STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
HAL025035		B. WING		05/01/2024		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	1 00/0	1/2024
THE GAR	RDENS OF TRENT		NSWICK AV N, NC 2856			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.D BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
		ensure Section conducted and 4/30/24 and 05/01/24.				
D 432	10A NCAC 13F .11 Care	06 (f) Settlement Of Cost Of	D 432			
	10A NCAC 13F .11 Care	06 Settlement Of Cost Of				
	(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.					
	facility failed to ens for 4 of 4 residents	et as evidenced by: s and record reviews, the ure the Estate Administrator (#7,#8,#9, #10) received the 30 days after the resident's				
	The findings are:					
	Board Refund form -She was discharge -Her financial respo 01/06/24There was docume amount of \$895.97 -The form was sign	ent #7's Move-out/Room and revealed: ed due to death on 01/07/24. ensibility end date was entation that a refund in the was requested on 01/08/24. ed by the corporate Billing e entered amount as approved				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL025035	B. WING		05/0	01/2024	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
THE GARDENS OF TRENT		JNSWICK AV RN, NC 2856				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Administrator on 0 -His family member -He thought he was -He thought the rest the facility within a of his family member -He thought there home office that was owed. Review of an accorrevealed a check issued on 05/01/24 Telephone intervier Clerk for the facility 05/01/24 at 4:48president #7's was was sent on 05/01 -She thought she fidure a refund in the was given approver 04/30/24. Attempted telephore Financial Operation office on 05/01/24 Attempted telephore of 105/01/24 Attempted telephore of 105/01/24 Refer to telephone Payable Clerk for the 105/01/24 at 4:48president was given approver 105/01/24.	w with Resident #7's Estate 5/01/24 at 3:22pm revealed: er passed away on 01/07/24. It is sowed approximately \$895. It is owed \$895.97 was \$4. It is owed \$895.97 was \$4. It is owed \$895.97 and the check \$1/24. It is owed \$895.97 and the check \$1/24. It is owed \$895.97 and the check \$1/24. It is owed \$1/24 and \$1/24 and \$1/24 and \$1/24 and \$1/24 and \$1/25 an					

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STATE FORM 6899 FF3811 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL025035	B. WING		05/	01/2024
	NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT STREET AD 2915 BRU NEW BER			_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 432	Refer to interview won 05/01/24 at 3:30 2. Review of Reside Board Refund form -She was discharge -Her financial responsive to 102/16/24. -There was docume amount of \$762.07 -The form was not standard to 102/16/24. Telephone interview Administrator on 05/16/24 at 4:48pm -Resident #7's was -The funds were apout on 05/01/24. Attempted telephore Financial Operation office on 05/01/24 at 4:48pm -Resident #7's was -The funds were apout on 05/01/24. Attempted telephore Financial Operation office on 05/01/24 at 4:48pm -Resident #7's was -The funds were apout on 05/01/24. Attempted telephore Financial Operation office on 05/01/24 at 4:48pm -Resident #7's was -The funds were apout on 05/01/24. Attempted telephore Financial Operation office on 05/01/24 at 4:48pm -Financial Operation office	with the Area Clinical Director pm. ent #8's Move-out/Room and revealed: ed due to death on 02/17/24. ensibility end date was entation that a refund in the was requested on 02/19/24. eigned for approval. with Resident #8's Estate 6/01/24 at 5:15pm revealed: r died on 02/17/24. ed a refund and she was not a due from the facility. Int invoice for Resident #8 the amount of \$762.07 was with the Accounts Payable of corporate office on revealed: owed \$762.07. eproved and a check was sent the interview with the Director of as for the facility's corporate at 4:15pm was unsuccessful. The interview with the er for the facility's corporate at 4:40 was unsuccessful. Interview with the Accounts he facility's corporate office on the facility's corporate at 4:40 was unsuccessful.	D 432			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BOILDING.				
		HAL025035	B. WING		05/0	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS OF TRENT		NSWICK AV			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
D 432	D 432 Continued From page 3 Refer to interview with the Administrator on 05/01/24 at 10:04am. Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm.		D 432			
	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 01/09/24There was documentation that a refund in the					
	amount of \$1,206 w	vas requested on 01/12/24. signed for approval.				
	Review of an account invoice for Resident #9 revealed a check in the amount of \$379.44 was issued on 05/01/24.					
		oproved and a check was sent				
		ne interview with Resident #8's or on 05/01/24 at 5:15pm was				
	Financial Operation	ne interview with the Director of as for the faclility's corporate at 4:15pm was unsuccessful.				
	Accounting Manage	ne interview with the er for the faclility's corporate at 4:40 was unsuccessful.				

