

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL045081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/17/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUNDVIEW FAMILY CARE HOMES - UNIT C

**247 KENDRICK COURT
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 conducted an annual survey on 05/16/19-05/17/19.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify 1 of 3 sampled residents (Resident #2) primary care provider of a significant weight loss. The findings are: Review of Resident #2's current FL2 dated 04/29/19 revealed: -Diagnoses included epileptic seizures, mental retardation, hyponatremia, hypothyroidism, and gastroesophageal reflux disease. -There was a physician's order for weekly weights. -There was an order for a regular diet. Review of Resident #2's FL2 dated 11/26/18 revealed an order for weekly weights. Review of Resident #2's March 2019 electronic Medication Administration Record (eMAR) revealed: -On 03/05/19, the documented weight was 321.2 lbs. -On 03/12/19, the documented weight was 322.1 lbs. -On 03/19/19, the documented weight was 295.4	C 246	<u>C246</u> Weights will be reviewed monthly for any significant weight loss. Scale will be checked to ensure accuracy. Any change in excessive clothing, etc will be documented if it is felt to be contributing to the difference in weights. Staff received additional training to ensure they know what is considered a significant unplanned weight loss/gain and requirement to notify administration and primary care.	6/30/19

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

U7FR11

If continuation sheet 1 of 8

Reviewed and Accepted
Date: 08/12/19
cs

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NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOMES - UNIT C			STREET ADDRESS, CITY, STATE, ZIP CODE 247 KENDRICK COURT FLAT ROCK, NC 28731		
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C 246	Continued From page 1 lbs. -On 03/26/19, the documented weight was 295.8 lbs. Review of Resident #2's April 2019 eMAR revealed: -On 04/02/19, the documented weight was 296.3 lbs. -On 04/09/19, the documented weight was 296.7 lbs. -On 04/16/19, the documented weight was 296.3 lbs. -On 04/23/19, the documented weight was 294.9 lbs. -On 04/30/19, the documented weight was 295.3 lbs. Review of Resident #2's May 2019 eMAR revealed: -On 05/07/19, the documented weight was 275 lbs. -On 05/14/19, the documented weight was 275 lbs. Observation of Resident #2's weight check on 05/16/19 at 4:03pm revealed the resident weighed 271 lbs. Record review of Resident #2's March through May 2019 documented weights revealed: -The resident was documented to have lost 46.2 lbs. from 03/05/19 to 05/13/19. -There was no documentation Resident #2's Nurse Practitioner had been notified of the weight loss. Review of Resident #2's Nurse Practitioner's notes dated 01/07/19 revealed: -The visit was a routine follow up for chronic medical problems.	C 246			

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C 246	Continued From page 2 -Morbid obesity-the resident has gained 40 pounds in the past 18 months. -The resident's weight was documented as 321.8 lbs. Interview with Resident #2 on 05/17/19 at 8:55am revealed: -Facility staff weighed her "pretty often." -She thought they weighed her weekly. -She was not sure whether she had lost a lot of weight recently or not. -She had not noticed any changes in how her clothes fit her recently. Interview with the Supervisor-In-Charge (SIC) on 05/16/19 at 3:57pm revealed: -Resident #2 slept a lot during the day and was "up and down all night long" urinating due to the effects of some of her medications. -She had not noticed a change in Resident #2's weight. -She had not noticed a change in the resident's documented weights. -She had not notified the resident's primary care provider of the documented weights. -The scales used to routinely weigh Resident #2 "may be wrong." -The batteries had recently had to be replaced in the scale used to weigh Resident #2. Telephone interview with Resident #2's Nurse Practitioner on 05/17/19 at 10:00am revealed: -She had spoken with the Property Manager on 05/16/19 about Resident #2's weight change. -She did not believe the resident truly had a 46 lbs. weight loss. -"I don't know how accurate that scale is." -Resident #2's albumin and total protein blood tests were performed back in August 2018 and the results were "fine."	C 246		

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C 246	Continued From page 3 -A weight of 274 lbs. "sounds more reasonable." Interview with the Property Manager on 05/17/19 at 10:05am revealed: -Resident #2's NP's assistant had access to the facility's eMARs to enable them to monitor the residents vitals and weights. -Their eMAR system had the capability to monitor weights and send out a message to staff about alerting the physician of changes, however, this capability was not currently set up. -She had been unable to find any documentation where NP had been notified about the resident's weight changes. -The SIC would be responsible for notifying the NP of a significant weight change for a resident.	C 246			
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a	C 342			

