's Care Note and Accident/Incident report dated 04/29/19 was no longer employed and was not available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 33 Fall risk assessments were requested for Resident #3 on 09/18/19; however, were not provided prior to survey exit. e. Review a fifth Accident/Incident Report for Resident #3 dated 05/29/19 at 2:24pm revealed: -Resident #3 slid out of the wheelchair. -The fall prevention program was initiated. -Hospice ordered Resident #3 a high back wheelchair. Interview with MA who documented Resident #3's Accident/Incident Report dated 05/29/19 at 2:24pm revealed: -Resident #3 fell out of wheelchair due to trying to clean the floor. -Resident #3 was not sent out to hospital after notification to the hospice nurse. Fall risk assessments were requested for Resident #3 on 09/18/19; however, were not provided prior to survey exit. f. Review of a sixth Accident/Incident Report for Resident #3 dated 06/18/19 at 8:32pm revealed: -Resident #3 fell out of the wheelchair. -Hospice ordered Resident #3 a high back wheelchair to tilt her back to keep her from falling forward, which was originally ordered on 05/29/19. Review of an EMS call record dated 06/18/19 at 7:14pm revealed: -Resident #3 was lying on her left side and there was some blood on the floor. -Staff stated that she fell out of her wheelchair and hit her head on the floor. Review of hospital emergency department note	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 34	D 270		

for Resident #3 dated 06/18/19 revealed:
-Resident #3 had an unwitnessed fall.
-Resident #3 was discharged back to the facility on 06/18/19.
-The resident was diagnosed with minor closed head injury status post fall with skin abrasion to the forehead.

Review of a Care Note for Resident #3 dated 06/19/19 at 3:23pm (recorded as a late entry on 06/19/19 at 3:30pm) revealed:
-Resident #3 fell out of the wheelchair and was sent to emergency department at 7:15pm.
-Hospice was notified and left a voicemail.
-Resident #3 returned to facility at 10:00pm, with diagnoses of minor closed head injury status post fall and a skin abrasion to the forehead.

Review of Resident #3's hospice orders dated 06/18/19 revealed an order for a high back wheelchair.

Interview with Resident #3's family member on 09/19/19 at 4:25pm revealed after the high back wheelchair was put into place, other falls were prevented for the resident.

Interview with the Clinical Instructor on 09/25/19 at 10:15am revealed she was unable to locate any orders for Resident#3's fall mat or chair alarm.

Interview with Resident#3's Primary Care Provider (PCP) on 09/19/19 at 3:33pm revealed:
-The PCP was notified of the resident's falls.
-The PCP ordered a chair alarm and fall mat for Resident #3.
-She also wanted Resident #3 kept near the nursing station for supervision.
-She expected Resident #3 to be checked 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 _____	R 09/24/2019

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 270	Continued From page 35 every 15-30 minutes if she was in her room. Interview with current Executive Director (ED) on 09/20/19 at 2:05pm revealed: -She always expected the staff to use the chair and bed alarms. -Fall risk assessments should be completed on each resident on admission and if there was any significant change. -She did not know why fall risk assessments were not completed but would be completed from now on. Fall risk assessments were requested for Resident #3 on 09/18/19; however, were not provided prior to survey exit. Refer to the observations of the 100-hall on 09/17/19 at 4:10pm. Refer to the second observation of the 100-hall on 09/20/19 at 11:40am. Refer to the interview with a personal care aide (PCA) on 09/17/19 at 09:03am. Refer to the interview with a second PCA on 09/17/19 at 03:58pm. Refer to interview with a third PCA on 09/17/19 at 4:15pm. Refer to the interview with a medication aide (MA) on 09/17/19 at 4:38pm. Refer to the interview with a fourth PCA on 09/18/19 at 7:31am. Refer to the interview with a second MA on 09/20/19 at 11:49am.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 36 Refer to the interview with a fifth PCA on 09/20/19 at 11:57am. Refer to the telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm. Refer to the interview with the facility's Clinical Project Director on 09/22/19 at 1:45pm. 4. Review of Resident #7's current FL-2 dated 11/29/18 revealed: -Diagnoses included dementia and depression with anxiety. -There was documentation the resident was intermittently disoriented and wandered. -There was documentation the resident was ambulatory. -The recommended level of care was domiciliary/other Special Care Unit (SCU). Review of Resident #7's Resident Register revealed: -Resident #7 was admitted to the facility on 06/13/18 from a hospital. -Resident #7 has significant memory loss and required redirection.. -Resident #7 required assistance with dressing, bathing, toileting, grooming, and scheduling appointments. Review of Resident #7's Resident Assessment Plan (care plan) dated 11/29/18 revealed: -Resident #7 wandered, was always disoriented had significant memory loss and required re-direction. -The resident was ambulatory. -The resident required extensive assistance with bathing and dressing, limited assistance with toileting and was independent with mobility and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 37	D 270		

eating.
-The Resident Assessment Plan was signed by Resident #7's Primary Care Provider (PCP) and dated on 12/18/18.

Based on record reviews and interviews, Resident #7 was discharged from the facility on 08/06/19.

a. Review of an Accident/Incident Report for Resident #7 dated 05/17/19 at 4:58pm revealed:
-Resident #7 had a fall with injury.
-Resident #7 had skin tear on the right elbow and arm and complained of back pain when Emergency Medical Services (EMS) touched the resident's back.

Review of an EMS call report dated 05/17/19 at 4:10pm revealed:
-Resident #7 was found lying supine on the floor with several caregivers on the scene with him.
-The fall was unwitnessed, and staff did not know how long the resident had been lying on the floor.

Review of a Care Note for Resident #7 dated 05/17/19 at 9:47pm revealed the resident was sent to the hospital emergency department after a fall and a skin tear on the right elbow.

Review of a hospital Emergency Department Encounter for Resident #7 dated 05/17/19 revealed:
-Resident #7 had an unwitnessed fall.
-Resident #7 believed he had a head injury but was not speaking much.
-The resident had a skin tear on his right elbow but no other evidence of injury.
-The resident was discharged back to facility.

Interview with a medication aide (MA) 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 _____	R 09/24/2019

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 270	Continued From page 38 08/28/19 at 2:12pm revealed no safety interventions were implemented for Resident #7 after the fall on 05/17/19. Interview with a second MA on 08/28/19 at 2:25pm revealed no safety interventions were implemented for Resident #7 after the fall on 05/17/19. Review of Resident #7's May 2019 electronic medication administration record (eMAR) revealed there was no documentation of the fall prevention program or 72 hour monitoring following the 05/17/19 fall. Fall risk assessments were requested for Resident #7 on 09/18/19; however, were not provided prior to survey exit. b. Review of a second Accident/Incident Report for Resident #7 dated 08/05/19 at 6:34pm revealed: -Resident #7 was found on the floor. -Resident #7 was in the hospital scheduled for hip surgery. Review of an EMS call report dated 08/05/19 at 6:38pm revealed: -Resident #7 was found lying on the floor due to an unwitnessed fall. -Resident #7 was complaining of pain any time someone touched his left leg. Review of a Care Note for Resident #7 dated 08/06/19 at 12:46am revealed Resident #7 was being transported and admitted to a [named hospital] for a left hip fracture and would have surgery. The MA who documented Resident #7's Care	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 39 Note and Accident/Incident report dated 08/05/19 was not available for interview on 08/12/19. Attempted interview with the MA who documented Resident #7's Care Note and Accident/Incident report dated 08/05/19 on 09/29/19 at 4:25pm revealed the MA declined interview. Interview with Resident #7's responsible party (RP) on 09/20/19 at 11:41am revealed: -Resident #7 had a fall on 08/05/19 and there was no communication received from facility. -The RP received a telephone call from the hospital to give an update of resident's current condition. Interview with Resident #7's Primary Care Provider (PCP) on 09/19/19 at 3:33pm revealed the PCP was notified of resident falls, unknown to number, with the most recent fall on 08/05/19 resulting in hospitalization and discharge from facility. Resident #7 was not available for interview. Interview with current Executive Director (ED) on 09/20/19 at 2:05pm revealed: -Fall risk assessments should be completed on each resident on admission and if there was any significant change. -She did not know why fall risk assessments were not completed but would be completed from now on. Fall risk assessments were requested for Resident #7 on 09/18/19; however, were not provided prior to survey exit. Refer to the observations of the 100-hall on 09/17/19 at 4:10pm.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 40 Refer to the second observation of the 100-hall on 09/20/19 at 11:40am. Refer to the interview with a personal care aide (PCA) on 09/17/19 at 09:03am. Refer to the interview with a second PCA on 09/17/19 at 03:58pm. Refer to interview with a third PCA on 09/17/19 at 4:15pm. Refer to the interview with a medication aide (MA) on 09/17/19 at 4:38pm. Refer to the interview with a fourth PCA on 09/18/19 at 7:31am. Refer to the interview with a second MA on 09/20/19 at 11:49am. Refer to the interview with a fifth PCA on 09/20/19 at 11:57am. Refer to the telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm. Refer to the interview with the facility's Clinical Project Director on 09/22/19 at 1:45pm. 5. Review of Resident #8's current FL-2 dated 11/29/18 revealed: -Diagnoses included dementia, heart disease, hypertension, history of displaced femur fracture and muscle weakness. -There was documentation that the resident was intermittently disoriented. -There was documentation that the resident was semi-ambulatory.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 41 -The recommended level of care was documented as "domiciliary/other-special care unit." Review of Resident #8's Resident Assessment Plan (care plan) dated 12/17/18 revealed: -Resident #8 was always disoriented and was forgetful and needed reminders. -The resident was ambulatory with an aide or device. -The resident was fully dependent upon staff for bathing assistance and limited to assistance with dressing and independent with mobility and toileting. -The Resident Assessment Plan was signed by Resident #8's Primary Care Provider (PCP) and dated on 12/18/18. Observation of Resident #8's door to her room on 09/17/19 at 9:05am revealed a name plate which indicated her room number and her name. There was not a gold star sticker or half orange circle sticker beside her name. Observation of Resident #8 on 08/06/19 at 2:15pm revealed: -She was ambulating with a walker in the hall. -She had bruising to her entire face that was purplish/blue in color. Based on observations, interviews and record reviews, it was determined Resident #8 was not interviewable a. Review of an Accident/Incident Report for Resident #8 dated 06/06/19 at 11:20am revealed: -Resident #8 had a fall in the bedroom with injury. -Resident #8 was observed sitting on the floor, bleeding from her left temple. -The resident was sent to the hospital emergency	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 42	D 270		

department via EMS (Emergency Medical Services) on 06/06/19 at 11:20am.
-The fall prevention program was initiated.

Review of an EMS call report dated 06/06/19 at 11:26am revealed:
-Resident #8 had an unwitnessed fall in the hallway.
-Resident #8 had a small laceration to the left eyebrow on the temple side.

Review of a hospital Emergency Department Encounter for Resident #8 dated 06/06/19 at 11:53am revealed:
-Resident #8 presented after a fall.
-Resident #8 had a small laceration to the left brow and denied any other injuries.

Review of a Care Note for Resident #8 dated 06/06/19 at 2:39pm revealed:
-"Resident was observed sitting on floor."
-The resident was bleeding from the fall; some bleeding from the left side temple.
-The resident returned to the facility from the emergency department and was doing good at this time.

Attempted interview on 08/15/19 at 3:50pm with MA who sent Resident #8 to hospital on 06/06/19 was unsuccessful.

Review of Resident #8's June 2019 electronic medication administration record (eMAR) revealed there was no entry for the fall prevention program and no documentation the fall prevention program was initiated or 72 hour monitoring after the 06/06/19 fall.

Fall risk assessments were requested for Resident #8 on 09/18/19; however, were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 43 provided prior to survey exit. b. Review of a second Accident/Incident Report for Resident #8 dated 07/30/19 at 9:55am revealed -The resident was found on the floor in the bedroom and was injured. -The resident was laying on her left side with blood coming from her nose. Review of an EMS call report dated 07/30/19 at 10:00am revealed: -Resident #8 suffered from a fall resulting in a nose bleed. -Staff found Resident #8 lying in the prone position awake but disoriented with small amount of blood on the ground. Review of a Care Note for Resident #8 dated 07/30/19 at 10:16am revealed Resident #8 was sent to the emergency department after a fall. Review of a hospital Emergency Department Encounter for Resident #8 dated 07/30/19 at 12:23pm revealed: -Resident #8 had an unwitnessed fall. -Resident #8 appeared to have landed on her face with some swelling to her nose and an abrasion to her upper nose. -The resident was given a prescription for an antibiotic and was to follow up with Ear Nose and Throat Specialist. -Diagnoses included fall and nasal septum fracture. Telephone interview with the MA who documented Resident #8's Care Note and Accident/Incident report dated 07/30/19 on 08/11/19 at 1:45pm revealed: -The MA walked into Resident #8's room and	D 270		

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 44	D 270		

found her lying on the floor next to the air conditioner unit.
-She contacted EMS and sent the resident out for evaluation.
-No safety interventions were put into place for Resident #8 related to her falls.

Interview with Resident #8's Primary Care Provider (PCP) on 09/19/19 at 3:33pm revealed:
-The PCP was notified of the resident's falls.
-The resident used a walker and did not like to sit down.
-Resident #8 should be kept close to the nursing station for increased supervision.
-She expected staff to check on the resident every 15-30 minutes.

Based on observations, interviews and record reviews, it was determined Resident #8 was not interviewable.

Attempted telephone interview with Resident #8's family on 09/19/19 at 4:40pm and 09/20/19 at 11:55am was unsuccessful.

Interview with current Executive Director (ED) on 09/20/19 at 2:05pm revealed:
-Fall risk assessments should be completed on each resident on admission and if there was any significant change.
-She did not know why fall risk assessments were not completed but would be completed from now on.

Fall risk assessments were requested for Resident #8 on 09/18/19; however, were not provided prior to survey exit.

Refer to the observations of the 100-hall on 09/17/19 at 4:10pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 45 Refer to the second observation of the 100-hall on 09/20/19 at 11:40am. Refer to the interview with a personal care aide (PCA) on 09/17/19 at 09:03am. Refer to the interview with a second PCA on 09/17/19 at 03:58pm. Refer to interview with a third PCA on 09/17/19 at 4:15pm. Refer to the interview with a medication aide (MA) on 09/17/19 at 4:38pm. Refer to the interview with a fourth PCA on 09/18/19 at 7:31am. Refer to the interview with a second MA on 09/20/19 at 11:49am. Refer to the interview with a fifth PCA on 09/20/19 at 11:57am. Refer to the telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm. Refer to the interview with the facility's Clinical Project Director on 09/22/19 at 1:45pm. _____ Observations on the 100-hall on 09/17/19 at 4:10pm revealed: -There were gold stars on the name plates of some of the resident rooms. -There was a gold star next to the resident name who resided in room 111. -There were gold stars next to the two resident names who resided in room 107.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 46 A second observations of the door plates on the 100-hall on 09/20/19 at 11:40am revealed there were no gold stars on the resident name plates. Interview with a personal care aide (PCA) on 09/17/19 at 9:03am revealed: -She knew a resident was a fall risk if they were unstable when they stood up and if they "wobbled". -There was a 72-hour assessment completed when a resident had a fall. -She said that was a "hard question" when asked if she had received instructions on residents that were a fall risk; she did not respond with additional information related to instructions she had received. Interview with second PCA on 09/17/19 at 3:58pm revealed: -At change of shift, the PCAs walked through the hallway completing room by room report on each resident. -The MAs would give the PCAs report. -She was not sure what the gold stars stood for outside of some resident room doors. Interview with third PCA on 09/17/19 at 4:15pm revealed: -If a resident had a gold star outside of their door, the resident was a fall risk. -She could not name all the residents who were fall risks. -If a resident fell, the PCA would notify the MA, the PCAs did not touch the resident. -The PCAs did not check the resident on any specific frequency. They typically rounded every hour and half during the night. Interview with a medication aide (MA) on 09/17/19 at 4:38pm revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 47 -Residents that were a fall risk were indicated in a book at the desk. -Most of the residents that were a fall risk had fall mats or chair and bed alarms. Interview with a fourth PCA on 09/18/19 at 7:31am revealed: -She was working the 200 hall today. -"The department head" did the fall risk assessments. -The PCAs and MAs were responsible for the 72 hours follow up. -The 72 hours follow up required 30 minute checks on the resident. -The 30-minute checks were not documented anywhere. -The 30-minute checks were to make sure the resident was safe and, in a chair, or in the bed. Interview with a second MA on 09/20/19 at 11:49am revealed: -She had been employed at the facility for one year. -There used to be stickers on the residents' rooms name plates. -The gold star meant do not resuscitate. -The orange half circle meant the resident was a fall risk. -She remembered the stickers being up because she had helped put them up (no dates provided). Interview with a fifth PCA on 09/20/19 at 11:57am revealed: -There was a board at the front desk and in the medication room that listed the residents who had fallen. -The resident's name were kept on the board for 72 hours. -There used to be stickers on residents' room doors to identify residents that were fall risk.	D 270		

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 48 -The stickers must have been removed "this week." Telephone interview with the former Executive Director (ED) on 09/20/19 at 1:00pm revealed fall risk assessments were to be done monthly on all residents. Interview with the facility's Clinical Project Director on 09/22/19 at 1:45pm revealed: -In November 2018, a program was implemented at the facility to decrease residents' falls. -The program was significant to the facility because of the number of falls and repeated falls. -The program engaged the residents in activities when awake and staff was trained to anticipate their needs. -When not involved in activities, staff was required to check the residents every 15 minutes when not in bed. -The program required the staff to monitor the residents and documentation which included the residents' behaviors, falls, incontinent issues, and activities. -The program had no more than eight residents participating and there was a 1 to 8 staff/resident ratio. -A staff member was selected by management and trained to work in the program. -The program was working because there were decreased falls and injuries. -An example provided was a resident was falling every day before placed in the program, but decreased to no falls after 90 days in the program -The ED and another manager were trained and copy of the training manual was left in the facility with the ED. -When the former ED started, she was trained on the program by another (outgoing) ED. -The former ED did not continue the program to	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 49	D 270		

decrease the residents' falls.

6. Review of Resident #19's FL-2 dated 11/29/18 revealed:
- Diagnoses included dementia, pain, and generalized weakness.
-The resident's recommended level of care was domiciliary/special care unit

Review of Resident #19's care plan dated 01/25/19 revealed:
-The resident had a history of wandering and ambulated with an aide or a device.
-The resident was forgetful and sometimes disoriented.
-The resident required extensive assistance from the staff with bathing and skin care.

Review of an Accident/Incident report for Resident #19 dated 08/01/19 revealed:
-On 08/01/19 at 8:00am, Resident #19's eyes were red and swollen and the resident complained of pain of both eyes.
-Cold compresses were applied to both eyes and the resident's Primary Care Provider (PCP) was notified.
-The resident was sent to the local emergency department and returned with diagnoses of periorbital cellulitis (inflammation and infection of the eyelid and portions of skin around the eye anterior to the orbital septum) and conjunctivitis (inflammation of the outermost layer of the eye and the inner surface of the eyelids).

Review of a local hospital emergency department report for Resident #19 dated 08/01/19 revealed:
-Resident #19 arrived at the emergency department via ambulance at 8:32am.
-The resident presented with eye problems. She had been rubbing her eyes with baby wipes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 50	D 270		

had used one pack of wipes since last night.
-The resident had bilateral eye redness and swelling.
-The resident was diagnosed with bilateral periorbital cellulitis and bilateral conjunctivitis.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 revealed:
-He was aware Resident #19 was transported to the hospital on 08/01/19 and was diagnosed with conjunctivitis and periorbital cellulitis.
-The resident had dementia and needed to be watched by the staff.
-Staff used the premoistened wipes when providing incontinent care to the residents and the wipes were left in Resident #19's room.
-The staff should not leave the wipes in the residents' rooms.
-He did not know how often the staff checked on Resident #19 when she was in her room but the resident usually sat in the hallway near the nurse's station during the day.

Interview with a first shift personal care aide (PCA) on 09/24/19 at 9:15am revealed:
-Resident #19 was confused and required assistance with activities of daily living (ADLs).
-The resident used a wheelchair to ambulate but could ambulate short distances.
-Around the last week of July 2019, the resident started using the disposable premoistened disposable wipes, which were left in the residents' rooms, to clean her face.
-The PCA observed the resident using multiple sheets of the wipes to wipe her face on multiple occasions.
-She did not stop the resident from using the wipes and did not report it to a supervisor.
-She thought the resident was only using the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 51	D 270		

wipes, but later observed the resident rinsing the wipes under running water at her bathroom sink and pumping the antibacterial soap from the dispenser on the wipes to wash her face and her perineal/vaginal area.
-The resident's face was observed with a red rash and the area around both eyes was red and swollen about one week later.
-The resident complained her eyes were hurting and observed her using the wipes to scrub her face near her eyes.
-The PCA told the resident not to use the wipes or soap in the dispenser to clean her skin but the resident was confused and did not understand.
-The resident was sent to the emergency department and treated for eye infection.
-The resident continued to be checked every 30 minutes and there were no changes in her supervision after first seen using the wipes.

Interview with the Executive Director (ED) on 9/24/19 at 5:25pm revealed:
-She was not aware of the incident with the wipes because she had only been working at the facility since last week.
-Staff should have monitored Resident #19 when she was in her room (every 15-30 minutes) and all of the wipes and hand soap should have been removed from her bathroom immediately.

Based on observations, interviews, and record reviews it was determined Resident #19 was not interviewable.

Attempted telephone interview with Resident #19's primary care provider at 09/18/19 at 12:05pm and 09/19/19 at 4:00pm was unsuccessful.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 270	Continued From page 52 The facility failed to provide supervision for 6 of 12 sampled residents (#1, #2, #3, #5, #7, and #19) in accordance with the facility's policies and procedures and each residents' assessed needs and current symptoms which resulted in 19 falls between 04/28/19 and 09/01/19 resulting in 3 bone fractures, multiple head injuries and a bilateral eye infection. Resident #2 sustained a hip fracture and a head injury; Resident #7 sustained a hip fracture; Resident #5 sustained a nose fracture and head injury; Resident #3 sustained 2 closed head injuries; and Resident #1 sustained a head injury and Resident #19 who rubbed eyes with multiple premoistened body wipes and sustained bilateral eye injury/infection. The facility's failure resulted in serious physical harm which constitutes a TYPE A1 VIOLATION for neglect. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/18/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 24, 2019.	D 270		
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.	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 _____	R 09/24/2019

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 53 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 4 of 12 sampled residents (#4, #5, #14, #17) including failure to notify the primary care provider (PCP) of blood sugars greater than 400 (#5), failure to send a resident to the emergency department who fell and sustained a fractured hip (#14), failure to refer a resident to physical/occupational therapy (#4), and failure to notify the PCP of a resident (#17) with a draining, red, painful eye; bilateral lower extremity pitting edema; mycotic toenails; and an open wound to the outer right great toe. 1. Review of Resident #14's current FL-2 dated 11/29/18 revealed: -Diagnoses included vascular dementia, hypertension, syncope, chronic kidney disease, hyperkalemia and depressive disorder. -There was documentation Resident #14 was intermittently disoriented. -There was documentation Resident #14 was semi-ambulatory and required a wheelchair. Review of Resident #14's care plan dated 11/29/18 revealed: -Resident #14 was sometimes disoriented, had significant loss of memory and needed to be redirected. -Resident #14 was ambulatory with a wheelchair. -There was no documentation completed in the section for the assessment of transfers to/from bed or chair. -Resident #14 was incontinent to bowel and bladder.	D 273		

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D 273	Continued From page 54 -Resident #14 required extensive assistance from staff with bathing, dressing and toileting. Review of an Incident/Accident report for Resident #14 dated 06/12/19 at 5:05am revealed: -It was documented the incident occurred on 06/12/19 at 5:05am. -The incident report was completed on 06/12/19 at 2:39pm by the medication aide (MA) who worked the 11pm-7am shift the previous night (06/11/19) when the incident occurred. -The resident was found sitting on the edge of her wheelchair "holding on". -The resident had a skin tear on the upper outer right arm. -The wound was cleaned, and an antibiotic cream was applied, and it was covered with a 4"x4" bandage. -There was no documentation in the sections: location, witnessed, reported, staff who discovered incident, pain observation, body observation, referral/follow-up, or notifications. Review of a second Incident/Accident report for Resident #14 dated 06/12/19 at 2:00pm revealed: -It was documented the incident occurred on 06/12/19 at 2:00pm. -The incident report was completed by the 06/12/19 at 4:22pm, by the MA who worked the 7am-3pm. -The resident was "complaining of pain". -There was no further documentation describing the pain or location. -There was no documentation in the sections: location, witnessed, reported, staff who discovered incident, pain observation, body observation, or referral/follow-up. -There was documentation the primary care provider (PCP) was notified at 2:15pm, and a message was left for the resident's representative	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 55 at 2:30pm. Review of an Emergency Medical Services (EMS) report for Resident #14 dated 06/12/19 revealed: -At 2:26pm on 06/12/19, EMS arrived at the facility. -EMS found Resident #14 laying in bed "screaming in pain" with no staff in the room. -Resident #14 was alert and disoriented. -Resident #14 stated she remembered falling. -Staff reported Resident #14 fell sometime between 7:00pm and 11:00pm the night before (on 06/11/19). -The fall was unwitnessed and Resident #14 was found lying on the floor around midnight. -The staff reported that Resident #14 had been complaining about right hip pain since the fall so they called EMS. -Resident #14 had a skin tear on her right shoulder with controlled bleeding that was covered with 4x4 gauze. -Resident #14 had a right-hand laceration that was dressed by the facility staff prior to EMS arrival. -Resident #14 was transferred and arrived at the hospital emergency department at 3:45pm. Review of Emergency Department notes for Resident #14 dated 06/12/19 at 4:20pm revealed: -Resident #14 had significant pain of her right hip. -An x-ray of Resident #14's hip showed a right-sided acetabular (hip) fracture. -Resident #14 was admitted to the hospital. Review of the Hospital Discharge Summary for Resident #14 dated 06/21/19 at 2:44pm revealed: -Resident #14 was admitted on 06/12/19 for pain control and consultation to undergo a major procedure to repair her pelvic fracture. -Resident #14 was found to be a non-surgical	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 _____	R 09/24/2019

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D 273	Continued From page 56	D 273		

candidate.
-Resident #14 was discharged back to the adult care facility on 06/21/19 with a hospice consultation and would be placed on blood thinners to prevent clots and pain medication.
-Resident #14 had strict non-weight bearing precautions on her right leg and was to be rolled every two hours to avoid pressure ulcers.

Review of Hospice Notes for Resident #14 dated 06/21/19 to 07/11/19 revealed:
-Resident #14 was admitted to hospice on 06/21/19 with an order for complete bedrest.
-Resident #14 was incontinent to bowel and bladder.
-Resident #14 was ordered Fentanyl Transdermal Patch 72 hour,12MCG/HR, one patch every 72 hours for pain control.
-Resident #14 had to be medicated with Oxycodone 5mg tablet for pain control, 30 minutes prior to personal care and repositioning.
-Hospice was called to the facility on 07/11/19 to assess Resident #14 for death that was confirmed.