Division of Health Service Regulation

STATE FORM 6899 FF3811 If continuation sheet 4 of 7

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TRENT 2915 BRUNSWICK AVENUE NEW BERN, NC 28562 PROVIDER SUMMARY STATEMENT OF DEPICIENCIES TAG SUMMARY STATEMENT OF DEPICIENCIES 10 SUMMARY STATEMENT OF DEPICIENCIES TAG SUMMARY STATEMENT OF DEPICIENCIES 10 PREFIX TAG COntinued From page 4 Refer to Interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 14/8pm. Refer to interview with the Area Clinical Director on 05/01/24 at 10/04am. Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm. 4. Review of Resident #10's Move-out/Room and Board Refund Form revealed: -She was discharged on due to death on 01/08/24Her financial responsibility end date was 01/06/24There was documentation that a refund in the amount of \$895.97 was requested on 01/08/24The rorm was not signed for approval. Review of an account invoice for Resident #10 revealed a check in the amount of \$1,370.97 was issued on 05/01/24 at 41/8pm revealed: -Resident #7's was owed \$1,370.97The funds were approved and a check was sent out on 05/01/24 at 4.48pm revealed: -Resident #7's was owed \$1,370.97The funds were approved and a check was sent out on 05/01/24 at 4.48pm revealed: -Resident #7's was owed \$1,370.97The funds were approved and a check was sent out on 05/01/24 at 4.48pm revealed: -Resident #7's was owed \$1,370.97The funds were approved and a check was sent out on 05/01/24 at 4.48pm revealed: -Resident #7's was owed \$1,370.97The funds were approved and a check was sent out on 05/01/24 at 4.48pm and a check was sent out on 05/01/24 at 4.48pm and a check was sent out on 05/01/24 at 4.5pm was unsuccessful.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
CALL DATE CONTINUES CALL CA			HAL025035	B. WING		05/	01/2024
PRÉFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) D 432 Continued From page 4 Refer to telephone interview with the Accounts Payable Clerk for the facilitity sorporate office on 05/01/24 at 3:30pm. 4. Review of Resident #10's Move-out/Room and Board Refund Form revealed: -She was discharged on due to death on 01/08/24There was documentation that a refund in the amount of \$985.97 was requested on 01/08/24There was not signed for approval. Review of an account invoice for Resident #10 revealed a check in the amount of \$1,370.97 was issued on 05/01/24. Telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24. Attempted telephone interview with Resident #8's Estate Administrator on 05/01/24 at 5:19pm was unsuccessful. Attempted telephone interview with the Director of Financial Operations for the facility's corporate			2915 BRU	NSWICK AV	ENUE		
Refer to telephone interview with the Accounts Payable Clerk for the facility's corporate office on 05/01/24 at 4:48pm. Refer to interview with the Administrator on 05/01/24 at 10:04am. Refer to interview with the Area Clinical Director on 05/01/24 at 3:30pm. 4. Review of Resident #10's Move-out/Room and Board Refund Form revealed: -She was discharged on due to death on 01/08/24Her financial responsibility end date was 01/06/24There was documentation that a refund in the amount of \$895.97 was requested on 01/08/24The form was not signed for approval. Review of an account invoice for Resident #10 revealed a check in the amount of \$1,370.97 was issued on 05/01/24. 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 \$1,370.97The funds were approved and a check was sent out on 05/01/24. Attempted telephone interview with Resident #8's Estate Administrator on 05/01/24 at 5:19pm was unsuccessful. Attempted telephone interview with the Director of Financial Operations for the facility's corporate	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
