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SOUNDVIEW II # 2	34 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 conducted an annual and follow up survey on 09/20/22.	C 000		
C 079	10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (6) have supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This rule apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 3 of 3 sampled resident bathrooms had paper towels or hand towels available for resident use. The findings are: Interviews with residents on 09/20/22 between 8:28am and 8:34am revealed: -"We hardly ever have any paper towels in the bathrooms." -"They don't have any hand towels in the bathrooms." -"They need something in there that I can use to dry my hands." Tour of the facility on 09/20/22 at 8:46am revealed bathrooms #1, #2 and #3 had no paper towels or hands towels available for resident use. Interview with the Administrator on 09/20/22 at 10:06am revealed:	C 079		

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C 079	Continued From page 1 -There should be paper towels available in all three bathrooms. -He had plenty of paper towels in storage. -He was not aware there were no paper towels in any of the three bathrooms. Observation of an external storage building on 09/20/22 at 10:20am revealed an unopened box of thirty paper towel rolls. Interview with the Supervisor in Charge (SIC) on 09/20/22 at 10:54 revealed: -She no longer put paper towels in the resident's bathrooms. -The residents were flushing the paper towels down the toilet and clogging it. -They used to keep hand towels in the bathrooms, but they kept on disappearing. -She often found the hand towels in the resident's rooms.	C 079		
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 interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 2 sampled residents related to a missed dermatology appointment and a referral for physical therapy (Resident #3). The findings are: Review of Resident #3's current FL2 dated 02/02/22 revealed diagnoses included	C 246		

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C 246	Continued From page 2 degenerative joint disease (DJD). Review of the Resident Register for Resident #3 revealed an admission date of 01/05/22. a. Review of signed physician's orders for Resident #3 dated 04/22/22 revealed: -Resident #3 had plaques (red and white patches of skin) on the right elbow, both hands, and right knee. -There was a referral for dermatology due to psoriasis (autoimmune disease characterized by raised areas of abnormal skin). Interview with the former Supervisor in Charge (SIC) on 09/20/22 at 9:15am revealed Resident #3 had an appointment with local dermatologist in July 2022 but it had been canceled and rescheduled for December 2022. Telephone interview with a representative at the local dermatology office on 09/20/22 at 9:50am revealed: -The facility had requested an appointment for Resident #3 in May 2022 and that appointment was scheduled for 07/06/22. -The appointment had been confirmed with the facility on 07/01/22. -Resident #3 did not show up for his appointment on 07/06/22 and the facility did not call to reschedule the appointment. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 09/20/22 at 10:04am revealed: -She had ordered the dermatology referral for Resident #3 at the his request. -She had prescribed a new medication for the resident's plaques and was having good results.	C 246		

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C 246	Continued From page 3 Interview with Resident #3 on 09/20/22 at 11:07am revealed he needed to see a dermatologist because he still had psoriasis. Interview with the Administrator on 09/20/22 at 9:55am revealed: -He did not know why Resident #3 did not show up for his dermatology appointment on 07/06/22 and that the appointment was not rescheduled. -Resident #3 was able to drive himself to his appointments but it was the facility's responsibility to follow up and reschedule the appointments. b. Review of signed physician's orders for Resident #3 dated 05/17/22 revealed referral for physical therapy (PT). Interview with the former Supervisor in Charge (SIC) on 09/20/22 revealed: -The facility's contracted Nurse Practitioner (NP) sent the PT referrals to a local home health agency and the facility was responsible for following up on the referral. -The SIC called the local home health agency weekly but no one had been out to see the resident. Telephone interview with a representative from the local home health agency on 09/20/22 at 9:58am revealed they did not receive a referral for home health PT for Resident #3 and they did not receive any telephone calls from the facility to follow up on it. Telephone interview with the facility's contracted NP on 09/20/22 at 10:04am revealed: -Resident #3 ambulated with a walker and was having difficulty on uneven surfaces. -She expected the facility to follow up on the order for PT.	C 246		

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C 246	Continued From page 4 Interview with Resident #3 on 09/20/22 at 11:07am revealed: -He needed PT. -PT had not been to see him yet and he did not know why. Interview with the Administrator on 09/20/22 at 9:55am revealed: -When an order for a referral was written the facility was responsible for faxing the order to the local home health agency and following up to ensure it was done. -He did not know why the order was missed.	C 246		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed	C 335		

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C 335	Continued From page 5 container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination for 2 of 3 residents sampled (Resident #1 and #2). The findings are: 1. Resident #1's current FL-2 dated 01/26/22 revealed diagnoses included attention deficit hyperactivity disorder, Tourette's Syndrome (a neurological condition causing unwanted involuntary muscle movements), obsessive compulsive disorder, reflux disease and hypothyroidism. Observation in Resident #1's room on 09/20/22 at 8:28am revealed: -One plastic medication cup containing 5 pills on the top of his mini refrigerator. -A second empty plastic medication cup was	C 335		

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C 335	Continued From page 6	C 335		

placed directly on top of the medications in the first plastic medication cup.
-Neither medication cup had any identifying information indicating who the medications were for, what the medications were, when the medications were to be taken and protection from contamination.

