PRINTED: 07/05/2017
FORM APPROVED

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
	FCL045091	A. BUILDING: _____ B. WING _____	07/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW FAMILY CARE HOMES UNIT F	24 EAST MONET FLAT ROCK, NC 28731

(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 and the Henderson County Department of Social Services conducted an annual survey on July 3, 2017.	C 000	C315 - Order clarified and corrected. - Correct order in MAR - Correct medication on hand	7/3/17
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain order clarification regarding furosemide for 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 6/16/17 revealed: -Diagnoses which included congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation and heart disease. -An order for furosemide 40mg, 1 tablet by mouth, daily (furosemide is used to reduce extra fluid in the body).	C 315	Supervisory staff will review orders and assist med tech with obtaining clarifications timely. Audits will be completed comparing medication labels to MAR at least monthly by supervisory staff Additional education provided to med tech regarding importance/ urgency of clarifying all unclear/conflicting orders.	7/31/17 7/31/17 7/31/17

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/17/17

STATE FORM 6899 OH8911 If continuation sheet 1 of 3

REVIEWED & accepted Casey Fitzgerald 7/17/17

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C 315	Continued From page 1	C 315		

Review of Resident #2's record revealed an admissions date of 6/21/17.

Review of Resident #2's June 2017 and July 2017 electronic Medication Administration Record (eMAR) revealed:
-An entry for furosemide 40mg, 1 tablet by mouth, every day.
-Furosemide 40mg, 1 tablet by mouth, every day was documented as administered on both eMAR's.

Observation on 7/3/17 at 12:25pm of Resident #2's medication on hand revealed:
-Furosemide 20mg, 1 tablet by mouth, daily, was in stock.
-The date the medication was dispensed was 6/20/17.

Interview on 7/3/17 at 8:35am and 11:35am with Resident #2 revealed:
-Staff administered his medications.
-He had no concerns about his medications.
-He was not sure of the specific medications he was taking.
-Has had no trouble with swelling of his legs or arms.
-He has not seen a doctor since he moved in to the facility.

Interview on 7/3/17 at 12:27pm with staff at the prescribing physician's office revealed:
-Prior to admissions to the facility, Resident #2 had been residing at a skilled nursing facility (SNF).
-While at the SNF, the doctor had ordered the furosemide to be decreased from 40mg to 20mg on 4/13/17.
-At a 6/20/17 physician's visit, the Doctor learned

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C 315	Continued From page 2	C 315		

the decrease had not occurred and discussed the issue with the Nurse Manager at the SNF.
-They have no concerns regarding Resident #2's health care at his current facility.

Interview on 7/3/17 at 11:40am with the Supervisor in Charge revealed:
-She had noticed the furosemide discrepancy on 6/23/17.
-She had not contacted a supervisor, the pharmacy or the prescribing physician to obtain clarification of the discrepancy.
-She was going to "address it today".
-"Last week was hectic" because supervisory and administrative staff for this facility and a sister facility were on vacation and she was "passing meds at both houses".
-She had been administering only "one pill" of furosemide (20mg).

Interview on 7/3/17 at 1:05pm with the Administrator revealed:
-He had picked-up Resident #2 from the SNF and brought him to the facility.
-It was his responsibility to review the records and log-in the medications.
-"This was an oversight on my part. I must have just missed this" (seeing the discrepancy).