STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE GARDENS OF NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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 a follow-up survey on 08/04/26 through 08/05/26.	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; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free of hazards including not properly securing an oxygen cylinder in a resident's room. Review of the facility's undated Oxygen and Storage policy revealed oxygen tanks should be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other. Review of the facility's census report on 08/04/26 revealed there were 54 residents living in the facility. Observation of room 201 on 08/04/26 at 9:00am revealed:	D 079		

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D 079	Continued From page 1 -There was an oxygen (O2) cylinder leaning in the corner in between the wall and dresser. -The O2 cylinder was in a black sleeve. -The O2 cylinder was not in a crate. Interview with the resident in room 201 on 08/04/26 at 9:00am revealed: -She put the O2 cylinder in the corner of her room. -The O2 cylinder was empty. -She used a concentrator and portable O2. -She was told to the put the O2 cylinder in the corner by staff because they had no place else to put the cylinder. -The O2 cylinder had been in the corner of her room for "a long time." Interview with a medication aide (MA) on 08/04/26 at 3:08pm revealed: -O2 cylinders were supposed to be stored in the facility's O2 room in a crate. -O2 cylinders were stored in the O2 room in crates because they were not supposed to be stored on the floor. -She was unsure why O2 cylinders were not supposed to be stored on the floor. -She did not notice the O2 cylinder in room 201. -The O2 cylinder should not have been in room 201 because the resident stopped using that type of cylinder approximately 2 months ago and switched to a concentrator and portable cylinder. -She was unsure why the O2 cylinder was in room 201 or why the cylinder was not secured. -The Resident Care Coordinator (RCC) was supposed to do a walk through every morning. -Whomever disconnected the O2 cylinder was responsible for ensuring the cylinder was stored in a crate. -The sleeve the O2 cylinder was stored in was the bag that held the cylinder on the back of the	D 079		

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D 079	Continued From page 2 wheelchair. Interview with the RCC on 08/04/26 at 3:18pm revealed: -O2 cylinders were to be stored in the crate in the facility's locked O2 room. -O2 cylinders were stored in the facility's locked O2 room because the cylinders were dangerous. -The O2 cylinders could explode if they fell over. -There were residents residing in the facility that were smokers, which also posed a hazard if exposed to the O2 cylinders. -She was not aware there was an unsecured O2 cylinder in room 201. -She and the MAs were responsible for ensuring O2 cylinders were stored properly. -She was unsure why the O2 cylinder was in room 201. -She did a walkthrough of the facility once or twice a day. -She went into room 201 yesterday (08/03/26) but did not notice the O2 cylinder. Interview with the Administrator on 08/04/26 at 3:35pm revealed: -O2 cylinders were supposed to be stored in crates or O2 holders in the facility's O2 room for safety. -O2 cylinders were at risk of being knocked over and exploding if not stored properly. -She was not aware of the O2 cylinder in room 201. -She was unsure why the O2 cylinder was in room 201 and why the O2 cylinder was unsecured. -The RCC was responsible for ensuring that O2 cylinders were properly stored. -The RCC was supposed to do daily walkthroughs of the facility to check for issues, resident safety, and ensure the rooms were clean	D 079		

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D 079	Continued From page 3 with beds made. -She was unsure when the RCC last conducted a walkthrough of the facility. -No one mentioned the O2 cylinder in room 201 to her. -The MAs were responsible for assisting the residents with switching the O2 cylinders. -The resident in room 201 no longer used the metal O2 cylinder.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 5 sampled residents (#2) related to the need for a refill for an expired medication that was used to treat seizures. The findings are: Review of the facility's medication administration policy dated 11/2018 revealed: -Residents may actively refuse medications. -Continuous medication refusal must be reported to the prescriber and there must be documentation of prescriber notification of such. Review of Resident #2's current FL2 dated 03/06/26 revealed: -Diagnoses included epilepsy, unspecified dementia, impulse disorder, muscle wasting and atrophy and rheumatoid arthritis.	D 273		

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-He was intermittently disoriented.
-There was an order for Lacosamide 100mg, take 1 two times a day. (Lacosamide is used to treat seizures.)

Review of Resident #2's care plan dated 03/03/26 revealed:
-He was independent with eating.
-He required supervision with grooming.
-He required limited assistance with ambulation.
-He required extensive assistance with transfers, toileting and bathing.
-He was totally dependent with dressing.