Interview with Resident #1 on 09/20/22 at 8:28am revealed:
-The Supervisor in Charge (SIC) gave his evening pills to him at breakfast on 09/20/22.
-He had eaten breakfast around 7:00am on 09/20/22.
-The SIC usually gave him his evening medications to take back to his room at breakfast.
-He had not requested that the SIC leave his medications in his room.
-He was not sure why the SIC left medications in his room.

Interview with the SIC on 09/20/22 at 8:51am and 10:54am revealed:
-Resident #1 was going out with a family member later in the day on 09/20/22.
-She gave Resident #1 his medications for the day at breakfast.
-She poured his medication in a plastic medication cup for him to take to his room.
-There was no identifying information on the plastic medication cup.
-She had always prepared medications for residents that were leaving the facility on an outing that way.
-No one had told the way she prepared medications for residents leaving the facility on an outing was wrong.

Interview with the Administrator on 09/20/22 at

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C 335	Continued From page 7 10:06am revealed: -Medications leaving the facility with a resident for the day were to be packaged in a plastic baggie by the Medication Aide. -Resident #1 did not have orders to self-administer his medications. -Medications for Resident #1 should not be left in his room. -The SIC should have waited to give Resident #1 his medication right before he left the facility. 2. Resident #2's current FL-2 dated 01/26/22 revealed diagnoses included reflux disease, high blood pressure, obesity, schizophrenia and tobacco use. Observation in Resident #2's room on 09/20/22 at 8:34am revealed: -One plastic medication cup containing 2 pills on a side table. -A second plastic medication cup containing 13 pills on a side table. -A third empty plastic medication cup was placed on top of the second plastic medication cup containing the 13 pills. -The medications cups had no identifying information indicating who the medications were for, what the medications were, when the medications were to be taken and protection from contamination. Interview with Resident #2 on 09/20/22 at 8:34am revealed: -The 2 pills in the first plastic medication cup were his 2:00pm medications to take on 09/20/22. -The 13 pills in the second plastic medication cup were his 7:00pm medications to take on 09/20/22. -The SIC gave him the medications in both cups for the rest of the day when he was at breakfast	C 335		

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C 335	Continued From page 8 on 09/20/22. Interview with the SIC on 09/20/22 at 8:51am and 10:54am revealed: -Resident #2 was going out with a friend later in the day on 09/20/22. -She gave Resident #2 his medications for the day at breakfast. -She poured his medication in 2 different plastic medication cups for him to take to his room. -There was no identifying information on the plastic medication cup. -She had always prepared medications for residents that were leaving the facility on an outing that way. -No one had told the way she prepared medications for residents leaving the facility on an outing was wrong. Interview with the Administrator on 09/20/22 at 10:06am revealed: -Medications leaving the facility with a resident for the day were to be packaged in a plastic baggie by the Medication Aide. -Resident #2 did not have orders to self-administer his medications. -Medications for Resident #2 should not be left in his room. -The SIC should have waited to give Resident #2 his medication right before he left the facility.	C 335		
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	C 350		

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C 350	Continued From page 9 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 imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents, who self-administered medications, had orders to self-administer a prescription medication that treats high blood sugar that was kept in the residents room (Resident #3). The findings are: Review of Resident #'s current FL2 dated 02/02/22 revealed: -Diagnoses included degenerative joint disease. -Medication orders included Trulicity (treats high blood sugar) 1.5mg/0.5ml pen injector, inject one pen weekly. Review of the Resident Register for Resident #3	C 350		

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C 350	Continued From page 10 revealed an admission date of 01/05/22. Review of a physician's progress note for Resident #3 dated 03/18/22 revealed an additional diagnosis of Type 2 diabetes. Review of Resident #3's electronic Medication Administration Record (eMAR) for 08/01/22 - 09/20/22 revealed: -There was an entry for Trulicity 1.5mg/0.5ml inject every week with an administration time of 8:00am. -There was documentation the Trulicity 1.5mg/0.5ml had been administered at 8:00am weekly. Observations of Resident #3's medications on hand on 09/20/22 at 10:20am revealed there was a box of 4 trulicity 1.5mg/0.5ml injectables give one weekly in a refrigerator in Resident #3's room. Review of physician's orders for Resident #3 on 09/20/22 revealed there were no orders for Resident #3 to self administer medications. Interview with the Supervisor in Charge (SIC) on 09/20/22 at 10:25am revealed: -Resident #3 knew how to administer the medication to himself. -Resident #3 had been administering the medication to himself at home before his admission to the facility. -She thought the resident had a physician's order to self administer the medication. -The order must have been missed. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 09/20/22 at 11:05am revealed she did not know Resident #3 was	C 350		

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C 350	Continued From page 11 administering the trulicity to himself. Interview with the Property Manager on 09/20/22 at 10:40am revealed: -The resident required an order from the physician to self administer medications. -The physician or a nurse would need to ensure the resident was competent to administer their own medications. -The physician's order to self administer the Trulicity had been missed.	C 350		