STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011277	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW II #32	32 SMITH GRAVEYARD RD 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 survey on September 11, 2024.	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 interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and health care needs for 1 of 3 sampled residents (#2) related to a missed 6-month follow-up with the primary care provider (PCP) and a podiatrist appointment. The findings are: Review of Resident #2's current FL2 dated 01/05/24 revealed diagnoses included hypertension, chronic kidney disease stage 2, schizophrenia, depression and a communicable disease. a. Review of Resident #2's PCP notes dated 08/30/23 revealed he was seen for a routine visit and required a follow-up visit in 6 months. Interview with Resident #2 on 09/11/24 at 9:15am revealed: -He needed a visit scheduled with his PCP to have his bloodwork checked. -The Supervisor-in-Charge (SIC) was supposed to help him set up his medical appointments and transportation. -The SIC told him that he had called to get an appointment scheduled but he still had not been	C 246		

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C 246	Continued From page 1	C 246		

to see his PCP.
-The SIC did not tell him when the appointment was scheduled.
-He had a medical condition which required bloodwork to be drawn to monitor his health.
-He had not had any bloodwork drawn or seen his PCP in over a year.

Review of Resident #2's record revealed there were no PCP progress notes or lab results since 06/21/22.

Review of Resident #2's PCP progress notes dated 08/30/23 that were faxed to the facility per request on 09/11/24 revealed there was an order for a follow-up appointment in 6 months (around 02/29/24).

Interview with the SIC on 09/11/24 at 10:33am revealed:
-Resident #2 had not been seen by the PCP in "maybe a year".
-Resident #2 did not see the PCP for a 6-month follow-up.
-Sometimes Resident #2 would go to his medical appointments and sometimes he refused.

Second interview with the SIC on 09/11/24 at 2:00pm revealed:
-He did not know why Resident #2 missed the appointment with the PCP on 03/21/24.
-Resident #2 had a right to refuse to go to medical appointments.
-He did not know if Resident #2 refused to go the appointment with the PCP on 03/21/24 because he did not document refusals.
-He did not call Resident #2's PCP office to cancel or reschedule an appointment; "that mistake was on me".

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C 246	Continued From page 2 Second interview with Resident #2 on 09/11/24 at 2:29pm revealed he did not remember refusing to go to any medical appointments including the one with the PCP on 03/21/24. Telephone interview with a social worker from Resident #2's PCP office on 09/11/24 at 3:00pm revealed: -Resident #2 was in a program at the PCP's office specialized in living with a chronic medical condition that provided all medical care and medications needed for Resident #2. -Resident #2 was supposed to follow-up every 6 months to stay active in the program. -Resident #2 was at risk of being dropped from the program if he was not seen as soon as possible. -She had tried to call the facility "multiple" times regarding the missed follow-up appointment for Resident #2 and did not get an answer or someone would answer the phone and then hang up on her. Telephone interview with a registered nurse (RN) from Resident #2's PCP's office on 09/11/24 at 4:52pm revealed: -Resident #2 was 7 months overdue for a follow-up appointment to closely monitor a sexually transmitted disease. -Resident #2 was supposed to follow-up at the office every 6 months. -Resident #2 was at risk of being dropped from the program specialized in living with a chronic medical condition which would be detrimental to Resident #2's health because he would not get the medications needed to keep the disease from progressing. -There was documentation from the medical practice the social worker had made multiple attempts to contact the facility regarding Resident	C 246		

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C 246	Continued From page 3 #2's missed follow-up appointment. -There was no documentation in the system of any notifications from the facility to Resident #2's PCP for the missed follow-up appointment. Refer to the interview with the Administrator on 09/11/24 at 2:48pm. Attempted telephone interview with Resident #2's PCP on 09/11/24 at 11:05am was unsuccessful. b. Review of Resident #2's primary care provider (PCP) notes dated 08/30/23 revealed there was a referral to a podiatrist for chronic right foot pain. Review of Resident #2's record revealed there were no progress notes from a podiatrist or emergency room (ER) reports. Review of a faxed ER report from Resident #2's PCP's office revealed: -Resident #2 was seen in the ER for foot pain on 12/03/23. -Resident #2 reported "months if not more" of bilateral foot pain with numbness and tingling that was worse in the right foot. -Resident #2 was diagnosed as having psychosis neuropathy caused by nerve damage from a chronic medical condition. -Resident #2 was prescribed medication for the neuropathy and advised to follow-up with a podiatrist. Interview with the Supervisor-in-Charge (SIC) on 09/11/24 at 2:00pm revealed: -He knew Resident #2 had a referral made by the PCP on 08/30/23 to see a podiatrist. -Resident #2 only complained of foot pain on 08/30/23 so he did not schedule the referral appointment with a podiatrist for Resident #2.	C 246		

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C 246	Continued From page 4	C 246		

-He was responsible for scheduling referral appointments for Resident #2.
-He did not call Resident #2's PCP to clarify if the referral was still needed for Resident #2.