Review of Resident #2's Resident Agreement dated 12/08/22 revealed:
-Under Admission Process it stated under no circumstances may the community admit or retain an individual as a resident in the community if: the individual poses a threat to himself or others; the community does not have the ability to provide the assisted living services needed by the individual.
-The resident/representative agrees to have a medical assessment of the resident completed by a physician or primary care practitioner on an annual basis and within 10 days of the resident experiencing a significant change in condition.
-The resident/ representative agrees to provide a copy of the resident's annual medical evaluation to the community.
-Failure to have a medical assessment completed will result in involuntary termination of this agreement.

Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Lacosamide 100mg, take 1 every 12 hours, scheduled for 9:00am and

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9:00pm.
-Lacosamide 100mg was documented as "refused" at 9:00am from 06/11/26 through 06/19/26 and from 06/22/26 through 06/29/26.
-Lacosamide 100mg was documented as "charted in error" on 06/21/26 and 06/30/26.
-Lacosamide 100mg was documented as "refused" at 9:00pm from 06/11/26 through 06/19/26 and from 06/22/26 through 06/30/26.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for Lacosamide 100mg, take 1 every 12 hours, scheduled for 9:00am and 9:00pm.
-Lacosamide 100mg was documented as "refused" at 9:00am from 07/01/26 through 07/20/26 and from 07/22/26 through 07/31/26.
-Lacosamide 100mg was documented as "refused" at 9:00pm from 07/01/26 through 07/02/26, from 07/04/26 through 07/11/26, and from 07/13/26 through 07/31/26.

Review of Resident #2's August 2026 eMAR for 08/01/26 through 08/04/26 revealed:
-There was an entry for Lacosamide 100mg, take 1 every 12 hours, scheduled for 9:00am and 9:00pm.
-Lacosamide 100mg was documented as "refused" at 9:00am from 08/01/26 through 08/04/26.
-Lacosamide 100mg was documented as "other" on 08/01/26 and as "refused" on 08/02/26 at 9:00pm.

Observations of Resident #2's medication on hand on 08/05/26 at 10:32am revealed:
-There was 1 card of Lacosamide 100mg on the medication cart for Resident #2.
-The dispense date was 04/23/24 with 60 pills

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dispensed and 8 pills left.
-The beyond-use date was 10/22/24. (The beyond use date is the final date the medication should be used after the pharmacy has dispensed, repackaged, or opened the medication.)

Interview with Resident #2 on 08/05/26 at 2:26pm revealed:
-He had not had a seizure since he stopped taking the seizure medication.
-The facility staff were trying to give him medication that he was taking when he was first admitted to the facility.
-He was taking medication when he was not sick.

Interview with Resident #2's family member on 08/05/26 at 2:48pm revealed:
-Resident #2 had been at the facility for approximately 3 years.
-Resident #2 started refusing to see a primary care provider (PCP) "some time ago".
-Resident #2 told her he did not know the facilities contracted PCP was the doctor and he was not going to talk to that person.
-Another family member of Resident #2 took him to see a PCP about 2 months ago.
-An appointment had been set up by the family for Resident #2 to see a PCP on 08/13/26.

Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 12:00pm and 5:27pm revealed:
-When administering medication, MAs were to compare the medications on the cart with the eMAR 3 times before administering the medications.
-The eMAR showed all the medications that were due at that time.
-She was aware Resident #2's Lacosamide

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expired.
-The facility could not get the medication refilled because Resident #2 would not see a PCP.
-Lacosamide was a controlled substance with required a written prescription to refill.
-She sent a facility physician's order form to the last appointment that Resident #2 attended on 03/06/26, but the PCP did not complete the form.
-She contacted the facility's contracted PCP to see Resident #2 so the prescription for Lacosamide could be written but Resident #2 refused to see the PCP.
-The facility's contracted PCP could not write the prescription for Lacosamide for Resident #2 without seeing him.
-Resident #2 had not had any seizures since not receiving Lacosamide.
-Resident #2's Lacosamide expired so it would not be offered.
-She knew Resident #2 had to have a PCP, and she informed family and staff of this.
-She requested a Care Plan Meeting with Resident #2's POA to discuss his refusal to see a PCP and the need for medication refill.

