STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045080	A. BUILDING: _____ B. WING _____	07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW FAMILY CARE HOMES - UNIT B	32 OXBOW LANE 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 27, 2017.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure two common bathroom doors were kept in good repair. The findings are: Interview with the Facility Site Manager on 7/27/17 at 8:15am revealed there were six residents currently living in the facility. Observations during the initial tour of the facility on 7/27/17 from 8:20am to 8:25am revealed: -There were three bathrooms for the residents in the facility, two in the middle of the resident bedroom hallway and one at the end of the hallway. -The bathroom at the end of the hallway was temporarily out of service. -The two doors on the middle bathrooms would become stuck on the hallway floor when opening the door. -The two doors opened up approximately to a 40	C 074	C074 Bathroom doors shaved down to allow for easy openings on 7/27/17 8/27/17 Administrative staff shall monitor the maintenance of the facility at least monthly until compliance is reached. All repairs shall be completed within 30 days. Repairs will be submitted to maintenance within 24 hours.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 8/30/17

STATE FORM 6899 1S4F11 If continuation sheet 1 of 8

Reviewed & accepted Casey Fitzgerald 9/18/17

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C 074	Continued From page 1 or 45 degree angle from the door frame. Interviews with three residents on 7/27/17 revealed: -All three residents stated both doors had been that way for "a long time" or "for a while". -One resident indicated there was a resident who used a [rollator] who "could hardly wait for them to fix the doors because it takes him everything he can to get them opened". -One resident indicated observing staff working on the doors, but have yet to "shave off the bottom of the doors". Interview with Resident #2 on 7/27/17 at 9:10am revealed: -He ambulated with a rollator. -He was able to get into the bathrooms but "it was hard". -He had to "grab both door handles to balance himself and push the doors hard to open them". -He had not fallen when opening the doors. -"Someone had looked at the doors and were supposed to shave them off." -Both doors had been like that "for a long time". Review of the current local health department facility inspection report dated 3/20/17 revealed no comment about the condition of the bathroom doors. Interview with the Supervisor-in-Charge (SIC) on 7/27/17 at 10:40am revealed: -He had started working at the facility "about three weeks ago". -The middle bathroom doors were getting stuck when trying to open them since he had started working in the facility. -The maintenance staff were aware of the doors but he did not know when they would be fixed.	C 074		

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C 074	Continued From page 2 -He assisted Resident #2 with getting the doors opened and closed. Second interview with the Facility Site Manager on 7/27/17 at 11:10am revealed: -She was aware of the condition of the bathroom doors. -She had sent a maintenance request in on 6/21/17 and again on 7/26/17. -The doors were on the schedule to be repaired on Monday (7/31/17). -She had just received a text message from the Administrator and the doors "would be fixed today" (7/27/17). -She had not been made aware of the difficulties Resident #2 had with operating the doors.	C 074	C350 Self-administer order obtained from resident's physician for doses taken out of the facility. Med-tech supervisor will monitor all exceptions weekly. Med tech supervisor will obtain self administer orders from physician for any doses that are routinely taken out of the facility by a resident.	8/30/17
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not	C 350		

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C 350	Continued From page 3 imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure that 1 of 1 resident (Resident #1) had a self-administration order signed by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record. The findings are: Observations of Resident #1's room on 7/27/17 at 8:25am revealed: -On a small table under the one window in the room there were two prescription bottles. -Both bottles were pharmacy labeled and both were empty. -One bottle was labeled Oxycodone 5/325mg (used to relieve moderate to severe pain), take 1-2 tablets every 4-6 hours as needed for dental pain. The filled date was 5/16/17 and 30 pills were dispensed. -The second bottle was labeled Amoxicillin 500mg (used to many types of infections), 1 tablet three times per day until gone. The filled date was 5/16/17 and 30 pills were dispensed. Review of Resident #1's current FL2 dated 3/29/17 revealed diagnoses of paranoid schizophrenia, generalized arthralgia, hypertension, type 2 diabetes mellitus and severe morbid obesity. Review of Resident #1's record revealed:	C 350		

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C 350	Continued From page 4	C 350		

-An admission date of 12/2/08.
-No self-administration order signed by a physician documented in the resident's record.

