| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CHASE SAMARITAN ASSISTED LIVING | 30 DALEA DRIVE ASHEVILLE, NC 28805 |

| (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 |
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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow-up survey on September 30-October 01, 2015. | {D 000} | | |
| {D 338} | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews the facility failed to provide a reasonable response to the request to provide a smoke free area for residents who do not smoke.<br><br>The findings are:<br><br>Observation of the facility's front porch on 09/30/15 at 9:19am revealed:<br>-A male resident was sitting on the front porch smoking.<br>-The right side of porch had three folding chairs and numerous ashes on the porch.<br>-The left side of porch also had ashes noted and no chairs.<br>-The right side of building on the front porch had several black streaks where cigarettes were put out on the side of the building.<br>- A"No Smoking"sign was posted on the wall outside of the front door.<br>-A "No smoking inside" sign was posted on the main entry door.<br><br>Observation of the non-smoking resident's porch | {D 338} | | |

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| {D 338} | Continued From page 1<br>on 09/30/15 at 9:24am revealed:<br>-A 3'x3' white sign and "No Smoking " was written with large red letters.<br>-Two female residents were smoking on the porch.<br><br>Observation of the non-smoking resident's porch on 09/30/15 at 4:30pm revealed:<br>-Two female residents smoking on the porch.<br>-Two staff members standing between the gazebo and porch talking with residents.<br>-Staff entered the building without saying anything to the residents who were smoking on the non-smoking porch.<br><br>Observation of the front porch on 09/30/15 at 4:40pm revealed a male resident smoking on front porch.<br><br>Observation of the non-smoking resident's porch on 10/01/15 at 10:40am revealed:<br>-A female staff member smoking on the non-smoking porch.<br>-A male resident sitting in a rocking chair not smoking.<br><br>Observation of the non-smoking resident's porch on 10/01/15 at 12:45pm revealed:<br>-A resident was smoking on the non-smoking porch.<br>-The Resident Care Coordinator (RCC) and the Facility Director walked by a resident who was smoking on the porch and did not say anything to the resident as they entered building.<br><br>A confidential interview was conducted with a female resident smoking on the porch on 09/30/15 at 9:24am revealed:<br>-"There are lots of residents who smoke outside, the staff smokes out there with us. Residents will | {D 338} | | |

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| {D 338} | Continued From page 2<br>go out in the parking lot or walk down the road to the front door. One female resident walks around the building as she smokes."<br><br>A confidential interview with a male resident on the non-smoking resident's porch on 10/01/15 at 10:40am revealed:<br>- He had no problem with staff smoking on the non-smoking porch.<br>-"I smoke out here too."<br><br>Interview with the Facility Director on 10/01/15 at 2:40pm regarding observation on 10/01/15 at 12:45pm revealed she was unaware she had walked by a resident who was smoking on the non-smoking resident's porch.<br><br>Confidential interviews with 6 residents on 09/30/15 and 10/01/15 revealed:<br>-No smoking signs were posted on the front porch and the women's side porch in front of the office.<br>-Residents and staff smoke on the front porch, both side porches and gazebo daily.<br>-"There is no space outside where residents or staff don't smoke or that you can't smell where they had been smoking."<br>-"We just can't smoke inside."<br>-"No one has ever said I can't smoke here."(Resident was smoking on the front porch.)<br>-Staff were not consistent in asking residents not to smoke in non-smoking areas as staff also smoke in designated non-smoking areas.<br><br>Confidential interviews on 09/30/15 with first and second shift Personal Care Assistants and Medication Aides revealed:<br>-Residents can smoke on men's side porch and gazebo.<br>-Residents are not supposed to smoke on front | {D 338} | | |

