STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		FCL011237	B. WING		07/	14/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
SOUND	VIEW FAMILY CARE I	HOMES - UNIT J	TER AVENUE IOUNTAIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
	The Adult Care Lic annual survey on 7	ensure Section conduted an 7/14/15.					
C 330	10A NCAC 13G .10 Administration	004(a) Medication	C 330				
	(a) A family care h preparation and ac prescription and no by staff are in acco (1) orders by a lice which are maintain	004 Medication Administration nome shall assure that the liministration of medications, on-prescription and treatments ordance with: nsed prescribing practitioner and in the resident's record; and otton and the facility's policies					
	Based on observat review, the facilty f	et as evidenced by: tion, interview, and record ailed to assure all medications 1 of 3 sampled residents (#1) as prescribed.					
	The findings are:						
	Resident #1 reveal -Diagnoses which schizophrenia and mellitusOrder for cobalam intramuscular as o to treat pernicious	included seizure disorder, insulin dependent diabetes nin 1000 mcg/ml mg, inject 1ml rdered. (Vitamin B-12 is used anemia and to prevent fatigue, y loss, and other problems with					
	Medication Administrevealed:	d July 2015 electronic stration Records (e-MARs) 00 mcg/ml, inject 1 ml					

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

(X6) DATE TITLE

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		FCL011237	B. WING		07/1	4/2015
NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOMES - UNIT J STREET ADDRESS, CITY, STATE, ZIP CODE 138 CENTER AVENUE BLACK MOUNTAIN, NC 28711						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 330	intramuscularly as of -No documentation administered. Review of physiciar revealed an order forml intramuscular or Review of Resident documented admin on 3/24/15 by a Horough Common of the overstock medication Resident #1's medication Resident #	directed. the B-12 injections had been orders, dated 10/31/14, or B-12 1,000 mcg/ml, inject 1 order month. #1's record revealed the last istration of B-12 injection was me Health (HH) nurse. medication cart where ons were stored revealed cations on hand included 1000 mcg inject 1ml dered with the following dent #1 on 7/14/15 at 12:30pm or B-12 injections for at least 2 or not think it was right the ged him for the B-12 when he ring the injections. I he had less energy the last 2 dam, interview with the ge (SIC), Staff A, from a sister treet revealed: ity "today," 7/14/15, to assist cause she was new to this and Resident #1's chart and	C 330			
		nentation Resident #1 had tions since March 2015.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL011237	B. WING		07/	14/2015	
	PROVIDER OR SUPPLIER	OMES - UNIT J	DRESS, CITY, S FER AVENUE IOUNTAIN, N	TATE, ZIP CODE C 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
C 330	Telephone call to R physician office on Resident #1's phys next week, but ano information as follo -Per review of Resifind a diagnosis of B-12 -The last lab availa was dated Septeml goodThis physician statif the facility could a started back this m Interview with Staff revealed: -He did not know wadminister the B-12 the facility in April, I-He would make ar the facility staff to a administered as ore -He would call the prot dispense any m 2015He would assure Finjection "today." On 7/14/15 at 12:15 SIC, Staff B, reveal -The B-12 was stor the medication cart where the daily mer-The B-12 injection	esident #1's primary care 7/14/15 at 12:10pm revealed cian was out of the office until ther physician provided ws: dent #1's chart, she could not be periodic an anion and deficiency. Dele in the chart for B-12 levels per 2014 and the levels were ed Resident #1 would be fine ssure the B-12 injections were onth (July). A on 7/14/15 at 11:30am The hythe HH nurse did not the injections when she was in May, June, and July 2015. The entry on the e-MAR to flag the ssure the B-12 injections were dered. The periodic and the levels were dered. The periodic and the levels the B-12 injections were dered. The periodic and the levels the B-12 injections were dered. The periodic and the levels the better the state of the better	C 330				
	would require MA's injections had beer	monthly scheduled task which to respond monthly if the B-12 administered. nsultation" which the HH nurse					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	DATE SURVEY COMPLETED	
		FCL011237	B. WING		07/1	4/2015	
NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOMES - UNIT J STREET ADDRESS, CITY, STATE, ZIP CODE 138 CENTER AVENUE BLACK MOUNTAIN, NC 28711							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
C 330	signs when injection the B-12 injections did not forget to add -Staff B understood	ns are given should have had listed to assure the HH nurse	C 330				

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