| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL011198 | A. BUILDING: _____ B. WING _____ | 01/20/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERGREEN LIVING HOME #13 | 353 FAMILY RIDGE ROAD LEICESTER, NC 28748 |

| (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 |
|---|---|---|---|---|
| C 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey on January 19, 2017 with an exit conference via telephone on January 20, 2017. | C 000 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews, and record review, the facility failed to assure aspirin was administered as ordered to 1 of 3 sampled residents (Resident #1).<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 8/30/16 revealed diagnoses included Type II Diabetes Mellitus, erosive gastritis, Parkinson's Disease, hypertension, peripheral neuropathy and history of diabetic foot ulcer.<br><br>Review of Resident #1's Resident Register revealed an admission date of 1/28/15.<br><br>Review of Resident #1's physician order dated 10/20/16 revealed:<br>-Ultrasound of bilateral lower extremities. | C 330 | | |

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| C 330 | Continued From page 1<br>-Aspirin (used to prevent blood clots) 81mg daily.<br><br>Review of Resident #1's radiology report of the ultrasound of the bilateral lower extremities dated 10/20/16 completed at 1:42pm revealed:<br>-Clinical findings "claudication" (cramping pain in the legs induced by exercise, typically caused by obstruction of the arteries.)<br>-Resident #1 was found to have "a normal right ankle brachial index with triphasic signal. Toe pressure is mildly reduced at 62mmHg."<br>-The resident was found to have "left brachial index is mildly reduced with a biphasic signal and moderately reduced toe pressure."<br><br>Review of Resident #1's record revealed no order to discontinue aspirin 81mg daily.<br><br>Review of Resident #1's October and December 2016 and January 2017 Medication Administration Records (MARs) revealed:<br>-There was no entry for aspirin 81mg daily on the MARs.<br>-There were no documented administrations of aspirin for Resident #1.<br><br>Observation of Resident #1's medications available in the facility on 1/19/17 at 11:25am revealed:<br>-There was no aspirin 81mg strength in Resident #1's medications.<br>-There were 2 bottles of house stock aspirin 81mg strength available in the medication cart.<br><br>Interview with Resident #1 on 1/19/17 at 8:55am revealed:<br>-Staff "were providing the medications" to her as her primary care provider had ordered them.<br>-She denied ever running out of any of her medications. | C 330 | | |

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| C 330 | Continued From page 2<br>-The Supervisor-In-Charge was the one who administered medications to her.<br>-She had no complaints concerning her medications.<br><br>Telephone interview with the facility pharmacy on 1/19/17 at 10:45am revealed:<br>-The pharmacy had never received the order for Resident #1 for aspirin 81mg daily.<br>-The pharmacy had never received a discontinue order from the Family Nurse Practitioner who wrote the order.<br><br>Interview with the Administrator on 1/19/17 at 11:20am revealed:<br>-"The pharmacy did not get the order at all."<br>-"The resident refuses to take aspirin, because it causes her to have a sour stomach."<br>-The Administrator was unaware of the order and was not sure how it was missed by staff and was not faxed to the pharmacy per facility policy.<br><br>Review of Resident #1's record revealed there was no documentation of the Family Nurse Practitioner who had ordered the aspirin having been notified the resident was refusing to take the aspirin.<br><br>Interview with the Supervisor-In-Charge on 1/19/17 at 12:40pm revealed Resident #1 "used to take aspirin, but not now...it upset her stomach."<br><br>Attempted telephone interviews on 1/19/17 at 11:33am and on 1/20/17 at 10:05am with Resident #1's Family Nurse Practitioner who had written the order for the aspirin was unsuccessful by exit. | C 330 | | |