Interview with the Administrator on 08/05/26 at 11:46am and 6:06pm revealed:
-She had been the Administrator for approximately 1 year and Resident #2 had not had a PCP during that time.
-Facility staff attempted to obtain assistance from a family member but Resident #2 still refused to see a PCP.
-Resident #2 was seen by a PCP with a mobile unit in March 2026 after a family member took him for a hospital follow up.
-Facility staff attempted to obtain a PCP for Resident #2, but he refused to see anyone.
-A Care Plan meeting was set up with Resident #2's POA In July 2026 to discuss the need for a

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D 273	Continued From page 8 PCP and the fact that the facility could not meet Resident #2's need without a PCP. Telephone interview with a local Nurse Practitioner (NP) with the local mobile unit on 08/05/26 at 11:33am revealed: -She worked with a mobile medical unit. -She saw Resident #2 one time. -Resident #2 was brought in by a family member for a hospital follow up and to establish care on 03/06/26 because Resident #2 did not want to see the facility's PCP. -Resident #2 was non-compliant with his Lacosamide. -The risk of not taking the Lacosamide depended on each individual person. -She was not Resident #2's PCP so she was unsure if he was taking his medications and how not taking the medications would affect him. [Refer to tag 277, 10A NCAC 13F .0902(d) Health Care]	D 273		
D 277	10A NCAC 13F .0902 (d) Health Care 10A NCAC 13F .0902 Health Care (d) The following shall apply to the resident's physician or physician service: (1) The resident or the resident's responsible person shall be allowed to choose a physician or physician service to attend the resident. (2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802	D 277		

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D 277	Continued From page 9 of this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 1 of 5 residents sampled (#2) was allowed a choice of primary care providers (PCP) other than the facility's contracted PCP. The findings are: Review of Resident Agreement for Resident #2 dated 12/08/22 revealed: -The resident/representative agreed to have a medical assessment of the resident completed by a physician or primary care practitioner on an annual basis and within 10 days of the resident experiencing a significant change in condition. -The resident/ representative agreed to provide a copy of the resident's annual medical evaluation to the community. -Failure to have a medical assessment completed would result in involuntary termination of the agreement. Review of Resident #2's current FL2 dated 03/06/26 revealed: -Diagnoses included unspecified dementia, epilepsy, impulse disorder, muscle wasting and atrophy and rheumatoid arthritis. -The resident was intermittently disoriented. - The FL2 was signed by a mobile unit primary care provider (PCP). Review of Resident #2's Resident Register revealed he was admitted to the facility on	D 277		

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D 277	Continued From page 10 12/08/22. Review of Resident #2's care plan dated 03/03/26 revealed: -The care plan was signed by a mobile Unit PCP and dated 03/09/26. -He was independent with eating. -He required supervision with grooming. -He required limited assistance with ambulation. -He required extensive assistance from staff with transfers, toileting, and bathing. -He was totally dependent upon staff with dressing. Interview with Resident #2's family member on 08/05/26 at 2:48pm revealed: -She was Resident #2's power of attorney (POA). -Resident #2 had been living at the facility for approximately 3 years. -He started refusing to see the PCP "some time ago." -He told her that he did not know that the facility's contracted PCP was a doctor and was not going to talk to that PCP. Review of Resident #2's progress notes revealed: -On 01/07/26, Resident #2's POA was contacted to sign a consent form for Resident #2 to see the facility's contracted PCP. -On 01/19/26, Resident #2's POA was contacted about Resident #2 not allowing the facility's contracted PCP to treat him and was advised that he was required to see a PCP in order to remain a resident of the facility. -On 02/26/26, Resident #2 was sent to the emergency department (ED) due to shortness of breath and coughing up blood. -Resident #2 was taken as a "walk in" to his previous PCP's office for follow up to the 02/26/26 ED visit (date note provided), but the office	D 277		

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refused to see him.
-After the previous PCP refused to see Resident #2, his family member scheduled a PCP appointment for him at a mobile unit.

Interview with Resident #2 on 08/05/26 at 9:29am revealed:
-He did not have shortness of breath and never had shortness of breath.
-He did not have any breathing issues.

Telephone interview with a Registered Nurse (RN) at Resident #2's previous PCP's office on 08/05/26 at 5:02pm revealed the PCP had not seen Resident #2 in "years" (exact date unknown) and there was no documentation of any provider in their office prescribing medication to Resident #2 since 2020.

Telephone interview with a certified medical assistant (CMA) with a local mobile unit on 08/05/26 at 11:01am revealed:
-Resident #2 was seen by the nurse practitioner (NP) on 03/06/26 for a follow up to hospital visit.
-Resident #2 came to the appointment with a family member.
-Resident #2's medications were originally prescribed by another PCP in 2019.
-The mobile unit NP refilled the medications Resident #2 was already taking and completed an FL2 for him at that appointment.

