DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **FCL-040-009**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/07/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOZO FAMILY CARE HOME	**2757 MEWBORN CHURCH ROAD, SNOW HILL, NC 28580**

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)	COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/07/22.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement orders for 1 of 3 sampled residents (#2) who had orders for daily blood pressure monitoring with parameters and instructions to notify the primary care provider if outside those parameters. The findings are: Review of Resident #2's current FL-2 dated 12/17/21 revealed: -Diagnosis included hypertension. -There was an order for metoprolol ER 50mg to be administered each day. (Metoprolol is a medication used to decrease blood pressure in people with hypertension.) Review of Resident #2's physicians order dated 12/17/21 revealed an order to notify the physician of blood pressure less than 90/50 or greater than 170/100.	C 249		

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C 249	Continued From page 1 Review of Resident #2's physicians order dated 08/01/22 revealed an order to obtain blood pressure readings each day and to notify the medical doctor (MD) for blood pressures 80/50 or less. Interview with Resident #2 on 10/07/22 at 8:45am revealed: -She had a blood pressure machine beside her bed that she used each morning. -She did not know why her blood pressures were being obtained each morning. -She felt well, sometimes had headaches and was not dizzy. Review of Resident #2's vital signs chart obtained by the facility for August 2022 revealed: -There was documentation vital signs were obtained on 08/01/22 with a blood pressure of 132/76. -There was documentation vital signs were obtained on 08/22/22 with a blood pressure reading of 124/78. -There was no documentation Resident #2’s blood pressure was obtained by the facility from 08/02/22 through 08/21/22 and from 08/23/22 through 08/31/22. - Blood pressure readings were not obtained and recorded by the facility daily as ordered by the physician in August 2022 for Resident #2. Review of Resident #2's blood pressure readings for August 2022 from a telehealth program revealed documentation that blood pressures were obtained each day in August with readings that ranged from 86/57 to 129/64.	C 249		

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C 249	Continued From page 2 Review of Resident #2's vital signs chart obtained by the facility for September 2022 revealed: -There was documentation vital signs were documentation vital signs were obtained on 09/19/22 with a blood pressure reading of 113/79. -There was no documentation blood pressures readings were obtained by the facility from 09/01/22 through 09/04/22, from 09/06/22 through 09/18/22 and from 09/20/22 through 09/30/22. -Blood pressure readings were not obtained and recorded by the facility daily as ordered by the physician in September 2022 for Resident #2. Review of Resident #2's blood pressure readings for September 2022 from a telehealth program revealed commendation that blood pressure readings were obtained each day in September with readings that ranged from 78/45 to 121/78. Review of Resident #2's vital signs chart obtained by the facility October 2022 revealed: -There was documentation vital signs were obtained on 10/03//22 with a blood pressure reading of 103/57. -There was no documentation blood pressures readings were obtained by the facility from 10/01/22 through 10/02/22 and from 10/03/22 through 10/07/22. -Blood pressure readings were not obtained and recorded by the facility daily as ordered by the physician in October 2022 for Resident #2.	C 249		

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C 249	Continued From page 3 Telephone interview with Resident #2's Registered Nurse (RN) at the office of her primary care provider (PCP) on 10/07/22 at 1:05pm revealed: -Daily blood pressure checks were ordered to monitor blood pressure readings. -Resident #2 used a machine through a telehealth program to take her blood pressure. -The blood pressure readings were sent from the machine to a "cloud" which then uploaded the blood pressure readings directly to the medical record. -The nurse with the telehealth program reviewed the blood pressure readings and had made notification to the PCP that blood pressures had been low on 09/21/22 but she had not received any notification from the facility staff. -She was not sure how often the nurse reviewed the blood pressure readings but the September 2022 readings uploaded to the medical record on October 1, 2022. -She expected the facility to ensure the resident's blood pressure was obtained each morning and to notify the PCP if blood pressures fell outside the ordered parameters. -If Resident #2's blood pressure was too low, her body would not get the oxygen it needed and she may need to be taken to the local emergency department for intravenous fluids to prevent her from going into shock or she could experience heart arrhythmia. Interview with the Supervisor in Charge (SIC) on 10/07/22 at 1:38pm revealed: -She was aware Resident #2 had a physician's order for blood pressure monitoring each morning and to notify the PCP if blood pressure fell below 90/50 but was not aware the parameters had changed to 80/50 on 08/01/22.	C 249		

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C 249	Continued From page 4 -Staff assisted Resident #2 to obtain her blood pressure each morning with the machine that was kept by the bedside and sent the readings to a nurse with a telehealth program but she only documented 2 sets of vital signs as that was what the facility required. -She had never notified the PCP when Resident #2's blood pressure fell outside of parameters because she expected the nurse with telehealth to report them to the PCP. -Resident #2 never displayed or complained of symptoms when her blood pressure was low but she would receive a call from the nurse with telehealth asking her to recheck the blood pressure. Interview with the Administrator on 10/07/22 at 1:52pm revealed: -She was aware of the physician's order to obtain blood pressure daily for Resident #2. -She was aware of the parameters and instructions to notify the PCP if the blood pressure readings fell outside of those parameters. -She was not aware staff should have documented blood pressure reading each day as ordered. -She thought since Resident #2 participated in a telehealth program to monitor her blood pressure, the telehealth staff were responsible for documenting the blood pressures and notifying the PCP as needed and not the facility staff. Attempted telephone interview with Resident #2's telehealth program nurse on 10/07/22 at 1:00pm was unsuccessful.	C 249		

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C257	Continued From page 5 10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: 2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods stored and served to residents was protected from contamination related to observations of foods that were removed from original packaging being stored unlabeled and undated. The findings are: Observation of the facility's refrigerator freezer on 10/07/22 at 9:02am revealed: -There was a quart size storage bag in the freezer that was not labeled or dated; Contents was not identifiable and not in the original packaging. -There were 4 gallon sized storage bags in the freezer that were not labeled or dated and; Contents was not identifiable and not in the original packaging. -There was 1 gallon size storage bag in the freezer that was not labeled or dated that appeared to be chicken. Observation of the facility's kitchen cabinet on 10/07/22 at 9:20am revealed there was a plastic	C 257		

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C 257	Continued From page 6 storage container that was approximately one fourth full of cereal that was removed from its original packaging that was not labeled or dated. Interview with the Supervisor in Charge (SIC) on 10/07/22 at 9:02am revealed: -The quart size storage bag in the freezer was turkey necks that had been picked up on the previous Monday. -She was unsure of when the other items were purchased and stored. -She knew items stored that were not in the original packaging should be labeled and dated. -She did not know why the items in the freezer were not labeled or dated. Second interview with the SIC on 10/07/22 at 1:38pm revealed: -All staff were responsible for labeling and dating the food at the time they were stored when the food item was removed from the original packaging. -She did not know which staff had stored the items in the freezer without labeling and dating or when they were removed from original packaging. -The cereal was placed in the plastic container by the previous shift staff for serving that morning. Interview with the Administrator on 10/07/22 at 1:52pm revealed: -She expected the any staff who opened, removed from original packaging and stored food items to label and date the item immediately and prior to storing. -Staff were taught to label and date items at the time of opening upon hire and the teaching was reinforced during staff meetings.	C 257		

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C 257	Continued From page 7 -There was no process in place for inspecting food storage to ensure staff were labeling and dating food items that were stored.	C 257		

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