Attempted telephone interview with the	D 432	Refer to telephone Payable Clerk for th 05/01/24 at 4:48pm Refer to interview w 05/01/24 at 10:04an Refer to interview w on 05/01/24 at 3:30 4. Review of Reside Board Refund Form-She was discharge 01/08/24. -Her financial responda 1/06/24. -There was docume amount of \$895.97. -The form was not so Review of an accourance on 05/01/24 at 4:48pm Resident #7's was and the funds were apout on 05/01/24. Attempted telephone Estate Administration unsuccessful. Attempted telephone of 1/06/01/24 at 4:48pm Resident #7's was and the funds were apout on 05/01/24. Attempted telephone Estate Administration of 1/06/01/24 at 4:48pm Resident #7's was and the funds were apout on 05/01/24. Attempted telephone Estate Administration of 1/06/01/24 at 4:48pm Resident #7's was and the funds were apout on 05/01/24. Attempted telephone Estate Administration of 1/06/01/24 at 4:48pm Resident #7's was and 1/06/01/24 at 4:48pm Resident #	interview with the Accounts are facility's corporate office on a with the Administrator on an are with the Area Clinical Director and a revealed: and on due to death on an are requested on 01/08/24. Signed for approval. Int invoice for Resident #10 and the amount of \$1,370.97 was are with the Accounts Payable are vealed: owed \$1,370.97. Approved and a check was sent are interview with Resident #8's are on 05/01/24 at 5:19pm was are interview with the Director of as for the facility's corporate at 4:15pm was unsuccessful.	D 432			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUI	MDED:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
	A. BOILDING.	A. BOILDING.	
HAL025035	B. WING		05/01/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE	E, ZIP CODE	
THE GARDENS OF TRENT	2915 BRUNSWICK AVENU NEW BERN, NC 28562	ΙΕ	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
Accounting Manager for the facility's coroffice on 05/01/24 at 4:40 was unsuccess. Refer to telephone interview with the Acc Payable Clerk for the facility's corporate 05/01/24 at 4:48pm. Refer to interview with the Administrator 05/01/24 at 10:04am. Refer to interview with the Area Clinical I on 05/01/24 at 3:30pm. Telephone interview with the Accounts P Clerk on 05/01/24 at 3:30pm. Telephone interview with the Accounts P Clerk on 05/01/24 at 4:48pm revealed: -She thought refunds should have been resident's Estate Administrator within 30 of a resident's deathThe facility completed the Move-out/Ro Board Refund Form and would send it to Accounts ReceivableAccounts Receivable would verify the a and enter the refund into the system and form to herIt was her responsibility to send the refundence on the amount was approvedThe paperwork for to request refunds for residents that died was submitted by the staff but it was not entered into the system staff in the Accounts Receivable department. Interview with the Administrator on 05/01 10:04am revealed: -The form to request a refund following a resident's death was completed by the fasent to Accounts Receivable within 2 day resident's death.	counts coffice on on Director ayable sent to a -45 days om and o mounts d send the ind or the facility om by the nent. ecent staff 1/24 at a acility and	DEFICIENCY)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		HAL025035	B. WING		05/	01/2024
	PROVIDER OR SUPPLIER	2915 BR	DDRESS, CITY, S UNSWICK AV RN, NC 2856			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 432	responsible for issue AdministratorShe was aware a rissued within 30 day authority to approve -She did not know visending the refunds office. Interview with the A 05/01/24 at 3:30pm -The facility was residently was residently in the Account corporate officeOnce the amount viresponsibility of Accounts and the account of the amount viresponsibility of Accounts and the account of the amount viresponsibility of Accounts and the account of the amount viresponsibility of Accounts and the accounts and the accounts and the accounts are accou	refund was supposed to be any but she did not have the error or send the refund. Why there was a delay in the but the Accounts Payable area Clinical Director on revealed: Sponsible for completing the disposal but the Accounts Payable at the was verified, it was the counts Payable to send the ents' Estate Administrator and	D 432			

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