Review of Resident #2's mobile unit visit progress notes dated 03/06/26 revealed:
-Resident #2 was residing in an assisted living facility (ALF) but did not have a PCP.
-Resident #2 was seen for a hospital follow-up related to an ED visit for a cough.

Telephone interview with the NP with the local

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mobile unit on 08/05/26 at 11:33am revealed:
-Resident #2 was brought in by a family member for a hospital follow up and to establish care on 03/06/26 because Resident #2 did not want to see the facility's PCP.
-Resident #2's family member advised that Resident #2 was non-compliant with his medications to include Lacosamide (used to treat seizures, including epileptic seizures).
-She refilled medications for Resident #2 based on his hospital discharge paperwork.
-She was not Resident #2's PCP; she saw Resident #2 one time.
-She was unsure if he was taking his medications and how not taking the medications would affect him.

Second review of Resident #2's progress notes revealed:
-On 04/16/26, Resident #2 was asked if he wanted to go to the ED after requesting cough syrup. He initially declined; however, he was sent to the ED due to wheezing, coughing, and high fever.
-He returned to the facility on the same day (04/16/26).
-On 07/01/26, Resident #2's POA was contacted by the Resident Care Coordinator (RCC) to schedule a Care Meeting.
-On 07/07/26, a care coordination meeting was held with Resident #2's POA regarding concerns about Resident #2's refusal to see the facility's contracted PCPs.
-On 07/22/26, Resident #2 stated he felt like he had a "stroke" but refused to go the ED.
-He agreed to go to the ED after talking to his POA; he returned to the facility the same day (07/22/26).

Interview with Resident #2's family member on

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D 277	Continued From page 13 08/05/26 at 2:48pm revealed the family had scheduled an appointment for Resident #2 to see an outside PCP on 08/13/26. Interviews with the RCC on 08/05/26 at 12:00pm and 5:27pm revealed: -She became the RCC approximately September/October 2025 and Resident #2 did not have a PCP at that time. -She was unsure of the last time Resident #2 had an established PCP. -Resident #2 was sent to the ED if there were any noticeable changes or concerns since he had no PCP. -Resident #2's family members were informed that he needed to see a PCP. -She contacted Resident #2's POA on 01/07/26 to sign a consent for Resident #2 to see the facility's contracted PCP. -Resident #2 refused to see the facility's contracted PCP twice so the facility's contracted PCP discontinued services with him. -Resident #2's POA was contacted to sit with Resident #2 while the facility's contracted PCP saw him, but the POA advised she had to work. -A family member took Resident #2 to a previous PCP, but that office refused to see Resident #2; the reason was unknown. -A family member took Resident #2 to an outside mobile unit to be seen. -She requested a Care Plan Meeting with Resident #2's POA in July 2026 to discuss his refusal to see a PCP and the need for medication refills. -The POA was informed that a 30-day discharge notice would be issued because Resident #2 did not have a PCP (date not provided). -All residents were supposed to have a PCP, whether it was the facility's contracted PCP or an outside PCP.	D 277		

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D 277	Continued From page 14 -She was responsible for making sure residents had a PCP. Interview with the Administrator on 08/05/26 at 6:06pm revealed: -She had been the Administrator for approximately 1 year and Resident #2 had not had a PCP during that time. -Resident #2 was sent to the ED if there were any issues. -A Care Plan meeting was set up with Resident #2's POA in July 2026 to discuss medication refusal, the need for a PCP and the fact that the facility could not meet Resident #2's need without a PCP. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care] [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration] _____ The facility failed to ensure a resident (#2) had a primary care provider (PCP). The facility did not know the last time Resident #2 had an established PCP and required the resident's family members to make arrangements for the resident to be evaluated by an outside PCP. The resident's diagnoses included unspecified dementia and epilepsy. From January 2026 to July 2026, the resident required evaluation in the hospital emergency department on three occasions because he did not have a PCP. The resident did not have a current FL2 or medication orders until his family scheduled and took the resident to an outside mobile PCP in March 2026. 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 correction in	D 277		

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D 277	Continued From page 15 accordance with G.S. 131D-34 on 08/05/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2026.	D 277		
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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#2) related to a medication used to treat seizures. The findings are: Review of the facility's medication administration policy dated 11/2018 revealed: -Medications were administered in accordance with written orders of the prescriber. -There was nothing in the policy provided	D 358		

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regarding expired medications.

a. Review of Resident #2's current FL2 dated 03/06/26 revealed:
-Diagnoses included epilepsy, unspecified dementia, impulse disorder, muscle wasting and atrophy and rheumatoid arthritis.
-There was an order for Lacosamide 100mg, take 1 two times a day. (Lacosamide is used to treat seizures.)