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| {D 338} | Continued From page 3<br>porch but they do anyway.<br>-Not sure who regulates resident's smoking, "I guess we could ask them to move."<br>-"We redirect them if they are smoking on the front porch or in the wrong place."<br>-"Staff can smoke on the porches too."<br>-"Residents smoke on the non-smoking porches, staff do too. We remind them not to smoke on the front porch."<br><br>An interview with the RCC on 10/01/15 at 10:30am revealed:<br>-Residents can smoke on the men's and women's smoke porch and the gazebo but they will also smoke out in the parking lot and the sidewalks.<br>-Residents are not supposed to smoke on the front porch. "If they do we ask them to move."<br>-There is one resident who wanted a place to go where he could not smell smoke or be around it. He usually sits on the front porch when he wants to go out.<br><br>An interview with the Facility Director and the Facility Manager on 10/01/15 at 10:45am revealed:<br>-Smoking issues were discussed in resident council meeting this past Monday.<br>-"We have tried to put up signs and talk with residents when we catch them smoking in the wrong place".<br>-"Not sure what we can do. We're trying to figure it out."<br>- "At this time we don't have a smoke free place but we continue to try and get the residents not to smoke on the front porch. We have been working on this issue for the past year." | {D 338} | | |

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| {D 358} | Continued From page 4 | {D 358} | | |
| {D 358} | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO A TYPE B VIOLATION<br><br>Based on these findings, the previous Type B Violation was not abated.<br><br>Based on observations, record reviews, and interviews, the facility failed to assure medications (Augmentin, Neurontin, and Oxycodone) were administered as ordered to 3 of 7 sampled residents (#1, #6, and #7).<br><br>The findings are:<br><br>A. Review of Resident #7's current FL2 dated 07/07/15 revealed:<br>-Diagnosis of delusional disorder, somatic type specified personality disorder with mixed cluster B traits, hepatitis C, osteopenia and osteoporosis and history of osteomyelitis lower left leg.<br>-A physician's order for Oxycodone HCL (pain medication) 5mg three times a day.<br><br>Review of Resident #7's Control Drug Sheet for Oxycodone HCL 5mg three times a daily revealed staff did not document the administration of Oxycodone 10 times from 08/15/15 through | {D 358} | | |

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| {D 358} | Continued From page 5<br><br>09/28/15 on the following dates and times:<br>08/15/15 8am<br>08/15/15 2pm<br>08/15/15 8pm<br>09/15/15 8am<br>09/15/15 8am<br>09/15/15 8pm<br>09/16/15 8am<br>09/16/15 2pm<br>09/16/15 8pm<br>09/17/15 8am<br><br>Review of Resident #7's Medication Administration Records (MARs) 08/15/15 through 09/28/15 revealed staff documented Oxycodone HCL 5mg three times daily as administered with no exceptions noted on the front or back of the MAR when there was not enough medication on hand to receive Oxycodone HCL 5mg dose as ordered by the physician.<br><br>Interview with Resident #7 on 10/01/15 revealed:<br>-She had not received her pain medications as ordered.<br>-She had an increase in her pain during those times and knew what her medication looks like.<br>-She had complained to facility staff about running out of her medications.<br>-She was unable to provide exact dates but stated the last time had been in the "past week to week and a half".<br><br>Interview with the Resident Care Coordinator (RCC) on 10/01/15 at revealed:<br>-She was aware of Resident #7's missing doses of Oxycodone HCL 5mg on the Control drug sheet.<br>-She assumed the gap was when the facility was getting another hard script for Resident #7 and the Pharmacy could not send any more | {D 358} | | |

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| {D 358} | Continued From page 6<br>medication unless they had the hard script.<br><br>Interview with the pharmacist at the dispensing pharmacy on 10/01/15 at 11:55am revealed:<br>-They had received the prescription for Oxycodone HCL 5mg three times daily on 08/14/15.<br>-They received the prescription of Oxycodone HCL 5mg three times a daily on 09/16/15 at 2:15pm.<br><br>A confidential interview with two facility staff members revealed:<br>- Resident #7 did receive pain medication, but could not recall missed medications.<br>-One of the staff members did recall the resident complaining of pain but could not recall any other information.<br><br>Interview with the Facility Manager on 10/01/15 at 11:40 am revealed:<br>-She reviewed Controlled Drug sheets monthly.<br>-She had noticed Resident #7 had a gap on the Controlled Drug sheets.<br>-She asked the RCC to explain and was told the RCC thought it was a gap between the end of one prescription, the medical doctor writing a hard script and receiving it from pharmacy.<br><br>Refer to facility's policy and procedure on ordering medications<br><br>B. Review of Resident #1's current FL2 dated 09/25/15 revealed:<br>-Diagnoses of respiratory failure, exacerbation of chronic obstructive pulmonary disease, altered mental status, and chronic back pain.<br><br>Continued record review revealed:<br>-A previous FL2 dated 07/18/15 with an additional | {D 358} | | |

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| {D 358} | Continued From page 7 | {D 358} | | |

diagnosis of hepatitis B.
-A previous FL2 dated 02/17/14 with an admission date of 02/09/14.

