

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted and Annual Survey on 04/30/24 and 05/01/24.	D 000		
D 432	<p>10A NCAC 13F .1106 (f) Settlement Of Cost Of Care</p> <p>10A NCAC 13F .1106 Settlement Of Cost Of Care</p> <p>(f) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the facility during the month. This is to be done within 30 days after the resident's death.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the Estate Administrator for 4 of 4 residents (#7,#8,#9, #10) received the refund owed within 30 days after the resident's death.</p> <p>The findings are:</p> <p>1. Review of Resident #7's Move-out/Room and Board Refund form revealed: -She was discharged due to death on 01/07/24. -Her financial responsibility end date was 01/06/24. -There was documentation that a refund in the amount of \$895.97 was requested on 01/08/24. -The form was signed by the corporate Billing Manager beside the entered amount as approved on 01/09/24.</p>	D 432		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(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 432	<p>Continued From page 1</p> <p>Telephone interview with Resident #7's Estate Administrator on 05/01/24 at 3:22pm revealed: -His family member passed away on 01/07/24. -He thought he was owed approximately \$895. -He thought the request for refund was made by the facility within a day or two following the death of his family member. -He thought there was a problem at the corporate home office that was delaying the refund that he was owed.</p> <p>Review of an account invoice for Resident #7 revealed a check in the amount of \$895.97 was issued on 05/01/24.</p> <p>Telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm revealed: -Resident #7's was owed \$895.97 and the check was sent on 05/01/24. -She thought she first found out Resident #7 was due a refund in the beginning of April 2024 and was given approval to release the funds on 04/30/24.</p> <p>Attempted telephone interview with the Director of Financial Operations for the facility's corporate office on 05/01/24 at 4:15pm was unsuccessful.</p> <p>Attempted telephone interview with the Accounting Manager for the facility's corporate office on 05/01/24 at 4:40 was unsuccessful.</p> <p>Refer to telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm.</p> <p>Refer to interview with the Administrator on 05/01/24 at 10:04am.</p>	D 432		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(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 432	<p>Continued From page 2</p> <p>Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm.</p> <p>2. Review of Resident #8's Move-out/Room and Board Refund form revealed: -She was discharged due to death on 02/17/24. -Her financial responsibility end date was 02/16/24. -There was documentation that a refund in the amount of \$762.07 was requested on 02/19/24. -The form was not signed for approval.</p> <p>Telephone interview with Resident #8's Estate Administrator on 05/01/24 at 5:15pm revealed: -Her family member died on 02/17/24. -She had not received a refund and she was not aware a refund was due from the facility.</p> <p>Review of an account invoice for Resident #8 revealed a check in the amount of \$762.07 was issued on 05/01/24.</p> <p>Telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm revealed: -Resident #7's was owed \$762.07. -The funds were approved and a check was sent out on 05/01/24.</p> <p>Attempted telephone interview with the Director of Financial Operations for the facility's corporate office on 05/01/24 at 4:15pm was unsuccessful.</p> <p>Attempted telephone interview with the Accounting Manager for the facility's corporate office on 05/01/24 at 4:40 was unsuccessful.</p> <p>Refer to telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm.</p>	D 432		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(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 432	<p>Continued From page 3</p> <p>Refer to interview with the Administrator on 05/01/24 at 10:04am.</p> <p>Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm.</p> <p>3. Review of Resident #9's Move-out/Room and Board Refund form revealed: -She was discharged on due to death on 01/10/24. -Her financial responsibility end date was 01/09/24. -There was documentation that a refund in the amount of \$1,206 was requested on 01/12/24. -The form was not signed for approval.</p> <p>Review of an account invoice for Resident #9 revealed a check in the amount of \$379.44 was issued on 05/01/24.</p> <p>Telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm revealed: -Resident #9's was owed \$379.44. -The funds were approved and a check was sent out on 05/01/24.</p> <p>Attempted telephone interview with Resident #8's Estate Administrator on 05/01/24 at 5:15pm was unsuccessful.</p> <p>Attempted telephone interview with the Director of Financial Operations for the facility's corporate office on 05/01/24 at 4:15pm was unsuccessful.</p> <p>Attempted telephone interview with the Accounting Manager for the facility's corporate office on 05/01/24 at 4:40 was unsuccessful.</p>	D 432		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(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 432	<p>Continued From page 4</p> <p>Refer to telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm.</p> <p>Refer to interview with the Administrator on 05/01/24 at 10:04am.</p> <p>Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm.</p> <p>4. Review of Resident #10's Move-out/Room and Board Refund Form revealed: -She was discharged on due to death on 01/08/24. -Her financial responsibility end date was 01/06/24. -There was documentation that a refund in the amount of \$895.97 was requested on 01/08/24. -The form was not signed for approval.</p> <p>Review of an account invoice for Resident #10 revealed a check in the amount of \$1,370.97 was issued on 05/01/24.</p> <p>Telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm revealed: -Resident #7's was owed \$1,370.97. -The funds were approved and a check was sent out on 05/01/24.</p> <p>Attempted telephone interview with Resident #8's Estate Administrator on 05/01/24 at 5:19pm was unsuccessful.</p> <p>Attempted telephone interview with the Director of Financial Operations for the facility's corporate office on 05/01/24 at 4:15pm was unsuccessful.</p> <p>Attempted telephone interview with the</p>	D 432		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(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 432	<p>Continued From page 5</p> <p>Accounting Manager for the facility's corporate office on 05/01/24 at 4:40 was unsuccessful.</p> <p>Refer to telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm.</p> <p>Refer to interview with the Administrator on 05/01/24 at 10:04am.</p> <p>Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm.</p> <hr/> <p>Telephone interview with the Accounts Payable Clerk on 05/01/24 at 4:48pm revealed:</p> <ul style="list-style-type: none"> -She thought refunds should have been sent to a resident's Estate Administrator within 30-45 days of a resident's death. -The facility completed the Move-out/Room and Board Refund Form and would send it to Accounts Receivable. -Accounts Receivable would verify the amounts and enter the refund into the system and send the form to her. -It was her responsibility to send the refund checks once the amount was approved. -The paperwork for to request refunds for the residents that died was submitted by the facility staff but it was not entered into the system by the staff in the Accounts Receivable department. -Some refund requests got lost due to recent staff turnover in the accounting department. <p>Interview with the Administrator on 05/01/24 at 10:04am revealed:</p> <ul style="list-style-type: none"> -The form to request a refund following a resident's death was completed by the facility and sent to Accounts Receivable within 2 days of a resident's death. -Once it was approved, Accounts Payable was 	D 432		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
---	--

(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 432	<p>Continued From page 6</p> <p>responsible for issue the check to the Estate Administrator.</p> <p>-She was aware a refund was supposed to be issued within 30 days but she did not have the authority to approve or send the refund.</p> <p>-She did not know why there was a delay in sending the refunds by the Accounts Payable office.</p> <p>Interview with the Area Clinical Director on 05/01/24 at 3:30pm revealed:</p> <p>-The facility was responsible for completing the Move-out/Room and Board Refund Form and sending it to Accounts Receivable at the corporate office.</p> <p>-Once the amount was verified, it was the responsibility of Accounts Payable to send the refund to the residents' Estate Administrator and was not the responsibility of the facility.</p>	D 432		