

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL045091</b>         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/03/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUNDVIEW FAMILY CARE HOMES UNIT F</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24 EAST MONET<br/>FLAT ROCK, NC 28731</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 000                                                                         | Initial Comments<br><br>The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey on July 3, 2017.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C 000                                                                                 |                                                                                                                          |                                                        |
| C 315                                                                         | 10A NCAC 13G .1002(a) Medication Orders<br><br>10A NCAC 13G .1002 Medication Orders<br>(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:<br>(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;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to obtain order clarification regarding furosemide for 1 of 3 sampled residents (Resident #2).<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 6/16/17 revealed:<br>-Diagnoses which included congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation and heart disease.<br>-An order for furosemide 40mg, 1 tablet by mouth, daily (furosemide is used to reduce extra fluid in the body). | C 315                                                                                 |                                                                                                                          |                                                        |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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| C 315                                                                         | <p>Continued From page 1</p> <p>Review of Resident #2's record revealed an admissions date of 6/21/17.</p> <p>Review of Resident #2's June 2017 and July 2017 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-An entry for furosemide 40mg, 1 tablet by mouth, every day.</li> <li>-Furosemide 40mg, 1 tablet by mouth, every day was documented as administered on both eMAR's.</li> </ul> <p>Observation on 7/3/17 at 12:25pm of Resident #2's medication on hand revealed:</p> <ul style="list-style-type: none"> <li>-Furosemide 20mg, 1 tablet by mouth, daily, was in stock.</li> <li>-The date the medication was dispensed was 6/20/17.</li> </ul> <p>Interview on 7/3/17 at 8:35am and 11:35am with Resident #2 revealed:</p> <ul style="list-style-type: none"> <li>-Staff administered his medications.</li> <li>-He had no concerns about his medications.</li> <li>-He was not sure of the specific medications he was taking.</li> <li>-Has had no trouble with swelling of his legs or arms.</li> <li>-He has not seen a doctor since he moved in to the facility.</li> </ul> <p>Interview on 7/3/17 at 12:27pm with staff at the prescribing physician's office revealed:</p> <ul style="list-style-type: none"> <li>-Prior to admissions to the facility, Resident #2 had been residing at a skilled nursing facility (SNF).</li> <li>-While at the SNF, the doctor had ordered the furosemide to be decreased from 40mg to 20mg on 4/13/17.</li> <li>-At a 6/20/17 physician's visit, the Doctor learned</li> </ul> | C 315                                                                                 |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| C 315                                                                         | <p>Continued From page 2</p> <p>the decrease had not occurred and discussed the issue with the Nurse Manager at the SNF.<br/>-They have no concerns regarding Resident #2's health care at his current facility.</p> <p>Interview on 7/3/17 at 11:40am with the Supervisor in Charge revealed:<br/>-She had noticed the furosemide discrepancy on 6/23/17.<br/>-She had not contacted a supervisor, the pharmacy or the prescribing physician to obtain clarification of the discrepancy.<br/>-She was going to "address it today".<br/>-"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".<br/>-She had been administering only "one pill" of furosemide (20mg).</p> <p>Interview on 7/3/17 at 1:05pm with the Administrator revealed:<br/>-He had picked-up Resident #2 from the SNF and brought him to the facility.<br/>-It was his responsibility to review the records and log-in the medications.<br/>-"This was an oversight on my part. I must have just missed this" (seeing the discrepancy).</p> | C 315                                                                                 |                                                                                                                          |                                                        |