Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011194	A. BUILDING: _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN LIVING HOME #2	102 COUNTRY TIME LANE 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 The Adult Care Licensure Section conducted an annual survey on 12/08/21.	C 000		
C 327	10A NCAC 13G .1003 (e) Medication Labels 10A NCAC 13G .1003 Medication Labels (e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for administration to a resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure a prescription medication was not transferred from one container to another except when prepared for administration to a resident for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's FL2 dated 11/08/21 revealed: -Diagnoses included dementia, chronic back pain, atrial fibriliation, and osteoporosis. -There was an order for pregabalin (used to relieve neuropathic pain) 75mg three times a day. -There was an order for pregabalin 75mg twice a day as needed for pain. Review of Resident #1's primary care provider (PCP) order dated 09/01/21 revealed pregabalin 75mg one capsule every eight hours for pain.	C 327	• The Three Capsules of Pregabalin 75mg and a multidose package containing a Capsule of Pregabalin 75mg and a half of Trazodone 50mg tablet were returned immediately to the Pharmacy for identification and replacement of returned medications. — 12/8/21 • Admin gave an education to MA to never repackaging the medication. — 12/8/21. • Four Capsules of Pregabalin 75mg and half tablet of Trazodone were refilled, at the Pharmacy (medication identification was done) and administered to the resident at scheduled times unless it was refused. — 12/9/21. • Admin or Appointed Staff made random medication check daily. — 12/9/21 ~ 12/16/21. • Admin or Appointed Staff will make random medication Check weekly for 3 month, — 12/17/21 ~ 3/25/22. • Admin or Appointed staff will conduct random medication check monthly. — 3/26/22 ~ ongoing.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ADMINISTRATOR (X6) DATE 1/07/22

Reviewed and Acknowledged
Date: 01/10/22 CS

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C 327	Continued From page 1 Observation of Resident #1's medications on hand on 12/08/21 at 12:50pm revealed: -Most of the resident's scheduled medications were in multidose packaging. -There was one bubble package of pregabalin 75mg capsules with 30 of 30 capsules remaining of quantity 90 dispensed on 12/03/21. -There was a second bubble package of pregabalin 75mg capsules with 26 of 30 capsules remaining of quantity 90 dispensed on 12/03/21. -There was a clear plastic gallon bag which contained three bottles of ordered over-the-counter medications. -Inside the clear plastic gallon bag were six multi-dose packages of medications. -One multidose package was labeled with a computer-generated label with Resident #1's name for 12/08/21 for the evening administration time of 5:00pm. -The package had not been opened and there were two tablets inside which matched the computer-generated label identifying the contents. -A second multidose package was labeled with a computer-generated label with Resident #1's name for 12/08/21 for the bedtime administration time of 8:00pm. -The package had been opened and there was one-half white round tablet and one-half white and half burgundy capsule inside. -The white and burgundy capsule matched the capsules in the bubble pack of pregabalin 75mg capsules. -The label on the 12/08/21 bedtime administration multidose pack identified the contents as one-half trazodone 50mg tablet and did not identify white/burgundy capsule. -A third multidose package was labeled "unused" with a computer-generated label and it had been opened.	C 327	• Pharmacy RN gave all MA training on medication administration. - 1/5/22.	

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C 327	Continued From page 2 -On the top of the third package, "12/08/21" was handwritten, and there were two additional signs handwritten in a language other than English added to the label. -Inside the package, there was one white and burgundy capsule. -A fourth multidose package was labeled with a computer-generated label with Resident #1's name for 12/09/21 for the morning administration time of 7:30am. -The package contained six and one-half tablets which matched the printed label identifying the contents. -A fifth multidose package was labeled "unused" with a computer-generated label and it had been opened. -On the top of the fifth package, "12/09/21" was handwritten and two additional signs handwritten in a language other than English. -Inside the package, there was one white and burgundy capsule. -A six multidose package was labeled "unused" with a computer-generated label and it had been opened. -On the top of the sixth package the "9" was handwritten and two additional signs handwritten in a language other than English. -Inside the package, there was one white and burgundy capsule. Review of Resident #1's November 2021 Medication Administration Record (MAR) revealed: -There was an entry for pregabalin 75mg one capsule every eight hours for pain scheduled at 6:00am, 2:00pm, and 10:00pm. -Pregabalin was documented as administered every eight hours from 11/01/21 through 11/30/21. Review of Resident #1's December 2021 MAR	C 327		