Interviews with Resident #1 on 7/27/17 at 8:25am and 10:20am revealed:
-The Oxycodone and Amoxicillin were prescribed to him following a dental procedure.
-The pill bottles were in his room because he "takes his own meds".
-He knew the Amoxicillin was "so he wouldn't get an infection" and "he took all of the pills".
-He used all of the Oxycodone pills due to pain and discomfort after the dental procedure.
-He did not know, nor could not remember if staff were aware of these medications. Following the procedure he went to the pharmacy, had the prescriptions filled and returned to the facility.
-He had his own vehicle and provided his own transportation.
-He left the facility on a daily basis and "took his medications with him".
-He had been taking his own medications for "about a year".
-He stated he knew what medications he was taking.

Review of the facility's resident sign-in/sign-out log book revealed Resident #1 had signed out every day starting on 7/20/17 through 7/27/17.

Review of Resident #1's Care Plan dated 4/20/17 revealed handwritten notation listed under Activities of Daily Living, Other section was medication administration with an indicator of 4, totally dependent.

Review of the July 2017 electronic medication administration record (eMAR) revealed:
-The 5:00pm dose of metformin ER 500mg, take

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C 350	Continued From page 5	C 350		

one tablet by mouth twice daily with food (used to control high blood sugar) was documented as given to the resident to take later 26 out of 27 opportunities.
-The 8:00pm dose of benztropine 0.5mg, take one tablet by mouth twice daily (used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs) was documented as given to the resident to take later 27 out of 27 opportunities.
-The 8:00pm dose of carvedilol 25mg, take two tablets by mouth twice daily, hold is systolic blood pressure is below 100 (used to treat hypertension) was documented as given to the resident to take later 27 out of 27 opportunities.
-The 8:00pm dose of fish oil 1,000mg, take one capsule by mouth twice daily (used to help lower triglyceride levels in the blood) was documented as given to the resident to take later 27 out of 27 opportunities.
-The 8:00pm dose of risperidone 2mg, take one tablet by mouth twice daily (used to treat schizophrenia) was documented as given to the resident to take later 27 out of 27 opportunities.
-The 8:00pm dose of simvastatin 40mg, take one tablet by mouth at bedtime (used to help lower "bad" cholesterol and fats (such as LDL, triglycerides) and raise "good" cholesterol (HDL) in the blood) was documented as given to the resident to take later 27 out of 27 opportunities.

Review of the June 2017 eMAR revealed:
-The 5:00pm dose of metformin ER 500mg was documented as given to the resident to take later 9 out of 30 opportunities.
-The 8:00pm dose of benztropine 0.5mg was documented as given to the resident to take later 26 out of 30 opportunities.
-The 8:00pm dose of carvedilol 25mg was

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C 350	Continued From page 6 documented as given to the resident to take later 26 out of 30 opportunities. -The 8:00pm dose of fish oil 1,000mg was documented as given to the resident to take later 26 out of 30 opportunities. -The 8:00pm dose of risperidone 2mg was documented as given to the resident to take later 26 out of 30 opportunities. -The 8:00pm dose of simvastatin 40mg was documented as given to the resident to take later 26 out of 30 opportunities. Interview with the Supervisor-in-Charge (SIC) on 7/27/17 at 10:40am revealed: -He had started working at the facility "about three weeks ago". -Resident #1 almost always left the facility on a daily basis and took his evening medications with him. -The 5:00pm medication was placed in a "separate zip lock bag" than the 8:00pm medications. -The bags are labeled with the time of the medication. -Resident #1 checked his own blood pressure and provided the SIC with a record of the pressures. -He had not noticed the empty pill bottles in Resident #1's room. -Resident #1 had been taking his meds with him ever since he started working for the facility. Interview with the Facility Site Manager on 7/27/17 at 10:15 am and 11:10am revealed: -Resident #1 had been taking his medications with him when he left the facility for about 1 year. Resident #1 had "a girlfriend" he went to visit almost daily. -The medications are placed in "a baggie" with a copy of the MAR, "he (resident #1) knows his	C 350		

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C 350	Continued From page 7 pills". -Resident #1 had his own blood pressure cuff. -If he (resident #1) did not take a pill, he would return it to the SIC. -Resident #1 made all his own appointments except the podiatrist. He also had his own car and drove himself to his appointments. -She was not aware of the empty pill bottles in his room. -She did not know the reason a facility report of consultation form had been completed by the dentist and returned to the facility. A form is sent with the resident to his appointments. -Staff were to talk about the appointment with Resident #1 when he returned from the doctor's office. -She had discussed this issue with Resident #1 primary care physician (PCP), and based on that conversation, they did not believe the resident was self-administering his medications. -She would discuss the issue with Resident #1's new PCP who would be at the facility on 7/28/17.	C 350		