
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			COMPLETED C 12/14/2018	
,,		HAL011133	B. WING				
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE	nan bernan an		
HASE SA	MARITAN ASSISTED L	VING	EA DRIVE LLE, NC 28805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) DEFICIENCY) DEFICIENCY				N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 000	Initial Comments	<u> </u>	D 000				
	Buncombe County D conducted an annual complaint investigation The complaint investigation	sure Section and The epartment of Social Services and follow up survey and on on 12/13/18 to 12/14/18. gation was initiated by the epartment of Social Services					
D 105	10A NCAC 13F .031	(a) Other Requirements	D 105	Facility staff unaware that	at extension		
(a m ca op Ti B	(a) The building and	l Other Requirements all fire safety, electrical, nbing equipment in an adult		cords had been purchase			
	care home shall be n operating condition.	naintained in a safe and		being used by residents. immediately and explain	•		
		ns and interviews, the facility		that they were not allow	-		
	and electrical equipm	he building and all fire safety ent were maintained in a I to the use of extension		fire marshall. Maintenar to monitor resident room		:	
	The findings are:	it fooms.		items, such as extension	cords.		
(f - c v v r - e	from 10:02am to 10:4 -There were Christm coffeepot plugged into were plugged into an resident's room. -There were Christm extension cord which	ne initial tour on 12/13/18 40am revealed: as lights, a fan, and a o two extension cords which electrical wall outlet in one as lights plugged into an was plugged into an n a second resident room.		:	12/14/18		
	10:02am and 10:40a			· · · · · · · · · · · · · · · · · · ·			
sion of He	-The residents had p alth Service Regulation	urchased the extension					
ORATORY		SUPPLIER REPRESENTATIVE'S SIGNATU		facility direct		(X6) DATE 9 19	
TE FORM	()	Reviewed and accept	6899	G6PB11 RD	lf continu	ation sheet 1 of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011133	B. WING	B. WING	
	OVIDER OR SUPPLIER		DDRESS, CITY, STA		₽₽₽ @ye44@20%\$
	ONDER OR SOFT EIER		ADRIVE		
CHASE SA	MARITAN ASSISTED	LIVING	LLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
D 105	Continued From pag	ge 1	D 105		
	cords from a local st				
	-No one had told the could not be used.	e residents extension cords			
	could not be used.				
	Interview on 12/13/1	18 at 2:10pm with the			
	Executive Director	•			
		n cords should not be used.			
	-Some residents bu				
		-			
		18 at 10:00am with the			
	Maintenance Direct	or revealed:			
	-He did not know ho	ow the residents got the			
	extension cords.				
į	-When he saw exter	nsion cords in the facility, he			[
	removed them.				
	Interview on 12/14/ Marshall revealed:	18 at 1:30pm the local Fire			
		on cords could cause the			
	electrical circuit to c				
		ere a fire hazard and should			
	not be used.				
				Facility to ensure that all dieta	ny staff
D 283	10A NCAC 13F .09	04(a)(2) Nutrition and Food	D 283	, se source that an aleta	iy stall
2	Service	(-,(-,)		members are aware of proper	thawing
	- +				-
		04 Nutrition and Food Service		techniques and following them	Cleaning
	(a) Food Procurem	ent and Safety in Adult Care			in eleanning
	Homes:			schedule to be followed by die	tary staff
		erage being procured, stored,			cary scan
		by the facility shall be		and monitored by Director and	other
ļ	protected from cont	amination.			other
	This Dula is not	at as evidenced by:		management staff.	
	This Rule is not me	ons, interviews, and record	1		
		failed to protect all food from		1/9/19)
	contamination relati	ed to improper thawing of			
		Ve.			
				<u></u>	

	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011133	(X2) MULTIPLE C A. BUILDING: B. WING		COMI	SURVEY PLETED C /14/2018
AME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	TANA KUCAMATI KANTATATA ILI TATA KUMATA	<u></u>
		30 DAI	EA DRIVE			
HASE SA	MARITAN ASSISTED L	VINC	ILLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 283	Continued From page	≥2	D 283			
	The findings are:					
	Observation of the kit 11:20am revealed: -There were 2 packs submerged in water i compartment sink. -There was no water -There was a large at buildup surrounding t -There were brown a the front of the oven of Observation of the kit	mount of black greasy he burners of the stove. nd white dried drips along				
	water in the first sink sink. -There was no water	nately 40 pieces of en completely submerged in of a three compartment flowing into into the sink. ok on 12/13/18 at 2:00pm				
	revealed: -He had worked at th rehired to start 12/13 -He had been trained facility in the past. -He had not received -The Cook had forgo the freezer on the ev -He always submergileft it in the refrigerate -There was a cleaning is my first day back (e facility in the past and was /18. I by "other cooks" in the Safe-Serve training. Itten to take the ham out of ening of 12/12/18. ed frozen meat in water or or to thaw out. g schedule posted "but this to work)".				
	posted on a wall on 1	hen cleaning schedule 2/13/18 at 2:01pm revealed o were to be cleaned on				