Review of Resident #2's Resident Agreement dated 12/08/22 revealed the community would inventory resident medications that had been ordered by physicians to ensure that the resident had the necessary supply of said medication available.

Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Lacosamide 100mg, take 1 every 12 hours, scheduled for 9:00am and 9:00pm.
-Lacosamide 100mg was documented as "refused" at 9:00am from 06/11/26 through 06/19/26 and from 06/22/26 through 06/29/26.
-Lacosamide 100mg was documented as "charted in error" on 06/21/26 and 06/30/26.
-Lacosamide 100mg was documented as "refused" at 9:00pm from 06/11/26 through 06/19/26 and from 06/22/26 through 06/30/26.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for Lacosamide 100mg, take 1 every 12 hours, scheduled for 9:00am and 9:00pm.
-Lacosamide 100mg was documented as "refused" at 9:00am from 07/01/26 through

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07/20/26 and from 07/22/26 through 07/31/26.
-Lacosamide 100mg was documented as "refused" at 9:00pm from 07/01/26 through 07/02/26, from 07/04/26 through 07/11/26, and from 07/13/26 through 07/31/26.

Review of Resident #2's August 2026 eMAR for 08/01/26 through 08/04/26 revealed:
-There was an entry for Lacosamide 100mg, take 1 every 12 hours, scheduled for 9:00am and 9:00pm.
-Lacosamide 100mg was documented as "refused" at 9:00am from 08/01/26 through 08/04/26.
-Lacosamide 100mg was documented as "other" on 08/01/26 and as "refused" on 08/02/26 at 9:00pm.

Observation of Resident #2's medication on hand on 08/05/26 at 10:32am revealed:
-There was 1 card of Lacosamide 100mg on the medication cart for Resident #2.
-The dispense date was 04/23/24 with 60 pills dispensed and 8 pills remaining.
-The beyond-use date was 10/22/24. (The beyond use date is the final date the medication should be used after the pharmacy has dispensed, repackaged, or opened the medication.)

Review of Resident #2's progress notes revealed:
-On 07/22/26, Resident #2 stated he felt like he had a "stroke" but refused to go the emergency department (ED).
-He agreed to go to the ED after talking to his POA; he returned to the facility the same day (07/22/26).

Interview with Resident #2 on 08/05/26 at 2:26pm revealed:

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-He had not had a seizure since he stopped taking the seizure medication.
-The facility staff were trying to give him medication that he was taking when he was first admitted to the facility.
-He was taking medication when he was not sick.

Interview with Resident #2's family member on 08/05/26 at 2:48pm revealed Resident #2 had not had a seizure in over a year.

Interview with a medication aide (MA) on 08/05/26 at 2:31pm revealed:
-She did not offer Resident #2 Lacosamide because the medication was expired.
-When the pharmacy consultant from the facility's contracted pharmacy came to do cart audits, the medications Resident #2 refused were either destroyed at that time or sent back to the pharmacy with the pharmacy consultant.
-She completed a cart audit November 2025 and informed the Resident Care Coordinator (RCC) about Resident #2's expired Lacosamide.
-The RCC advised she was trying to get a primary care provider (PCP) to see Resident #2 so the Lacosamide could be refilled.
-Resident #2 had not had any seizures since she started working at the facility 1 year ago.

Interview with a second MA on 08/06/26 at 6:45pm revealed:
-She was aware Resident #2's Lacosamide was expired.
-She documented "refused" on Resident #2's eMAR for the Lacosamide but knew the medication could not be administered because it was expired.
-She was unsure why Resident #2's Lacosamide was expired.
-She asked coworkers about the expired

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Lacosamide but did not mention the expired medication to management.
-When medications expired, the RCC was to be notified.
-Cart audits were done by the MAs once weekly and the RCC assisted at times.
-Resident #2 had not had any seizures.

Interview with the RCC on 08/05/26 at 12:00pm and 5:27pm revealed:
-She became the RCC in September/October 2025.
-She was aware Resident #2's Lacosamide was expired.
-The facility could not get the medication refilled because Resident #2 would not see a PCP.
-Lacosamide was a controlled substance (CS) with required a written prescription to refill.
-She sent a facility physician's order form requesting a new prescription for Lacosamide to the last appointment that Resident #2 attended at a mobile unit on 03/06/26, but the Nurse Practitioner (NP) did not sign the form.
-She contacted the facility's contracted PCP to see Resident #2 so the prescription for Lacosamide could be written but Resident #2 refused to see the PCP in approximately January 2026.
-The facility's contracted PCP could not write the prescription for Lacosamide for Resident #2 without seeing him.
-Resident #2 had not had any seizures since not receiving Lacosamide.
-Resident #2's Lacosamide expired so it would not be offered to him.