Record review revealed a medication order for Resident #1 dated 08/27/15 for Augmentin 875mg/125mg every 12 hours for 7 days, with a start date of 08/27/15 and an ending date of 09/03/15. (Augmentin is a antibiotic used for a variety of infections.)

Per record review, the Augmentin order had been sent from a local emergency room via an electronic prescription (e-script) on 08/27/15 at 6:13am.

Review of Resident #1's Medication Administration Record (MAR) for August 2015 revealed no entry for Augmentin.

Review of Resident #1's MAR for September 2015 revealed:
-A handwritten entry for Augmentin 875/125, 1 tablet every 12 hours for 7 days, with scheduled times of administration of 8am and 8pm.
-The Augmentin had been initialed as administered twice daily from 8am on 09/01/15 through 8pm on 09/07/14, completing the 14 doses.

Interview with the Resident Care Coordinator (RCC) on 10/01/15 at 2:45pm revealed:
-She was responsible to faxing medication orders to the pharmacy.
-She was responsible for changing the MAR to reflect those medication changes.

Interview on 10/01/15 at 11:55am with the pharmacist at the dispensing pharmacy revealed:
-They received the electronic prescription

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| {D 358} | Continued From page 8<br>(e-script) on 08/27/15.<br>-They dispensed and sent the Augmentin 875/125 in the delivery tote to the facility on 08/27/15.<br>-Medication totes were usually delivered to the facility in the early evening (no time specified).<br><br>Interview with Resident #1 on 10/01/15 at 2:42pm revealed:<br>-She believed the Augmentin was for an ear infection, but was not sure.<br>-She did not recall how many days it took to start the antibiotic after she went to the emergency room.<br><br>Interview with the RCC on 10/01/15 at 2:47pm revealed:<br>-"It didn't make sense not to start the antibiotic for 4 days."<br>-Resident #1 may have been in the hospital on those days.<br><br>Per review the facility MARs and observation of a medication pass, the RCC also worked as a medication aide in the facility.<br><br>Interview with the Facility Director on 10/01/15 at 2:55pm revealed she was not aware of Resident #1 being out of the facility from 08/27/15 through 08/31/15.<br><br>Review of Resident #1's MARs for August 2015 revealed the resident's other medications were initialed as administered from 08/27/15 through 08/31/15.<br><br>Attempted interview with the prescribing physician on 10/01/15 at 3:15pm was unsuccessful.<br><br>Refer to facility's policy and procedure on ordering medications | {D 358} | | |

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| {D 358} | Continued From page 9<br><br>C. Review of Resident #6's current FL2 dated 06/16/15 revealed:<br>-Diagnoses of alcohol abuse, bipolar disorder, depression, rheumatoid arthritis, and lupus.<br>-A medication order for Gabapentin (Generic Neurontin) 300mg/24 hours, 1 daily.<br><br>Review of Resident #6 record revealed:<br>-A subsequent medication order dated 07/07/15 for Gabapentin 300mg, 2 capsules (600mg) at bedtime.<br>-A subsequent medication order dated 08/13/15 for Gabapentin 300mg, 2 capsules at bedtime.<br>-A subsequent medication order dated 08/26/15 for Gabapentin 300mg, 2 capsules at bedtime.<br><br>Review of Resident #6's Medication Administration Records (MARs) for August 2015 revealed:<br>-A computer generated entry for Neurontin (Gabapentin) 300mg, 1 capsule once daily, with a scheduled administration time of 8am, and a handwritten note, "order changed 08/26/15." (Neurontin is a medication used to treat seizure disorders, behaviors, and nerve pain.)<br>-A handwritten entry for Gabapentin 300mg, 2 tablets at bedtime, with a scheduled administration time of 8pm.<br>-One capsule of Gabapentin 300mg was initialed as administered from 08/01/15 through 08/26/15, and 2 capsules of Gabapentin 300mg were documented as administered from 08/27/15 to 08/31/15.<br><br>Review of Resident #6's MARs for September 2015 revealed:<br>-An entry for Gabapentin 300mg, 2 capsules at bedtime with a scheduled administration time of 8pm. | {D 358} | | |

