

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2021
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 2		STREET ADDRESS, CITY, STATE, ZIP CODE 60 G HORNOT CIRCLE ASHEVILLE, NC 28806		
(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 The Adult Care Licensure Section conducted an annual survey on 03/24/21 with an exit conference via telephone on 03/25/21.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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: Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (Resident #2) related to laboratory orders for lithium and Clozaril blood levels. The findings are: Review of Resident #2's current FL2 dated 08/05/20 revealed: -Diagnoses included schizoaffective disorder, depressive type, and post traumatic stress disorder. -There was an order for lithium (treats mood disorders) 150mg daily. -There was an order for Clozaril (antipsychotic) 150mg daily at bedtime. Review of the Resident Register for Resident #2 revealed an admission date of 03/06/19.	C 249		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 249	Continued From page 1 Review of a physician's order dated 11/09/20 for Resident #2 revealed increase the Clozaril to 200mg daily at bedtime. Review of a physician's order dated 02/02/21 for Resident #2 revealed to obtain laboratory values for lithium level (used to determine the therapeutic range of medication in the blood) and Clozaril level (used to determine effectiveness of the medication). Review of the laboratory results for Resident #2 on 03/24/21 revealed there was no lithium level or Clozaril level. Interview with Resident #2 on 03/24/21 at 10:38am revealed: -Resident #2 felt "fine". -Resident #2 did not want to answer any questions. Interview with the Supervisor in Charge (SIC) on 03/24/21 at 11:00am revealed: -Resident #2 had routine laboratory orders. -She thought the specimens for the lithium and Clozaril levels had been obtained during the routine laboratory blood draw. -When she received new laboratory orders she would fax them to the pharmacy and give the order to the Administrative Assistant and she "takes care of it". Interview with the Administrative Assistant on 03/24/21 at 12:00pm revealed: -She knew Resident #2 had routine laboratory blood specimen draws. -She did not know if the lithium level or Clozaril level had been obtained. -When laboratory orders from mental health providers were received the orders were faxed to	C 249		

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C 249	Continued From page 2 their contracted local medical group. -The local medical group would then fax the orders to a local laboratory agency. Interview with the Administrator on 03/24/21 at 12:57pm revealed: -When an "outside" provider writes a laboratory order it is forwarded to the contracted local medical group. -The local medical group then forwards the order to a local laboratory agency. -Laboratory specimens are collected on Mondays and results received on Wednesdays through Fridays. -The Administrative Assistant would then send the results to the SICs. -The order was missed. -She thought the laboratory agency never received the order to obtain the lithium and Clozaril levels. Telephone interview with Resident #2's physician's nurse on 03/24/21 at 3:49pm revealed the lithium and Clozaril blood levels were not obtained. Attempted telephone interview with Resident #2's physician on 03/24/21 at 12:33pm and 3:49pm was unsuccessful.	C 249		