Interview with the Administrator on 08/05/26 at 11:46am and 6:06pm revealed:
-She was aware Resident #2's Lacosamide expired.

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-Resident #2's new FL2 and physician's order sheet was received on 03/06/26.
-The physician's order sheet was sent to the facility's contracted pharmacy, but the pharmacy advised a written prescription was needed for Lacosamide because it was a CS.
-She did not contact the PCP that signed Resident #2's FL2 and physician's order sheet to request a written prescription.
-She did not know if the RCC contacted the PCP that signed Resident #2's FL2 and physician's order sheet to request a written prescription.
-She was not aware Resident #2's Lacosamide prescription was sent to the local pharmacy by the PCP Resident #2 saw in 03/06/26.
-The RCC was responsible for contacting the PCP that signed Resident #2's FL2 and physician's order sheet to request a written prescription.

Telephone interview with a Registered Nurse (RN) at Resident #2's previous PCP office on 08/05/26 at 5:02pm revealed:
-The PCP was not available.
-It was unknown who originally prescribed Lacosamide 100mg to Resident #2.
-There was no documentation of any provider in that office prescribing medication to Resident #2 since 2020.
-There was no diagnosis documented for Resident #2's Lacosamide 100mg prescription.

Telephone interview with a certified medical assistant (CMA) with a local mobile unit on 08/05/26 at 11:01am revealed:
-Resident #2 informed the NP that he did not take his medications, including his seizure medication.
-Resident #2's Lacosamide prescription was sent to a local pharmacy on 03/06/26.
-It was unknown whether or not the facility was

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aware Resident #2's prescription refills were sent to the local pharmacy but the family member that accompanied Resident #2 to the appointment was informed.

Telephone interview with a NP with the local mobile unit on 08/05/26 at 11:33am revealed:
-She refilled Lacosamide 100mg for Resident #2.
-Resident #2's refill prescriptions were sent to a local pharmacy on 03/06/26.
-Resident #2's family member advised that Resident #2 was non-compliant with his medication to include his seizure medication (Lacosamide).
-The expectation was that none of the resident's medication expired.
-The risk of not taking Lacosamide depended on each individual person.

Attempted telephone interview with the facility's contracted pharmacy on 08/05/26 at 8:46am and 3:02pm was unsuccessful.

Refer to interview with Resident #2's family member on 08/05/26 at 2:48pm.

Refer to interview with a medication aide (MA) on 08/06/26 at 10:44am.

Refer to interview with a second MA on 08/05/26 at 2:31pm.

Refer to interview with a third MA on 08/06/26 at 6:45pm.

Refer to interview with the Resident Care Coordinator (RCC) on 08/05/26 at 12:00pm and 5:27pm.

Refer to interview with the Administrator on

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D 358	Continued From page 22 08/05/26 at 11:46am and 6:06pm. Refer to telephone interview with a certified medical assistant (CMA) with a local mobile unit on 08/05/26 at 11:01am. Refer to telephone interview with a local Nurse Practitioner (NP) with the local mobile unit on 08/05/26 at 11:33am. b. Review of Resident #2's current FL2 dated 03/06/26 revealed there was an order for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer, inhale 3ml by nebulization every 4 hours as needed for shortness of breath/wheezing. Review of Resident #2 physician's order sheet dated 03/06/26 revealed there was no order for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer. Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed there was no entry for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer. Review of Resident #2's July 2026 eMAR revealed there was no entry for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer. Review of Resident #2's August 2026 eMAR revealed there was no entry for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer. Observation of Resident #2's medication on hand on 08/05/26 at 10:32am revealed there was no Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer available for administration. Interview with Resident #2 on 08/05/26 at 9:29am revealed:	D 358		

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-He did not have shortness of breath and never had shortness of breath.
-He did not use a nebulizer.
-He did not have any breathing issues.

Review of Resident #2's progress notes revealed:
-On 04/16/26, Resident #2 was asked if he wanted to go to the ED after requesting cough syrup. He initially declined; however, he was sent to the ED due to wheezing, coughing, and high fever.
-He returned to the facility on the same day (04/16/26).