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C 342	Continued From page 4 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate and complete for 1 of 3 sampled residents (Resident #1) related to a missing administration time for Creon for evening snack. The findings are: Review of Resident #1's current FL2 dated 04/07/19 revealed: -Diagnoses included seizure disorder, diabetes, asthma, gastroesophageal reflux disease, and anxiety disorder. -There was an order for Creon DR (replaces enzymes the pancreas cannot produce to aid in the digestion of food) 24,000 units take three capsules with meals. -There was an order for Creon DR 24,000 units take two capsules with snacks. Review of Resident #1's FL2 dated 01/19/19 revealed: -There was an order for Creon DR 24,000 units take three capsules with meals. -There was an order for Creon DR 24,000 units take two capsules with snacks. Interview with Resident #1 on 05/16/19 at 2:02pm, on 05/17/19 at 8:30am, and on 05/17/19 at 11:00am revealed: -She received Creon with three meals a day and three snacks a day for pancreas inefficiency. -She ate three meals and three snacks a day. -"I take a bedtime snack."	C 342	<u>C342</u> MAR updated to include administration of the medication with bedtime snack. Times for snack administration are 10AM, 2pm and 8pm. Resident will be interviewed monthly until substantial compliance is reached regarding this medication. MAR's will be checked quarterly as well as medication cart audits to ensure accuracy of the MAR and correct medication administration times/doses.	6/30/19

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C 342	Continued From page 5 Review of Resident #1's October 2018 through December 2018 electronic Medication Administration Record (eMARs) revealed: -There were entries for Creon DR 24,000 units take 3 capsules three times daily with meals scheduled for 8:00am, 12:00pm and 5:00pm. -There were entries for Creon DR 24,000 units take 2 capsules with snacks scheduled at 10:00am and 2:00pm. -The Creon was documented as administered from 10/01/18 to 12/31/18 for all opportunities. Review of Resident #1's January 2019 through February 2019 eMARs revealed: -There were entries for Creon DR 24,000 units take 3 capsules three times daily with meals scheduled for 8:00am, 12:00pm and 5:00pm. -There were entries for Creon DR 24,000 units take 2 capsules with snacks scheduled at 10:00am and 2:00pm. -The Creon was documented as administered from 01/01/19 to 02/28/19 for all opportunities. Review of Resident #1's March 2019 eMAR revealed: -There was an entry for Creon DR 24,000 units take 3 capsules three times daily with meals scheduled for 8:00am, 12:00pm and 5:00pm. -There was an entry for Creon DR 24,000 units take 2 capsules with snacks scheduled at 10:00am and 2:00pm. -The Creon was documented as being administered with meals for 91 occurrences out of 93 opportunities (the medication was documented as not administered on 03/05/19 at 12:11pm "given to resident to take later" and on 03/13/19 at 4:14pm "out of facility".) -The Creon was documented as being administered with 10:00am and 2:00pm snack for	C 342		

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C 342	Continued From page 6 59 occurrences out of 62 opportunities (the medication was documented as not administered on 03/05/19 at 10:00am, on 03/05/19 at 2:36pm "given to resident to take later", on 03/13/19 at 4:14pm "out of facility", and on 03/26/19 at 1:34pm "out of facility." Review of Resident #1's April 2019 through May 2019 eMARs revealed: -There were entries for Creon DR 24,000 units take 3 capsules three times daily with meals scheduled for 8:00am, 12:00pm and 5:00pm. -There were entries for Creon DR 24,000 units take 2 capsules with snacks scheduled at 10:00am and 2:00pm. -The Creon was documented as being administered from 04/01/19 to 05/16/19 for all opportunities. Observation of Resident #1's available medications on 05/16/19 at 12:10pm revealed: -There were three bubble packs of Creon DR 24,000 unit capsules. -One bubble pack with a fill date of 04/28/19 had two capsules left out of 30 capsules. -The two bubble packs with fill dates of 04/28/19 had 30 capsules each totaling 60 capsules. Telephone interview with the contracted facility pharmacy on 05/16/19 at 3:22pm revealed: -They had been sending a 20 day supply of Creon 24,000 unit capsules (300 capsules) with each dispense for Resident #1. -The 20 day supply included 3 capsules for three meals a day and 2 capsules for three snacks a day totaling 15 capsules a day for 20 days or 300 capsules. Review of Resident #1's pharmacy medical expenses from 10/22/18 to 4/28/19 revealed the	C 342			

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C 342	Continued From page 7 pharmacy dispensed 300 capsules of Creon DR 24,000 unit capsules on 10/22/18, 11/13/18, 12/04/18, 12/26/18, 01/17/19, 02/10/19, 03/10/19, 04/02/19, and 04/28/19. Telephone interview with Resident #1's gastroenterology physician's nurse on 05/17/19 at 9:42am revealed: -The resident was taking the Creon for pancreatic insufficiency. -The last pancreatic enzymes that were done in their office "were elevated." -The resident was instructed to continue Creon with meals and snacks and was "under fairly good control." -If Resident #1 did not receive the Creon as ordered, she would experience abdominal pain, nausea, vomiting, and could experience a spike in body temperature. Interview with the SIC on 05/16/19 at 3:32pm and 05/17/19 at 10:15am revealed: -Resident #1 did not "always" take a snack. -Resident #1 spent a large part of her time in another facility on the property visiting with another resident. Interview with the Relief SIC on 05/17/19 at 10:35am revealed: -Resident #1 took the Creon at breakfast, 10am snack, lunch, 2pm snack, and at dinnertime. -The resident did not get Creon at bedtime because "it's not scheduled for bedtime."	C 342			