

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL045091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/07/2023
NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOMES UNIT F		STREET ADDRESS, CITY, STATE, ZIP CODE 24 EAST MONET 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 a follow-up survey and complaint investigation on 06/07/23.	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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to notify the mental health provider and primary care provider (PCP) for 1 of 3 sampled residents (Resident #3) related to two incidents of physical aggression. The findings are: Review of Resident #3's current FL2 dated 02/08/23 revealed diagnoses included schizoaffective disorder bipolar type, autism, and substance abuse disorder. Review of Resident #3's Resident Register revealed a admission date of 01/28/23. Review of Resident #3's Care Plan dated 02/08/23 revealed: -The resident was a prior resident of the facility. -The resident began living independently resulting in severe auditory and visual hallucinations requiring hospitalization due to medication noncompliance. -The resident was readmitted to the facility and continued to have "some hallucinations."	C 246		

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

TITLE

(X6) DATE

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C 246	Continued From page 1 Interview with the Relief Supervisor-in-Charge (SIC) on 06/07/23 at 9:15am revealed: -One evening at the end of April 2023 after 9:00pm, Resident #3 knocked on the staff quarter's door. -He followed Resident #3 because he "looked like he wanted to talk." -He followed Resident #3 through the living room. -While walking through the living room, Resident #3 pointed at something through the window on the front porch. -He thought Resident #3 wanted to show him something on the front porch. -As soon as he stepped out onto the porch, Resident #3 "started swinging" with closed fists. -He stepped back through the front door and tried to shut the door. -Resident #3 "barreled" through the front door and came "swinging" at the Relief SIC's face. -He was unable to leave the living room with Resident #3 continuing to hit him. -He then put one hand on Resident #3's sleeve and grabbed both of the resident's legs with his other hand to take the resident to the ground. -He and Resident #3 fell to the floor together, breaking through the locked medication room door. -He "cuddled" Resident #3 to keep him from fighting more and to help the resident to calm down. -Two police officers and the Administrator came to the facility shortly after calls were made to them. -He did not know why Resident #3 was not taken for an evaluation on the evening of the event. -He did not know why Resident #3's medications were not reviewed or changed after the event. -The SIC was responsible for notifying Resident #3's PCP or mental health provider.	C 246		

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C 246	Continued From page 2 -He did not know why the SIC did not notify Resident #3's PCP or mental health provider about the incident. -He did not know if the Administrator notified Resident #3's PCP or mental health provider. -A week later, Resident #3 tried to hit the SIC with a closed fist. -The SIC put her arm up to block Resident #3's swing to prevent the resident from hitting her. -The Administrator was notified. -Resident #3 was sent to the hospital for an evaluation. Interview with the SIC on 06/07/23 at 9:56am revealed: -Resident #3 "swung" a closed fist at her on 04/28/23. -She put her arm up to block Resident #3's swing. -She immediately shut the door to the medication room between her and Resident #3. -She notified the Administrator. -She did not notify Resident #3's PCP about the incident. -She did not notify Resident #3's mental health provider about the incident. -She thought the Administrator would notify the PCP and the mental health provider about the incident. Review of Resident #3's emergency department discharge summary dated 05/01/23 revealed: -The reason for the visit was for hallucinations. -There were no orders for follow-up appointments with the mental health provider or PCP. Telephone interview with Resident #3's Nurse Practitioner (NP) on 06/07/23 at 11:10am revealed: -She was the PCP for Resident #3. -The facility staff did not notify her about Resident	C 246		

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C 246	Continued From page 3 #3's incidents of physical aggression. -She expected the staff to notify Resident #3's mental health provider concerning Resident #3's physically aggressive behaviors. Telephone interview with Resident #3's family member on 06/07/23 at 11:52am revealed: -He attended Resident #3's mental health care appointments with him. -Resident #3 routinely experienced auditory hallucinations in the afternoons. -The hallucinations were "maddening" to Resident #3. Interview with the Administrator on 06/07/23 at 10:45am and 1:35pm revealed: -He had received a telephone call at the end of April 2023 from the Relief SIC. -Resident #3 physically attacked the Relief SIC. -He and the police were called to the facility to respond to the incident. -The Administrator spoke to Resident #3 about "redirecting himself." -He was able to get the situation "resolved" without calling the mobile mental health crisis team for assistance. -He did not notify Resident #3's PCP or mental health provider about the incident. -Resident #3 was not evaluated by his PCP or mental health provider after the incident. -Resident #3 was not taken to the hospital for evaluation. -He did not notify Resident #3's PCP or mental health provider because he "handled" the situation with Resident #3 "on his own." Attempted interview with Resident #3's mental health provider on 06/07/23 at 11:26am was unsuccessful.	C 246		

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C 246	Continued From page 4 Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. _____ The facility failed to notify Resident #3's mental health provider and primary care provider of two incidents of physical aggression which was detrimental to the residents health and safety and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/07/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 22, 2023.	C 246			