Interview with a medication aide (MA) on 08/06/26 at 10:44am revealed:
-She was not aware Resident #2 had an order for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer.
-MAs used the physician's order sheet as a guide to show what medication the residents should be taking.
-Cart audits were done weekly.
-When completing cart audits, MAs compared the physician's order sheet to what was on the cart; the FL2 was not used.
-If a medication was not listed on the physician's order sheet, the MA would not know to look for the medication on the cart.
-Resident #2 had not exhibited shortness of breath.

Interview with the second MA on 08/06/26 at 6:45pm revealed:
-She was not aware Resident #2 had an order for Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer.
-Resident #2 had not experienced shortness of breath.

Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 10:00am, 12:00pm and

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D 358	Continued From page 24 5:27pm revealed: -She was unsure why Resident #2's Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer was not on the eMARs because the FL2 with the medication listed had been scanned into their computer system. -The Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer may not have been on the order that was sent to the pharmacy. -When a new FL2 was received, the FL2 was sent to the facility's contracted pharmacy and scanned into the facility's computer system. -If there was a new medication on the FL2, the pharmacy automatically sent the medication to the facility. -She was unable to see what was sent to the facility's contracted pharmacy, an FL2 or physician's order sheet. -The FL2 was only sent to the facility's contracted pharmacy when the resident was a new admit or there were a lot of medication changes. -The eMAR audits were done when cart audits were done. -Cart audits were done weekly by the MAs. -When completing a cart audit, MAs compared the physician's order sheet to the medications on the cart. -Resident #2's cart audit was done last week. -If a medication was not listed on the physician's order sheet, the MA would not have known to look for the medication. -She found out yesterday, 08/04/26, that Resident #2's Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer was not listed on the physician's order sheet. -She was unsure why Resident #2's Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer was not listed on the physician's order sheet. -The RCC and MAs were responsible for making sure the physician's order sheet was correct.	D 358		

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-She or the person that sent Resident #2's physician's order sheet to the pharmacy should have reviewed the physician's order sheet.
-She was unsure who sent Resident #2's physician's order sheet to the facility's contract pharmacy.
-She saw and spoke with Resident #2 daily and he had not exhibited shortness of breath or wheezing.

Telephone interview with a certified medical assistant (CMA) with a local mobile unit on 08/05/26 at 11:01am revealed:
-Resident #2 did not complain of shortness of breath while visiting their office.
-The Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer prescription for Resident #2 was sent to a local pharmacy.

Telephone interview with a Nurse Practitioner (NP) with the local mobile unit on 08/05/26 at 11:33am revealed:
-She refilled Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer for Resident #2.
-Resident #2 was prescribed Ipratropium-albuterol 0.5-2.5mg/3ml nebulizer while in the hospital for shortness of breath in March 2026 so she prescribed the medication for as needed administration.
-Resident #2 did not present to her with shortness of breath.

Attempted telephone interview with the facility's contracted pharmacy on 08/05/26 at 8:46am and 3:02pm was unsuccessful.

Refer to interview with Resident #2's family member on 08/05/26 at 2:48pm.

Refer to interview with a medication aide (MA) on

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THE GARDENS OF NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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 26 08/06/26 at 10:44am. Refer to interview with a second MA on 08/05/26 at 2:31pm. Refer to interview with a third MA on 08/06/26 at 6:45pm. Refer to interview with the Resident Care Coordinator (RCC) on 08/05/26 at 12:00pm and 5:27pm. Refer to interview with the Administrator on 08/05/26 at 11:46am and 6:06pm. Refer to telephone interview with a certified medical assistant (CMA) with a local mobile unit on 08/05/26 at 11:01am. Refer to telephone interview with a local Nurse Practitioner (NP) with the local mobile unit on 08/05/26 at 11:33am. _____ Interview with a medication aide (MA) on 08/06/26 at 10:44am revealed: The Resident Care Coordinator (RCC) was responsible for sending the FL2 or 6-month physician's order sheet to the facility's contracted pharmacy. -The physician's order sheet was good for 6 months unless the medication was a controlled substance (CS). -The physician's order sheet was used by the facility's contracted pharmacy to dispense the residents' medications. Telephone interview with a certified medical assistant (CMA) with a local mobile unit on 08/05/26 at 11:01am revealed: -Resident #2 was seen by the nurse practitioner	D 358		

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(NP) on 03/06/26 after a hospitalization.
-Resident #2's medications were originally prescribed by another primary care provider (PCP) in 2019.
-The mobile unit NP refilled the medications Resident #2 was already taking.
-Resident #2 came to the appointment with a family member and the NP completed a FL2 at that time.
-She did not know if the facility was aware that the medications were sent to a local pharmacy but the family member that brought Resident #2 to the appointment was informed.