Interview with a medication aide (MA) on 09/24/19 at 2:45pm revealed:
-She had taken care of Resident #14 since she was admitted on 09/28/18.
-Resident #14 was a "sweet lady and never complained about anything in the past".
-She was working the 7am-3pm shift on 06/12/19 when Resident #14 was complaining of severe hip pain.
-She was told by a personal care aide (PCA) who worked the 11pm-7am shift on 06/11/19, that Resident #14 was found on the floor at 5:05am the morning of 06/12/19.
-She witnessed Resident #14 in severe pain while sitting in her wheelchair in the dining room at

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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 57 breakfast and at lunch on 06/12/19. -While Resident #14 was eating her breakfast on 06/12/19 she was crying and saying "I'm hurting, I'm hurting". -Resident #14 was also crying that day (06/12/19) during her lunch meal. -Every time someone moved her in her wheelchair on the morning of 06/12/19 she would "scream in pain". -She was not working on Resident #14's hall that morning (06/12/19), but she knew the other MA that was working on Resident #14's hall was calling EMS to have Resident #14 transported to the emergency department. -She thought the other MA had called EMS after breakfast, but when she saw Resident #14 at lunch, she realized then that EMS had not been called yet. Interview with a second MA on 09/24/19 at 3:00pm revealed: -On 06/12/19 she was working the 7am-3pm shift helping the Executive Director (ED) when Resident #14 was complaining of severe hip pain. -The other MA working 7am-3pm on 06/12/19 who was taking care of Resident #14 told her at 2:00pm the resident was experiencing a lot of pain during breakfast and lunch, and was "screaming out in pain" when they put her back in bed after both meals. -On 06/12/19 at 2:00pm, when she was told by the MA (who was taking care of Resident #14) that Resident #14 was having pain, she called EMS to have Resident #14 transferred to the emergency department. -She was told by the MA who worked the previous 11-7 shift on 06/11/19, that Resident #14 obtained a skin tear from the bathroom door knob during the 11-7 shift, and that Resident #14 would not stop yelling out that she was hurting.	D 273		

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 58	D 273		

-She was told by two PCAs that worked the 11pm-7am shift on 06/11/19 that Resident #14 was found on the floor.
-On 06/12/19, the PCA that worked on Resident #14's 200 hall found her on the floor at 5:00am and called the MA for help. They then called another PCA from the 100 hall to help.
-The two PCA's picked Resident #14 up and put her back in bed.
-The 11pm-7am MA did not write an incident report at the time Resident #14 was found on the floor on 06/12/19 at 5:05am.
-The MA completed the incident report later that day (06/12/19) when she was called back to work to write an incident report.
-The MA denied that Resident #14 was found on the floor, but the PCA who helped put Resident #14 back in the bed confirmed in a written statement that Resident #14 was found laying on the floor screaming in pain and that the MA on duty witnessed Resident #14 laying on the floor. No one witnessed Resident #14's fall.
-The protocol for unwitnessed falls was to send the resident to the emergency department if bleeding, injured or in pain, and call the PCP whether the resident was sent to the emergency department or not.

Interview with ED on 9/24/19 at 3:40pm revealed:
-She started as the ED for the facility on 09/16/19.
-She had Resident #14's two incident reports, each dated 06/12/19, with one at 5:05am and one at 2:00pm.
-She had no other information regarding the incidents for Resident #14.
-She was told only what was outlined in the two incident reports.
-For any unwitnessed falls, the resident should be assessed and if there was any indication of injury

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 59	D 273		

or pain, the resident should be sent to the emergency department.
-The PCP was supposed to be notified of all incidents.
-Any resident should be been sent out to the emergency department if found on the floor in pain.
-She did not know there was a delay in sending Resident #14 to the emergency department on 06/12/19.
-If Resident #14 had severe pain during breakfast on 06/12/19, EMS should have been called then; there should not have been a delay to call EMS until 2:00pm on 06/12/19.

Attempted interview on 09/24/19 at 4:00pm with a third shift PCA who worked 11pm-7am on 06/11/19 was unsuccessful.

Attempted interview on 09/24/19 at 4:10pm with a third shift MA who worked 11pm-7am on 06/11/19 was unsuccessful.

Attempted interview on 09/24/19 at 4:15pm with another third shift MA who worked 11pm-7am on 06/11/19 was unsuccessful.

Attempted interview with Resident #5's family member on 09/24/19 at 4:20pm was unsuccessful.

Telephone interview with Resident #14's PCP on 09/24/19 at 4:25pm revealed:
-She was told on the afternoon of 06/12/19 that Resident #14 was being sent to the emergency department because she was in pain after being found on the floor during the 11pm-7am shift on 06/11/19.
-She was not notified prior that Resident #14 was found on the floor on 06/11/19 during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 60	D 273		

11pm-7am shift until 06/12/19 at 2:00pm, when she was being transferred to the emergency department for complaints of pain.
-It was her expectation that any resident found on the floor and in pain should be sent to the emergency department immediately.
-She knew that Resident #14 fractured her hip and was admitted to the hospital but was not eligible for surgery.
-She knew that Resident #14 was discharged to the facility "days later" on Hospice and she was notified "days later" (she can't remember how many days later) that Resident #14 had died.

2. Review of Resident #5's current FL-2 dated 06/03/19 revealed diagnoses included type II diabetes with hyperglycemia, Alzheimer's disease, vascular dementia, dysphagia, abnormalities of gait, repeated falls, cognitive communication deficit, hyperlipidemia, hypertension, and gastroesophageal reflux disease (GERD).

Review of Resident #5's Resident Register revealed an admission date of 06/11/19.

Review of a primary care provider (PCP) order for Resident #5 dated 07/25/19 revealed:
-Use Novolog Flexpen 100/ml insulin pen per sliding scale.
-Check blood sugar before meals and at bedtime.
-Administer Novolog per sliding scale for finger stick blood sugar (FSBS) result of 201-250 give 2 units, for FSBS 251-300 give 4 units, for FSBS 301-350 give 6 units, for FSBS 351-400 give 8 units, and for FSBS 400 and greater give 10 units and call the PCP.

Review of Resident #5's July 2019 electronic medication administration record (e-MAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 61 revealed: -There was an entry for Novolog Flexpen 100/ml insulin pen with sliding scale; check FSBS before meals and at bedtime; follow sliding scale for FSBS result of: 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, 400 and greater give 10 units and call the PCP. -On 07/27/19 at 8:00pm, staff documented Resident #5's FSBS was 409 and 10 units of Novolog insulin administered; there was no documentation of PCP notification. -On 07/28/19 at 8:00pm, staff documented Resident #5's FSBS was 475 and 10 units of Novolog insulin administered; there was no documentation of PCP notification. Review of Resident #5's August 2019 e-MAR revealed: -There was an entry for Novolog Flexpen 100/ml insulin pen with sliding scale; check FSBS before meals and at bedtime; follow sliding scale for FSBS result of: 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, 400 and greater give 10 units and call the PCP. -On 08/12/19 at 5:00pm, staff documented Resident #5's FSBS was 507 and 10 units of Novolog insulin administered; there was no documentation of PCP notification. -On 08/17/19 at 8:00pm, staff documented Resident #5's FSBS was 410 and 10 units of Novolog insulin administered; there was no documentation of PCP notification. Review of Resident #5's September 2019 e-MAR revealed: -There was an entry for Novolog Flexpen 100/ml insulin pen with sliding scale; check FSBS before meals and at bedtime; follow sliding scale for	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 _____	R 09/24/2019

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 62 FSBS result of: 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, greater than 400 give 10 units and call the PCP. -On 09/08/19 at 8:00pm, staff documented Resident #5's FSBS was 458 and 10 units of Novolog insulin administered; there was documentation that the PCP was notified. -On 09/09/19 at 8:00pm, staff documented Resident #5's FSBS was 403 and 10 units of Novolog insulin administered; there was documentation that the PCP was notified. Review of Resident #5's electronic Resident Progress Notes revealed there was no documentation Resident #5's PCP was notified of the following blood sugar results: FSBS 409 on 07/27/19 at 8:00pm, FSBS 475 on 07/28/19 at 8:00pm, FSBS 507 on 08/12/19 at 5:00pm, or FSBS 410 on 08/17/19 at 8:00pm. Observation of Resident #5 on 09/18/19 at 8:30am revealed: -The resident was sitting in his room in a high back wheelchair. -The resident had a two-inch diameter reddened sore that was covered with a scab on his right shin. -The resident had several small reddened sores on both legs. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Interview with a medication aide (MA) on 09/19/19 at 3:25pm revealed: -Resident #5 "always" had high blood sugars (above 201) that required additional Novolog insulin.	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 _____	R 09/24/2019

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 63 -There were several times she had to call Resident #5's PCP for blood sugars greater than 400 since he was admitted. -If she called the PCP for a FSBS greater than 400 she would document it in the "parameters notes" on the e-MAR. -She did not know why she did not document calling the PCP for the 409 BS on 07/27/19 and 475 on 07/28/19. -The process was to document calling the PCP in the "parameters notes" on the e-MAR or in the Resident Progress Notes for BS results 400 and greater. -It was the responsibility of the Resident Care Coordinator (RCC), Director of Resident Care/Licensed Practical Nurse (DRC/LPN) and MAs to assure the medication orders were filled by the pharmacy and listed correctly in the e-MAR. Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful. Interview with the DRC/LPN on 9/23/19 at 10:15am revealed: -He had started working at the facility in July 2019. -He knew Resident #5 had a history of high blood sugars and was on a sliding scale Novolog insulin. -The process for the MA documenting notification of the PCP for a FSBS result of 400 and greater, was to immediately document in the e-MAR under the "parameters notes" section, or in the Resident Progress Notes. -He did not know Resident #5's PCP was not notified for several FSBS results of 400 and greater.	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 _____	R 09/24/2019

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 64	D 273		

Interview with Resident #5's PCP on 09/23/19 at 1:00pm revealed:
-Resident #5 had a history of high blood sugars.
-She had expected the FSBS checks to be done before each meal and at bedtime and Novolog sliding scale insulin given as directed.
-She had expected to be notified for any FSBS 400 and greater for Resident #5.
-She could not remember if she was notified of Resident #5's FSBS result of 409 on 07/27/19 at 8:00pm, FSBS result of 475 on 07/28/19 at 8:00pm, FSBS result of 507 on 08/12/19 at 5:00pm or FSBS result of 410 on 08/17/19 at 8:00pm.
-She knew she had been notified by the MA several times in September 2019 for Resident #5's FSBS greater than 400 and she ordered additional insulin to be given.
-The potential effects on Resident #5 having prolonged uncontrolled high blood sugars could be cardiovascular disease, peripheral vascular disease, neuropathy, visual problems, and kidney failure.

Interview with the Executive Director (ED) on 09/24/19 at 5:00pm revealed:
-She started as the ED for the facility on 09/16/19.
-She did not know Resident #5's PCP was not notified of FSBS results of 400 and greater.
-She expected staff to follow the PCP's orders for FSBS checks and PCP notification.

3. Review of Resident #17's current FL-2 dated 07/31/19 revealed:
-Diagnoses included dementia, hypertension, alcohol abuse, coronary artery disease, and anxiety/acute encephalopathy.
-There was documentation the resident was constantly disoriented and incontinent of bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 65 and bladder. Review of Resident #17's Resident Register revealed: -There was an admission date of 06/28/19. -The resident required assistance with bathing, dressing, transfers, and toileting. -The resident had significant memory loss requiring direction. Review of Resident #17's Initial Resident Assessment Plan (care plan) dated 08/22/19 revealed: -The resident wandered and resisted care; was verbally abusive, disruptive, injurious to self, always disoriented; and had significant memory loss requiring direction. -The resident's skin section was documented as "normal". Pressure areas, decubiti, and other were blank. -The resident was incontinent daily of bowel and bladder. -The resident required extensive assistance form staff with bathing, dressing, transfers, and ambulation. -The resident was fully dependent upon staff for toileting. a. Observation of Resident #17 on 09/23/19 at 2:15pm revealed: -The resident was sitting in a shower chair being showered by a personal care aide (PCA). -The resident's lower legs were swollen from his toes to just below his knees. Observation of Resident #17 on 09/24/19 at 5:55pm revealed: -He was sitting in a wheelchair in his room. -The resident was wearing dark no slip hospital footies.	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 _____	R 09/24/2019

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 66 -The resident's hospital footies were removed by the PCA. -The resident's toes and feet were swollen. -The resident had pitting edema in his bilateral lower extremities just below his knees. -There were circumferential indention's in his bilateral lower extremities just above the ankles where the top of the footies stopped. Interview with a family member for Resident #17 on 09/24/19 at 5:58pm revealed: -The family member did not know the resident had bilateral lower extremity edema. -The family member expected to have been informed the resident had bilateral lower extremity edema. -The family member expected the resident to have been evaluated by the resident's PCP for bilateral lower extremity edema. Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 3:55pm revealed: -All staff were trained on when to notify the Primary Care Provider (PCP) of resident concerns such as a change in status, falls, vital signs out of parameter, unresponsiveness, redness, bruising, and anything that was not normal for the resident. -The last training on when to notify the PCP was in August 2019. -Training on when to notify the PCP was also part of the new hire process. Interview with a PCA on 09/23/19 at 2:15pm revealed: -Resident #17 had bilateral lower extremity edema since he first arrived at the facility. -She had told a medication aide (MA) in the past Resident #17 had bilateral lower extremity	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 _____	R 09/24/2019

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 67	D 273		

edema.
-She did not remember when she had told the MA Resident #17 had bilateral lower extremity edema.
-She would not have documented when she told the MA Resident #17 had bilateral lower extremity edema because she never documented on the residents.
-The MAs would have been responsible for notifying Resident #17's Primary Care Provider (PCP) about the resident's bilateral lower extremity edema.

Interview with a second PCA on 09/23/19 at 2:19pm revealed:
-Resident #17 had swelling in both of his legs since he first arrived at the facility.
-She had told the MAs before Labor Day Resident #17 had swelling in his legs.
-She did not know which MA she had told about Resident #17's bilateral leg swelling.
-She did not document when or who she told about Resident #17's bilateral leg swelling because the PCAs did not document on the residents.

A second interview with the DRC/LPN on 09/23/19 at 2:39pm revealed:
-The MA who was caring for the resident would be responsible for reporting any abnormalities to the PCP either in person or by a phone call.
-Contact with the PCP would be documented in the resident care notes by the MA.
-The MA would contact the on-call provider for nights, weekends, or holidays.
-Sometimes Resident #17's PCP would answer call after hours.
-He had seen Resident #17's bilateral lower extremity edema several times in passing the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 68	D 273		

-Resident #17's lower extremity edema would come and go depending on how much the resident was up during the day.
-Resident #17's PCP examined the swelling in the resident's legs 2 and ½ weeks ago.
-That visit was documented in a PCP visit note and was not in the resident's facility record.
-Not all of Resident #17's PCP visit notes had been filed in the resident's record.
-He would provide all Resident #17's PCP visit notes that were not filed in Resident #17's record.

Interview with a MA on 09/23/19 at 3:40pm revealed:
-Resident #17 had swelling in his legs since the last part of July 2019.
-She had told Resident #17's PCP about the leg swelling sometime after 07/29/19.
-She did not document informing the PCP of Resident #17's leg swelling.
-She thought Resident #17 had been seen by his PCP on 07/31/19.
-She was told by Resident #17's PCP that the swelling in the residents' legs was because of the resident's hernia.
-She had not told Resident #17's PCP about the swelling in the resident's legs since he was seen by the PCP on 07/31/19.

Review of Resident #17's PCP visit notes revealed:
-There were visit notes for 07/31/19, 08/07/19, and 08/14/19.
-There was no documentation of leg edema.

Additional PCP notes were requested for Resident #17 on 09/23/19; however, were not provided prior to survey exit.

Review of Resident #17's progress notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 69	D 273		

from 06/30/19 to 09/20/19 revealed:
-There was no documentation of lower extremity edema.
-There was no documentation the resident's PCP was notified of the lower extremity edema.

Telephone interview with Resident #17's PCP on 09/24/19 at 5:10pm revealed:
-He did not know Resident #17 had bilateral lower extremity edema.
-He expected staff to let him know Resident #17 had bilateral lower extremity edema so he could assess the resident.
-Resident #17 used a wheelchair for mobility, did not elevate his legs, and had peripheral vascular disease (PVD). (PVD causes reduced blood flow to the legs occurring when the veins narrow which cause pain and cramping in the legs, hips, and buttocks.)
-If he had been notified about Resident 17's bilateral lower extremity edema he could have ordered compression stockings (hose that emit pressure to decrease swelling), had the resident elevate his legs to decrease swell, or ordered Lasix (a medication which helps decrease fluid in the body).
-The bilateral lower extremity edema placed Resident #17 at risk for deep vein thrombosis (a blood clot), and stasis disease because he had decreased mobility.

Interview with the Executive Director (ED) on 09/24/19 at 6:15pm revealed:
-She just started at the facility 09/16/19.
-She did not know Resident #17 had bilateral lower extremity edema.
-She expected the PCP to have been notified of Resident #17's bilateral lower extremity edema when first noticed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 70	D 273		

Based on observations, interviews, and record reviews it was determined Resident #17 was unable to answer questions about his bilateral lower extremity edema.

b. Observation of Resident #17 on 09/24/19 at 5:55pm revealed:
-He was sitting in a wheelchair in his room.
-The resident was wearing dark no slip hospital footies.
-The resident's hospital footies were removed by a personal care aide (PCA).
-There was an open wound the size of a half dime located on the residents right outer great toe.
-The inside of the wound was cratered, brownish red, and dry.
-The perimeter of the wound was flaky, and cream colored with redness extending around the wound.

Interview with Resident #17's family member on 09/24/19 at 5:58pm revealed:
-The family member did not know the resident had a wound on his right great toe.
-The family member was upset because the resident had a wound on his right great toe.
-The family member expected the resident to have seen the PCP for the wound on his right great toe.
-The family member expected to have been informed by the facilty the resident had a wound on his right great toe.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 3:55pm revealed:
-All staff were trained on when to notify the Primary Care Provider (PCP) of resident concerns such as a change in status, falls, vital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 71	D 273		

signs out of parameter, unresponsiveness, redness, bruising, and anything that was not normal for the resident.
-The last training on when to notify the PCP was in August 2019.
-Training on when to notify the PCP was also part of the new hire process.

Interview with the PCA on 09/24/19 at 5:55pm revealed:
-She provided personal care to Resident #17.
-She had not noticed the wound on Resident #17's right great toe.
-If she had noticed the wound on Resident #17's right great toe she would have told the MA.

A second interview with the DRC/LPN on 09/23/19 at 2:39pm revealed:
-The MA who was caring for the resident would be responsible for reporting any abnormalities or changes in the resident's skin to the Primary Care Provider (PCP) either in person or by a phone call.
-The MA would contact the on-call provider for nights, weekends, or holidays
-Sometimes Resident #17's PCP would answer call after hours.

A second interview with the DRC/LPN on 09/24/19 at 6:05pm revealed:
-He had seen the wound to the outside of Resident #17's right great toe that was not open around the second week of September 2019.
-He did not notify Resident #17's PCP about the wound because the wound was scabbed and closed at that time.
-He had not followed up on Resident #17's wound because he though the wound was healing and did not need additional care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 72	D 273		

Telephone interview with Resident #17's PCP on 06/24/19 at 6:00pm revealed:
-He had seen Resident #17 last week and did not know about the wound to Resident #17's outer right great toe.
-He had not been told of a wound to Resident #17's outer right toe.
-He expected staff to have told him Resident #17 had a wound.
-He would have ordered a triple antibiotic ointment for the wound to prevent infection.
-It was a possibility the wound could have become infected if left untreated.

Review of Resident #17's progress notes dated from 06/30/19 to 09/20/19 revealed:
-There was no documentation of a wound to Resident #17's outer right great toe.
-There was no documentation the resident's PCP was notified of the wound to Resident #17's outer right great toe.

Interview with the Executive Director (ED) on 09/24/19 at 6:15pm revealed:
-She just started at the facility 09/16/19.
-She did not know Resident #17 had a wound to his outer right great toe.
-She expected Resident #17's PCP to have been informed about the wound as soon as it was discovered.

Based on observations, interviews, and record reviews it was determined Resident #17 was unable to answer questions about the wound on his outer right great toe.

c. Observation of Resident #17 on 09/24/19 at 5:55pm revealed:
-He was sitting in a wheelchair in his room.
-His right eye was closed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 73	D 273		

-The resident opened his right eye on request.
-There was a yellow to cream colored mucus to the residents right upper eye lashes and lid. The lashes were matted.
-The corner of the resident's right upper eye lid was red and swollen.
-The rim of the residents lower right eye was reddish pink in color and swollen.

Interview with Resident #17 on 09/24/19 at 5:55pm revealed:
-His right eye was painful.
-Closing his right eye helped with the pain.
-He did not know how long his right eye had been painful.

Interview with a family member for Resident #17 on 09/24/19 at 5:58pm revealed:
-The resident had right eye pain and drainage for "several weeks".
-The family member had told Medication Aides (MAs) and PCAs the resident's right eye was painful and draining.
-The family member could not remember which MA or PCA had been told.

Interview with a personal care aide (PCA) on 09/24/19 at 6:00pm revealed she had not seen Resident #17's right eye was red and draining.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 3:55pm revealed:
-All staff were trained on when to notify the Primary Care Provider (PCP) of resident concerns such as a change in status, falls, vital signs out of parameter, unresponsiveness, redness, bruising, and anything that was not normal for the resident.
-The last training on when to notify the PCP was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 74	D 273		

in August 2019.
-Training on when to notify the PCP was also part of the new hire process.

A second interview with the DRC/LPN on 09/23/19 at 2:39pm revealed:
-The MA who was caring for the resident would be responsible for reporting any abnormalities or changes in the resident's eye to the Primary Care Provider (PCP) either in person or by a phone call.
-The MA would contact the on-call provider for nights, weekends, or holidays
-Sometimes Resident #17's PCP would answer call after hours.

A third interview with the DRC/LPN on 09/24/19 at 6:05pm revealed he had just been told by the PCA Resident #17's right eye was draining and red.

Review of Resident #17's progress notes dated from 06/30/19 to 09/20/19 revealed:
-There was no documentation the resident's right eye was red, draining, and/or painful.
-There was no documentation the resident's PCP was notified about the resident's right eye draining, red, and/or painful.

Telephone interview with Resident #17's PCP on 09/24/19 at 6:00pm revealed:
-He had last seen the resident 1 week ago.
-He had noticed the resident kept his right eye closed.
-The resident's right eye was not draining or red at that visit.
-He expected staff to have notified him the resident's right eye was red and draining.
-The resident "may" of had conjunctivitis.
-If told the resident's right eye was red and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 75	D 273		

draining, he would have ordered antibiotic eye drops for the resident.

Interview with the Executive Director (ED) on 09/24/19 at 6:15pm revealed:
-She started working at the facility 09/16/19.
-She did not know Resident #17's right eye was painful, red, swollen, and draining.
-She expected Resident #17's PCP to have been notified the residents right eye was painful, swollen, and draining.

d. Observation of Resident #17 on 09/24/19 at 5:55pm revealed:
-He was sitting in a wheelchair in his room.
-The resident was wearing dark no slip hospital footies.
-The resident's hospital footies were removed by the personal care aide (PCA).
-All ten of the resident's toenails were thick and dark yellow.
-The resident's right second to fifth toenails and left great to fifth toenails extended just past the tips of his toes.
-The resident's left great toenail was dark yellow to brownish in color, the base of the toenail was dark gray to black in color.
-The left great toe nail lifted from the nail bed and between the nail bed and nail was black in color. The edges were jagged.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/24/19 at 6:05pm revealed:
-He knew Resident #17's toenails were thick, yellow, and extended past the resident's toes; and the left great toe nail was lifted from the nail bed and between the nail bed and nail was black in color with jagged edges.
-He had not reported Resident #17's toenails 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 _____	R 09/24/2019

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 76	D 273		

the Primary Care Provider (PCP) because he was going to refer the resident to the facility podiatrist on the next scheduled visit to the facility.
-Resident #17 had not previously been seen by the podiatrist.
-He did not know when the podiatrist was scheduled to visit the facility.
-He could not remember the last time the podiatrist was at the facility.
-The podiatrist was scheduled to visit the facility on 09/07/19 but canceled because of Hurricane Dorian.

Review of Resident #17's progress notes dated from 06/30/19 to 09/20/19 revealed:
-There was no documentation the resident's toenails were thick, yellow, and extended past the resident's toes; and the left great toe nail was lifted from the nail bed and between the nail bed and nail was black in color with jagged edges.
-There was no documentation the resident's PCP was notified about the resident's toenails.

Telephone interview with Resident #17's PCP on 09/24/19 at 6:00pm revealed:
-He had not been notified of Resident #17's toenails being yellow, thick, extending past his toes, or the left great toenail elevated from the nail bed and black at the base of the nail and between the nail and nailbed.
-If he had of known of the resident's toenails, he would have referred the resident to podiatry.
-He expected staff to have informed him of the conditions of the residents' toenails.

Interview with the Executive Director (ED) on 09/24/19 at 6:15pm revealed:
-She just started at the facility 09/16/19.
-She did not know Resident #17's toenails where thick, yellow, extended past his toes, and the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 77	D 273		

great toenail was elevated from the nail bed.
-She expected Resident #17's PCP to have been informed of the condition of the resident's toenails as soon as discovered.

Based on observations, interviews, and record reviews it was determined Resident #17 was unable to answer questions about his toenails.
4. Review of Resident #4's current FL-2 dated 11/21/18 revealed diagnoses included vascular dementia, anemia, spinal stenosis, hypertension, osteoarthritis, depression, gastro-esophageal reflux disease, hypothyroidism, anxiety, and left rotator cuff syndrome.

Review of physician's orders for Resident #4 revealed:
-There was a physician's order request dated 06/14/19 for physical therapy/occupational therapy (PT/OT) to evaluate and treat as indicated to increase safety. There was a signature for the primary care provider (PCP) on the request and dated 06/19/19.
-There was a second physician's order request dated 06/18/19 for PT/OT documenting the resident may benefit from PT/OT to decrease risk of falls, increase safety and increase functional independence. There was a signature for the PCP on the request and dated 06/26/19.
-There was a physician's order dated 08/14/19 for PT/OT to evaluate and treat to increase ability to perform self-care tasks, increase safety, and decrease risks of falls.
-There was a physician's order dated 09/04/19 for PT/OT to evaluate and treat to increase overall strength and mobility to facilitate increased independence during functional tasks.

Review of a face-to-face primary care provider encounter for Resident #4 dated 06/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 78	D 273		

revealed:
-The resident was generally weak.
-The resident ambulated independently with a walker.
-The resident had a slow shuffling waddle gait.
-The resident had experienced recurrent falls in the recent and distant past.
-The resident experienced multiple joint aches secondary to arthritic changes to both hips and knees and had a rigid gait.
-The resident would benefit from PT/OT for improving gait, balance, and strength to lower extremities.

Review of a face-to-face primary care provider encounter for Resident #4 dated 08/14/19 revealed:
-The resident was generally weak.
-The resident ambulated independently with a walker.
-The resident had a slow shuffled gait.
-The resident's gait remained unstable and the resident was at high risk for falls with injuries.
-The resident had several falls in the recent and distant past with consequent injuries.
-The resident's mentation had declined and the resident was not a candidate for a cane or a walker.
-The resident had been tried with those assistive devices and was observed carrying the walker rather than using it appropriately, further increasing her instability.
-A wheelchair was implemented, and the resident was observed pushing the wheelchair rather than sitting and using it appropriately.
-The resident would benefit from PT/OT for improving gait, balance, and strength to lower extremities.