Interview with Resident #2 on 09/11/24 at 2:29pm revealed:
-He had chronic pain, numbness, and tingling in both of his feet but more so on the right foot.
-He last saw a podiatrist 1 ½ - 3 years ago and an assessment of his feet was completed, and toenail care was provided.

Telephone interview with a registered nurse (RN) from Resident #2's PCP's office on 09/11/24 at 4:52pm revealed:
-Resident #2 complained of foot pain when he was last seen on 08/30/23 and a referral was made to a podiatrist in the same office.
-She could not find any record of Resident #2 being seen by a podiatrist.
-The office received a fax from a local hospital where Resident #2 was seen in the ER for foot pain on 12/30/23.
-There was no documentation in the computer system that the facility called to notify the PCP of the missed podiatrist referral.

Refer to the interview with the Administrator on 09/11/24 at 2:48pm.

Attempted telephone interview with Resident #2's PCP on 09/11/24 at 11:05am was unsuccessful.

_____

Interview with the Administrator on 09/11/24 at 2:48pm revealed:
-He was not aware Resident #2 missed a follow-up appointment with the PCP or a referral to see a podiatrist.
-The SIC was responsible for reviewing new

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C 246	Continued From page 5 orders and scheduling follow-up appointments and referrals for new appointments. -The SIC was responsible to reschedule any appointments that were missed. -He also got a copy of the PCP's progress notes and he also missed the referral for Resident #2 to follow-up with a podiatrist. -He expected the SIC to reschedule any appointments that were missed or schedule appointments for referrals made.	C 246		
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 record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (#2) with orders for vital sign checks once weekly including a blood pressure, pulse, oxygen saturation, and weight. The findings are: Review of Resident #2's current FL2 dated 01/05/24 revealed: -Diagnoses included hypertension. -There was an order to complete vital sign checks once weekly including a blood pressure, pulse,	C 249		

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C 249	Continued From page 6 oxygen saturation, and weight. Review of Resident #2's physician's orders dated 06/25/24 revealed there was an order to complete vital sign checks once weekly including a blood pressure, pulse, oxygen saturation, and weight. Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check vital signs weekly including blood pressure, pulse, oxygen saturation and weight. -There was documentation the vital signs were not completed on 07/03/24, 07/10/24, 07/17/24, 07/24/24 with the reason documented as "rescheduled". -There was documentation the vital signs were not completed on 07/31/24 with the reason documented as "resident refused". Review of Resident #2's August 2024 eMAR revealed: -There was an entry to check vital signs weekly including blood pressure, pulse, oxygen saturation and weight. -There was documentation the vital signs were not completed on 08/07/24, 08/14/24, 08/21/24, 08/28/24 with the reason documented as "rescheduled". Review of Resident #2's 09/01/24-09/11/24 eMAR revealed: -There was an entry to check vital signs weekly including blood pressure, pulse, oxygen saturation and weight. -There was documentation the vital signs were not completed on 09/04/24 and 09/11/24 with the reason documented as "rescheduled".	C 249		

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C 249	Continued From page 7 Interview with the Supervisor-in-Charge (SIC) on 09/11/24 at 10:33am revealed: -He tried to check Resident #2's vital signs once a month. -He was unaware Resident #2 had orders to check vital signs weekly. -The task to check vital signs weekly "popped" up on the eMAR every Wednesday for him to complete but he just signed the task as not completed with the reason as rescheduled. -He did not know the last time Resident #2's vital signs were checked. -Resident #2 refused to have his vital signs checked. -He did not notify Resident #2's primary care provider (PCP) that Resident #2 refused to have his vital signs checked or that the vital signs were not completed. Interview with Resident #2 on 09/11/24 at 2:19pm revealed: -The facility staff did not check his vital signs weekly or monthly. -The SIC never asked to check his vital signs, but the SIC could check the vital signs if he wanted to. -The last time staff checked his vital signs was about 8 months ago. Telephone interview with Resident #2's PCP registered nurse (RN) on 09/11/24 at 4:52pm revealed: -There were no notifications documented in the system that Resident #2's PCP was notified that Resident #2 refused to have vital signs checked or that the vital signs were not completed. -Resident #2 was ordered to have vital signs checked weekly. Interview with the Administrator on 09/11/24 at	C 249		

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C 249	Continued From page 8 2:48pm revealed: -He was supposed to get all the orders to check vital signs weekly changed to monthly. -He was responsible to check all the physician's orders, make sure they were entered on the eMAR correctly, and clarify the orders if needed. -He did not contact Resident #2's PCP to get an order to change the vital sign checks from weekly to monthly, "that's on me". -He expected staff to check Resident #2's vital signs weekly as ordered. Attempted telephone interview with Resident #2's PCP on 09/11/24 at 11:05am was unsuccessful.	C 249		