STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011383	A. BUILDING: _____ B. WING _____	03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW II # I	36 SMITH GRAVEYARD ROAD 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 and the Buncombe County Department of Social Services conducted an annual survey on March 28, 2018.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medication was administered as ordered by a prescribing practitioner to 1 of 3 sampled resident's (Resident #2) related to lisinopril. The findings are: Review of Resident #2's current FL2 dated 7/7/17 revealed: -Diagnoses included hypertension, glaucoma and diabetes mellitus. -Medication orders included lisinopril 10mg tablet, take 1/2 tablet once a day (for blood pressure and kidney protection). Review of Resident #2's January 2018 medication administration record (MAR) revealed: -There was an order for lisinopril 10mg tablet, take 1/2 tablet once a day. -The date the medication had been entered on	C 330		

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C 330	Continued From page 1 the MAR was 8/18/16. Review of subsequent physician's orders in Resident #2's record revealed an order written 2/14/18 for lisinopril 10mg tablet, take 1/2 tablet twice a day. Review of Resident #2's February 2018 MAR revealed: -There was an order for lisinopril 10mg tablet, take 1/2 tablet once a day. -The order written 2/14/18 for lisinopril 10mg tablet, take 1/2 tablet twice a day had not been transcribed to the MAR. -The resident's blood pressures from 2/15/18 to 2/28/18 had ranged from 110 to 135 over 62 to 88. Review of Resident #2's March 2018 MAR revealed: -There was an order for lisinopril 10mg tablet, take 1/2 tablet once a day. -The order written 2/14/18 for lisinopril 10mg tablet, take 1/2 tablet twice a day had not been transcribed to the MAR. -The resident's blood pressures from 3/1/18 to 3/28/18 had ranged from 106 to 164 over 61 to 101. Observation of Resident #2's medication on hand revealed there was a bubble pack of lisinopril 10mg 1/2 tablets available for administration. Interview on 3/28/18 at 2:02pm with the Medication Aide (MA)/Supervisor-in-Charge (SIC) and the Administrator revealed: -When the MA/SIC received new orders she would review the orders, fax the orders to the pharmacy and send a picture of the orders to the Administrator.	C 330		

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C 330	Continued From page 2 -The Administrator would enter the orders via computer to the resident's MAR. -Once entered on the MAR, the orders were locked and only the Administrator could change the time, extend the discontinue date etc. -Resident #2 had been seen by her physician on 2/14/18. -The MA/SIC had not seen or reviewed Resident #2"s orders dated 2/14/18. -The Administrator had not reviewed the orders dated 2/14/18, "I missed them. I made a mistake. I just missed them." Interview on 3/29/18 at 9:55am with Resident #2's physician revealed: -She did not know Resident #2 was not being administered lisinopril 10mg tablet, 1/2 tablet twice a day. -She had last seen the resident at an appointment on 2/14/18. -The facility had sent a physician order sheet (POS), not a copy of the resident's current MAR, to the appointment. -When she reviewed the POS, she did not notice the discrepency in the lisinopril orders. -After reviewing Resident #2's most recent blood pressures, the physician stated, "There was no harm done".	C 330		