Review of Resident #4's record revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 79	D 273		

-There was documentation for an OT evaluation dated 07/03/19.
-There was no further documentation of OT evaluations for Resident #4.
-There was no documentation for any PT evaluations for Resident #4.

Observations of Resident #4 at intervals during the survey revealed the resident walked in the hallways with a slow gait using a rollator walker.

Interview with the primary care provider (PCP) on 09/18/19 at 11:30am revealed:
-He thought Resident #4 had PT/OT numerous times in the past.
-Previous falls for Resident #4 were "sometimes precipitated by trying to keep the resident from falling".

Interview with the contracted therapy provider representative on 09/19/19 at 11:35am revealed:
-She did not have any notes for PT evaluations for Resident #4.
-Resident #4 was on physical therapy from 12/19/18 through 05/16/19 for weakness and unsteadiness which was discontinued by the PCP when the resident had a mild cervical spine injury. The physical therapy was placed on hold pending approval from the PCP to restart.
-She only had one OT evaluation for Resident #4 which was dated 07/03/19.
-She thought Resident #4 may have indicated during the OT evaluation, that she would not participate in PT.
-The therapy provider communicated with the Resident Care Coordinator (RCC) or Executive Director (ED) if a resident refused therapy and expected the facility to document the refusals and get an order to discontinue the therapy.
-The therapy provider screened residents at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 80	D 273		

facility quarterly.
-Therapy referrals could come from their screening, from a fall, or from the physician.
-The 09/04/19 physician's order request for referral to PT was written for a new assessment to continue to evaluate the resident to get her back to baseline.

Second interview with the contracted therapy provider representative on 09/19/19 at 2:58pm revealed:
-A verbal communication was provided to a former RCC (named) on 07/03/19 when Resident #4 refused the PT evaluation after three attempts.
-The contracted therapy provider never received the 08/14/19 order for OT/PT evaluation.
-The 09/04/19 PT/OT evaluation order was received on 09/18/19 when the regional nurse called her about the PT/OT evaluations, which was probably prompted by surveyor inquiry.
-Either the PT or OT evaluation would be completed today (09/19/19) and the other evaluation would be completed on Saturday (09/21/19).

Interview with the Director of Resident Care (DRC/LPN) on 09/19/19 at 6:30pm revealed:
-Orders for PT/OT evaluations were given to him for processing.
-He was responsible for sending PT/OT orders for evaluations to the in-house rehab therapy provider.
-He expected OT/PT orders, which he considered non-emergent, to be processed within 24 hours.
-He was not sure if the 08/14/19 PT/OT evaluation order was the one Resident #4 refused but knew she refused therapy once or twice in August 2019.
-When the facility received orders for the in-house therapy provider, the orders were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 81	D 273		

physically handed to a therapy provider representative.
-He would expect a response from the in-house therapy provider the same day as the order was provided to the contracted therapy provider representative.
-He did not know what happened to the PT/OT evaluation order dated 09/04/19.

Telephone interview with the previous ED on 09/20/19 at 12:25pm revealed:
-Her last day as ED was 09/13/19.
-The facility's corporation had requested the PT/OT evaluations be sent to the in-house rehab provider.
-Any PT/OT evaluation requests were provided to the in-house rehab provider by "walking it over to them".
-She expected the evaluations to be initiated within 24 hours.
-Residents were discussed at daily stand up meetings.
-She did not know Resident #4 did not have the 08/14/19 or 09/04/19 PT/OT evaluations as ordered.

Based on observations and record review, Resident #4 was not interviewable.

_____

The facility failed to assure referral and follow up for Resident #14 who sustained an unwitnessed fall on 06/11/19, was picked up and placed back to bed by two staff members, allowed to cry and scream in pain until emergency management services was called on 06/12/19. On emergency services arrival, the resident was found alone, in her bed screaming in pain; later diagnosed with a hip fracture requiring surgery but was not a surgical candidate. The facility failed to notify Resident #17's Primary Care Provider (PCP) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 82 lower extremity edema, eye pain and drainage, and skin breakdown. The facility's failure resulted in serious injury and neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/19/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 24, 2019.	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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 5 of 8 sampled residents (#2, #5, #6, #10, #17) for	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 _____	R 09/24/2019

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 83	D 276		

fingerstick blood sugar checks (#5, #10), thrombo-embolic deterrent (TED) hose (#5), weekly weights (#5), laboratory tests (#5, #6, #17) and wheelchair and chair alarms (#2).

The findings are:

1. Review of Resident #5's current FL-2 dated 06/03/19 revealed:
-Diagnoses included type II diabetes with hyperglycemia, Alzheimer's disease, vascular dementia, dysphagia, abnormalities of gait, repeated falls, cognitive communication deficit, hyperlipidemia, hypertension, and gastroesophageal reflux disease (GERD).
-The resident was documented as constantly disoriented.
-There was documentation resident required assistance with bathing and dressing.

Review of Resident #5's Resident Register revealed an admission date of 06/11/19.

Review of Resident #5's Initial Resident Assessment Plan dated 08/29/19 revealed:
-The resident was sometimes disoriented, had significant memory loss and needed to be directed.
-The resident was non-ambulatory and required a wheelchair.
-The resident was fully dependent upon staff for toileting, ambulation, bathing, dressing, grooming, and transferring.

a. Review of Resident #5's physician's order dated 06/17/19 revealed an order for fingerstick blood sugar (FSBS) checks four times a day before meals and at bedtime.

Review of Resident #5's June 2019 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 276	Continued From page 84 Medication Administration Record (e-MAR) revealed: -There was a computer-generated entry for FSBS checks four times a day before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm and 8:00pm. -There was no documentation of any blood sugar documented from 06/11/19 through 06/24/19. -There were 2 of 4 opportunities when no blood sugar readings were documented on 06/25/19. -Resident #5's blood sugars ranged from 110 to 344 between 06/25/19 and 06/30/19. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Interview with a medication aide (MA) on 09/19/19 at 3:25pm revealed: -Resident #5 often had high blood sugars that would sometimes require additional insulin to be given based on his sliding scale. -Resident #5's FSBS was supposed to be checked every day before meals and at bedtime. -She did not know there was a delay in Resident #5's FSBS checks being done in June 2019. Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful. Interview with the Former Executive Director (Former ED) on 09/20/19 at 12:30pm revealed: -She did not know there was a delay in Resident #5's FSBS checks being done in June 2019. -The Resident Care Coordinator (RCC) audited the resident records in July 2019 and did not report that there was a delay in FSBS checks being done in June 2019.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 276	Continued From page 85 Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/23/19 at 10:15am revealed: -He had started working at the facility in July 2019. -He was told there had been some delay with Resident #5 getting his FSBS checks prior to his hire. Interview with Resident #5's Primary Care Provider (PCP) on 09/23/19 at 1:00pm revealed: -Resident #5 had a history of high blood sugars. -She thought Resident #5 was getting his FSBS done with his insulin sliding scale when he was admitted on 06/11/19. -She wrote an order on 06/17/19 for FSBS checks four times a day before meals and at bedtime. -She did not know that Resident #5 did not get his FSBS checks after he was admitted until 06/25/19, at which time she re-wrote the order. -She expected the FSBS checks to be done before each meal and at bedtime. -The potential effects on Resident #5 having prolonged uncontrolled high blood sugars could be cardiovascular disease, peripheral vascular disease, neuropathy, vision problems, and kidney failure. -She did not know if Resident #5 had experienced any of these symptoms as a result of not receiving his FSBS checks from his admission to the facility on 06/11/19 until 06/25/19. Interview with the Executive Director (ED) on 09/24/19 at 5:00pm revealed: -She started as the ED for the facility on 09/16/19. -She did not know Resident #5 had a delay in his FSBS checks from 06/17/19 to 06/25/19. -It was her expectation for staff to do FSBS	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 _____	R 09/24/2019

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 276	Continued From page 86	D 276		

checks for Resident #5 as ordered by his PCP.
-It was the responsibility of the RCC, ED and Clinical Manager (CM) to process FSBS orders and manually enter the order onto the eMAR.

b. Review of Resident #5's current FL-2 dated 06/03/19 revealed there was an order for Thrombo-Embolic Deterrent Hose (TED), to be put on every morning and taken off every night.

Observation of Resident #5 on 09/18/19 at 8:30am revealed:
-The resident was sitting in his room in a high back wheelchair.
-The resident was wearing shorts and a short-sleeved shirt but had no shoes or socks on.
-The resident was not wearing TED hose.
-The resident had a two-inch diameter reddened sore that was covered with a scab on his right shin.
-The resident had several small reddened sores on both legs.
-Both resident's lower legs were swollen with approximately one-half inch pitting edema on both ankles where his socks met his ankles.

Additional observations of Resident #5 revealed:
-The resident was not wearing TED hose on 09/18/19 at 5:30pm, 09/19/19 at 12:20pm, 09/20/19 at 11:50am, 09/23/19 at 9:00am, and 09/24/19 at 5:30pm.
-Resident #5's bilateral lower extremities were swollen and there was approximately one-half inch pitting edema on both ankles during each observation.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 276	Continued From page 87 Interview with a medication aide (MA) on 09/19/19 at 3:25pm revealed: -She often passed medications to Resident #5 since he was admitted on 06/11/19. -She did not know Resident #5 had an order for TED hose. -She had never seen Resident #5 wear TED hose. -Resident #5 "always" had swollen legs. Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful. Review of Resident #5's June 2019 electronic Medication Administration Record (e-MAR) revealed there was no entry for TED hose to be put on every morning and taken off every night, or documentation of use. Review of Resident #5's July 2019 e-MAR revealed there was no entry for TED hose to be put on every morning and taken off every night, or documentation of use. Review of Resident #5's August 2019 e-MAR revealed there was no entry for TED hose to be put on every morning and taken off every night, or documentation of use. Review of Resident #5's September 2019 e-MAR revealed there was no for TED hose to be put on every morning and taken off every night, or documentation of use. Interview with the Former Executive Director (Former ED) on 09/20/19 at 12:30pm revealed: -She did not know that Resident #5 had an order for TED hose. -She had never seen Resident #5 wear TED	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 _____	R 09/24/2019

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 88 hose. -Resident #5 "always" had swollen legs. Interview with Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 9/23/19 at 10:15am revealed: -He had started working at the facility in July 2019. -The Executive Director (ED), Resident Care Coordinator (RCC) or former DRC at the time should have communicated with the facility pharmacy that Resident #5 did not have TED Hose. -The process to follow was the staff (ED, RCC or DRC/LPN) would notify the pharmacy of orders. -The pharmacy would request measurements for the TED Hose. -The ED, RCC or DRC/LPN would send measurements to the pharmacy. -The ED, RCC or DRC/LPN would enter the TED hose order in the e-MAR. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/19 at 11:00am revealed: -There was no information in the pharmacy system that Resident #5 had an order for TED hose. -She did not know why Resident #5's TED hose order on the FL-2 was not entered in the e-MAR by the facility. -TED hose were not on Resident #5's dispensing records. -It was the facility's responsibility to inform the pharmacy of the measurements and enter it on the e-MAR. Telephone interview with Resident #5's Primary Care Provider (PCP) on 09/23/19 at 1:00pm revealed:	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 _____	R 09/24/2019

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 89	D 276		

-She did not know Resident #5 had not been wearing his TED hose.
-Resident #5 had bilateral lower extremity edema.
-The potential effects on Resident #5 not wearing his TED hose as ordered included an increase in lower extremity edema and increase in pain due to the swelling.
-She expected Resident #5 to be wearing TED hose every day as ordered on the FL-2 dated 06/03/19.

Interview with the current ED on 9/24/19 at 5:05pm revealed:
-She as the ED for the facility on 09/16/19.
-She did not know Resident #5 was not wearing his TED hose as ordered.
-Measurements for TED hose should have been sent to the pharmacy by the ED, RCC or DRC.
-It was the responsibility of the RCC, ED and Clinical Manager (CM) to process TED hose orders and manually enter the order onto the eMAR.

c. Review of Resident #5's current FL-2 dated 06/03/19 revealed:
-There was an order for weekly weights.
-Resident #5's weight was documented 180.6 pounds (lbs).

Review of an emergency department admission report dated 07/26/19, Resident #5 weight was documented as 200 lbs.

Review of Resident #5's June 2019 electronic Medication Administration Record (e-MAR) revealed there was no entry for weekly weights, and no weights documented.

Review of Resident #5's July 2019 e-MAR revealed there was no entry for weekly weights,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 90 and no weights documented. Review of Resident #5's August 2019 e-MAR revealed there was no entry for weekly weights, and no weights documented. Review of Resident #5's September 2019 e-MAR revealed: -There was an entry for vital signs and weight on the first of each month. -There was no entry for weekly weights. -There was documentation of a weight of 179 lbs. on 09/01/19. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful. Interview with the Former Executive Director (Former ED) on 09/20/19 at 12:30pm revealed: -She did not know Resident #5 had an order for weekly weights on his FL-2. -The personal care aides (PCAs) were supposed to have been recording all weights in a notebook. -She had discovered that some PCAs were not weighing residents as they should had been, so she went into the e-MAR system in August 2019, and entered monthly weights to be completed for all residents on the first of each month. -Beginning on 09/01/19, Resident #5 should have received a monthly weight. Interview with a Divisional Registered Nurse on 09/20/19 at 1:10pm revealed: -There were no weights recorded for Resident #5 in the weight notebook since he was admitted on	D 276		

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

(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 91 06/11/19. -The only weight recorded for Resident #5 since admission was documented on the e-MAR on 09/01/19. Interview with Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 9/23/19 at 10:15am revealed: -He had started working at the facility in July 2019. -He did not know Resident #5 had weekly weights ordered. -The facility policy for all residents was to have monthly weights unless otherwise ordered by the Primary Care Provider (PCP). -The Executive Director (ED), Resident Care Coordinator (RCC) or prior DRC at the time should have clarified with PCP if Resident #5 was to have weekly weights versus monthly. Telephone interview with Resident #5's PCP on 09/23/19 at 1:00pm revealed: -She did not know Resident #5 had an order for weekly weights on his FL-2. -Resident #5 was "fine" with monthly weights. -She expected the PCAs to weigh residents as ordered. -She did not know Resident #5 had a weight gain of 20 lbs in one month when he went to the emergency department in July 2019. -She thought the weight gain could have been an error caused by the weight of his wheelchair since his weight was back down in September 2019. Interview with the current ED on 09/24/19 at 5:05pm revealed: -She started as the ED for the facility on 09/16/19. -She did not know Resident #5 had an order for weekly weights on his FL-2.	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 _____	R 09/24/2019

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 92	D 276		

-It was the responsibility of the RCC, ED and Clinical Manager (CM) to process weight orders and manually enter the order on the eMAR.

d. Review of Resident's #5's physician's order dated 08/13/19 revealed an order for the following laboratory tests: complete blood count (blood test to evaluate overall health), hemoglobin A1C (blood test to show average level of blood sugar over the past 2-3 months), lipid profile (blood test to show a measure of cholesterol and triglycerides), liver enzymes (blood test to show liver enzymes the liver releases in response to disease), vitamin D (blood test to measure the level of Vitamin D), and vitamin B12 (blood test to measure the level of Vitamin B12) .

Review of Resident #5's record revealed there were no results for the labs ordered on 08/13/19.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful.

Interview with the former ED on 09/20/19 at 12:15pm revealed:
-She was not aware Resident #5's labs ordered on 08/13/19 were not completed.
-Orders for labs were supposed to be placed into a designated binder at the nursing station.
-The agency that was contracted by the facility to draw labs for the residents would come to the facility every two weeks and would call prior to their scheduled visit to confirm if there were any pending labs ordered.
-During morning stand-up meetings at the facility,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 93	D 276		

staff would discuss any new orders.
-The Resident Care Coordinator (RCC) and the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) were responsible for following up on any new orders.

Interview with the DRC/LPN on 09/23/19 at 10:15am revealed:
-He had started working at the facility in July 2019.
-Resident #5 did not receive the required lab tests that were ordered on 08/13/19.
-The management team completed a chart audit on 09/20/19, at which time it was discovered Resident #5's tests were not completed.
-He did not know why the lab orders were missed, but it may be because it was not filed chronologically in the record.
-He had called an outpatient provider earlier that day, on 09/23/19, and had scheduled Resident #5 to get the lab tests completed that week.
-He and the RCC were responsible for processing all lab orders.
-The facility utilized a contracted lab provider that came to the facility every two weeks.
-For routine lab tests, he or the RCC would make a copy of the order, complete the lab slip, paperclip both forms together and put it in a designated binder for the lab provider's next visit.
-If the required labs were needed sooner than the date of the lab provider's next visit, they would send a message to the lab provider or would schedule an outpatient visit with another contracted provider who could complete the labs sooner.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 09/23/19 at 1:00pm revealed:
-She was not aware Resident #5's labs ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 94	D 276		

on 08/13/19 were not completed.
-The labs were ordered by another physician she worked with that wanted them completed so he could have a baseline, since he had not seen Resident #5 before.
-Her expectation for lab orders would be to complete the labs as ordered within the given timeframe ordered.

Interview with the Executive Director (ED) on 09/24/19 at 5:00pm revealed:
-She was not aware Resident #5's labs ordered on 08/13/19 were not completed.
-Her expectations for lab orders was to be implemented immediately which was defined as within 24 hours.

2. Review of Resident #17's current FL-2 dated 07/31/19 revealed:
-Diagnoses included dementia, hypertension, alcohol abuse, coronary artery disease, and anxiety/acute encephalopathy.
-There was documentation the resident was constantly disoriented, incontinent of bowel and bladder, and semi-ambulatory.

Review of Resident #17's previous FL-2 dated 06/17/19 revealed:
-Diagnoses included dementia, hypertension, and Wernicke Korsakoff Syndrome. (Wernicke Korsakoff Syndrome is a type of brain disorder caused by lack of Vitamin B-1, or Thiamine).
-There was documentation the resident was intermittently disoriented.

a. Review of a hospital discharge summary for Resident #17 dated 07/29/19 revealed:
-The resident was admitted 07/26/19 and discharged 07/29/19.
-There was documentation the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 95	D 276		

diagnosed with a urinary tract infection (UTI).
-There was an order for Amoxicillin 500 milligrams (mg) every eight hours for a total of nine doses. (Amoxicillin is a medication used to treat infection).

Review of a Primary Care Provider (PCP) visit note for Resident #17 dated 08/07/19 revealed:
-The resident was evaluated for a UTI.
-The resident was diagnosed with a UTI during a hospital admission from 07/26/19 - 07/29/19.
-The resident was discharged from the hospital with orders for Amoxicillin.
-The resident was to complete the course of Amoxicillin as ordered at hospital discharge.

Review of a laboratory (lab) order for Resident #17 dated 08/26/19 revealed an order for urinalysis (UA) with culture and sensitivity (C&S). (A urine test that detects disorders such as a urinary tract infection and grows the bacteria to determine which antibiotic would effectively treat the infection).

Review of Resident #17's PCP visit notes, lab results, and progress notes revealed:
-There was no documentation a UA C&S had been collected per the 08/26/19 order.
-There was no documentation of an attempt to collect a UA C&S.
-There was no documentation the PCP had been notified a urine sample could not be obtained in order to complete the UA C&S lab.

Interview with the former Executive Director (ED) on 09/20/19 at 12:15pm revealed:
-Ordered labs were supposed to be placed into a designated binder at the nursing station.
-The agency that was contracted by the facility to obtain labs would come to the facility every two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 96	D 276		

weeks and would call prior to the scheduled visit to confirm if there were any pending ordered labs.
-During morning stand-up meetings at the facility, staff would discuss any new orders.
-The Resident Care Coordinator (RCC) and the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) were responsible for following up on any new lab orders.

Interview with the DRC/LPN on 09/23/19 at 2:39pm revealed:
-It was the responsibility of the DRC/LPN, medication aides (MA), and RCC to process lab orders.
-The lab orders would be given to the DRC/LPN, MA, or RCC by the provider to process.
-Whoever received the lab order would copy the order and the resident face sheet.
-The lab slip would be completed and placed in the lab binder with the copy of the lab order and resident face sheet.
-The contracted lab provider would come to the facility every other week, review the labs in the lab binder, and perform the ordered labs.
-If the required labs were needed sooner than the date of the lab providers's next visit, they would send a message to the lab provider or would schedule an outpatient visit with another contracted provider who could complete the tests sooner.
-The DRC/LPN, MA, and RCC were responsible to ensure the labs were obtained by reviewing documents in the lab binder for documentation the labs were obtained and the lab results were received.
-He did not know how often the lab binder was reviewed to ensure labs were obtained.
-He had not reviewed the lab binder to ensure labs were obtained since he started, 07/15/19.
-He did not know anything about UA C&S 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 _____	R 09/24/2019

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 97 dated 08/26/19 for Resident #17. Interview with a MA on 09/23/19 at 3:40pm revealed: -The DRC/LPN would be the primary person to get the lab orders from the PCP. -If the DRC/LPN was not in the building, the MA would get the orders from the PCP. -She did not know the process for lab orders. -UA's would be obtained from the residents by the MAs or Personal Care Aides (PCAs). -She had tried to collect the UA C&S for Resident #17. -The UA C&S for Resident #17 could not be obtained because the resident would not void in the urine collection device. -She had asked the DRC/LPN what to do after she tried to collect a urine sample from the resident and the resident did not provide a urine sample. -She never received a response from the DRC/LPN. -She told Resident #17's PCP she could not collect a urine sample for the UA C&S. -She did not remember when she told the PCP she was unable to obtain a urine sample from Resident #17. -She did not remember what Resident 317's PCP said regarding collection of the UA C&S. -She "may not" have documented in Resident #17's progress notes that she notified Resident #17's PCP a urine sample could not be obtained. A second interview with the DRC/LPN on 09/23/19 at 6:05pm revealed the MA did not tell him a urine sample could not be obtained for Resident #17. Interview with the ED on 09/24/19 at 5:00pm revealed she expected all orders needed to be	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 _____	R 09/24/2019

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 98 implemented immediately which was defined as within 24 hours. Telephone interview with Resident #17's PCP on 09/24/19 at 5:10pm revealed: -He did not know why he ordered the UA C&S dated 08/26/18 for the resident. -He did not know the 08/26/19 UA C&S had not been obtained for the resident. -He expected staff to have notified him the UA C&S was not obtained so he could have given different orders. -If he had been notified the UA C&S for the resident had not been obtained, he would have ordered a straight catheterization or sent the resident to the Emergency Department for evaluation of a UTI. Based on observations, interviews, and record reviews, it was determined Resident #17 was not interviewable. Attempted telephone interview with Resident #17's family member on 09/24/19 at 3:30pm was unsuccessful. b. Review of a physicians order for Resident #17 dated 07/31/19 revealed: -There was an order to discontinue Depakote 125mg twice daily (Depakote is a medication used to treat seizure and bipolar disorders). -There was a medication order for Depakote 250mg twice daily. -There was a laboratory (lab) order for a Depakote level in 7 days (08/07/19). (A Depakote level is a lab blood test used to determine the concentration of Depakote in the blood to maintain a therapeutic level of the medication in the bloodstream and monitor toxicity The therapeutic range for Depakote is 50-125 µg/mL)	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 _____	R 09/24/2019

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 99 Review of Resident #17's Primary Care Provider (PCP) visit notes, lab results, and progress notes revealed there was no documentation a Depakote lab level had been obtained for the order dated 07/31/19. Interview with the former Executive Director (ED) on 09/20/19 at 12:15pm revealed: -Ordered labs were supposed to be placed into a designated binder at the nursing station. -The agency that was contracted by the facility to obtain labs on the residents would come to the facility every two weeks and would call prior to the scheduled visit to confirm if there was any pending ordered labs. -During morning stand-up meetings, staff would discuss any new orders. -The Resident Care Coordinator (RCC) and the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) were responsible for following up on any new orders. Interview with the DRC/LPN on 09/23/19 at 2:39pm revealed: -It was the responsibility of the medication aides (MA), DRC/LPN, and RCC to process lab orders. -The lab order would be given to the MA, DRC/LPN, or RCC by the provider to process. -Whoever received the lab order would copy it and the resident face sheet. -The lab slip would be completed and placed in the lab binder with the copy of the lab order and resident face sheet. -The contracted lab provider would come to the facility every other week, review the labs in the lab binder, and perform the ordered lab. -If the required labs were needed sooner than the date of the lab provider's next visit, they would send a message to the lab provider or would	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 _____	R 09/24/2019

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 100	D 276		

schedule an outpatient visit with another contracted provider who could complete the tests sooner.
-The DRC/LPN, MAs, and RCC were responsible to ensure the labs were obtained by reviewing documents in the lab binder for documentation obtained and the lab results were received.
-He did not know how often the lab binder was reviewed to ensure labs were obtained.
-He had not reviewed the lab binder to ensure labs were obtained since he started, 07/15/19.
-He did not know anything about a Depakote level order dated 07/25/19 for Resident #17.

Interview with a MA on 09/23/19 at 3:40pm revealed:
-She did not know anything about a Depakote lab order for Resident #17.
-The DRC/LPN would be the primary person to get the lab orders from the PCP.
-If the DRC/LPN was not in the building the MA would get the orders from the PCP.
-She did not know the process for lab orders.

Interview with the current ED on 09/24/19 at 5:00pm revealed she expected all orders needed to be implemented immediately which was defined as within 24 hours.

Telephone interview with Resident #17's PCP on 09/24/19 at 5:10pm revealed:
-He ordered a Depakote lab to determine if the medication was at a therapeutic level in Resident #17's blood because he was changing the resident's Depakote dosages.
-He had not been notified the 07/25/19 Depakote level had not been obtained.
-If he had known the Depakote level had not been obtained, he would have reordered the level to be certain the medication was at a therapeutic range

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 101	D 276		

in the resident's bloodstream.
-He expected the Depakote lab order to have been performed as ordered.

Based on observations, interviews, and record reviews it was determined Resident #17 was not interviewable.

Attempted telephone interview with Resident #17's family member on 09/24/19 at 3:30pm was unsuccessful.

3. Review of Resident #6's FL-2 dated 05/22/19 revealed diagnoses included unspecified dementia with behavior disturbance, mental retardation, incontinence, and behavior disorder.

Review of a physician's order for Resident #6 dated 06/19/19 revealed there was an order for laboratory (lab) blood work for Resident #6's thyroid-stimulating hormone (TSH) level (A blood test to find out if your thyroid gland is working).

Review of a physician's order from Resident #6's Primary Care Provider (PCP) dated 08/03/19 revealed an order to obtain labs for a complete blood count with a differential (CBCD) (A blood test used to evaluate overall heath. A complete blood count test measures several components of the blood including red blood cells, hemoglobin, hematocrit, and platelets, a complete metabolic panel (CMP) (A blood test that measures glucose level, electrolytes, fluid balance, kidney function, and liver function), a TSH level, and a Hemoglobin A1c (HbA1c) (A common blood test used to diagnose type 1 and type 2 diabetes).