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| {D 358} | Continued From page 10<br>-Two capsules of Gabapentin 300mg were documented as administered from 09/01/15 through 09/30/15.<br><br>Interview with Resident #6 on 10/01/15 at 2:20pm revealed:<br>-She took the Neurontin for pain and to help her sleep.<br>-She slept better with 2 capsules at bedtime rather than 1 capsule.<br>-She wasn't sure when the dose changed from 1 capsule to 2 capsules per day.<br><br>Interview with the RCC on 10/01/15 at 2:45pm revealed:<br>-She was responsible to faxing medication orders to the pharmacy.<br>-She was responsible for changing the MAR to reflect those medication changes.<br>-"A lot of our residents see outside doctors, but we don't make any changes in their medication regimen without contacting the resident's primary care doctor."<br><br>Review of Resident #6's medication order changes for Neurontin, on 07/07/15, 08/13/15, and 08/26/15, came from Resident #6's primary care physician.<br><br>Interview with the pharmacist at the dispensing pharmacy on 10/01/15 at 11:55am revealed:<br>-The only two orders the pharmacy had on file and dispensed for Resident #6's Neurontin 300mg were on 07/27/15 for 1 capsule daily, and the other on 08/27/15 to change the Neurontin 300mg to 2 capsules at bedtime.<br><br>Review of Resident #6's medications on hand at 3:00pm on 09/30/15 revealed a bubble pack of Neurontin 300mg labeled, 2 capsules at bedtime, | {D 358} | | |

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| {D 358} | Continued From page 11<br>with a dispense date of 10/01/15.<br><br>Refer to facility's policy and procedure on ordering medications.<br>_____<br><br>During an interview on 09/30/15 at 10:30am with the RCC revealed the verbal policy and procedure for ordering medication was:<br>-The RCC reviewed all MARs 1-2 times weekly.<br>-The Physician came to facility on Wednesday and MARs were reviewed prior to the visit and he wrote hard scripts for narcotic refills.<br>-The scripts were sent to pharmacy and medications were returned to the facility the next day.<br>-When the pharmacy sent a refill request to the facility, the form was filled out and signed by the Physician and returned to the Pharmacy.<br>-When routine medications were in the last row of the bubble pack, a sticker was pulled from the bubble pack and sent to pharmacy. Pharmacy would then send a new bubble pack.<br>-The RCC did not provide a written policy.<br><br>On 10/01/15 the facility provided the following Plan of Protection:<br>-The facility will ensure all physician orders are transcribed on the MAR and ordered from the pharmacy on the day they are received.<br>-Facility will ensure all medications are delivered and ready for administration in accordance with the physician's orders.<br>-All narcotics (Class II) will be ordered a week prior to running out of the medication.<br><br>THE FACILITY PROVIDED A DATE OF CORRECTION FOR THIS UNABATED TYPE B VIOLATION OF OCTOBER 05, 2015. | {D 358} | | |

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| (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 |
|---|---|---|---|---|
| {D912} | Continued From page 12 | {D912} | | |
| {D912} | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to provide care and services which were adequate, appropriate, and incompliance with relevant federal and state laws and rules and regulations related to medication administration.<br><br>The findings are:<br><br>Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered to 3 of 7 (#1, #6, and #7) sampled residents. (Augmentin, Neurontin, and Oxycodone.) [(Refer to tag D358, 10A NCAC 13F .1004(a) Medication Administration, Unabated Type B Violation.)] | {D912} | | |
| D917 | G.S. 131D-21(7) Declaration of Resident's Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>7. To receive a reasonable response to his or her requests from the facility administrator and staff.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews the facility failed to assure every resident received a reasonable response to his or her request from | D917 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL011133 | A. BUILDING: _____ B. WING _____ | R 10/01/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHASE SAMARITAN ASSISTED LIVING | 30 DALEA DRIVE ASHEVILLE, NC 28805 |

| (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 |
|---|---|---|---|---|
| D917 | Continued From page 13<br>the facility administrator and staff by not enforcing the smoking policy.<br><br>The findings are:<br><br>Based on observations and interviews the facility failed to provide a reasonable response to the request to provide a smoke free area for residents who do not smoke. [(Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights.)] | D917 | | |