Telephone interview with the NP with the local mobile unit on 08/05/26 at 11:33am revealed:
-She worked with a mobile medical unit.
-She saw Resident #2 one time.
-Resident #2 was brought in by a family member for a hospital follow up and to establish care on 03/06/26 because Resident #2 did not want to see the facility's PCP.
-She refilled medications for Resident #2 based on his hospital discharge paperwork from March 2026.
-She was not Resident #2's PCP so she was unsure if he was taking his medications and how not taking the medications would affect him.

_____

The facility failed to administer medications as ordered to 1 of 5 sampled residents. Resident #2 was diagnosed with epilepsy and had not been administered a medication used to treat seizures. The seizure medication that was available on the medication cart had a beyond-use date of 10/22/24. The resident did not have an as needed nebulizer available for administration to treat shortness of breath and wheezing that was ordered March 2026. On 04/16/26 the resident went to the the hospital for wheezing and

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D 358	Continued From page 28 coughing. The failure to administer medications as ordered was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 08/05/26 for this violation.	D 358		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage	D 394		

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form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure controlled substances for 1 of 2 sampled residents (#2) were returned to the pharmacy within 90 days of expiration.

The findings are:

Review of Resident #2's current FL2 dated 03/06/26 revealed diagnoses included epilepsy, unspecified dementia, impulse disorder, muscle wasting and atrophy and rheumatoid arthritis.

Observation of Resident #2's medication on hand on 08/05/26 at 10:32am revealed:
-There was 1 card of Lacosamide 100mg on the medication cart for Resident #2. (Lacosamide is used to treat seizures.)
-The dispense date was 04/23/24 with 60 pills

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dispensed and 8 pills remaining.
-The beyond-use date was 10/22/24. (The beyond use date is the final date the medication should be used after the pharmacy has dispensed, repackaged, or opened the medication.)

Review of Resident #2's Controlled Substance Quantity Tracking log for Lacosamide 100mg revealed the quantity of tablets left was 8.

Interview with a medication aide (MA) on 08/05/26 at 2:31pm revealed she completed a cart audit November 2025 and informed the Resident Care Coordinator (RCC) about the expired Lacosamide.

Interview with a second MA on 08/05/26 at 6:45pm revealed:
-She was unsure why Resident #2's Lacosamide expired or why it was still on the cart.
-She asked coworkers about the expired Lacosamide but did not mention the expired medication to management.
-When medications expired, the RCC was to be notified.
-Cart audits were done by the MAs once weekly and the RCC assisted at times.
-She was unsure of what the facility's contracted pharmacy process was for medication destruction.

Interview with the RCC on 08/05/26 at 12:00pm and 5:27pm revealed:
-She and the MAs were responsible for completing cart audits.
-She was aware Resident #2's Lacosamide expired in 2024.
-Resident #2's Lacosamide was still on the cart because Resident #2 needed a refill of the

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medication.

Interview with the Administrator on 08/05/26 at 4:52pm and 6:06pm revealed:
-She was aware Resident #2's Lacosamide expired.
-She was unsure why the Lacosamide was still on the cart.
-The RCC and MAs were responsible for completing cart audits.
-Expired medications were given to the RCC.
-The RCC would complete a disposal sheet on the medication, and the medication was locked up until the pharmacy consultant came to the facility.
-The RCC contacted the pharmacy consultant regarding the need for medication disposal.
-The pharmacy consultant arrived at the facility within a week of the RCC calling.
-The pharmacy consultant destroyed the medication on site after the count was verified by the pharmacy consultant and Administrator.
-Refused controlled substances were disposed of using "Drug Buster" if taken out of the pack (Drug Buster is a chemical solution used to dispose of prescription and over the counter medications).
-The medication destruction form was uploaded to the resident's file in the computer.

Interview with the Regional Vice President of Operations (RVPO) on 08/05/26 at 6:26pm revealed:
-The facility's contracted pharmacy had to destroy controlled substances.
-The medication destruction sheet was completed by the RCC or Administrator.
-The medication was stored in the Administrator's office until the pharmacy consultant came to the facility.
-The facility's contracted pharmacy was

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D 394	Continued From page 32 supposed to leave a copy of the medication destruction sheet in a binder. -She was unsure why Resident #2's Lacosamide was still on the medication cart. Attempted telephone interviews with the facility's contracted pharmacy on 08/05/26 at 8:46am and 3:02pm were unsuccessful.	D 394		