Review of Resident #6's lab results revealed:
-The most current lab results were dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 102 04/19/19. -There was no lab result for the TSH lab ordered on 06/19/19. -Resident #6's had a TSH result of 7.31 on 04/19/19. (The normal reference range for TSH was documented as 0.27-4.20) -There was no lab result for the CBCD, TSH, CMP, and HgbA1c lab ordered on 08/03/19. Review of Resident #6's PCP Notes dated 06/30/19, 07/23/19, 08/01/19, 08/04/19, and 08/21/19 revealed: -Resident #6 had abnormal bloodwork results dated 04/19/19. -Red blood cell count of 3.75L (Low: reference range is 4.20-5.40). -Glucose (GLU) result of 114H (High: reference range is 70-99). -Blood urea nitrogen (BUN) result of 20.6H (High: reference range is 6-20). -Potassium (K+) result of 5.3H (High: reference range is 3.3-5.1). -Aspartate aminotransferase or serum glutamic-oxaloacetic transaminase AST (SGOT) result of 39H (High: reference range is 0-32). -Alkaline phosphatase (ALK PHOS) result of 193H (High: reference range is 40-129). -Osmolality result of 238L (Low: reference range is 285.0-295.0). -Globulin result of 3.8H (High: reference range is 2.0-3.5). -TSH result of 7.31H (High; reference range is 0.27-4.20). -There was no documentation for blood work completed beyond the date of 04/19/19. Telephone Interview with Resident #6's PCP on 09/19/19 at 12:00pm revealed: -He was not aware Resident #6's labs ordered on 06/19/19 and 08/03/19 were not completed.	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 _____	R 09/24/2019

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 103	D 276		

-His expectations for lab orders would be to complete the lab work as ordered.

Interview with the Executive Director (ED) on 09/20/19 at 11:35am revealed:
-She was not aware Resident #6's labs ordered on 06/19/19 and 08/03/19 were not completed.
-She expected for all orders to be implemented immediately which was defined as within 24 hours.

Interview with the former ED on 09/20/19 at 12:15pm revealed:
-She was not aware Resident #6's labs ordered on 06/19/19 and 08/03/19 were not completed.
-Ordered blood work was supposed to be placed into a designated binder at the nursing station.
-The agency that was contracted by the facility to draw blood work on the residents would come to the facility every two weeks and would call prior to the scheduled visit to confirm if there was any pending ordered blood work.
-During morning stand-up meetings at the facility staff would discuss any new orders.
-The Resident Care Coordinator (RCC) and the Director of Resident Care (DRC)/Licensed Practical Nurse (LPN) were responsible for following up on any new orders.

Interview with the DRC/LPN on 09/23/19 at 10:15am revealed:
-He and the RCC were responsible for processing all lab orders.
-The facility utilized a contracted lab provider that came to the facility every two weeks.
-For routine lab tests, he or the RCC would make a copy of the order and complete the lab slip and then paperclip both forms together and put it in a designated binder for the lab's next visit.
-If the required labs were needed sooner than the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 104	D 276		

date of the lab's next visit, they would send a message to the lab vendor or would schedule an outpatient visit with another contracted provider who could complete the tests sooner.

4. Review of Resident #2's current FL2 dated 06/03/19 revealed diagnoses included Alzheimer's disease with late onset, type II diabetes mellitus, depressive disorder, frequency of micturition, muscle weakness, unspecified dementia with behavior disturbance, and dysphagia.

Review of Resident #2's care notes, hospital records and Accident/Incident reports dated from 04/28/19-09/01/19 revealed:
-The resident had a fall on 04/28/19 that resulted in a hip fracture and surgery and a subsequent stay in a rehabilitation (rehab) facility.
-Resident #2's returned to the facility from rehab on 06/03/19.
-The resident had five falls from 07/05/19 - 09/01/19 that resulted in skin tears, contusions, and bruises.

Review of a physician's order for Resident #2 dated 06/10/19 revealed there was an order for a wheelchair.

Review of hospice notes for Resident #2 dated 06/11/19 revealed there was a wheelchair delivered to the facility for Resident #2 and signed for by staff.

Review of a physician's order for Resident #2 dated 06/18/19 revealed there was an order for a chair/bed alarm, hospital bed, and fall mat.

Review of hospice notes for Resident #2 dated 06/20/19 revealed there was a chair/bed alarm,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 276	Continued From page 105 hospital bed and fall mat delivered to the facility and signed for by staff. Review of a physician's order for Resident #2 dated 06/27/19 revealed there was an order for a chair/bed alarm and a wheelchair. Review of hospice notes for Resident #2 dated 06/27/19 revealed there was a chair/bed alarm and a wheelchair delivered and signed for by staff. Observation of Resident #2 on 07/19/19 at 12:00pnm revealed: -She was in her bed without a bed alarm in use. -A medication aide (MA) looked for the bed alarm but was only able to to find the cord to the bed alarm. Review of a physician's order for Resident #2 dated 09/02/19 revealed there was an order to have the chair alarm on while the resident was up in the wheelchair and an order to have the bed alarm on bed while the resident was in bed. Interview with Resident #2's hospice registered nurse (RN) on 09/19/19 at 12:43pm revealed: -Resident #2 was ordered a wheelchair on 06/10/19 which was delivered to the facility on 06/11/19 but was given to another resident. -Resident #2 was ordered a hospital bed, fall mat and chair alarm on 06/18/19; the items were delivered to the facility on 06/20/19 and given to another resident. -Resident#2 was using another resident's wheelchair and did not have a chair alarm in use during her visit on 06/18/19. -She had been to the facility to see Resident #2 again on 06/25/19 and she did not have a chair alarm on at that visit either.	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 _____	R 09/24/2019

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 276	Continued From page 106 -She reordered Resident #2's wheelchair and chair alarm on 06/27/19 and it was delivered to Resident #2 on 06/27/19. Interview with a personal care aide (PCA) on 09/18/19 at 7:31am revealed: -Resident #2 had a fall mat, bed and chair alarm. -She got the fall mat, bed and chair alarm in June 2019. -The fall mat and bed alarm were used every time Resident #2 was in the bed. -The chair alarm was used when Resident #2 was in the chair because she tried to get up and walk. -Resident #2 could not walk. -Resident #2 could stand with assistance to transfer but could not do it without staff assistance. Interview with Resident #2's Primary Care Provider (PCP) on 09/18/19 at 11:36 revealed he expected the chair and bed alarms to be used all the time. Interview with a family member of Resident #2 on 09/19/19 at 4:21pm revealed: -Resident #2 had several falls. -She fractured her hip, had to have surgery, and went to rehab after one of her falls. -She went to visit Resident #2 about a month ago and the chair alarm was not on. -She asked a staff member about the chair alarm, but she did not get an answer. -The chair alarm had been on the visits after that. -Resident #2 also had a bed alarm. -She could not remember how many falls Resident #2 had had since getting the alarms. -She was not aware Resident #2's wheelchair and chair/bed alarm was given to the wrong resident when delivered to the facility in June	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 _____	R 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 107 2019. Interview with the current Executive Director (ED) on 09/20/19 at 10:10am revealed: -She was not working at the facility when Resident #2's wheelchair and chair/bed alarm were delivered to the facility and given to other residents. -Her expectation of what should happen would be when medical equipment arrived at the facility was the equipment would be labeled with the resident's name -An example provided was a wheelchair would be the labeled underneath the arm. -The equipment would be logged in by the serial numbers and the resident name kept on file in the office and then it would be given to the resident. -She expected the correct resident to get equipment when it was delivered to the facility. Telephone interview with the previous ED on 09/20/19 at 1:00pm revealed: -She could not verify Resident #2 had the chair alarm on every time she was in her chair or had a fall. -When Resident#2's wheelchair was delivered, her name was put on the back and it was given to Resident #2. -She could not recall the date the wheelchair was delivered. -She did not know a wheelchair and chair/bed alarms were delivered from the durable medical equipment (DME) provider for Resident #2 that the resident did not receive. Telephone interview with the Clinical Resource Specialist at the DME provider on 09/20/19 at 4:30pm revealed: -She kept a record of each time a wheelchair and chair/bed alarms were delivered to the facility for	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 108 Resident #2. -On 06/11/19 at 2:05pm there was a delivery of a wheelchair to the facility for Resident #2 and signed for by staff. -On 06/20/19 at11:49am there was a delivery for a chair/bed alarm, hospital bed and a fall mat to the facility for Resident #2 and signed for by staff. -There was a second order for a wheelchair and chair/bed alarm delivered on 06/27/19 at 10:14am for Resident #2 and signed for by staff. -On 07/19/19 at 3:09pm there was a pick up of a wheelchair at facility's request because Resident #2 had two wheelchairs in her room. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable. 5. Review of Resident #10's current FL-2 dated 08/06/19 revealed diagnoses included dementia, type II diabetes mellitus, hypertension and chronic renal insufficiency, Review of Resident #10's Resident Register revealed she was admitted on 08/06/19. Review of physician order for Resident #10 dated 08/06/19 revealed there was an order for finger stick blood sugar (FSBS) checks every morning before breakfast and call physician if FSBS was greater than (>) 200. Review of Resident #10's electronic medication administration record for August 2019 revealed: -There was no documentation of FSBS having been checked two out of five days. -There was no documentation of FSBS having been checked on 08/07/19. -There was no documentation of FSBS having been checked on 08/10/19.	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 _____	R 09/24/2019

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 276	Continued From page 109 Review of Resident #10's progress notes dated 08/08/19 at 5:58am revealed: -Resident was found on the floor and her blood sugar was 66 at 5:49. -Resident was sent out to the emergency department (ED). Review of the Emergency Management Service report on 08/08/19 revealed resident #2 was found lying supine on the ground alert but confused. Review of a hospital emergency department discharge record for Resident #2 on 08/08/9 revealed diagnoses included hypoglycemia, fall encounter, and skin tear to the right forearm. Interview with the current ED on 09/20/19 at 2:05pm revealed: -She did not know the orders to check Resident #10's FSBS every morning was not followed. -She started as the ED on 09/16/19. -What should have happened was the order being sent to the pharmacy. -The pharmacy should have reviewed the order. -Then it would have been approved by the Director or Resident Care (DRC) or Resident Care Coordinator (RCC) and the blood sugar would appear on the eMAR. _____ The facility failed to assure implementation of an order for compression stockings for over 4 months for Resident #5, who was a diabetic and had a history of ongoing lower extremity edema, resulting in the resident experiencing ongoing edema and risk of worsening edema and pain related to the edema; failed to implement weekly weights as ordered for over seven weeks; and failed to implement orders for finger stick blood	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 _____	R 09/24/2019

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D 276	Continued From page 110 sugar checks, increasing the resident's risk of high and/or low blood sugar and complications related to unknown high and/or low blood sugar. Resident #17 did not receive an antibiotic to treat a urinary tract infection (UTI) and failed have a laboratory (lab) test completed as ordered to identify if the UTI was resolved, placing the resident at risk of complications of unresolved UTI. Resident #2, who had a history of multiple falls, had a delay in implementation of orders for a wheelchair and bed/chair alarms due to the equipment being given to other residents and the alarms were not used as ordered for the resident's safety and to prevent falls, placing the resident at increased risk for falls and injury. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/20/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2019.	D 276		
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: TYPE B VIOLATION Based on observations, record review, and interviews, the facility failed to ensure residents	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 _____	R 09/24/2019

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 338	Continued From page 111	D 338		

were free from verbal abuse related to a staff member treating/speaking to Resident # 13 in a disrespectful and threatening manner.

The findings are:

Review of Resident #13's current FL-2 dated 07/11/19 revealed a diagnosis of dementia.

Interview with Resident #13 on 09/20/19 at 2:20pm revealed:
-About 2 months month ago, Staff C became angry at her because she walked behind the nurse's station and got a donut.
-She did not remember what Staff C told her, but Staff C draw her hand back at her.
-Staff C did not hit her.
-Staff C told the resident to watch her [explicative] mouth.
-She did not report the incident to anyone.

Interview with Staff C on 09/19/19 at 2:15pm revealed:
-She worked at the facility about 3 ½ -4 years.
-All of the residents had Alzheimer's/dementia and some of the residents had their "moments" and got agitated or had "sundowner's behaviors".
-Resident #13 always sat at the nurse's station when she was out of her room. She thought she worked at the facility and would walk behind the nurse's station or reach over the counter at the nurse's station. The staff would always redirect her.
-About 2 months ago, she was accused of cursing at Resident #13 over donuts after she walked behind the nurse's station and took a donut from a box (they were the staff's donuts).
- She asked Resident #13 to put the donut down and leave from behind the nurse's station.
-The former Executive Director (ED) and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 112	D 338		

Director of Resident Care (DRC) came to the facility at 10:45pm one night in July or August 2019 (do not remember the date) and questioned her about the incident.
-They informed her an anonymous report stated she had cursed at Resident #13 because she picked up a donut from behind the nurses station.
-She was suspended for 2 ½ weeks while the ED investigated the incident, but was allowed to come back to work after the investigation was completed.
-She had not cursed or threatened Resident #13.

Confidential former staff interview revealed:
-About 2 months ago (2nd shift), a hospice agency had delivered donuts for the staff and the donuts were left on the desk at the nurse's station.
-Resident #13 walked behind the nurse's station and picked up one of the donuts.
-She was passing medications on the 100 Hall but could view the nurse's station.
-She heard and saw Staff C "screaming" at Resident #13 "you are not suppose to be back here, stay your [explicative] from behind here".
-This was not the first time she witnessed Staff C screaming at Resident #13.
-About 2 weeks before Staff C "hollered" at Resident #13 at the nurse's station.
- The resident walked to the front entrance after the Emergency Medical Services (EMS) came to the facility to pick up another resident.
-The resident asked EMS what was going on and Staff C screamed at her "none of your [explicative business] and go back where you were. Don't be nosey."
-Other staff were present and observed the incident but she did not remember who they were.
-Staff C did not hit the residents but she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 113 verbally abusive to them. -She did not report the incident to the former ED because she would not have done anything. - If Staff C would have found out, the former staff not sure what she would have done. -She was scared of Staff C because she often became angry at work and used foul and threatening language. Interview with the DRC on 9/20/19 revealed: -The former ED followed up with the report of Staff C's verbal abuse of Resident #13 and the incident involving the donut. -Interviews by the former ED with 2 second shift personal care aides (PCA) revealed they were not aware of Staff C being harsh or verbally abusive to Resident #13. -Staff C was suspended by the former ED for 2 weeks but was allowed to start back to work after the ED finished her investigation. Interview with the current ED on 09/24/19 at 4:05pm revealed: -She was not the ED when the alleged verbal abuse of Resident #13 occurred. -Her expectation was that any type of resident abuse, including verbal abuse be reported to her. -Verbal abuse should be reported to the Healthcare Personnel Registry (HCPR). -There was no documentation of a HCPR report regarding verbal abuse of Resident #13 by Staff C The facility failed to assure the residents were free from mental and physical abuse resulting in Resident #13 being repeatedly subjected to verbal abuse by Staff C. This failure was detrimental to the resident's health, safety and welfare and constitutes a Type B violation.	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 _____	R 09/24/2019

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 114 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2019.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based observations, interviews, and records reviews the facility failed to clarify medication orders for 2 of 6 residents sampled for a diabetic resident who went 43 days without clarification of	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 344	Continued From page 115	D 344		

the sliding scale coverage for insulin (#5) and an antipsychotic (#17).

The findings are:

1. Review of Resident #5's current FL-2 dated 06/03/19 revealed:
-Diagnoses included type II diabetes with hyperglycemia, Alzheimer's disease, vascular dementia, dysphagia, abnormalities of gait, repeated falls, cognitive communication deficit, hyperlipidemia, hypertension, and gastroesophageal reflux disease (GERD).
-There was an order for Levemir100u/ml inject 45units subcutaneously twice a day. (Levemir is a long-acting insulin used to lower high blood sugar.)
-There was an order for Novolog 100u/ml per sliding scale four times per day. (Novolog is a rapid-acting insulin used to lower high blood sugar.)

Review of Resident #5's Resident Register revealed an admission date of 06/11/19.

Review of a subsequent Primary Care Provider (PCP) order for Resident #5 dated 06/17/19 revealed fingerstick blood sugar (FSBS) checks four times a day before meals and at bedtime.

Review of a subsequent PCP order for Resident #5 dated 07/25/19 revealed:
-Use Novolog Flexpen 100/ml insulin pen per sliding scale.
-Check FSBS before meals and at bedtime.
-Administer Novolog per sliding scale for blood sugars 201-250 give 2 units, for blood sugars 251-300 give 4 units, for blood sugars 301-350 give 6 units, for blood sugars 351-400 give 8 units, and for blood sugars 400 and greater give

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 344	Continued From page 116 10 units and call the PCP. Review of the pharmacy dispensing records for Resident #5 from 06/01/19 through 09/23/19 revealed three Novolog Flexpen 100/ml insulin pens were dispensed to the facility on 07/26/19. Review of Resident #5's June 2019 electronic Medication Administration Record (e-MAR) revealed: -There was an entry for Levemir FlexTouch U-100 Insulin pen; 100u/ml inject 45 units subcutaneously twice daily. -There was documentation Levemir 45 units was given at 8:00am and 8:00pm 06/12/19 to 06/30/19. -There was no entry for Novolog Flexpen 100/ml insulin pen with sliding scale from 06/11/19 to 06/30/19. -There was a computer-generated entry for FSBS checks four times a day before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm and 8:00pm. -There was no documentation of FSBS results documented from 06/11/19 through 06/24/19. -There were 2 of 4 opportunities when no FSBS results were documented on 06/25/19. -Resident #5's FSBS results ranged from 110 to 344 from 06/25/19 to 06/30/19. Review of Resident #5's July 2019 e-MAR revealed: -There was an entry for Levemir FlexTouch U-100 Insulin pen; 100u/ml inject 45 units subcutaneously twice daily. -There was documentation Levemir 45 units was given at 8:00am and 8:00pm from 07/01/19 to 07/31/19. -There was an entry for Novolog Flexpen 100/ml insulin pen with sliding scale; check blood sugar	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 117	D 344		

before meals and at bedtime; follow sliding scale: 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, 400 and greater give 10 units and call the PCP.
-There was no documentation Novolog Flexpen 100/ml insulin pen with sliding scale was performed and Novolog administered per sliding scale order from 07/01/19 to 07/24/19 and there was no documentation in the "Exceptions" section.
-There was a computer-generated entry for FSBS checks four times a day before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm and 8:00pm.
-Resident #5's FSBS results ranged from 116 to 412 from 07/01/19 to 07/24/19, with 74 out of 96 blood sugars above 201 that would have required administration of sliding scale insulin (SSI).
-It was documented that Novolog Flexpen 100/ml insulin pen with sliding scale was performed and SSI administered per order from 07/25/19 to 07/31/19.
-Resident #5's FSBS results ranged from 130 to 475 from 07/25/19 to 07/31/19.
-Between 07/25/19 and 07/31/19, there was documentation Resident #5 received between 2-10 units of Novolog insulin for 21 out of 26 opportunities that his blood sugar was above 201.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

Interview with a medication aide (MA) on 09/19/19 at 3:25pm revealed:
-When Resident #5 was admitted on 06/11/19, the pharmacy had called her to get clarification on what sliding scale insulin (SSI) to use.
-She called the PCP and left a message that clarification was needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 118 -She was working and helping the new Executive Director (ED) at the time and thought another MA was following up with the PCP to get Resident #5's sliding scale insulin order clarified. -She did not know Resident #5's Novolog Flexpen with sliding scale was not implemented until 07/25/19, over 6 weeks from when he was admitted. -Resident #5 "always" had high blood sugars (above 201) that required additional Novolog insulin. -There were several times she had to call Resident #5's PCP for blood sugars greater than 400 since he was admitted. -For all new admissions, the FL-2 was faxed to the pharmacy. -The pharmacy would add the medication as a new order in the e-MAR and the Resident Care Coordinator (RCC), Director of Resident Care/Licensed Practical Nurse (DRC/LPN) or MA would approve the order and it would appear on the e-MAR for the staff to see. -It was the responsibility of the RCC, DRC/LPN and MAs to assure the medication orders were filled by the pharmacy and listed correctly on the e-MAR. Telephone Interview with the pharmacist from the facility's contracted pharmacy on 09/20/19 at 9:45am revealed: -Resident #5's FL-2 was faxed to the pharmacy by the facility on 06/11/19. -The pharmacy called the facility on 06/11/19 at 5:21pm and spoke with a MA to get clarification on what sliding scale to use with the Novolog Flexpen 100/ml insulin pen. -The pharmacy had not received any additional clarification from the facility, so the pharmacy called the PCP on 06/17/19 for clarification of the sliding scale.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 119	D 344		

-A verbal order was given on 06/17/19 by the PCP regarding the use of a sliding scale.
-The verbal order was not entered by the pharmacy into the e-MAR until 07/25/19.
-She did not know why the order was not entered by the pharmacy on 06/17/19.
-On 07/26/19, the pharmacy dispensed three Novolog Flexpen 100/ml insulin pens.
-The pharmacy never received any feedback or clarification from the facility regarding the 06/11/19 order for Novolog Flexpen sliding scale.

Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful.

Review of Resident #5's Care Notes revealed:
-On 07/06/19 a MA sent notification to the PCP with documentation which read "Resident's blood sugar has been high lately, he has a Novolog Pen but no order to use it or a sliding scale. Can you look over his blood sugars."
-On 07/11/19, the PCP responded "yes".
-On 07/21/19, the MA documented the PCP was notified that Resident #5's blood sugar was 530 at dinner. The PCP gave a one time dose order of 14 units of Novolog and then a sliding scale order.

Interview with the Former Executive Director (Former ED) on 09/20/19 at 12:30pm revealed:
-She knew there was a delay in starting Resident #5's Novolog sliding scale insulin after he was admitted on 06/11/19..
-The Resident Care Coordinator (RCC) audited the resident records in July 2019, and that was when the error was found in starting Resident #5's sliding scale insulin.
-It was the responsibility of the DRC/LPN, RCC and MAs to process all new admission orders by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 120	D 344		

faxing the FL-2 to the pharmacy as well as getting any required clarification.

Interview with DRC/LPN on 9/23/19 at 10:15am revealed:
-He had started working at the facility in July 2019.
-He did not know Resident #5 had a delay in his Novolog sliding scale insulin upon admission.
-The process to follow was the staff (ED, RCC or DRC/LPN) would notify the pharmacy of orders for new admissions by faxing the FL-2 to the pharmacy..
-The pharmacy would enter the medications in the eMAR and the ED, RCC, DRC/LPN or MA would then go into the system to approve or modify the order, at which time the order would appear for the facility staff to see.
-If an ordered required clarification, it was the responsibility of the DRC/LPN, RCC and MAs to contact the PCP and the pharmacy.
-If there were an "X" in the space on the eMAR, that would indicate the medication had not been started yet possibly because the facility staff had not approved it in the eMAR.
-He was told that back in June 2019, there was only one person who was approving or modifying the pharmacy orders on the eMAR, so there was a chance that Resident #5's medications "got missed".

Interview with Resident #5's PCP on 09/23/19 at 1:00pm revealed:
-Resident #5 had a history of high blood sugars.
-She was not aware that Resident #5 did not get his Novolog sliding scale insulin after he was admitted from 06/11/19 to 07/25/19.
-She had expected the FSBS checks to be done before each meal and at bedtime and Novolog sliding scale insulin given as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 121	D 344		

-The potential effects on Resident #5 having prolonged uncontrolled high blood sugars could be cardiovascular disease, peripheral vascular disease, neuropathy, visual problems, and kidney failure.
-She did not know if Resident #5 had experienced any of these symptoms as a result of not receiving his Novolog insulin per sliding scale insulin as ordered from 06/11/19 to 07/25/19.

Interview with the current Executive Director (ED) on 09/24/19 at 5:00pm revealed:
-She started as the ED for the facility on 09/16/19.
-She did not know that Resident #5 had a delay in Novolog sliding scale insulin after he was admitted on 06/11/19.
-It was her expectation for staff give Resident #5 his medications as ordered by his PCP.
-It was the responsibility of the RCC, ED and Clinical Manager (CM) to process medication orders by faxing them to the pharmacy, validating receipt of the medications and signing off the order on the eMAR so it will appear in the system to be given.
2. Review of Resident #17's current FL-2 dated 07/31/19 revealed:
-Diagnoses included dementia, hypertension, alcohol abuse, coronary artery disease, and anxiety/acute encephalopathy.
-The resident was documented constantly disoriented, incontinent of bowel and bladder, and semi-ambulatory.

Review of a medication order dated 08/05/19 for Resident #17 revealed there was an order for "Haldol 5mg BID prn agitation may take with Klonapin". (Haldol is an antipsychotic medication used to treat certain mental disorders. Clonazepam is generic for Klonapin and is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 122 sedative medication used to treat seizures, anxiety, and panic disorders). Review of a physician's order sheet dated 08/29/19 for Resident #17 revealed there was an order for Haldol 5mg twice daily prn agitation. May take with Clonazepam. Review of August 2019 electronic medication administration record (eMAR) for Resident #17 revealed: -There was an entry for Haldol 5mg twice daily prn agitation. May take with Clonazepam. -There was documentation Haldol was administered on 08/08/19 at 7:01pm, 08/11/19 at 1:10am, 08/12/19 at 12:38pm, 08/13/19 at 2:48am and 2:42pm, 08/16/19 at 1:39am, 08/17/19 at 9:24pm, 08/18/19 at 8:00am, 08/20/19 at 4:54pm, 08/21/19 at 4:23pm, 08/22/19 at 3:14pm, 08/23/19 at 10:55am and 9:24pm, 08/24/19 at 8:19am, 08/25/19 at 8:24pm, and 08/30/19 at 11:51am. Review of September 2019 eMAR for Resident #17 revealed: -There was an entry for Haldol 5mg twice daily prn agitation. May take with Clonazepam. -There was documentation Haldol was administered on 09/04/19 at 4:38pm, 09/06/19 at 1:30pm, 09/09/19 at 1:41pm and 4:34pm, 09/10/19 at 6:42pm, 09/11/19 at 3:24pm, 09/12/19 at 6:57pm, and 09/16/19 at 6:22pm. Interview with a medication aide (MA) on 09/19/19 at 11:50am revealed: -Twice daily prn agitation meant to administer every four to six hours as needed for agitation. -Twice daily meant to administer two times a day. -She would administer Haldol twice daily prn agitation to Resident #17 when he was agitated.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 123 -If Resident #17 was agitated six times a day she would only administer the Haldol as needed twice a day because it was ordered twice daily. -She did not know how often she could administer the Haldol as needed to Resident #17 if he remained agitated other than twice daily because there was not a specified ordered time frame. -If Resident #17 was still agitated after administering one dose of Haldol as needed, she would "maybe" wait two hours before administering a second dose. -She had never had to administer repeat doses of Haldol 5mg as needed for agitation to Resident #17. Interview with the current Executive Director (ED) on 09/19/19 at 12:15pm revealed: -Her first day at the facility was 09/16/19. -The facility did not have a twice daily prn policy. -She did not know there was an order for Resident #17's Haldol that needed clarification. -Haldol twice daily prn agitation was an incomplete order because there was not an hour or time frame specified to administer the Haldol. -The Haldol twice daily prn order needed to be clarified to avoid unnecessary administration or harm to Resident #17. -She expected the prescribing provider to provide twice daily prn time parameters. -She would contact the prescribing provider for clarification. Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/18/19 at 11:00am revealed: -The DRC/LPN, MAs, or Resident Care Coordinator (RCC) would be given the orders by the Primary Care Provider (PCP). -Whoever received the medication order from the PCP would be responsible for obtaining any	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 124 needed clarification for that specific order. -The medication order was then faxed to the pharmacy, the medication order was placed in a new order folder, pharmacy would enter the mediation order in the electronic medication system, the DRC/LPN or RCC would compare the original medication order to what was entered in the electronic medication system to ensure the medication orders matched, the medication order would then be released for the MA to administer the medication. A second interview with the DRC/LPN on 09/23/19 at 1:15pm revealed: -It was the responsibility of the medication aides (MAs) to contact the prescribing provider for medication clarification. -The MA would tell the DRC/LPN, RCC, and/or ED of the need for medication clarification so everyone would know what was going on with the medication. -He was not told clarification was needed for Haldol 5mg twice daily prn agitation. Attempted interview with Resident #17's family member on 09/24/19 at 3:30pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #17 was not interviewable. _____ The facility failed to assure clarification of medication orders for Resident #5 who was an insulin dependent diabetic and went from 06/11/19 - 07/24/19, a total of 43 days, without clarification of Novolog sliding scale coverage with 74 out of 96 opportunities from 07/01/19 - 07/24/19 of a blood sugar greater than 201 which placed the resident at risk for high blood sugar,	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 344	Continued From page 125 cardiovascular disease, and kidney failure. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2019.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION	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 _____	R 09/24/2019

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 126	D 358		

Based on observations, interviews, and record reviews, the facility failed to assure safe policies and procedures were established and maintained for medication administration; failed to assure medications were administered as ordered for 2 of 5 residents (#5, #19) observed during the medication passes, including errors with medications to treat infection, hypertension, fluid and urinary retention, and two vitamin supplements (#5), dry eyes and allergic rhinitis (#19); and for 6 of 7 residents sampled for record reviews (#2, #4, #5, #6, #17, #19) including delays in starting antibiotics (#6), an oral steroid (#19), medications for hypertension, high cholesterol, urinary retention, gastroesophageal reflux disorder, fluid retention (#5), missed doses of medications used to treat hypertension, high blood sugar, depression and psychotic disorders, and sliding scale insulin (#2), and failure to administer an antibiotic and delay in administration of medications used to treat hypertension, heart failure, depression, gastroesophageal reflux disorder, and alcohol withdrawal (#17).