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C 327	Continued From page 3 revealed: -There was an entry for pregabalin 75mg one capsule every eight hours for pain scheduled at 6:00am, 2:00pm, and 10:00pm. -Pregabalin was documented as administered every eight hours from 12/01/21 through 12/08/21 at 2:00pm. Interview with a Medication Aide (MA) on 12/08/21 at 1:18pm revealed: -He and one other staff administered medications at the facility. -He had removed four pregabalin capsules from Resident #1's labeled bubble pack and placed the pregabalin capsules into the multidose packages to make medication administration "easier." -He had added the pregabalin to the multidose unit packages in advance for "today's and tomorrow's doses" (12/08/21 and 12/09/21. -He administered the pregabalin doses he repackaged. Interview with the Administrator on 12/08/21 at 1:20pm revealed: -She was unaware the MA had been repackaging medications. -Resident #1's multidose packages which had been opened and tampered with would be sent back to the pharmacy for identification and replacement so the resident would not run out of any of the medications. Telephone interview with the Administrator on 12/08/21 at 2:45pm revealed: -It was not the facility's policy to have employees repackage medications. -The staff who had repackaged the pregabalin had not been told to repackage medications. -The staff would be reeducated and "never again" would the staff repackage medications.	C 327		

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C 327	Continued From page 4 Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. The failure of the facility to ensure prescription medications were not transferred from the container prepared by the dispensing pharmacy to a container that did not have the resident's name nor descriptions of the medications inside the container put Resident #1 and other resident's in the facility at risk of receiving the wrong medications or incorrect dosing of a medication (Resident #1). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2021.	C 327		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or	C 612	• SIC was given education about the importance of always checking Temp. and screening for Covid Symptoms - 12/8/21. • Admin or Appointed Staff will do reminding of compliance at each come on a daily basis for a week - 12/9/21 ~ 12/15/21.	

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C 612	Continued From page 5 emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to appropriate screening of visitors. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities, updated 09/10/21, revealed all visitors should be screened for the presence of fever and symptoms of the virus when entering the facility. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities updated 11/19/21 revealed all visitors should be screened for signs and symptoms of COVID-19 before entering the facility.	C 612	• Admin or Appointed staff will do reminding of compliance on a weekly basis for a month. – 12/16/21 ~ 1/10/22 • Admin or Appointed staff will do reminding of compliance on a monthly basis – 1/15/22 ~ ongoing. • Manager gave all staff education specifically for Covid-19 education for caregivers and staff. All SIC were re-educated that they must check immediately the temperature of visitors who enter inside of the facility. – 12/16/21. • Pharmacy RN gave all SIC Infection Prevention and Controls training, – 1/5/22.	

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C 612	Continued From page 6	C 612		

Review of the facility's visitation policy dated 07/01/20 revealed:
-All visitors will be screened for temperature and COVID-19 symptoms before entering the facility.
-The facility has the right to refuse visitation based upon screening and adherence to infection control measures.

Observation upon entrance into the facility on 12/08/21 at 8:50am revealed:
-The Supervisor-In-Charge (SIC) met the surveyor at the front door.
-The SIC did not check the surveyors' temperature.
-The SIC did not screen the surveyor for signs and symptoms of COVID-19 illness.
-The SIC asked the surveyor to complete an entry in a visitors' log with the following information: date and time of the visit, the visitor's name, phone number, and the visitor's associated corporation.

Interview with the Manager on 12/08/21 at 10:04am revealed:
-The SIC had forgotten to check the surveyors' temperature and ask the COVID-19 screening questions upon entry.
-The staff were supposed to check the temperature of each visitor and ask them COVID-19 screening questions.
-There were two thermometers available on the table at the front door specifically to be used for this purpose.
-It was the facility's policy to check the temperature and screen every visitor for symptoms of COVID19.

Telephone interview with the Administrator on 12/08/21 at 2:45pm revealed:

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C 612	Continued From page 7 -It was the facility's policy to check the temperature and ask COVID-19 screening questions for all visitors. -The SIC was responsible for checking the temperature and asking the screening questions. -The SIC had just forgotten to screen the surveyor upon entry.	C 612		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication labels. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure a prescription medication was not transferred from one container to another except when prepared for administration to a resident for 1 of 3 sampled residents (Resident #1) [Refer to Tag 327, 10A NCAC 13G .1003(e) Medication Labels (Type B Violation)].	C 912		