Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045118	A. BUILDING: _____ B. WING _____	C 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 3	178 KENDRICK COURT 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 an annual survey on March 11, 2020.	C 000	C335 Staff received additional training on medication administration policies. Staff reprimanded for not following facility policy regarding medication administration. Facility policy provides a 2 hour window for medication administration, 1 hour before, 1 hour after. Staff is responsible for administering medications for 6 residents.	4/11/2020
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 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.	C 335		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Victoria L Nunn | TITLE: Administrator | (X6) DATE: 4/9/2020

Reviewed and Accepted
Date: 04/09/20 CS

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C 335	Continued From page 1 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications prepared for administration in advance were identified up to the point of administration and protected from contamination for 3 of 3 residents who were administered medications during the 8:00am medication pass (Residents #1, #3, and #4). The findings are: Observation of the Supervisor-In-Charge (SIC) in the medication room on 03/11/20 at 8:05am revealed: -The SIC was wearing a sling to support her right arm. -The SIC prepared one resident's medications by referring to the electronic Medication Administration Record (eMAR) and pushing medications one by one from bubble packs into a clear plastic medicine cup. Observations of the SIC in the medication room on 03/11/20 at 8:07am revealed. -There were three clear plastic medication cups with multiple oral medications placed in a row on the top of the medication cart. -The SIC proceeded to stack the cups one inside the other. -The cups were not labeled with the names of the residents to which the medications were to be administered to. -The medications inside the cups were not protected from contamination. Interview with the SIC on 03/11/20 at 8:08am	C 335	Administrative staff will conduct record reviews, interviews to ensure medication aide is passing medications according to facility policy. Checks will be at least 3x weekly until substantial compliance is reached	

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C 335	Continued From page 2 revealed: -She was taking the three plastic cups to give the medications to three different residents. -She had not labeled the cups with the residents' names. -"I know I am not supposed to do this, but with my broken arm, I have to do this to get everything done." -Her arm had been broken for "six weeks." -The medications in the cups belonged to Residents #1, #3, and #4. -She knew which cup of medications was to be administered to each of the three residents even though the cups were not labeled with the residents' names. Interview with the SIC on 03/11/20 at 8:18am revealed: -She had administered the bottom cup of medications to Resident #4 who had been seated in the dining room at the time. -She had administered the middle cup of medications to Resident #3 who had been seated in the living room at the time. -She had administered the top cup of medications to Resident #1 who "doesn't get up for breakfast." -She normally would not pour three residents' medications to administer at one time. -She administered them at once so she would not have to "make all those trips." 1. Review of Resident #1's current FL2 dated 01/27/20 revealed: -Diagnoses included schizoaffective disorder, hypertension, hyperlipidemia, rheumatoid arthritis, and chronic pain. -There was an order for calcium 600mg + D (used to supplement calcium and vitamin D) one tablet daily. -There was an order for fluvoxamine 100mg	C 335		

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(used to treat depression) one tablet twice daily.
-There was an order for hydrocodone/acetaminophen 5-325mg (used to treat pain) one tablet twice daily.
-There was an order for leflunomide (used to treat rheumatoid arthritis) 20mg one tablet every day.
-There was an order for lisinopril 40mg (used to treat hypertension) one tablet every day.
-There was an order for meloxicam 7.5mg (used to treat arthritis) one tablet every day.
-There was an order for metoprolol ER 100mg (used to treat hypertension) one tablet every morning.
-There was an order for multivitamin (used as a vitamin supplement) one tablet every day.
-There was an order risperidone 1 mg (used to treat schizophrenia) one tablet every day.
-There was an order for ziprasidone 80mg (used to treat schizophrenia) one capsule twice daily.

Review of Resident #1's electronic Medication Administration Record March 2020 (eMAR) revealed there were entries for scheduled 8:00am administrations for calcium 600mg +D, fluconazole, fluvoxamine, hydrocodone/acetaminophen, leflunomide, lisinopril, meloxicam, metoprolol ER, multivitamin, and ziprasidone.