The findings are:

1. The medication error rate was 26% as evidenced by observation of 8 errors out of 30 opportunities during the 8:00am and 9:00am medication passes on 09/18/19.

a. Review of Resident #5's current FL-2 dated 06/03/19 revealed:
-Diagnoses included type II diabetes with hyperglycemia, Alzheimer's disease, vascular dementia, dysphagia, repeated falls, cognitive communication deficit, hyperlipidemia, hypertension, and gastroesophageal reflux disease (GERD).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 127	D 358		

-There was an order for Amlodipine Besylate 5mg daily. (Amlodipine Besylate is used to treat high blood pressure).
-There was an order for Fish Oil 100mg daily. (Fish Oil is used to treat high cholesterol).
-There was an order for Tamsulosin HCL 0.4mg daily. (Tamsulosin is used to treat urinary retention).
-There was an order for Lasix 40 mg daily. (Lasix is used to treat fluid retention).

Review of Resident #5's subsequent physician order sheet dated 08/29/19 revealed:
-There was an order for Amlodipine 5mg daily.
-There was an order for Tamsulosin 0.4mg daily.
-There was an order for Fish Oil 1000mg daily.
-There was an order for Lasix 40mg daily.

Review of Resident #5's medication order dated 09/12/19 revealed there was an order for Vitamin B-12 1000mcg daily. (Vitamin B-12 is a vitamin supplement).

Review of Resident #5's medication order dated 09/16/19 revealed there was an order for Doxycycline 100mg twice daily for ten days. (Doxycycline is an antibiotic used to treat infection.)

Review of Resident #5's September 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine 5mg daily with documentation of administration from 09/01/19 to 09/14/19 at 9:00am and on 09/16/19 to 09/18/19 at 9:00am.
-There was an entry for Vitamin B-12 1000mcg daily with documentation of administration from 09/13/19 to 09/18/19 at 9:00am.
-There was an entry for Doxycycline 100mg twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 128	D 358		

daily for ten days with documentation of administration on 09/18/19 at 8:00am.
-There was an entry for Fish Oil 1000mg daily with documentation of administration from 09/01/19 - 09/18/19 at 9:00am.
-There was an entry for Lasix 40mg daily with documentation of administration from 09/01/19 to 09/13/19 and 09/17/19 to 09/18/19 at 9:00am.
-There was an entry for Tamsulosin 0.4mg daily with documentation of administration from 09/01/19 to 09/18/19 at 9:00am.

Observation of the 8:00am and 9:00am medication passes on 09/18/19 revealed:
-The medication aide (MA) prepared oral morning medications for Resident #5 in a plastic medication administration cup, including Amlodipine 5mg, Lasix 40mg, Vitamin B-12 tablet 1,1000mcg, Doxycycline 100mg capsule, Tamsulosin 0.4mg capsule, and a Fish Oil 1000mg capsule.
-The MA placed 3 teaspoons of applesauce in a separate plastic medication administration cup.
-The MA crushed the Amlodipine, Lasix, and Vitamin B-12 tablet in a plastic sleeve.
-The MA poured the crushed medications into the applesauce in the separate plastic medication cup.
-The MA opened the capsules of Doxycycline and Tamsulosin and sprinkled the granules on the applesauce.
-The MA cut the tip of the Fish Oil capsule and squeezed the oil onto the applesauce.
-The MA mixed the apple sauce with the crushed tablets, granules, and Fish oil.
-The MA administered two separate servings of the apple sauce that contained the prepared medications to Resident #5.
-The MA placed the plastic medication cup in the trash on the side of the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 129	D 358		

-The plastic medication cup contained ¼ teaspoon of the applesauce with crushed medications.
-The applesauce was in the bottom and on the insides of the cup, and on the spoon used to administer the medications to Resident #5.
-Portions of the applesauce in the cup and on the spoon were tinted pink.
-Also, in the applesauce and on the inside sides of the plastic medication cup and on the spoon were tablet fragments that were pink, and white in color.
-The fragments also remained on the inside of the plastic medication cup.

Interview with the MA on 09/18/19 at 8:45am revealed it was normal for applesauce with medication fragments to remain in the plastic medication cup when she prepared and administered Resident #5 his medications.

A second interview with the MA on 09/19/19 at 12:37pm revealed:
-She had never been trained on how to mix and administer medications in applesauce since working at the facility.
-If she had been trained on how to mix and administer medications in applesauce, she would have administered the applesauce with prepared medications correctly to Resident #5.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/18/19 at 11:00am revealed:
-The MAs should always use the least amount of applesauce needed to mix medications and administer to residents to be certain all the medication was administered to the resident.
-He expected the MA to have administered all the applesauce and medication mixture to Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 130 #5. Review of Resident #5's September eMAR revealed: -The MA who performed the 09/18/19 8:00am and 9:00am medication passes administered 7 out of 17 doses of Amlodipine to the resident from 09/02/19 to 09/05/19, on 09/10/19, and from 09/17/19 to 09/18/19. -The MA who performed the 09/18/19 8:00am and 9:00am medication passes administered 2 out of 6 doses of Vitamin B-12 to the resident from 09/17/19 to 09/18/19. -The MA who performed the 09/18/19 8:00am and 9:00am medication passes administered 1 out of 1 doses of Doxycycline to the resident on 09/18/19. -The MA who performed the 09/18/19 8:00am and 9:00am medication passes administered 7 out of 18 doses of Fish Oil to the resident from 09/02/19 to 09/05/19, on 09/10/19, and from 09/17/19 to 09/18/19. -The MA who performed the 09/18/19 8:00am and 9:00am medication passes administered 7 out of 15 doses of Lasix to the resident from 09/02/19 to 09/05/19, on 09/10/19, and from 09/17/19 to 09/18/19. -The MA who performed the 09/18/19 8:00am and 9:00am medication passes administered 7 out of 18 doses of Tamsulosin to the resident from 09/02/19 to 09/05/19, on 09/10/19, and from 09/17/19 to 09/18/19 Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 09/19/19 at 3:07pm revealed: -She did random medication pass observations. -The last random medication pass observation was done one month ago on first and third shifts. -The MA observed during the 09/18/19 8:00am	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 _____	R 09/24/2019

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 131	D 358		

and 9:00am medication passes was observed by her one month ago during third shift.
-There were no concerns with the MA during the random medication pass observation.

Interview with the current Executive Director (ED) on 09/19/19 at 3:55pm revealed:
-She had started working at the facility on 09/16/19.
-She expected the MAs to administer all the mixture containing residents' medications.
-She expected the MAs to look in the medication cup to verify all the mixture containing medications was administered before throwing away the medication cup to ensure all the entire doses of medications were administered.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 09/23/19 at 1:25pm revealed:
-Amlodipine was prescribed to treat the resident's hypertension.
-Hypertension was known as a "silent killer" that could relate to a heart attack or stroke if the resident did not receive the full dose of Amlodipine because the blood pressure would increase.
-Lasix was prescribed to the resident to treat the resident's lower extremity edema.
-She was concerned the resident's lower extremity edema would worsen by not receiving the full dose of Lasix.
-If the resident's lower extremity edema did worsen it would cause pain and delayed wound healing because of no perfusion.
-Tamsulosin was prescribed to treat urinary retention. (Urinary retention is the inability to completely or partially empty the bladder causing urinary tract infection and/or pain.)
-Not receiving the full dose of Tamsulosin could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 132	D 358		

cause an increase in urinary retention.
-Doxycycline was prescribed for the resident to treat an infection.
-She could not remember the exact reason she prescribed Doxycycline to the resident.
-Doxycycline was "probably" prescribed to the resident to treat a respiratory infection.
-Not receiving the full dose of Doxycycline could cause the infection not to clear requiring the resident to receive a longer dose of oral antibiotics or possibly intravenous antibiotics.
-She was not concerned about the resident not receiving a full dose of the Fish Oil or Vitamin B-12 because they were vitamins.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

Attempted telephone interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful.

b. Review of Resident #19's current FL-2 dated 11/29/18 revealed diagnoses included dementia, pain, and generalized weakness.
-There was a medication order for Refresh Tears 0.5% 1 drop (gtt) in both eyes daily.
-There was a medication order for Flonase 50 micrograms (mcg) per actuation instill 1 spray in each nostril daily.

Review of a physician's order sheet for Resident #19 dated 08/29/19 revealed:
-There was a medication order for Refresh Tears 0.5% 1 gtt in both eyes daily.
-There was a medication order for Flonase 50 mcg per actuation instill 1 spray in each nostril daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 133	D 358		

Review of Resident #19's September 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase 50mcg per actuation instill 1 spray into each nostril daily with documentation as administered from 09/01/19 to 09/17/19 at 8:00am.
-There was an entry for Refresh Tears 0.5% instill 1gtt in both eyes twice daily with documentation as administered from 09/01/19 to 09/17/19 at 8:00am and 8:00pm.

Observation of the 8:00am and 9:00am medication passes on 09/18/19 revealed:
-Resident #19 was pushed in her wheelchair from the dining room to the medication cart located on the 200 hallway.
-The medication aide (MA) searched through the medication cart drawers.
-The MA told another MA she was unable to locate Resident #19's Refresh Tears on the medication cart.
-The Refresh Tears were not located and were not administered to Resident #19.
-The MA did not look for the Flonase to administer to Resident #19.
-Flonase was not administered to Resident #19.

Interview with the MA on 09/18/19 at 8:27am revealed Resident #19 had received all the medications due for the 8:00am and 9:00am medication pass other than the Refresh Tears because she could not locate the Refresh Tears on the medication cart.

A second interview with the MA on 09/18/19 at 10:30am revealed:
-She was unsure why Resident #19's Refresh Tears were not on the medication cart during the 09/18/19 medication pass.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 134 -The medication cart "must" have been audited on 09/17/19 because Resident #19's Refresh Tears were on the cart at that time. -Resident #19's Flonase was not administered during the medication pass because it was not on the medication cart. -She did not know why Resident #19's Flonase was not on the medication cart. -The Director of Resident Care/Licensed Practical Nurse (DRC/LPN) said the pharmacy was called 09/18/19 after the medication pass and the Refresh Tears and Flonase would be delivered today (09/18/19) by the pharmacy. Interview with the DRC/LPN on 09/18/19 at 11:00am revealed: -As soon as a medication was discovered not available for administration the MA was to call the pharmacy and have the medication delivered "STAT". -There should never have been a situation when a medication was not available for administration because it could be prevented by cycle fills or contacting the pharmacy when there were about four doses remaining or ordering "STAT". -He was told the morning of 09/18/19 Resident #19's Refresh Tears had expired and was removed from the medication cart 09/17/19. -Resident #19's Flonase was pulled from the medication cart on 09/17/19 because it had also expired. -The pharmacy was called 09/17/19 for a refill on Resident #19's Refresh Tears and Flonase but had not been received. -The pharmacy was called again today (09/18/19) because Resident #19's Refresh Tears and Flonase still had not been received as discovered during the 8:00am and 9:00 am medication pass observation. -Resident #19's Refresh Tears and Flonase	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 _____	R 09/24/2019

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 135 would be delivered today (09/18/19). Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/18/19 at 3:15pm revealed: -Refresh Tears was last filled for Resident #19 on 07/22/19 and should have lasted 75 days. -Refresh Tears was to be disposed of 90 days after opening. -Resident #19's Flonase was last dispensed 06/24/19. -Resident #19's Flonase contained 120 sprays in the bottle and should have lasted 60 days. -The Flonase dispensed on 06/24/19 should have ran out 08/25/19 or 08/26/19. -Resident #19's refill request order for Refresh Tears and Flonase was sent from the facility by (named) MA on 09/17/19 at 10:55pm. -The refills were to be sent the next business day (09/18/19) because they were not ordered "STAT". -If the facility had called and said they needed the Refresh Tears and Flonase the night of 09/17/19, the medications could have been sent and delivered that night. -Pharmacy services were always provided for the facility twenty - four hours a day seven days a week. -There was a back-up pharmacy for the facility for after hours, nights, weekends, and holidays when the regular pharmacy was closed. -If a medication was needed after hours, nights, weekends, or holidays the medication could be ordered "STAT" and would be delivered immediately either from the facility's main contracted pharmacy or the back-up pharmacy. -If a medication was ordered before 5:00pm the medication would be delivered the same day. -If a medication was not ordered "STAT" after hours the medication would be delivered the next	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 _____	R 09/24/2019

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 136 business day. Interview with a second MA on 09/18/19 at 4:20pm revealed: -The Executive Director (ED) removed Resident #19's Flonase and Refresh Tears from the medication cart during a medication cart audit on 09/17/19. -She did not know why they were pulled off the medication cart because she administered the Refresh Tears to Resident #19 the night of 09/17/19. -The ED told her to request a refill of Resident #19's Refresh Tears and Flonase. -She faxed a refill request for Resident #19's Refresh Tears and Flonase to the pharmacy on the night of 09/17/19. -She did not fax the refill request for Resident #19's Refresh Tears and Flonase as "STAT" because she was not told to request the refills as "STAT". -The Refresh Tears and Flonase that were removed from the medication cart on 09/17/19 were stored in the medication room. Observation of Resident #19's Refresh Tears on 09/18/19 at 4:26pm revealed: -The Refresh Tears bottle was blue and stored in a transparent brown plastic medication vial labeled for the resident. -There was a handwritten opened date of 07/30/19 documented on the transparent brown plastic medication vial that contained the Refresh Tears bottle. -The Refresh Tears bottle had documentation of a handwritten opened dated of 04/30/19. -The Refresh Tears bottle had documentation of an electronic expiration date of April 2021. -The Refresh Tears bottle was approximately 1/4th full.	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 _____	R 09/24/2019

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 137 Observation of Resident #19's Flonase bottle on 09/18/19 at 6:00pm revealed: -The Flonase bottle was in a transparent brown plastic medication vial labeled for the resident. -There was a handwritten opened date of 05/20/19 documented on the transparent brown plastic medication vial that contained the residents Flonase bottle. -The Flonase bottle had an electronic label with the resident's name and a date of 05/17/19. -The Flonase bottle had documentation of an electronic expiration date of November 2020. -The Flonase bottle was approximately 1/4th full. Interview with the current ED on 09/18/18 at 4:40pm revealed: -Resident #19 had two bottles of Refresh Tears on the medication cart during the 09/17/19 medication cart audit. -She removed one bottle of Resident #19's Refresh Tears and the Flonase from the medication cart on 09/17/19 during a medication cart audit. -The one bottle of Resident #19's Refresh Tears and the Flonase needed to be re-ordered because the open date for both bottles were greater than 30 days old. -She did not know what happened to the one bottle of Resident #19's Refresh Tears that was left on the medication cart during the 09/17/19 medication cart audit. -The one bottle of Resident #19's Refresh Tears that was left on the medication cart during the 09/17/19 cart audit was not expired. -She gave Resident #19's unexpired bottle of Refresh Tears to (named) MA on 09/17/19 because the resident had an order for Refresh Tears that was due at 8:00pm	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 _____	R 09/24/2019

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 138 A second interview with the second MA on 09/18/19 at 6:03pm revealed: -She did not know who documented the opened dates on Resident #19's Refresh Tears bottle or transparent brown plastic medication vial that contained the Refresh Tears bottle. -She did not know who documented the opened date on Resident #19's Flonase medication vial that contained the Flonase bottle. Review of a pharmacy refill request dated 09/17/19 revealed: -There was a label for Resident #19's Refresh Tears 0.5%. -There was a label for Resident #19's Flonase. -There was handwritten documentation which read "faxed" on the top left corner of the refill request. A second interview with the current ED on 09/19/19 at 3:55pm revealed: -The open date for Resident #19's Flonase was documented on the bottle as 05/20/19. -The Flonase was removed from the medication cart because the 05/20/19 bottle was no longer good. -The Refresh Tears for Resident #19 was expired and removed from the medication cart during the audit on 09/17/19. -She told (named) MA to re-order Resident #19's Flonase and Refresh Tears "STAT" the night of 09/17/19 so they would have been delivered the same night. Interview with the DRC/LPN on 09/23/19 at 12:45pm revealed: -There was no excuse for Resident #19's Refresh Tears and Flonase not being available for administration during the 09/18/19 medication pass.	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 _____	R 09/24/2019

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 139 -Medications ordered "STAT" from the pharmacy would be delivered the same day or night ordered. -He expected providers to be notified when medications were not administered. Telephone interview with Resident #19's PCP on 09/23/19 at 1:25pm revealed: -Refresh Tears was prescribed to Resident #19 for dry eyes. -She expected Refresh Tears to be administered to Resident #19 as ordered. -Not administering Refresh Tears to Resident #19 as ordered could cause the resident's eyes to dry causing pain and discomfort. -Flonase was prescribed to Resident #19 for allergic rhinitis. -She expected the Flonase to be administered as ordered. -Not administering the Flonase to Resident #19 as ordered could cause an increase in allergy and congestion. -She had not been notified Resident #19 did not receive the Refresh Tears or Flonase. Based on observations, interviews, and record reviews it was determined Resident #19 was not interviewable. 2. Review of Resident #4's current FL-2 dated 11/21/18 revealed diagnoses included vascular dementia, anemia, spinal stenosis, hypertension, osteoarthritis, depression, gastro-esophageal reflux disease, hypothyroidism, anxiety, and left rotator cuff syndrome. Review of a primary care provider (PCP) Patient Encounter for Resident #4 dated 07/17/19 revealed:	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 _____	R 09/24/2019

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 140	D 358		

-The resident was seen for follow-up status post a recent emergency department visit on 07/05/19 for a diagnosis of "accidental overdose".
-Staff indicated the resident had taken her own medications and was accidentally administered another residents medications.
-The resident was administered Atorvastatin 20mg (used in conjunction with diet to treat high levels of cholesterol), Clonazepam 0.5mg (a controlled substance used to treat seizures and panic disorders), and Carvedilol 12.5mg (used to treat hypertension and heart disorders) in error.

Review of a Medication Error Report with an Administrator/Manager (ED) signature dated 07/08/19 revealed:
-Resident #4 was listed as the named resident.
-The date of the error was documented as 07/05/19.
-There was documentation the medication error report was completed because medication was given to the wrong resident.
-In addition to the medications documented in the 07/17/19 PCP patient encounter report as administered, other medications listed as administered were preservision areds 250-200-40-1mg (vitamin supplement used to treat eye disorders), omeprazole 40mg (used to treat gastro-esophageal reflux disease and heartburn), Risperidone 0.5mg (used to treat schizophrenia), and Oxycodone 5-325mg (a controlled substance used to treat pain).

Review of an Event Detail report for Resident #4 dated on 07/05/19 at 9:49pm revealed:
-Resident #4 was "accidentally given wrong meds [medications] by [a] trainee".
-The resident's vital signs were documented as temperature 99.2 degrees Fahrenheit, pulse rate was 77, and blood pressure at 155/83mm/Hg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 141 -The resident had returned to the facility from a local hospital ED at 11:46pm on 07/05/19. -There was documentation the report was completed by a former Medication Aide (MA). Review of physician orders for Resident #4 revealed: -There were no physician's orders for Atorvastatin, Clonazepam, Carvedilol, Risperidone, Oxycodone, or preservision areds in any dosage or frequency. -There was a physician's order dated 11/21/18 for omeprazole capsule delayed release 20mg capsule every morning. Review of Resident #4's electronic Medication Administration Records (eMARs) for 07/05/19 revealed: -There was documentation of administration of Lorazepam (used to treat anxiety) 0.5mg tablet at 8:00pm by the former MA. -There was documentation of administration of Duloxetine (used to treat depression and anxiety) delayed release 30mg capsule 8:00pm by the former MA. -There was documentation of administration of Duloxetine delayed release 30mg capsule at 8:00am. -There was documentation of administration of Aspirin (used to treat heart disorders) 81mg delayed release tablet at 8:00am. -There was documentation of administration of Furosemide (used to treat fluid retention) 20mg two tablets at 8:00am. -There was documentation of administration of Potassium Chloride (dietary supplement) 20mEq tablet at 8:00am. -There was documentation of administration of Levothyroxine 150mcg (used to treat a low level of the thyroid hormone) at 9:00am.	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 _____	R 09/24/2019

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 142	D 358		

-There was documentation of administration of Omeprazole 20mg delayed release capsule at 6:30am.
-There was documentation of administration of Diclofenac sodium get 1% (used to treat pain) topical at 8:00am and 8:00pm.

Interview with Resident #4's Primary Care Provider (PCP) on 07/10/19 at 2:50pm revealed he was very worried because Resident #4 received another resident's medications in error along with her own medications.

Second interview with Resident #4's PCP on 09/18/19 at 11:54am revealed:
-Resident #4 had been administered someone else's medication one time.
-He thought the medication aide was training a new medication when the incident occurred.
-Resident #4 was prescribed blood pressure medications and the other resident's medications administered included blood pressure medications. (The PCP did not name the medications the resident had been administered).
-Resident #4 was sent to the local hospital emergency department for evaluation.
-He wanted the hospital to keep the resident overnight for monitoring but could not tell the hospital emergency department what to do, so he told facility staff to "watch" the resident.
-He was notified of the occurrence immediately.
-Facility staff notified him the resident returned to the facility.
-He did not know how the incident occurred, but voiced concern with the Administrator "that it not happen again".

Telephone interview with the former MA on 09/19/19 at 12:42pm revealed:
-She was employed at the facility from 10/2018 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 _____	R 09/24/2019

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 143 07/09/19 as a MA. -She was training another staff member on medication administration on the date Resident #4 was administered wrong medications in error. -The former trainee took the medications she had prepared for another resident and administered the medications to Resident #4 when she got a personal call during the medication pass. -She left to take the personal call and told the former trainee she would be back. -The MA from the other hall (named) came to help out the former MA trainee. - The MA from the 200 hall "took my place on the medication cart for 100-hall." -She did not know how or why Resident #4 was administered the other resident's medication, but guessed the other MA and trainee were not paying attention where she left off to take the call. -She had already administered Resident #4 her 8:00pm medications. -She had prepared the other resident's medication and left the medications in the top drawer of the medication cart. -When she returned from answering her telephone call, she noticed the former trainee and other MA coming out of Resident #4's room together. -She asked them what they were doing in Resident #4's room. -The MA said they had just given Resident #4 her medication. -She did not ask who administered the wrong medications to Resident #4. -The incident occurred after dinner between 7:00pm and 8:00pm. -She contacted the Supervisor and the resident was sent out to the hospital for evaluation. -The former trainee had not been "signed off" to administer medications at the facility. -The former trainee told management she had	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 _____	R 09/24/2019

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 144 administered the medications and had not followed what she was told when the staff went to answer the telephone. Interview with the named MA on 09/19/19 at 4:07pm revealed: -She was working on the 200-hall on 07/05/19 as the MA. -She did not go in Resident #4's room with the former trainee. Second telephone interview with the former MA on 09/19/19 at 3:31pm revealed: -She left the medication cart unlocked when she went to answer the emergent personal telephone call from a family member. -She kept the keys to the medication cart with her. -She was trained to lock the medication cart anytime she was leaving the medication cart. -She had administered Resident #4's medications to the resident and had signed them off on the resident's eMARs. -She had prepared the other resident's medications and checked "prep" but had not administered the medications prior to answering the phone call. Telephone interview with the former Executive Director (ED) on 09/20/19 at 12:45pm revealed: -She was aware Resident #4 had been administered the wrong medications but could not remember exact date. -The MA who was responsible for the medication cart [named] prepared a resident's medication and left the medications out on the medication cart, went to answer a telephone call when the former MA trainee "took it upon herself and administered the medications prepared for another resident to Resident #4.	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 _____	R 09/24/2019

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 145	D 358		

-She thought there were seven (7) medications prepared in the medication cup and administered to Resident #4 in error.
-During training, the trainee was not supposed to touch the medication cart, keys, or anything on the medication cart.
-The medication aide in training was supposed to only "shadow" the MA, and medications should not be left on the medication cart.
-The former MA should have never taken the telephone call until the medication pass was completed.

Interview with the current ED on 09/20/19 at 2:50pm revealed:
-She was not at the facility so anything she said would be hearsay.
-She knew one MA was training another staff as a MA and stepped away from the medication car.
-The trainee administered the prepared medications to Resident #4 in error.
-She would expect if one MA was training another MA, the trainee should not be administering medication.

Interview with the current Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/23/19 at 12:30pm revealed:
-He was hired at the facility on 07/15/19.
-He only remembered the former ED asking him about the medication error report.
-He thought there were 6 or 7 medications but did not know the names of the medications "alleged" to have been administered in error.

Third telephone interview with the former MA on 09/23/19 at 1:25pm revealed:
-When she sent resident #4 out by EMS, she provided EMS with a list of all the other resident's medications scheduled for the 8:00pm medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 146	D 358		

pass, except insulin because she knew she had not prepared the insulin.
-The former trainee had not had any prior training on the medication cart with her.
-She had not been provided any instructions from management as to what to do when training another staff on the medication cart.

Interview with the Clinical Manager (CM) on 09/23/19 at 9:17am revealed:
-She was told the former MA was training another trainee on the medication cart, went to do something with another resident, and the former MA trainee allegedly administered medications to the wrong resident.
-She was told the medications administered to Resident #4 in error were left in a cup in the top drawer of the medication cart but was not told the names of the medications in the cup.
-Every time a MA stepped away from the medication cart, it was supposed to be locked.

Attempted telephone interview on 09/19/19 at 3:29pm, 09/19/19 at 5:08pm, and 09/23/19 at 7:23am with the former trainee who was identified as having administered Resident #4 another resident's medications was unsuccessful.