Interview with Resident #1 on 03/11/20 at 8:45am revealed:
-She had received her medications that morning from the SIC.
-She had received the correct medications that morning.

Refer to the interview with the Property Manager on 03/11/20 at 2:50pm.

Refer to the telephone interview with the

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C 335	Continued From page 4 Administrator on 03/11/20 at 3:00pm. 2. Review of Resident #3's current FL2 dated 06/03/19 revealed diagnoses included schizophrenia, hypothyroidism, episodic mood, anxiety, and gastroesophageal reflux disease. Review of Resident #3's physician orders dated 01/03/20 revealed: -There was an order for buspirone 30mg (used to treat the symptoms of anxiety) one tablet two times a day. -There was an order for clozapine 100mg (used to treat schizophrenia) one tablet two times a day. -There was an order for fish oil 1000mg (used to treat hyperlipidemia) one capsule every morning. -There was an order for fluphenazine 10mg (used to treat schizophrenia) one tablet two times a day. -There was an order for hydroxyzine 50mg (used to treat anxiety) one capsule three times a day. -There was an order for lamotrigine 150mg (used to treat seizures) one tablet two times a day. -There was an order for multivitamin (vitamin supplement) one tablet daily. -There was an order for pantoprazole 40mg (used to treat gastroesophageal reflux disease) one tablet daily. -There was an order for ranitidine 150mg (used to treat gastroesophageal reflux disease) one tablet two times a day. Review of Resident #3's physician order dated 01/13/20 revealed change buspirone 30mg one tablet two times a day to buspirone 10mg one tablet three times a day. Review of Resident #3's physician order dated 03/10/20 revealed Vraylar (used to treat depression) 3mg one tablet every morning.	C 335		

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C 335	Continued From page 5 Review of Resident #3's March 2020 eMAR revealed there were entries for scheduled 8:00am administrations for buspirone, clozapine, fish oil, fluphenazine, hydroxyzine, lamotrigine, multivitamin, pantoprazole, ranitidine, and Vraylar. Interview with Resident #3 on 03/11/20 at 9:20am revealed: -She had received her medications that morning. -She had no concerns about her medications. Refer to the interview with the Property Manager on 03/11/20 at 2:50pm. Refer to the telephone interview with the Administrator on 03/11/20 at 3:00pm. 3. Review of Resident #4's current FL2 dated 01/27/20 revealed: -Diagnoses included bipolar with psychosis, anxiety, schizophrenia, and history of pulmonary embolism. -There was an order for citalopram 20mg (used to treat depression) 20mg one tablet daily. -There was an order for lamotrigine 150mg (used to treat bipolar disorder) 150mg one tablet two times a day. -There was an order for therems-m (vitamin supplement) one tablet daily. Review of Resident #4's March 2020 eMAR revealed there were entries for scheduled 8:00am administrations for citalopram, lamotrigine, and therems-m. Interview with Resident #4 on 03/11/20 at 9:11am revealed: -She routinely received her medications on time and did not run out of any medications. -She had received her morning medications that	C 335		

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C 335	Continued From page 6 morning. Refer to the interview with the Property Manager on 03/11/20 at 2:50pm. Refer to the telephone interview with the Administrator on 03/11/20 at 3:00pm. Interview with the Property Manager on 03/11/20 at 2:50pm revealed: -It was the facility's policy not to pre pour medications. -All of their staff who administered medications had been trained not to pre pour medications. -The SIC had an appointment to get the sling taken off her right arm "soon." -Other SICs in nine other buildings on site and the Property Manager were available to assist the SIC with anything she needed to take care of the residents and to help maintain the facility while the SIC's arm healed. Telephone interview with the Administrator on 03/11/20 at 3:00pm revealed: -It was against the facility's policy to pre pour medications. -All of the medication aides had been trained to never pre pour medications.	C 335		