3. Review of Resident #2's current FL-2 dated 06/03/19 revealed diagnoses included Alzheimer's disease with late onset, type 2 diabetes mellitus, depressive disorder, frequency of micturition, muscle weakness, unspecified dementia with behavior disturbances and dysphagia.

a. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was medication order for Depakote 250mg take one tablet twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 147 (Depakote is used to treat behaviors and/or mental health disorders). Review of Resident #2's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote 250mg take one tablet twice daily with administration times scheduled as 8:00am and 8:00pm. -There was documentation Depakote was not administered from 07/01/19 - 07/05/19 with documentation from 07/01/19 - 07/05/19 which read "drug unavailable." Review of Resident #2's pharmacy dispensing records revealed: -There were 12 tablets of Depakote 250mg dispensed on 06/05/19. -There were 60 tablets of Depakote 250mg dispensed on 07/05/19. Based on observations, record review and interviews, it was determined Resident #2 was not interviewable. Interview with Resident #2's Primary Care Provider (PCP) on 09/19/19 at 12:00pm revealed: -He did not remember being notified that Resident #2 did not receive her Depakote. -Missing doses of Depakote could have caused the resident's behaviors to escalate. -He did not remember if Resident #2 had increased behavior problems. -His expectation was for her to receive all her medications as ordered and to be notified if she did not. Interview with Resident #2's hospice registered nurse (RN) on 09/19/19 at 12:43pm revealed: -She had not been made aware that Resident #2	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 _____	R 09/24/2019

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 148	D 358		

had missed any medications.
-Missed doses of Depakote could have contributed to some of the falls she had in July 2019.
-She expected to be made aware if Resident #2 missed doses of her medications.

Interview with a pharmacist from the facility's contracted pharmacy on 09/19/19 at 3:49pm revealed if Resident #2 missed doses of Depakote she could have an increase in behavior problems.

Interview with the former Executive Director (ED) 09/20/19 at 12:38pm revealed she was not aware Resident #2 was not receiving her medications as ordered in July 2019.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.

b. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was a medication order for Glipizide 10mg take one tablet every day. (Glipizide is used to treat elevated blood sugars).

Review of Resident #2's July 2019 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 149	D 358		

medication administration record (eMAR) revealed:
-There was an entry for Glipizide 10mg take one tablet every day with a scheduled administration time of 8:00am.
-There was documentation Glipizide was not administered on 07/01/19 - 07/21/19.
-There was documentation from 07/01/19 - 07/14/19 at 8:00am which read "drug unavailable."
-There was documentation on 07/15/19 at 8:00am which read "will reorder today."
-There was documentation on 07/16/19 at 8:00am which read "waiting on refill order from doctor."
-There was documentation on 07/18/19 at 8:00am which read "I have wrote a refill order for this medication at least 3 times and gave it to the [staff title], so I am still waiting."
-There was documentation from 07/19/19 - 07/21/19 at 8:00am which read "drug not available."
-There was documentation of finger stick blood sugars (FSBS) ranging from 137mg/dl - 490 mg-dl from 07/01/19 - 07/21/19.

Review of Resident #2's pharmacy dispensing records revealed:
-There were 6 tablets of Glipizide 10 mg dispensed on 06/05/19.
-There were 30 tablets of Glipizide 10 mg dispensed on 07/22/19.

Based on observations, record review and interviews, it was determined Resident #2 was not interviewable.

Interview with Resident #2's Primary Care Provider (PCP) on 09/19/19 at 12:00pm revealed:
-Missing doses of Glipizide could have caused

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 150	D 358		

Resident 2's blood sugars to be elevated.
-His expectation was for the resident to receive all her medications as ordered and to be notified if she did not.
-He did not remember being notified Resident #2 did not receive her Glipizide as ordered.

Interview with a pharmacist from the facility's contracted pharmacy on 09/19/19 at 3:49pm revealed if Resident #2 missed doses of Glipizide, she could have increased blood sugars.

Interview with the former Executive Director (ED) 09/20/19 at 12:38pm revealed she was not aware Resident #2 was not receiving her medication as ordered in July 2019.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.

c. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was a medication order for Lisinopril 20mg take one tablet every day. (Lisinopril is used to treat high blood pressure).

Review of Resident #2's July 2019 electronic medication administration record (eMAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 151	D 358		

revealed:
-There was an entry for Lisinopril 20mg take one tablet every day with a scheduled administration time of 8:00am.
-There was documentation Lisinopril was not administered from 07/01/19 - 07/06/19 with with documentation which read "drug unavailable."

Review of Resident #2's pharmacy dispensing records revealed:
-There were 6 tablets of Lisinopril 20 mg dispensed on 06/05/19.
-There were 30 tablets of Lisinopril 20 mg dispensed on 07/05/19.

Based on observations, record review and interviews, it was determined Resident #2 was not interviewable.

Interview with Resident #2's Primary Care Provider (PCP) on 09/19/19 at 12:00pm revealed:
-Missing doses of Lisinopril could have caused Resident #2's blood pressure to be elevated.
-His expectation was for her to receive all her medications as ordered and to be notified if she did not.
-He did not remember being notified that Resident #2 did not receive her Lisinopril as ordered.

Interview with a pharmacist from the facility's contracted pharmacy on 09/19/19 at 3:49pm revealed if Resident #2 missed doses of Lisinopril, it could cause her to have increased blood pressure.

Interview with the former Executive Director (ED) 09/20/19 at 12:38pm revealed she was not aware Resident #2 was not receiving her medication as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 152 ordered in July 2019. Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm. Refer to the interview with the former ED on 09/20/19 at 12:38pm. Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm. Refer to the interview with the current ED on 09/24/19 at 5:00pm. Refer to the second interview with the current ED on 9/24/19 at 5:25pm. d. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was a medication order for Tamsulosin 0.4mg take one tablet every day. (Tamsulosin is used to treat urinary retention). Review of Resident #2's July 2019 electronic medication administration record (eMAR) revealed: -There was a computer generated entry for Tamsulosin 0.4mg take one tablet every day with a scheduled administration time of 9:00am. -There was documentation Tamsulosin was not administered from 07/19/19 - 07/26/19. With documentation which read "drug unavailable." Review of Resident #2's pharmacy dispensing records revealed: -There were 15 tablets of Tamsulosin 0.4mg dispensed on 06/26/19. -There were 15 tables of Tamsulosin 0.4mg dispensed on 07/23/19.	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 _____	R 09/24/2019

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 153 Based on observations, record review and interviews, it was determined Resident #2 was not interviewable. Interview with Resident #2's Primary Care Provider (PCP) on 09/19/19 at 12:00pm revealed: -Missing doses of Tamsulosin could have caused Resident #2 to have difficulty urinating. -His expectation was for her to receive all her medications as ordered and to be notified if she did not. -He did not remember being notified that Resident #2 did not receive her Tamsulosin as ordered. Interview with a pharmacist from the facility's contracted pharmacy on 09/19/19 at 3:49pm revealed if Resident #2 missed doses of Tamsulosin, it could cause difficulty with urination. Interview with the former Executive Director (ED) 09/20/19 at 12:38pm revealed she was not aware Resident #2 was not receiving her medication as ordered in July 2019. Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm. Refer to the interview with the former ED on 09/20/19 at 12:38pm. Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm. Refer to the interview with the current ED on 09/24/19 at 5:00pm. Refer to the second interview with the current ED	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 _____	R 09/24/2019

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 154 on 9/24/19 at 5:25pm. e. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was a medication order for Mirtazapine 7.5mg take one tablet every day at bedtime. (Mirtazapine is used to treat depression). Review of Resident #2's July 2019 electronic medication administration record (eMAR) revealed: -There was a computer generated entry for Mirtazapine 7.5mg take one tablet every day with a scheduled administration time of 8:00pm. -There was documentation Mirtazapine was not administered from 07/01/19 - 07/24/19 with documentation which read "drug unavailable." Review of Resident #2's pharmacy dispensing records revealed: -There were 6 tablets of Mirtazapine 7.5mg dispensed on 06/05/19. -There were 30 tablets of Mirtazapine 7.5mg dispensed on 07/24/19. Based on observations, record review and interviews, it was determined Resident #2 was not interviewable. Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 8:25am revealed: -He stated at the facility on 07/15/19. -He was not sure why Resident #2 did not get her Mirtazapine. Interview with Resident #2's Primary Care Provider (PCP) on 09/19/19 at 12:00pm revealed: -Missed doses of Mirtazapine could have caused Resident #2 to have an increase in behavior	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 _____	R 09/24/2019

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 155	D 358		

problems especially "sundowners".
-His expectation was for her to receive all her medications as ordered and to be notified if she did not.
-He did not remember being notified that Resident #2 did not receive her Mirtazapine.

Interview with the former Executive Director (ED) 09/20/19 at 12:38pm revealed she was not aware Resident #2 was not receiving her medication as ordered in July 2019.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.

f. Review of a physician's order for Resident #2 dated 06/28/19 revealed there was an order for Novolog Flex Pen Insulin 100 units (U) /milliliter(ml) sliding scale insulin (SSI) three times a day before meals according to the following sliding scale: for finger stick blood sugar (FSBS) of 0-200, give 0 units; for FSBS of 201-250, give 2 units; for FSBS of 251-300, give 3 units; for FSBS of 301-350, give 4 units; and for FSBS greater than 350 call the physician. (Novolog Flex Pen is a rapid acting insulin used to lower blood sugar).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 156 Review of Resident #2's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flex Pen 100U /ml SSI three times a day before meals according to the following sliding scale: for finger stick blood sugar (FSBS) of 0-200, give 0 units; for FSBS of 201-250, give 2 units; for FSBS of 251-300, give 3 units; for FSBS of 301-350, give 4 units; and for FSBS greater than 350 call the physician with scheduled administration times of 7:00am, 12:00pm, and 5:00pm. -On 07/01/19 at 5:00pm, Resident #2's FSBS was documented as 332 which would have required 4 units of SSI; the quantity of Novolog SSI documented was 0 Units and there was no administration site documented. -On 07/02/19 at 5:00pm, Resident #2's FSBS was documented as 361mg units; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -On 07/04/19 at 12:00pm, Resident #2's FSBS was documented as 261mg which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -On 07/05/19 at 12:00pm, Resident #2's FSBS was documented as 250mg which would have required 2 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -On 07/07/19 at 12:00pm, Resident #2's FSBS was documented as 293mg which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -On 07/08/19 at 12:00pm, Resident #2's FSBS was documented as 248 which would have required 2 units of SSI; the quantity of Novolog	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 _____	R 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 157 SSI documented was 0 units and there was no administration site documented. -There was documentation Novolog SSI was not administered from 07/09/19 - 07/20/19. -On 07/11/19 at 12:00pm, Resident #2's FSBS was documented as 343 which would have required 4 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -On 07/12/19 at 12:00pm, Resident #2's FSBS was documented as 294 which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -On 07/15/19 at 12:00pm, Resident #2's FSBS was documented as 261 which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented. -There was documentation on 07/19/19 at 5:00pm Resident #2's FSBS was documented as 335, which would have required 4 units of SSI; no SSI was administered with documentation which read "drug unavailable." -There was documentation on 07/20/19 at 7:00am Resident #2's FSBS was documented as 215, which would have required 2 units of SSI; no SSI was administered with documentation which read "drug unavailable." -There was documentation on 07/20/19 at 5:00pm Resident #2's FSBS was documented as 246, which would have required 2 units of SSI; no SSI was administered with documentation which read "drug unavailable." Interview with a medication aide (MA) on 09/24/19 at 2:55 pm revealed: -When the FSBS result was entered into the eMAR, the amount of SSI to administer automatically came up.	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 _____	R 09/24/2019

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D 358	Continued From page 158	D 358		

-Documentation of the site of administration must be entered in manually after that.
-She did not know how to tell if Resident #2 was administered the SSI as ordered or not.
-She did not remember not administering Resident #2 insulin on 07/01/19 and 07/02/19 at 5:00pm.
-She did not know why 0 units was documented on 07/01/19 and 07/02/19 as administered and no site of administration was documented.
-She would only document 0 units if none was need according to the sliding scale.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Novolog Flex Pen 100U /ml SSI three times a day before meals according to the following sliding scale: for finger stick blood sugar (FSBS) of 0-200, give 0 units; for FSBS of 201-250, give 2 units; for FSBS of 251-300, give 3 units; for FSBS of 301-350, give 4 units; and for FSBS greater than 350 call the physician with scheduled administration times of 7:00am, 12:00pm, and 5:00pm.
-There was documentation of 45 times SSI was due, but SSI was documented as given 33 times.
-On 08/02/19 at 12:00pm, Resident #2's FSBS was documented as 269 which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/20/19 at 12:00pm, Resident #2's FSBS was documented as 242 which would have required 2 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/21/19 at 12:00pm, Resident #2's FSBS was documented as 260 which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no

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D 358	Continued From page 159	D 358		

administration site documented.
-On 08/22/19 at 5:00pm, Resident #2's FSBS was documented as 342 which would have required 4 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/23/19 at 12:00pm, Resident #2's FSBS was documented as 324 which would have required 4 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/24/19 at 12:00pm, Resident #2's FSBS was documented as 305 which would have required 4 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/25/19 at 5:00pm, Resident #2's FSBS was documented as 298 which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/26/19 at 5:00pm, Resident #2's FSBS was documented as 300 which would have required 3 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/27/19 at 12:00pm, Resident #2's FSBS was documented as 320 which would have required 4 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/28/19 at 5:00pm, Resident #2's FSBS was documented as 219 which would have required 2 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.
-On 08/29/19 at 5:00pm, Resident #2's FSBS was documented as 240 which would have required 2 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 160	D 358		

administration site documented.
-On 08/31/19 at 12:00pm, Resident #2's FSBS was documented as 210 which would have required 2 units of SSI; the quantity of Novolog SSI documented was 0 units and there was no administration site documented.

Review of Resident #2's pharmacy dispensing records revealed:
-There were 3 Novolog Flex Pens dispensed on 06/14/19.
-There were 3 Novolog Flex Pens dispensed on 07/20/19.

Based on observations, record review and interviews, it was determined Resident #2 was not interviewable.

Interview with a second MA on 09/20/19 at 2:05pm revealed:
-When the FSBS result was entered into the eMAR, the amount of SS insulin that was to be administered came up.
-She did not know why the eMAR had would documentation of 0 units if there was insulin to be given.
-She did not know if 0 units meant it was administered or not since she was not the MA on the medication cart at that time it was documented.

Interview with a third MA on 09/24/19 at 3:20pm revealed:
-Once the FSBS result was entered on the eMAR, the amount of SSI to be administered came up.
-The site of administration must be documented manually, but the number of units of SSI came up and did not have to be manually documented.
-There was no way to tell if Resident #2 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 161	D 358		

administered the SSI as ordered unless the MA remembered administering the SSI.
Interview with the Resident Care Coordinator (RCC) on 09/19/19 at 8:12am revealed:
-When the FSBS result was entered onto the eMAR, the amount of SSI to be administered came up.
-The number of units of SSI administered and the site of administration must be documented.
-She did not know if Resident #2's SSI insulin was given or not, since it was not documented.

Interview with Resident #2's Primary Care Provider (PCP) on 09/19/19 at 12:00pm revealed:
-Missed doses of Novolog SSI could have caused Resident #2's blood sugars to be higher than they were.
-It would also have depended on what she was eating if her blood sugars would have been higher.
-His expectation was for the resident to receive all her medications as ordered and to be notified if she did not.
-He did not remember being notified that Resident #2 did not receive her Novolog SSI as ordered.

Interview with a pharmacist from the facility's contracted pharmacy on 09/19/19 at 3:49pm revealed if Resident #2 did not receive her Novolog SSI, it could have caused her blood sugars to be higher.

Interview with the former Executive Director (ED) 09/20/19 at 12:38pm revealed she was not aware Resident #2 was not receiving her medications as ordered in July 2019.

Interview with the current Executive Director on 09/24/19 at 3:59pm revealed:

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

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D 358	Continued From page 162 -She just started on 09/16/19. -She could not explain the documentation of 0 units of SSI on Resident #2's eMAR when there should have been SSI administered. -She did not know how to tell if Resident #2's SSI was administered or not. Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm. Refer to the interview with the former ED on 09/20/19 at 12:38pm. Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm. Refer to the interview with the current ED on 09/24/19 at 5:00pm. Refer to the second interview with the current ED on 9/24/19 at 5:25pm. 4. Review of Resident #17's current FL-2 dated 07/31/19 revealed: -Diagnoses included dementia, hypertension, alcohol abuse, coronary artery disease, and anxiety/acute encephalopathy. -There was documentation the resident was constantly disoriented, incontinent of bowel and bladder, and semi-ambulatory. Review of Resident #17's previous FL-2 dated 06/17/19 revealed: -Diagnoses included dementia, hypertension, and Wernicke Korsakoff Syndrome. (Wernicke Korsakoff Syndrome is a brain disorder caused by lack of Vitamin B-1 or Thiamine.) -There was documentation the resident was intermittently disoriented.	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 _____	R 09/24/2019

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 163 a. Review of a hospital discharge summary for Resident #17 dated 07/29/19 revealed: -The resident was admitted 07/26/19 and discharged 07/29/19. -The diagnosis was documented as Enterococcus faecalis urinary tract infection (UTI). -There was an order for Amoxicillin 500 milligrams (mg) every eight hours for a total of nine doses. (Amoxicillin is an antibiotic used to treat infection). Review of Resident #17's current FL-2 dated 07/31/19 revealed: -There was a medication order which read "Amoxicillin 500mg". -The medication order for Amoxicillin did not have a frequency or duration documented. Review of Resident #17's electronic medication administration record (eMAR) for July and August 2019 revealed there was no entry for Amoxicillin 500mg every eight hours, and no documentation Amoxicillin was administered. Review of Resident #17's pharmacy dispensing records revealed Amoxicillin had not been dispensed for Resident #17. Review of a hospital Emergency Department visit note for Resident #17 dated 08/04/19 revealed: -The resident was referred to the Emergency Department because of confusion, after administration of another (named) medication. -There was a Urinalysis (UA), Reflex performed. (A urine test to determine bacterial infection. If infection is resulted, a culture is performed. A culture determines the bacteria causing the infection and what antibiotic will treat 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 _____	R 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 164	D 358		

bacteria).
-The urine results contained trace leukocytes. (Leukocytes are enzymes in white blood cells. When leukocytes are present in urine there is an indication of infection. The normal values are negative).
-The leukocytes levels were 8. (Normal value is 0 to 3).
-The resident was diagnosed with acute cystitis (Cystitis is an inflammation of the urinary bladder usually related to a bacterial infection).

Review of a hospital Emergency Department medication order for Resident #17 dated 08/04/19 revealed there was an order for Cephalexin 500mg three times daily for seven days. (Cephalexin is an antibiotic used to treat infections such as urinary tract infections).

Interview with the Director of Resident Care /Licensed Practical Nurse (DRC/LPN) on 09/23/19 at 2:39pm revealed:
-He did not remember anything about the 07/29/19 hospital discharge summary for Resident #17.
-The hospital discharge summaries were not used for medication orders because the hospital provider did not know what medications the residents were taking.
-The residents' Primary Care Provider (PCP) would be called when residents returned from the hospital to obtain orders.
-The medication aide (MA) who received the resident's hospital paper work when the resident returned from the hospital was responsible for reviewing and processing the orders.
-He never saw Resident #17's 07/31/19 FL-2.
-The Amoxicillin order on Resident #17's 07/31/19 FL-2 was an incomplete order because there was not a frequency or duration listed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 165 -If the Amoxicillin for Resident #17 was not listed on the eMAR the FL-2 was probably never faxed to the pharmacy. Interview with a MA on 09/23/19 at 3:38pm revealed: -The MAs reviewed the FL-2's for new medications and compare them to the eMARs -The FL-2s were faxed to the pharmacy after the MAs compared them to the eMARs. -After the FL-2s were faxed to the pharmacy, they were given to the DRC/LPN for review and complete the orders after entered by pharmacy. -A fax transmission confirm receipt report would print after the FL-2 was faxed to the pharmacy. -The Amoxicillin 500mg order on Resident #17's Fl-2 dated 07/31/19 was an incomplete order. Interview with a second MA on 09/23/19 at 3:40pm revealed: -She faxed Resident #17's 07/29/19 hospital discharge summary to the pharmacy when the resident returned from the hospital. -The hospital discharge summaries would be filed in the resident's facility record after being faxed to the pharmacy. -She did not know who filed Resident #17's 07/29/19 discharge summary in his facility record after she faxed it to the pharmacy. -She did not remember if she contacted the pharmacy when the Amoxicillin was not sent for Resident #17. -She should have contacted the pharmacy when the Amoxicillin was not sent for Resident #17. -She completed Resident #17's FL-2 dated 07/31/19. -She documented the order for Amoxicillin 500mg on Resident #17's current FL-2 dated 07/31/19. -She transcribed the Amoxicillin 500mg order from Resident #17's 07/29/19 hospital discharge	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 _____	R 09/24/2019

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 166	D 358		

summary onto the current FL-2 dated 07/31/19.
-She did not know why she did not complete the Amoxicillin order on the FL-2.
-She did not know for certain, but believed she faxed Resident #17's current FL-2 dated 07/31/19 FL-2 and the 07/29/19 hospital discharge summary to the pharmacy.
-The DRC/LPN was responsible for reviewing all the FL-2s to ensure they were complete, and no clarification was needed.
-The FL-2's were filed in the resident's record's after they were faxed to the pharmacy.
-She did not remember filing Resident #17's FL-2 in the facility record.
-Resident #17 was not administered the Amoxicillin because it was not documented on the eMAR.

Review of Resident #17's FL-2 dated 07/31/19 revealed there was no fax transmission confirmation report attached to the FL-2.

Interview with the current Executive Director (ED) on 09/19/19 at 3:48pm revealed when a resident returned from the hospital, the DRC/LPN and the MAs would both review the resident's hospital records for orders.

A second interview with the current ED on 09/24/19 at 5:00pm revealed she expected all orders to be implemented immediately which was defined as within 24 hours.

A third interview with the current ED on 09/24/19 at 6:15pm revealed she did not know anything about Resident #17's Amoxicillin order.

Telephone interview with Resident #17's PCP on 09/24/19 at 5:10pm revealed:
-He had not been notified the resident was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 167	D 358		

administered Amoxicillin as ordered on the 07/29/19 hospital discharge.
-He expected the resident to have been administered Amoxicillin as ordered on the 07/29/19 hospital discharge.
-The resident could have become septic by not receiving the ordered dose of Amoxicillin effectively treat the UTI.(Sepsis is a potential life-threatening condition caused infection in the bloodstream which can lead to shock, organ failure, and death)
-He expected to have been notified the resident did not receive the Amoxicillin as ordered so he could have reassessed the resident for a UTI and ordered repeat antibiotics if needed.

Based on observations, interviews, and record reviews it was determined Resident #17 was not interviewable.

Attempted telephone interview with Resident #17's family member on 09/24/19 at 3:30pm was unsuccessful.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 168 b. Review of Resident #17's previous FL-2 dated 06/19/19 revealed there was a medication order for Coreg 3.125 milligrams (mg) twice daily with meals hold for systolic blood pressure (SBP) less than 110 and heart rate (HR) less than 60. (Coreg is a medication used to treat hypertension and heart failure). Review of Resident #17's hospital discharge summary dated 07/29/19 revealed there was an order for Coreg 3.125mg twice daily with meals. Review of Resident #17's current FL-2 dated 07/31/19 revealed there was a medication order for Coreg 3.125mg twice daily with meals. Review of Resident #17's hospital discharge summary dated 08/08/19 revealed there was an order for Coreg 3.125mg twice daily with meals. Review of Resident #17's physician order sheet dated 08/29/19 revealed there was an order for Coreg 3.125mg twice daily with meals hold for SBP less than 110 or HR less than 60. Review of Resident #17's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Coreg 3.125mg twice daily with meals hold for SBP less than 110 and HR less than 60 scheduled at 8:00am and 8:00pm. -There was documentation Coreg was not administered from 06/22/19 to 06/26/19 at 8:00am and 8:00pm because the medication was unavailable. -There was documentation Coreg was not administered on 06/27/19 at 8:00pm because the resident refused. -There was documentation Coreg was not	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 _____	R 09/24/2019

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 169	D 358		

administered on 06/28/19 at 8:00am because the medication was not available.
-There was documentation Coreg was not administered on 06/30/19 at 8:00pm because the medication was not available.
-There was documentation Coreg was administered on 06/27/19 at 8:00am without assessing the residents blood pressure and heart rate prior to administration.
-There was no documentation vital signs had been assessed on any date with the Coreg administration.
-Coreg was not administered for 12 out of 18 doses because the medication was not available.

Review of Resident #17's July 2019 eMAR revealed:
-There was an entry for Coreg 3.125mg twice daily with meals hold for SBP less than 110 or HR less than 60 scheduled at 8:00am and 8:00pm.
-There was documentation Coreg was not administered from on 07/29/19 at 8:00pm and 07/31/19 at 8:00am and 8:00pm because Coreg had not been received from the pharmacy.

Review of Resident #17's August 2019 eMAR revealed:
-There was an entry for Coreg 3.125mg twice daily with meals hold for SBP less than 110 or HR less than 60 scheduled at 8:00am and 8:00pm.
-There was documentation Coreg was not administered from 08/01/19 to 08/04/19 at 8:00am and 8:00pm because Coreg had not been received from the pharmacy.
-The resident's blood pressure and heart rate were not documented for 27 out of 27 opportunities with administration of Coreg from 08/05/19 to 08/31/19
-There was an entry for the fall prevention program which included checking vital signs 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 _____	R 09/24/2019

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 170	D 358		

each shift.
-Resident #17's blood pressure on 08/05/19 on 1st shift was documented as 136/78 and the HR was 86. On 2nd shift Resident #17's blood pressure was documented as 156/78 and the HR was 81.
-Resident #17's blood pressure on 08/06/19 on 1st shift was documented as 120/62 and the HR was 60. On 2nd shift Resident #17's blood pressure was documented as 152/76 and the HR was 76.
-Resident #17's blood pressure on 08/07/19 on 1st shift was 132/62 and the HR was 60.
-Resident #17's blood pressure on 08/08/19 on 2nd shift was 182/108 and the HR was 135.
-The resident's blood pressure ranged from 120/62 - 102/108 from 08/05/19 to 08/08/19.
-The resident's HR ranged from 60 - 135 from 08/05/19 - 08/08/19.

Review of Resident #17's pharmacy dispensing records revealed there were 60 tablets of Coreg 3.125mg dispensed on 06/21/19, 06/26/19, 07/31/19 and 08/03/19.

Interview with a MA on 09/20/19 at 11:50am revealed:
-She would check Resident #17's blood pressure and HR each time prior to Coreg administration.
-When she would document Coreg as administered as Resident #17 there would be a tab to document the residents blood pressure and HR.
-She would document Resident #17's blood pressure and HR in the eMAR when documenting Coreg as administered.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/23/19 at 12:37pm revealed the process 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 _____	R 09/24/2019

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 171 medication orders were as follows he did not know anything about the Coreg for Resident #17. A second interview with the DRC/LPN on 09/23/19 at 2:39pm revealed: -He expected Resident #17's blood pressure and pulse to have been assessed prior to Coreg administration and parameters followed per orders. -He expected the blood pressure and pulse to have been documented under the vital signs entry that was in the eMAR. -The August 2019 parameters for Coreg were not documented because there was nowhere in the Coreg eMAR order to document the parameters associated with Coreg administration. -The residents SBP and HR could have been documented under the vital signs section in the eMAR. -He expected the MAs to document notification to the PCP in the resident's progress notes. -The MAs could also document PCP notification in the eMAR under the medication that was not administered because there was a drop-down box that would allow documentation of additional information instead of only documenting "medication not available". -The SBP and HR was "probably" not documented because the MAs did not think of entering the results in the vital sign section of the eMAR. -The ED, DRC/LPN, RCC, or pharmacy could have assigned the task of entering the parameters for Coreg in the eMAR. -He expected the MAs to have notified Resident #17's PCP if the Coreg was not administered as ordered. -It was also the facility policy to notify the PCP when a resident was not administered a medication.	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 _____	R 09/24/2019

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 172 Interview with a second MA on 09/23/19 at 3:38pm revealed: -The Coreg was to have been held if the residents SBP was less than 110 or HR was less than 60. -She would obtain Resident #17's BP and HR when administering the Coreg, but there was nowhere to document the BP or HR for the resident in the eMAR. Interview with a third MA on 09/23/19 at 3:40pm revealed: -There was nowhere on the eMAR to enter Resident #17's SBP or HR for the Coreg. -If Resident #17's blood pressure and HR were obtained, they would have been documented in the resident's progress notes. -It was the responsibility of the DRC/LPN and the MA to be certain the residents' medications were always available for administration. -If medications were not available the pharmacy should have been called immediately to order the medication. -The conversation with the pharmacy should have been documented in the resident's progress notes. -At shift change, the on-coming shift should have provided verbal report of the status of Resident #17's medication. -The DRC/LPN should have followed up on the status of the medications. Telephone interview with Resident #17's PCP on 09/24/19 at 5:10pm revealed: -Coreg was prescribed to Resident #17 to reduce his cardiac risk for a heart attack by lowering blood pressure and reducing the work load of the heart. -Not administering Coreg to the resident as	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 _____	R 09/24/2019

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 173	D 358		

ordered could cause the resident to have hypertension, a stroke, or a myocardial infarction (a myocardial infarction is a life-threatening condition that usually occurs when blood flow to the heart muscle is abruptly cut off causing tissue damage. The heart muscle can never be repaired).
-He was not notified Resident #17 had missed doses of Coreg.

Based on observations, interviews, and record reviews it was determined Resident #17 was not interviewable.

Attempted interview with Resident #17's family member on 09/24/19 at 3:30pm was unsuccessful.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.

c. Review of Resident #17's current FL-2 dated 07/31/19 revealed there was an entry for Protonix 40 milligrams (mg) daily. (Protonix is used to treat gastroesophageal reflux disease).

Review of Resident #17's hospital discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 174	D 358		

summary dated 07/29/19 revealed there was an order for Protonix 40mg daily.

Review of Resident #17's previous FL-2 dated 06/17/19 revealed there was an order for Protonix 40mg before breakfast.

Review of Resident #17's June electronic medication administration record (eMAR) revealed:
-There was an entry for Protonix 40mg daily before breakfast scheduled at 8:00am
-There was documentation Protonix was not administered from 06/22/19 to 06/30/19 because the medication was unavailable.
-Protonix was not administered for 9 doses out of 9 opportunities

Review of Resident #17's July 2019 eMAR revealed:
-There was an entry for Protonix 40mg daily before breakfast at 8:00am.
-There was documentation Protonix was not administered from 07/01/19 to 07/04/19 because the medication was not available.
-There was documentation the resident was not at the facility from 07/05/19 to 07/29/19.
-There was no documentation Protonix was administered 07/30/19 - 07/31/19.
-Protonix was not administered for 6 doses out of 6 opportunities.

Review of Resident #17's August 2019 eMAR revealed:
-There was an entry for Protonix 40mg daily before breakfast scheduled at 8:00am from 08/01/19 to 08/06/19, 7:00am to 11:00am from 08/07/19 to 08/21/19, and 9:00am from 08/21/19 to 08/31/19.
-There was documentation Protonix was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 175	D 358		

administered on 08/01/19 because the medication was not available.
-There was documentation Protonix was not administered from 08/03/19 to 08/06/19 because the medication was not available.
-There was documentation Protonix was not administered for 5 doses out of 31 doses.

Review of Resident #17's pharmacy dispensing records revealed there were 30 tablets of Protonix dispensed on 07/31/19 and 08/14/19.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) and current Executive Director (ED) on 09/19/19 at 3:55pm revealed it was not acceptable for Resident #17's medications not to be available for administration.

Interview with a MA on 09/23/19 at 3:40pm revealed:
-It was the responsibility of the DRC/LPN and the MA to make certain the residents' medications were always available for administration.
-If medications were not available the pharmacy should have been called immediately to order the medication.
-The conversation with the pharmacy should have been documented in the resident's progress notes.
-At shift change, the on-coming shift should have provided verbal report of the status of Resident #17's medication.
-The DRC/LPN should have followed up on the status of the medications.

Telephone interview with Resident #17's PCP on 06/24/19 at 5:10pm revealed:
-Protonix was prescribed to the resident for gastroesophageal reflux disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 176 -Not administering Protonix to the resident as prescribed could cause an increase in reflux and acid production. -He was not aware of the resident complaining of increase in reflux. Based on observations, interviews, and record reviews it was determined Resident #17 was not interviewable. Attempted interview with Resident #17's family member on 09/24/19 at 3:30pm was unsuccessful. Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm. Refer to the interview with the former ED on 09/20/19 at 12:38pm. Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm. Refer to the interview with the current ED on 09/24/19 at 5:00pm. Refer to the second interview with the current ED on 9/24/19 at 5:25pm. 5. Review of Resident #5's current FL-2 dated 06/03/19 revealed: -Diagnoses included type II diabetes with hyperglycemia, Alzheimer's disease, vascular dementia, dysphagia, abnormalities of gait, repeated falls, cognitive communication deficit, hyperlipidemia, hypertension, and gastroesophageal reflux disease (GERD). -There was an order for Amlodipine Besylate 5mg daily (Amlodipine Besylate is used to treat high blood pressure).	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 _____	R 09/24/2019

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 177 -There was an order for Atorvastatin Calcium 10mg at bedtime. (Atorvastatin Calcium is used to treat high cholesterol). -There was an order for Fish Oil 100mg daily (Fish Oil is used to treat high cholesterol). -There was an order for Tamsulosin HCL 0.4mg daily (Tamsulosin is used to treat urinary retention). -There was an order for Pantoprazole Sodium 40mg at bedtime (Pantoprazole Sodium is generic for Protonix and it is used to treat gastroesophageal reflux disease). -There was an order for Furosemide 40mg daily (Furosemide is used to treat fluid retention). Review of Resident #5's Resident Register revealed an admission date of 06/11/19. Review of Resident #5's June 2019 electronic Medication Administration Record (e-MAR) revealed: -There was an entry for Amlodipine Besylate 5mg daily for administration at 8:00am with a start date documented as 06/21/19. -There was an entry for Atorvastatin Calcium 10mg scheduled for administration at 9:00pm with a start date documented as 06/21/19. -There was an entry for Fish Oil 1000mg daily scheduled for administration at 8:00am with a start date documented as 06/21/19. -There was an entry for Tamsulosin HCL 0.4mg daily scheduled for administration at 8:00am with a start date documented as 06/21/19. -There was an entry for Pantoprazole Sodium 40mg scheduled for administration at 9:00pm with a start date documented as 06/21/19. -There was an entry for Furosemide 40mg daily scheduled for administration at 8:00am with a start date documented as 06/21/19. -There was an "X" in each of the spaces on 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 _____	R 09/24/2019

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 178	D 358		

e-MAR from 06/11/19 to 06/20/19.
-There were no medications documented as administered from 06/11/19 to 06/20/19 and there was nothing documented in the "Exceptions" section.

Review of Resident #5's medication dispensing records revealed:
-Amlodipine Besylate 5mg quantity of 30 was dispensed on 06/11/19.
-Atorvastatin Calcium 10mg quantity of 30 was dispensed on 06/11/19.
-Fish Oil 100mg quantity of 30 was dispensed on 06/11/19.
-Tamsulosin HCL 0.4mg quantity of 30 was dispensed on 06/11/19.
-Pantoprazole Sodium 40mg quantity of 30 was dispensed on 06/11/19.
-Furosemide 40mg quantity of 30 was dispensed on 06/11/19.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

Interview with a medication aide (MA) on 09/19/19 at 3:25pm revealed:
-She did not know why Resident #5 did not receive his medications after he was admitted on 06/11/19 until 06/21/19, even though he received his daily doses of insulin when he was admitted.
-For all new admissions, the FL-2 was faxed to the pharmacy by the Resident Care Coordinator (RCC), Director of Resident Care/Licensed Practical Nurse (DRC/LPN) or MA.
-The pharmacy would add the medication as a new order in the e-MAR and the RCC, DRC/LPN or MA would approve the order and it would appear on the e-MAR for the staff to see.
-It was the responsibility of the RCC, DRC/LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 179 and MAs to assure the medication orders are filled by the pharmacy and listed correctly in the eMAR. Attempted interview with Resident #5's family member on 09/20/19 at 11:00am was unsuccessful. Telephone Interview with the pharmacist from the facility's contracted pharmacy on 09/20/19 at 9:45am revealed: -Resident #5's FL-2 was faxed to the pharmacy by the facility on 06/11/19. -Resident #5's Amlodipine Besylate 5mg, Atorvastatin Calcium 10mg, Fish Oil 100mg, Tamsulosin HCL 0.4mg, Pantoprazole Sodium 40mg, and Furosemide 40 mg were all dispensed and delivered to the facility on 06/11/19 at 11:00pm. -The medications were all entered on the e-MAR by the pharmacy on 06/11/19. Interview with the Former Executive Director (Former ED) on 09/20/19 at 12:30pm revealed: -She did not know there was a delay in Resident #5's medications from 06/11/19 to 06/20/19. -It was the responsibility of the DRC/LPN, RCC and MAs to process all new admission orders by faxing the FL-2 to the pharmacy. Interview with DRC/LPN on 09/23/19 at 10:15am revealed: -He had started working at the facility in July 2019. -He did not know Resident #5 had a delay in his medications upon admission. -The process to follow was the staff (ED, RCC or DRC/LPN) would notify the pharmacy of orders for new admissions by faxing the FL-2 to the pharmacy.	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 _____	R 09/24/2019

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 180	D 358		

-The pharmacy would enter the medications in the eMAR and the ED, RCC, DRC/LPN or MA would then go into the system to approve or modify the order, at which time the order would appear for the facility staff to see as scheduled for administration.
-If there were an "X" in the space on the eMAR, that would indicate the medication had not been started yet possibly because the facility staff had not approved it in the eMAR.
-He was told by a MA that back in June 2019, there was only one person who was signing off the pharmacy orders on the eMAR, so there was a chance that Resident #5's medications "got missed", meaning they did not get signed off and added to the eMAR.

Interview with Resident #5's Primary Care Provider (PCP) on 09/23/19 at 1:00pm revealed:
-She was not aware that Resident #5 did not get his medications from 06/11/19 - 06/21/19.
-She expected the staff to give Resident #5 all medications according to the orders unless she were otherwise notified.
-The potential effect of Resident #5 not receiving Amlodipine Besylate 5mg daily would be high blood pressure which was a "silent killer" for heart attack and stroke.
-She would not be concerned with the potential effect of Resident #5 not receiving Atorvastatin Calcium 10mg daily for 11 days because the medication had a long half life and it was for high cholesterol.
-She would not be concerned with Resident #5 not receiving Fish Oil 100mg daily.
-The potential effect of Resident #5 not receiving Tamsulosin HCL 0.4mg daily would be urinary retention.
-The potential effect of Resident #5 not receiving Pantoprazole Sodium 40mg daily would be gastro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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 181	D 358		

reflux.
-The potential effect of Resident #5 not receiving Furosemide 40mg daily would be lower extremity edema and pain as a result of the edema.
-She had not been notified that Resident #5 had experienced any of these symptoms as a result of not receiving the medications from 06/11/19 until 06/22/19.

Interview with the current Executive Director (ED) on 09/24/19 at 5:00pm revealed:
-She started as the ED for the facility on 09/16/19.
-She did not know Resident #5 had a delay in his medications from 06/11/19 - 06/21/19.
-It was her expectation for staff to administer Resident #5 his medications as ordered by his PCP.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.
6. Review of Resident #6's FL-2 dated 05/22/19 revealed diagnoses included unspecified dementia with behavior disturbance, mental retardation, incontinence, and behavior disorder.

Review of a hospital After Visit Summary 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 _____	R 09/24/2019

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D 358	Continued From page 182 Resident #6 dated 07/08/19 revealed: -Resident's #6's reason for visit was cough. -Her diagnosis was upper respiratory tract infection, unspecified type. Review of the New Order/Notification/Clarification for Resident #6 dated 07/09/19 revealed a verbal order from the primary care provider (PCP) for Ciprofloxacin 500 mg twice a day for seven days. Review of Resident #6's July 2019 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Ciprofloxacin HCL 500mg twice daily with administration times scheduled at 8:00am and 8:00pm with a start date of 07/10/19 and an end date of 07/16/19. -There was documentation Resident #6's Ciprofloxacin HCL was first administered at 08:00am on 07/15/19. -There was documentation Resident #6 refused the 8:00pm Ciprofloxacin dose on 07/15/19. -There was no documentation Ciprofloxacin HCL 500 mg was administered at 8:00am and 8:00pm on 07/17/19 and no documentation in the "Exceptions" section related to the missed doses. -There was no documentation Ciprofloxacin HCL 500 mg was administered at 8:00am and 8:00pm on 07/18/19 and no documentation in the "Exceptions" section related to the missed doses. -There was no documentation Ciprofloxacin HCL 500 mg was administered at 8:00am and 8:00pm on 07/19/19 and no documentation in the "Exceptions" section related to the missed doses. -There was no documentation Ciprofloxacin HCL 500 mg was administered at 8:00am and 8:00pm on 07/20/19 and no documentation in the "Exceptions" section related to the missed doses. -There was no documentation Ciprofloxacin HCL 500 mg was administered at 8:00am and 8:00pm	D 358		

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

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D 358	Continued From page 183	D 358		

on 07/21/19 and no documentation in the "Exceptions" section related to the missed doses.
-There was documentation Resident #6 was administered a total of three doses of Ciprofloxacin HCL on 7/15/19 at 8:00am, 7/16/19 at 8:00am, and 7/16/19 at 8:00pm.

Review of the pharmacy dispensing history for Resident #6 revealed a quantity of 14 Ciprofloxacin HCL 500 mg tablets were dispensed on 07/09/19.

Telephone interview with Resident #6's PCP on 09/19/19 at 12:00pm revealed:
-He was not aware that there was a delay in Resident #6's Ciprofloxacin, ordered on 07/09/19.
-He had no recollection there was a delay in the administration of Ciprofloxacin; it was too long ago.
-There were not any negative outcomes from what he saw when he visited Resident #6 in the facility this week.
-He was unsure why he had even written the order dated 07/09/19 for the Ciprofloxacin for Resident #6.
-He did not know why Resident #6 was hospitalized on 07/08/19.

Interview with medication aide (MA) on 09/19/19 at 03:00pm:
-When a new medication order was written the MA or Care Managers would fax the order to the pharmacy.
-The staff who faxed the medication order would wait for a confirmation fax.
-The pharmacy would add the medication as a new prescription order, but the medication would not appear on the eMAR as scheduled for administration until the Care Managers approved the order in the eMAR system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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D 358	Continued From page 184 Interview with second MA on 09/19/19 at 03:39pm: -When a new medication order was received the MAs would fax the order to pharmacy. -She would call the pharmacy in about ten to fifteen minutes to make sure the pharmacy received the fax. -Her goal was to try to get the medication as quickly as possible for the resident. -The Care Managers would approve the new medication orders so the order would be added to the eMAR and scheduled for administration. -She was unsure if anyone else had the access to approve new medication orders onto the eMAR. Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 06:20pm revealed: -He started his position at the facility on 07/15/19. -His primary responsibilities were oversight of all clinical situations which included medication passes and resident's care. -He was not aware that Resident #6's Ciprofloxacin which was ordered on 07/09/19 was not started until 07/15/19 (a 6 day delay). -He was unsure of why the delay in the administration of Ciprofloxacin occurred. -He questioned whether the Ciprofloxacin HCL was sitting in the drawer because it was waiting approval from the Interim Resident Care Coordinator (RCC), or the Supervisor-in-Charge (SIC). Interview with the current Executive Director (ED) on 09/20/19 at 11:35am revealed: -She started her position at the facility on 09/18/19. -She was not aware there was a delay in Resident #6's Ciprofloxacin ordered on 07/09/19	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 _____	R 09/24/2019

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D 358	Continued From page 185	D 358		

and not started until 07/15/19.
-Her expectation for a new medication order was it should be started immediately (within 24 hours) and to utilize the back-up pharmacy if an order came in after hours.
-The staff who received the new order would fax the order to the pharmacy, place a phone call to the pharmacy to confirm receipt of the fax, and to discuss the expectation of when the medication would be made available to the facility.
-Once the pharmacy received the new medication order, the pharmacy would typically add the new medication order into the eMAR within one hour.
-The ED, RCC, or the DRC/LPN would print the orders and check for the new orders.
-Once complete the ED, RCC, or DRC/LPN would verify the new medication and it would appear on the Resident's eMAR.
-Her expectation moving forward included the facility staff would follow the bucket system.

Interview with the former ED on 09/20/19 at 12:15pm revealed:
-The former ED's last day in her position was on 09/13/19.
-She did not know that Resident #6's Ciprofloxacin ordered on 07/09/19 was not started until 07/15/19.
-When a script for a new medication order would come in the MA, RCC, or DRC/LPN would fax to the pharmacy.
-If a medication wasn't covered the facility was responsible for following up with the provider.
-Her expectation for a new medication order that it should be started immediately within 24 hours.

Second interview with MA on 09/20/19 at 02:35pm revealed:
-In July 2019, she was the interim/acting RCC and she was able to approve new medications in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 358	Continued From page 186	D 358		

the eMAR system.
-New medication orders should be faxed to the pharmacy, the facility staff would wait for the arrival of the new medication, and then the new medication would be approved for the eMAR.
-She was not sure why there was a delay in the administration of Resident #6's Ciprofloxacin.

Refer to the interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 8:25am.

Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.

Refer to the interview with the former ED on 09/20/19 at 12:38pm.

Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm.

Refer to the interview with the current ED on 09/24/19 at 5:00pm.

Refer to the second interview with the current ED on 9/24/19 at 5:25pm.
7. Review of Resident #19's current FL-2 dated 11/29/18 revealed diagnoses included dementia, pain, and generalized weakness.

Review of an Accident/Incident report for Resident #19 dated 08/01/19 revealed:
-On 08/01/19 at 8:00am, Resident #19 eyes were red and swollen and the resident complained of eye pain of both eyes.
-Cold compresses were applied to both eyes and the resident's primary care provider (PCP) was notified.
-The resident was sent to the local emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 187	D 358		

department and returned with diagnoses of periorbital cellulitis and conjunctivitis.

Review of a local hospital emergency department report dated 08/01/19 revealed:
-The resident presented with eye problems. She had been rubbing her eyes with baby wipes and had used 1 pack of wipes since last night.
-The resident was diagnosed with bilateral periorbital cellulitis and bilateral conjunctivitis and ordered an antibiotic to treat the infected eye.
-The resident was to follow-up with an ophthalmologist and her primary care provider (PCP).

Review of a New Order/Notification/Clarification document from a local ophthalmologist dated 08/02/19 revealed an order to begin Medrol 4mg dose pack, a 6 day supply (a steroid prepackaged dose pack used to treat cellulitis).

Review of a Prescription History document for Resident #19 from the facility's pharmacy revealed the pharmacy received the order for the Medrol 4mg dose pack on 08/02/19.

Interview with a pharmacist at the facility's contracted pharmacy on 09/24/19 at 3:55pm revealed:
-The Medrol Dose Pack order for Resident #19 was received and dispensed on 08/02/19.
-The medication was delivered to the facility on 08/03/19 at 2:45am and a medication aide (MA) signed for the medication.

Review of Resident #19's August 2019 electronic medication administration record (eMAR) revealed:
-There were instructions to administer Medrol for 6 days.

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D 358	Continued From page 188 -On day one (08/03/19) there were instructions to administer two tablets before breakfast (8:00am), one tablet after lunch (12:00pm, one tablet after supper (at 5:00pm), and two tablets at bedtime (9:00pm). There was no documentation of administration of Medrol. -On day two (08/04/19) there were instructions to administer one tablet before breakfast (8:00am), one tablet after lunch (12:00pm, one tablet after supper (at 5:00pm), and two tablets at bedtime (9:00pm). There was no documentation of administration of Medrol. -On day three (08/05/19) there were instructions to administer one tablet before breakfast (8:00am), one tablet after lunch (12:00pm, one tablet after supper (at 5:00pm), and one tablet at bedtime (9:00pm). There was no documentation of administration of Medrol. -On day four (08/06/19) there were instructions to administer one tablet of medrol before breakfast 98:00am). There was no documentation of administration of Medrol. -The first dose of Medrol was documented as administered on 08/06/19 at 12:00pm. -There was documentation of administration of Medrol 4mg from 08/06/19 through 08/10/19. Interview with a second shift MA on 09/23/19 at 5:45pm revealed: -Resident #19 did not receive the Medrol until 08/06/19 at 12:00pm. -She did not know why the resident's Medrol was not started the day it was delivered. -When the medication was delivered to the facility by the pharmacy, it should have been placed in the narcotic box on the medication cart because it was a new medication and needed to be approved by the Resident Care Coordinator (RCC) or the Director of Resident Care/Licensed Practical Nurse (DRC/LPN).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 189 -The MAs would have known it was approved for administration when the medication appeared on the eMAR on 08/03/19. -She did not know why there was a delay in the medication being administered because the Medrol was on the eMars on 08/03/19. Interview with the DRC/LPN on 09/24/19 at 11:15am revealed he did not know why Resident #19's Medrol dose pack was not administered after delivery on 08/03/19 and not started until 08/06/19. Interview with Resident #19's primary care provider (PCP) on 09/24/19 at 4:26pm revealed: -She was aware a Medrol dose Pack was ordered for Resident #19 on 08/02/19. -The medication was ordered to treat the periorbital cellulitis and should have been started as soon as it was delivered to the facility to prevent the worsening of the cellulitis. -The PCP was not aware the medication was not started until 08/06/19. -The Medrol was effective in treating the periorbital cellulitis. Interview with the current Executive Director (ED) on 9/24/19 at 5:25pm revealed she had only worked at the facility since last week and was not aware of the delay in starting of Resident #19's Medrol Dose Pack. Refer to the interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 8:25am. Refer to the interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm.	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 _____	R 09/24/2019

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 190 Refer to the interview with the former ED on 09/20/19 at 12:38pm. Refer to the second interview with the DRC/LPN on 09/23/19 at 12:37pm. Refer to the interview with the current ED on 09/24/19 at 5:00pm. Refer to the second interview with the current ED on 9/24/19 at 5:25pm. _____ Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/19/19 at 8:25am revealed: -The facility used a bucket system for orders. -Once a medication order was faxed to the pharmacy the order would be placed in the bucket system: -After orders were faxed to the pharmacy they were placed in a yellow folder. -Once the order was entered in the electronic medication system by the pharmacy the order was placed in the orange folder to wait for medication delivery. -Orders that were incomplete, required a physician clarification, needed a hard copy, or required prior authorization by the physician were placed in a red folder. -Orders needing medical equipment, labs, oxygen, therapy, or required follow up from a hospital visit were placed in a blue folder. -Orders ready to file in the residents' facility record were placed in a green folder. -The DRC/LPN, Resident Care Coordinator (RCC), and the MAs monitored the folders. -The night shift MA took the medication and pulled the faxed order and checked off that the medication was in the facility. -The medications that were not checked off were	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 191 to be followed up on. -Cycle fill medications came in four days before they were to start. -One of the MAs was sending the medications that were left in the cycle back and starting on the new packets of medications. -This would cause the medications to run out before it was time to get a new cycle of medications. -He re-educated the MAs on the procedure of reordering medications and calling the physician on 08/16/19. -Medications should be re-ordered when there were 3 days of medication left. -Each blister card of medication had a date printed on it of when it could be reordered. -Each medication had a barcode sticker that could be peeled off, placed on a re-order page, and faxed to pharmacy for refills. -If there was a reason a medication could not be dispensed due to billing or an order change, then the provider must be notified to obtain a hold order, substitution order, or any additional orders. -There had been a lot of staff turn over the last few months. -The bucket system was not being followed. -No one was auditing the medication carts or being held accountable. Interview with the DRC/LPN and current Executive Director (ED) on 09/19/19 at 3:55pm revealed: -The current ED had started working at the facility on 09/16/19. -The ED had not yet initiated a cart audit for the facility but was in the process of initiating cart audits. -The DRC/LPN started completing cart audits twice weekly at the end of July 2019 or the first of August 2019.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 192	D 358		

-The DRC/LPN would print the resident's orders from the eMAR and give to the MAs.
-The MA's would compare the medication orders to the medications on the medication cart to assure all the medications were accounted, matched the orders, and enough were on hand to administer to the residents.
-The DRC/LPN had told the MAs to be certain there were always at least three days worth of medications on hand for all residents.
-"Sometimes" the DRC/LPN would check behind the MAs to assure the cart audits were being performed.
-The DRC/LPN did not know when the last medication cart audit was performed.
-He had not checked behind the MAs to assure the cart audits were performed.
-The previous RCC may have done the cart audits but he did not know for certain.

Interview with the former Executive Director (ED)on 09/20/19 at 12:38pm revealed:
-The DRC/LPN and RCC were responsible for following up on orders.
-The DRC/LPN, RCC and MAs were responsible for making sure the medications were in the building and available for administration.
-The pharmacy should have been notified immediately to order any medication that was not available to be administered.
-The physician should have been notified and an order obtained to hold the medication until It was delivered.
-Medication cart audits should have been done monthly.
-Medications should been re-ordered when there was a 7 day supply of medication left.
-The physician should have been notified for a new prescription; the prescription should have been faxed to pharmacy, so the medication could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 193 be available in the facility before the medication ran out. A second interview with the DRC/LPN on 09/23/19 at 12:37pm revealed: -The process for new orders on the eMARs was as follows: after orders were faxed to the facility pharmacy, the pharmacy would enter the orders, the order would go into an "approval" section in the electronic medication administration record (eMAR). -The DRC/LPN or RCC would review the orders and compare what was on the eMAR to the original order, if both matched the order would be approved onto the eMAR for the MAs to administer the medication. -When he first started working at the facility in July 2019, he ran a report which showed medications not administered to the residents because the medications were not available. -He did not know the process prior to his start date of 07/15/19. Interview with the current Executive Director (ED) on 09/24/19 at 5:00pm revealed: -She started as the ED for the facility on 09/16/19. -It was the responsibility of the RCC, ED, DRC/LPN and Clinical Manager (CM) to process medication orders by faxing them to the pharmacy, validating receipt of the medications from the pharmacy and signing off the order on the eMAR so the medication would appear as scheduled for administration. Second interview with the current ED on 9/24/19 at 5:25pm revealed medications which were ordered and delivered to the facility should be administered at the next dose time after delivery unless a clarification order was needed.	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 _____	R 09/24/2019

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 194	D 358		

The facility failed to assure medications were administered as ordered for 6 of 7 residents sampled for record review (#2, #4, #5, #6, #17, #19). Resident #4 was administered another resident's medication in error which resulted in emergent evaluation in a local hospital emergency department and diagnosed with an "accidental overdose"; Resident #17 a urinary tract infection (UTI) and did not receive an antibiotic as ordered to treat the UTI resulting in the resident being treated in the emergency department and diagnosed with acute cystitis and required a prescription of a different antibiotic and placed the resident at risk for sepsis (Sepsis occurs when chemical released in the bloodstream to fight an infection trigger inflammation which can cause multiple organ system failure resulting in death). Resident #17 was not administered 13 out of 18 doses of Coreg in June 2019, placing the resident at risk for hypertension, stroke, and/or death from a heart attack. Resident #5, who had a history of fluid retention and lower extremity edema, missed Lasix (prescribed to treat edema) from 06/01/19 - 06/21/19 placing the resident at risk for lower extremity edema and pain. Resident #2, who was a diabetic missed Glipizide from 07/01/19 - 07/21/19 and placed the resident at increased risk of higher blood sugar. Residents #2, #5, and #17 missed multiple doses of medications prescribed to treat high blood pressure which resulted in increased risk for high blood pressure and stroke. Resident #19 had a 4-day delay in an eye drop prescribed to treat cellulitis and conjunctivitis resulting in the resident having prolonged redness and eye swelling. Resident #6 had a 6-day delay in starting an antibiotic prescribed after a hospital visit for a UTI. The facility's failure resulted in the resident's not being

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D 358	Continued From page 195 administered the medication prescribed to maintain their physical and mental health and constitutes a Type A1 Violation for serious neglect. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/19/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 24, 2019.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure incidents resulting in injury and emergency room evaluation were reported to the Department of Social Services for 3 of 3 sampled residents (#2, #10, #17). The findings are:	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 196	D 451		

Review of the facility's Accident/Falls/Emergency and Fire Safety Policy revealed if the accident or incident required intervention greater than first aid, an Accident and Incident Form should be sent to the local county Department of Social Services (DSS) within 48 hours.

1. Review of Resident #2's current FL-2 dated 06/03/19 revealed:
-Diagnoses included Alzheimer's disease with late onset, Type II diabetes, other long-term drug therapy, frequency of micturition, muscle weakness, other abnormalities of gait and mobility, dysphagia, and unspecified dementia with behavioral disturbance.
-There was documentation Resident #2 was semi-ambulatory with the aid of a wheelchair.

Review of the Care Note for Resident #2 dated 09/01/19 at 8:31am revealed the resident was found on the floor and sent to the hospital emergency department.

Review of an Emergency Medical Services (EMS) call report dated 09/01/19 at 8:42am revealed:
-Resident #2 was found on the floor behind the door of her room.
-Resident #2 had a laceration on her left arm.
-Resident #2 was transported to the ED.

Review of a hospital Emergency Department Encounter note dated 09/01/19 for Resident #2 revealed:
-Resident #2 had an unwitnessed fall.
-A computed tomography (CT) scan of the head showed no injury. (A CT scan provides a series of x-rays from different angles to provide images of bones, soft tissues, and blood vessels).

Review of Resident #2's Accident/Incident

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D 451	Continued From page 197 Reports revealed there was no Accident/Incident report dated 09/01/19 and no documentation the local Department of Social Services (DSS) was notified. Interview with the current Executive Director (ED) on 09/24/19 at 10:50am revealed she did not know if an Accident/Incident report was completed for this incident or if DSS was notified. Refer to the interview with the Former ED on 09/13/19 at 9:55am. Refer to the interview with a medication aide (MA) on 09/24/19 at 9:30am. Refer to the interview with the current ED on 09/24/19 at 10:50am. 2. Review of Resident #10's current FL-2 dated 07/31/19 revealed: -Diagnoses included dementia, Type II diabetes, hypertension, and chronic renal insufficiency. -There was documentation that Resident #10 was ambulatory and constantly disoriented. Review of an Accident/Incident Report for Resident #10 dated 08/23/19 at 11:05pm revealed: -Resident #10 had a fall in his room with an injury to the right hip. -Emergency Medical Services (EMS) was called and Resident #10 was transferred to the hospital emergency department. -The report was signed by the Director of Resident Care (DRC)/Licensed Practical Nurse (LPN). -There was no documentation on the report that the local Department of Social Services (DSS) was notified.	D 451		

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D 451	Continued From page 198 Interview with the current Executive Director (ED) on 09/24/19 at 10:50am revealed she did not know if an Accident/Incident report was completed for this incident or if the local Department of Social Services was notified. Refer to the Interview with the Former ED on 09/13/19 at 9:55am. Refer to the interview with a medication aide (MA) on 09/24/19 at 9:30am. Refer to the interview with the current ED on 09/24/19 at 10:50am. 3. Review of Resident #17's current FL-2 dated 07/31/19 revealed diagnoses included dementia, hypertension, alcohol abuse, coronary artery disease, and anxiety/acute encephalopathy. Review of an Emergency Medical Services (EMS) report for Resident #17 dated 08/02/19 at 5:08pm revealed: -Resident #17 fell out of a wheelchair and hit the right side of his head and elbow. -Resident #17 was transported to the hospital for evaluation. Review of Resident #17's Accident/Incident Reports revealed there was no Accident/Incident report dated 07/31/19 and no documentation the local Department of Social Services (DSS) was notified. Interview with the current Executive Director (ED) on 09/24/19 at 10:50am revealed she did not know if an Accident/Incident report was completed for this incident or if DSS was notified.	D 451		

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D 451	Continued From page 199 Refer to the Interview with the Former ED on 09/13/19 at 9:55am. Refer to the interview with a medication aide (MA) on 09/24/19 at 9:30am. Refer to the interview with the current ED on 09/24/19 at 10:50am. _____ Interview with the Former Executive Director (ED) on 09/13/19 at 9:55am revealed: -The medication aides (MAs) were responsible for completing the Accident/Incident reports, which consisted of vitals, notifying the family or responsible party, the Primary Care Physician (PCP), and the Resident Care Coordinator (RCC). -The ED sent the completed Accident /Incident reports to the Department of Social Services (DSS) by fax or email. Interview with a MA on 09/24/19 at 9:30am revealed: -The MAs were responsible for completing the Accident/Incident reports, which included vital signs and a description of the incident. -The MAs were responsible for contacting the responsible party and the PCP. -The Accident/Incident reports were entered into the computer and management reviewed them. -The MA was not aware of the process of Accident/Incidents being reported to DSS. Interview with the current ED on 09/24/19 at 10:50am revealed: -The process for DSS notification was the MA on duty at the time an incident/accident occurred was responsible for completing a report in the computer and it would send notification to ED. -The ED would follow up on the Accident/Incident	D 451		

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D 451	Continued From page 200 report until the report was closed. -The ED was responsible for notifying DSS via email.	D 451		
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 on 11 of 30 shifts sampled on 10 dates between 04/28/19 - 07/08/19 to meet the needs of the residents residing in the Special Care Unit (SCU). The findings are: Review of the facility's current 2019 license revealed the facility was licensed as a SCU with a capacity of 60 beds. Review of the punch detail records for staff and census report dated 07/01/19 revealed: -The census was 44 residents. -The required staff hours for third shift was 35.2 hours.	D 465		

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D 465	Continued From page 201 -There were 15.32 staff hours provided on the third shift, a shortage of 21.48 hours. Review of the punch detail records for staff and census report dated 07/02/19 revealed: -The census was 46 residents. -The required staff hours for third shift was 36.8 hours. -There were 23.46 staff hours provided on the third shift, a shortage of 13.34 hours. Review of the punch detail records for staff and census report dated 07/03/19 revealed: -The census was 46 residents. -The required staff hours for third shift was 36.8 hours. -There were 31.13 staff hours provided on the third shift, a shortage of 5.67 hours. Review of the punch detail records for staff and census report dated 07/04/19 revealed: -The census was 46 residents. -The required staff hours for second shift was 46 hours. -There were 39.50 staff hours provided on the second shift, a shortage of 6.5 hours. -The required staff hours for third shift was 36.8 hours. -There were 24.30 staff hours provided on the third shift, a shortage of 12.5 hours. Review of the punch detail records for staff and census report dated 07/05/19 revealed: -The census was 46 residents. -The required staff hours for third shift was 36.8 hours. -There were 32.16 staff hours provided on the third shift, a shortage of 4.64 hours. Review of the punch detail records for staff and	D 465		

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D 465	Continued From page 202	D 465		

census report dated 07/06/19 revealed:
-The census was 46 residents.
-The required staff hours for second shift was 46 hours.
-There were 29.48 staff hours provided on the second shift, a shortage of 16.52 hours.
-The required staff hours for third shift was 36.8 hours.
-There were 16.17 staff hours provided on the third shift, a shortage of 20.63 hours.

Review of the punch detail records for staff and census report dated 07/07/19 revealed:
-The census was 46 residents.
-The required staff hours for second shift was 46 hours.
-There were 36.11 staff hours provided on the second shift, a shortage of 9.89 hours.
-The required staff hours for third shift was 36.8 hours.
-There were 24 staff hours provided on the third shift, a shortage of 12.8 hours.

Review of care notes, hospital records and incident /accident reports revealed Resident #2 fell on 07/07/19 at 8:00pm and was not sent to the emergency department.

Review of the punch detail records for staff and census report dated 07/08/19 revealed:
-The census was 46 residents.
-The required staff hours for third shift was 36.8 hours.
-There were 21.02 staff hours provided on the third shift, a shortage of 15.78 hours

Observation on 09/18/19 at 7:22 am of the 200 hall revealed there were three personal care aides (PCA) and one medication aide (MA) one duty.

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D 465	Continued From page 203 Confidential staff interview revealed sometimes there were three personal care aides (PCAs) working on the day shift, and staffing was good "today". Confidential interview with a second staff member revealed: -There were usually three PCAs on first shift. -There would be four PCAs on duty at times. -There are usually two medication aides (MA) on duty. -The last time there were three PCAs was the past week. Interview with a MA on 09/17/19 at 3:14pm revealed: -There were two MAs scheduled to work on second shift (3:00pm-11:00pm) each day. -There were four PCAs scheduled to work on second shift each day. -On third shift (11:00pm - 7:00am), there was one MA and three PCAs scheduled each day. Interview with a resident's family member on 09/19/19 at 11:05am revealed: -The family member visited the facility three times a day almost every day (morning, afternoon and evening). -There was never enough staff to care for the residents when the family member was at the facility. -There was more staff in the facility this week than the family member had ever observed. -Usually, there was only one MA administering medications to the residents on both halls and one PCA on each hall. -He checked on his family member often because he was worried she would not be taken care of or would have an accident such as a fall and the	D 465		

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D 465	Continued From page 204	D 465		

staff would not find her.

Interview with a second MA on 09/20/19 at 3:10pm revealed:
-She had previously worked as the interim Resident Care Coordinator (RCC) for a short period of time.
-Her responsibilities included completing the staff work schedule.
-Sometimes, she worked as a MA if staffing was short.

Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/24/19 at 11:32pm revealed:
-He started work at the facility on 07/15/19.
-He did the staffing schedule.
-He scheduled four personal care aides (PCA) on first shift and two medication aides (MA).
-He scheduled four PCAs on second shift and two MAs.
-He scheduled three PCAs on third shift and one MA.
-He was notified when there was a call out and he had to find coverage.

Second interview with a MA on 09/24/19 at 5:45pm revealed:
-She was the interim RCC for about two months.
-When she completed the employee work schedule, she used an old schedule as an example to determine how many staff to schedule.
-She scheduled three PCAs and two MAs on the 7:00am - 3:00pm shift, four PCAs and two MAs on the 3:00pm - 11:00pm shift, and three PCAs and one MA on 11:00pm - 7:00am shift.
-She had staffing guidelines to use but she was not able to figure the guidelines out.
-She came up with the number of staff to

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D 465	Continued From page 205 schedule based on the current number of employees.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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D 468	Continued From page 206 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that 1 of 3 sampled staff (Staff A) assigned to perform duties in a Special Care Unit (SCU), received 6 hours of orientation training within the first week of hire. The findings are: Review of the facility's current license effective 01/01/19 revealed the facility was an "Alzheimer's/ Dementia" SCU licensed for a capacity of 60 residents. Review of Staff A's personnel record revealed: -Staff A was hired on 07/19/19 as a personal care aide for 2nd shift on the SCU. -There was no documentation Staff A received 6 hours of (SCU) training within the first week of employment. Interview with the Administrator on 09/23/19 at 2:15pm revealed: -Staff A worked on 2nd shift in the SCU assisting residents with personal care and meals. -She did not know Staff A did not have documentation for 6 hours of orientation training within the first week of employment. -She was responsible for ensuring staff working in the SCU received the 6 hours of training during their first week of employment.	D 468		
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	D912		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
D912	Continued From page 207 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication orders and adult care home medication aide training and competency. The findings are: 1. Based observations, interviews, and records reviews the facility failed to clarify medication orders for 2 of 6 residents sampled for a diabetic resident who went 43 days without clarification of the sliding scale coverage for insulin (#5) and an antipsychotic (#17). [Refer to Tag D344 10A NCAC 13F .1002(a) Medication Orders (Type B Violation)]. 2. Based on interviews and record review, the facility failed to ensure a staff who administered medications had completed at least 5 hours of the state approved medication aide training and was competency validated prior to administering medications resulting in Resident #4 receiving another resident's medication in error. [Refer to Tag D935 G. S. 131D-4.5(B)(b) ACH Medication Aide Training and Competency (Type B Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 208	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received the care and services necessary to maintain their physical health and were free of neglect related to resident rights, medication administration, health care, implementation, and personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision to 6 of 12 sampled residents (#1, #2, #3, #7, #8, #19) in accordance with their current symptoms and assessed needs resulting in Residents (#1, #2, #3, #7, #8,) having multiple falls, being found on the floor, and sustaining multiple injuries to include fractures and facial and head injuries (#1, #2, #3, #7, and #8) and a resident (#19) having access to wipes when unsupervised causing an eye injury. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 4 of 12 sampled residents (#4, #5, #14, #17) including failure to notify the primary care provider (PCP) of blood sugars greater than 400 (#5), failure to send a	D914		

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	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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D914	Continued From page 209	D914		

resident to the emergency department who fell and sustained a fractured hip (#14), failure to refer a resident to physical/occupational therapy (#4), and failure to notify the PCP of a resident (#17) with a draining, red, painful eye; bilateral lower extremity pitting edema; mycotic toenails; and an open wound to the outer right great toe. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to assure safe policies and procedures were established and maintained for medication administration; failed to assure medications were administered as ordered for 2 of 5 residents (#5, #19) observed during the medication passes, including errors with medications to treat infection, hypertension, fluid and urinary retention, and two vitamin supplements (#5), dry eyes and allergic rhinitis (#19); and for 6 of 7 residents sampled for record reviews (#2, #4, #5, #6, #17, #19) including delays in starting antibiotics (#6), an oral steroid (#19), medications for hypertension, high cholesterol, urinary retention, gastroesophageal reflux disorder, fluid retention (#5), missed doses of medications used to treat hypertension, high blood sugar, depression and psychotic disorders, and sliding scale insulin (#2), and failure to administer an antibiotic and delay in administration of medications used to treat hypertension, heart failure, depression, gastroesophageal reflux disorder, and alcohol withdrawal (#17). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)].

4. Based on observations, interviews, and record reviews, the former Executive Director (ED) failed to assure the management, operations, and

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D914	Continued From page 210 policies of the facility were implemented and maintained for supervision, health care, medication orders, medication administration, special care unit staffing, adult care home medication aide training, and resident rights. [Refer to Tag D980 G. S. 131D-25 Implementation (Type A1 Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 5 of 8 sampled residents (#2, #5, #6, #10, #17) for fingerstick blood sugar checks (#5, #10), thrombo-embolic deterrent (TED) hose (#5), weekly weights (#5), laboratory tests (#5, #6, #17) and wheelchair and chair alarms (#2). [Refer to Tag D276 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 6. Based on observations, record review, and interviews, the facility failed to ensure residents were free from vebal abuse related to a staff member treating/speaking to Resident #13 in a disrespectful and threatening manner. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		
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	D935		

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D935	Continued From page 211 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. (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:	D935		

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D935	Continued From page 212 TYPE B VIOLATION Based on interviews and record review, the facility failed to ensure a staff who administered medications had completed at least 5 hours of the state approved medication aide training and was competency validated prior to administering medications resulting in Resident #4 receiving another resident's medication in error. The findings are: Review of an Event Details report dated 07/05/19 revealed: - Resident #4 was "accidentally" given wrong medications by a trainee. -The resident had returned to the facility from the emergency department on 07/05/19 with no new orders. -The resident had been observed for over two hours, was fine, and nothing had occurred during observation. Review of the former medication aide (MA) trainee's personnel record revealed: -The former trainee was hired on 06/07/18 as a personal care aide (PCA). -There was documentation of successfully passing the written medication administration exam on 07/18/17. -There was no documentation of medication clinical skills competency validation. -There was no documentation of completion of the state approved 5, 10 and/or 15-hour medication aide training course. Telephone interview on 09/19/19 at 12:42pm with a former Medication Aide (MA) who was training the MA trainee on 07/05/19 revealed: -She was training the former MA trainee and left	D935		

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D935	Continued From page 213	D935		

to take a personal phone call.
-She told the former trainee she would be back.
-Another (named) MA from the 200 hall "took my place on the medication cart for 100-hall" and came to help out the trainee while she took the personal call.
-The former MA trainee took the medications she (the MA) had prepared for another resident and administered the medications to Resident #4 when she was answering the personal call.
-The former MA trainee told "management" that she had administered the medications and had not followed what she (the MA) told to her (the trainee) to do.
-When she was trained on the medication cart by another MA, she and the MA training her prepared ("popped" the medications) the medications together and as a trainee, she would administer the medications with the MA training her "right behind me".
-When it became time for her to train a new MA, she trained them the way she was trained by preparing the medications together and the trainee administering the medications with her there with the them.
-After she prepared medications for a resident, she let the former MA trainee administer the medications and she was present with the former MA trainee as the medications were administered by the trainee.

Interview with the MA identified by the former MA on 09/19/19 at 4:07pm revealed:
-She was working on the 200-hall on 07/05/19 as the MA.
-She did not go in Resident #4's room with the former MA trainee to administer medications.

Telephone interview with the Former Executive Director (ED) on 09/20/19 at 12:45pm revealed:

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D935	Continued From page 214 -She was aware Resident #4 was administered medications that had been prepared and order for another resident in error but she could not remember the exact date of the incident. -The former (named) MA who was responsible for the medication cart on that hall prepared a resident's medications and left the prepared medications out on the medication cart. -While the MA who prepared the medications was answering the phone, a former MA trainee "took it upon herself" and administered the medication prepared for the other resident to Resident #4. -During training, the trainee was not supposed to touch the medication cart, keys, or anything on the medication cart, and "they are shadowing". -The minimum number of times a staff trained on the medication cart for medication administration was three times. -She did not know how many times the former MA trainee had trained on the medication cart prior to the incident when Resident #4 was administered the other resident's medications in error. Interview with the current ED on 09/20/19 at 2:50pm revealed: -She expected MAs to complete their required 5, 10 hour, and/or 15-hour medication aide training and corporate online medication training before going out to shadow another MA on the medication cart. -When one MA was training another, the trainee should not be administering medications. -After a MA trainee shadowed a MA on the medication cart, the Licensed Health Professional Support (LHPS) nurse was supposed to validate the MA trainee's medication administration skills competency during observation of a medication pass prior to the MA trainee being able to administer medications independently. -When a MA was being trained and "shadowing"	D935		

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D935	Continued From page 215 another MA, the MA trainee was only supposed to "watch" the MA administer medications. Interview with the Clinical Manager (CM) on 09/23/19 at 9:17am revealed: -Each facility identified their strongest medication aide supervisor to train "newcomers". -She did not have a role in training the MAs who were trainers for MA trainees. -Her duties included conducting the state approved 5 hour and 10 hour or 15-hour medication aide training courses. -She expected the MAs to follow the six rights of medication administration and not to administer medications they did not prepare. -She instructed MAs to ask the residents to state their names before administering medications. -Her training was geared more toward technique and safety of administering medications. -In May 2019, all MAs working in the facility had their medication competency clinical skills re-validated. -The licensed health professional support (LHPS) nurse was responsible for completing medication clinical skills competency validation for MAs. Interview with the LHPS nurse on 09/23/19 at 11:12am revealed: -Her duties included completing clinical skills competency validations for the MAs. -She completed the medication clinical skills competency validation after the MAs had completed the state approved 15-hour medication aide training course. -If she had completed the medication aide clinical skills validation checklist for a MA, the document would be in their personnel record. Second interview with the former MA on 09/23/19 at 1:25pm revealed:	D935		

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D935	Continued From page 216 -The day Resident #4 was administered another resident's medications in error was the first day the former MA trainee had trained on the medication cart with her. -She had not been given any instructions on medication administration training from the former ED or anyone in management as to what to do when training other MAs. Interview with the Director of Resident Care/Licensed Practical Nurse (DRC/LPN) on 09/24/19 at 3:35pm revealed: -The MA was was conducting the training was supposed to "provide for a visual demonstration" to the MA trainee. -Instructions provided to the MA who was conducting the training included the trainee was shadowing, to go at a pace that the trainee could see what the MA was doing, and to let the trainee look at the computer so they could see electronic administration records (eMARs). -He did not know of any written instructions or training provided to the MAs who provided training to others. -The MA who was being shadowed by the trainee was "not really a trainer but a demonstrator." -All training was completed by the LHPS nurse. Attempted telephone interview on 09/19/19 at 3:29pm, 09/19/19 at 5:08pm, and 09/23/19 at 7:23am with the former trainee who was identified as having administered Resident #4 another resident's medications was unsuccessful. The facility failed to ensure staff who administered medications had completed at least 5 hours of the state approved medication aide training and was competency validated prior to administering medications resulting in Resident #4 receiving another resident's medication in	D935		

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D935	Continued From page 217 error. The facility's failure was detrimental to the residents health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2019.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the former Executive Director (ED)/Administrator failed to assure the management, operations, and policies of the facility were implemented and maintained for supervision, health care, medication orders, medication administration, special care unit staffing, adult care home medication aide training, and resident rights. The findings are: Confidential staff interview revealed:	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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D980	Continued From page 218	D980		

-The facility was a "good" facility at one time.
-The former ED stayed in her office and did not come out or communicate with staff. She was not a communicator.

Confidential interview with a second staff revealed if the staff had to call out of work, they usually had to find their own coverage.

Confidential interview with a third staff revealed:
-The former ED stayed in the office with the door closed.
-When a telephone call came in for the former ED, whether hospital or family member, she would say take a message or instruct staff to talk to caller.

Confidential interview with a fourth staff revealed:
-There was a time when the former ED was asked for assistance with a task (task identified) but never provided the assistance requested from the staff.

Confidential interview with a fifth staff revealed:
-The former ED would avoid directly confronting issues.
-The staff had reached out to a corporate person about 3 months ago to let them know the facility was "not going in a good direction".
-About 3 months ago it was felt the facility was admitting residents who were not appropriate; they did not have dementia, but those residents were no longer at the facility.

Confidential interview with a concerned citizen revealed:
-Everything that was put in place by two corporate staff (named), the former ED changed it when she took over responsibility at the facility.
-The concerned citizen did not think the former

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D980	Continued From page 219	D980		

ED paid attention to what was told to her about what was going on with the residents.
-The former ED would not answer telephone calls, sometimes from family members.

Interview with the Divisional Vice President of Operations on 09/17/19 at 8:50am revealed:
-The former ED's last day working at the facility was on 09/13/19.
-The new ED started on 09/16/19.

Non-compliance was identified at violation level in the following rule areas:

1. Based on observations, interviews, and record reviews, the facility failed to provide supervision to 6 of 12 sampled residents (#1, #2, #3, #7, #8, #19) in accordance with their current symptoms and assessed needs resulting in Residents (#1, #2, #3, #7, #8,) having multiple falls, being found on the floor, and sustaining multiple injuries to include fractures and facial and head injuries (#1, #2, #3, #7, and #8) and a resident (#19) having access to wipes when unsupervised causing an eye injury. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]

2. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 4 of 12 sampled residents (#4, #5, #14, #17) including failure to notify the primary care provider (PCP) of blood sugars greater than 400 (#5), failure to send a resident to the emergency department who fell and sustained a fractured hip (#14), failure to refer a resident to physical/occupational therapy (#4), and failure to notify the PCP of a resident (#17) with a draining, red, painful eye; bilateral lower extremity pitting edema; mycotic toenails;

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D980	Continued From page 220 and an open wound to the outer right great toe. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure safe policies and procedures were established and maintained for medication administration; failed to assure medications were administered as ordered for 2 of 5 residents (#5, #19) observed during the medication passes, including errors with medications to treat infection, hypertension, fluid and urinary retention, and two vitamin supplements (#5), dry eyes and allergic rhinitis (#19); and for 6 of 7 residents sampled for record reviews (#2, #4, #5, #6, #17, #19) including delays in starting antibiotics (#6), an oral steroid (#19), medications for hypertension, high cholesterol, urinary retention, gastroesophageal reflux disorder, fluid retention (#5), missed doses of medications used to treat hypertension, high blood sugar, depression and psychotic disorders, and sliding scale insulin (#2), and failure to administer an antibiotic and delay in administration of medications used to treat hypertension, heart failure, depression, gastroesophageal reflux disorder, and alcohol withdrawal (#17). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 4. Based on observations, interviews, and record reviews, the former Executive Director (ED) failed to assure the management, operations, and policies of the facility were implemented and maintained for supervision, health care, medication orders, medication administration, special care unit staffing, adult care home medication aide training, and resident rights. [Refer to Tag D980 G. S. 131D-25	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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
D980	Continued From page 221 Implementation (Type A1 Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 5 of 8 sampled residents (#2, #5, #6, #10, #17) for fingerstick blood sugar checks (#5, #10), thrombo-embolic deterrent (TED) hose (#5), weekly weights (#5), laboratory tests (#5, #6, #17) and wheelchair and chair alarms (#2). [Refer to Tag D276 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 6. Based on observations, record review, and interviews, the facility failed to ensure residents were free from mental and physical abuse related to a staff member treating/speaking to Resident #13 in a disrespectful and threatening manner. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 7. Based observations, interviews, and records reviews the facility failed to clarify medication orders for 2 of 6 residents sampled for a diabetic resident who went 43 days without clarification of the sliding scale coverage for insulin (#5) and an antipsychotic (#17). [Refer to Tag D344 10A NCAC 13F .1002(a) Medication Orders (Type B Violation)]. 8. Based on interviews and record review, the facility failed to ensure a staff who administered medications had completed at least 5 hours of the state approved medication aide training and was competency validated prior to administering medications resulting in Resident #4 receiving another resident's medication in error. [Refer to Tag D935 G. S. 131D-4.5(B)(b) Adult Care Home Medication Aide Training and Competency (Type B Violation)].	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R 09/24/2019

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
D980	Continued From page 222 Interview with the current ED on 09/24/19 at 5:25pm revealed: -The former ED should have communicated to her supervisor (the vice president of operations) any staff shortages or any staffing issues. -The ED was instructed to communicate any concerns or problems to their supervisors weekly on the management conference calls (held every Monday). -The former ED reported a couple of staff problems related to staff members who were fired, but not overall staffing shortages. The former ED/Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations related to, personal care and supervision, health care, medication administration, residents' rights and special care unit staffing. The ED's failure resulted in residents falling and sustaining serious physical injuries, to include fractures and facial and head injuries, staff shortages, and residents not being administered medications and/or not receiving health care services necessary to maintain their physical and mental health which constitutes a Type A1 Violation for serious physical harm and neglect. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/24/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 24, 2019.	D980		