Division of Health Service Regulation STATE FORM

6899

G6PB11

If continuation sheet 3 of 34

2

	OVIDER OR SUPPLIER	HAL011133 STREET A	B. WING		(X3) DATE SURVEY COMPLETED C	
(X4) ID PREFIX	MARITAN ASSISTED LI	STREET A			12/14/2018	
PREFIX		VING	DDRESS, CITY, ST A DRIVE	ATE, ZIP CODE	98μπ μαζί έντο διακό έλα το δητά δυνοδομά ματα ματά ματά ματά ματά ματά ματά μα	
i	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
 	at 2:10pm revealed: -The Cook had worke and had been trained -The meat should have refrigerator to thaw o packaging, in a bowl flow of cold running v -She expected the clo	ecutive Director of 12/13/18 ed in the facility in the past ve been left in the r placed, in it's original of water with a continuous	D 283			
	 (a) An adult care hore preparation and adm prescription and non- by staff are in accord (1) orders by a licent which are maintained 	A Medication Administration ne shall assure that the inistration of medications, prescription, and treatments ance with: sed prescribing practitioner I in the resident's record; and on and the facility's policies	D 358	Facility to ensure that all medica are administered according to the current physician orders. Medic attended mandatory Diabetes Tr first week of December 2018, aff Director was made aware of the AHS during visit. Staff meeting of held to address and further revise administration and documentati Resident Care Coordinator (RCC)	e most ation staff raining the ter the issue by on 12/19/18 ew insulin on.	
	TYPE B VIOLATION Based on observatio reviews the facility fa medications as order	ns, interviews, and record		Med Tech to monitor insulin doc Any staff member continuing to incorrectly to be written up and	document	

⇒

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	, bonaconon		A. BOILDING:			
		HAL011133	B. WING		C 12/14/2018	
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	THE ZIP CODE	u anto al Trop de la Calanda de Calanderi de C	
		30 DALE		· ··· ·· ······························		
HASE \$4	AMARITAN ASSISTED		LE, NC 28805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPI DEFICIENCY) DEFICIENCY) CROSS-REFERENCED TO THE APPI			IN SHOULD BE COMPLETE DATE DATE		
D 358	Continued From page	ge 4	D 358	potentially lose medication	administration	
	omeprazole and doxycycline (Resident #2), insulin (Resident #3), eye drops (Resident #4), vitamin D3 (Resident #5), and vitamin D2 and			privelages. Director to mor	nitor a sampling of	
	vitamin D3 (Resider	-		residents weekly using atta	iched form A.	
	The findings are:			RCC and Lead MT to contin	ue to audit med	
	1. Review of Resid 04/17/18 revealed:	ent #1's current FL2 dated		carts weekly checking for any items that		
		cian order to check finger stick		need to be ordered includi	ng eye drops, PRN	
	blood sugars (FSBS			medications, etc. During the	his audit, staff to	
	Review of physician orders dated 10/01/18 revealed there was an order for Fiasp (treats high blood glucose) Sliding Scale Insulin (\$\$) four			also check for any D/C'ed medication. Director		
	times daily; FSBS <	<70 = 0 units, 70 - 150 = 0		provided training to RCC a	nd Lead MT	
	251-300 = 3 units, 3	unit, 201 -250 = 2 units, 301-350 = 4 units, 351-400 = 6		concerning physician orde	r processing and	
	units. Review of Resident	441's Ostabor 2019		clarification. Director to co	ontinue to monitor	
		stration Record (MAR)		this area weekly for 4 weeks then monthly if		
	-There was a hand	written entry for Fiasp SSI four eals, for FSBS <70 = 0 units,		improving per POP. Lead I		
	70-150 = 0 units, 1	51-200 = 1 unit, 201-250 = 2 units, 301-350 = 4 units,		along with PCP so that all orders circulate back		
	351-400 = 6 units, v	with scheduled administrations 2:00pm, 4:00pm, and 8:00pm.		to the PCP after being pro	cessed for review	
		00pm, the FSBS was 238 and		at weekly visit.		
	administered.			1,	/9/19	
		ian clarification order dated				
		Fiasp SSI, for FSBS <70 = 0				
		nits, 151-200 = 1 unit, 201-250				
		= 3 units, 301-350 = 4 units,	·····	· · · · · · · · · · · · · · · · · · ·	· - ··································	
	351-400 = 5 units, 3	>400 = 6 units.				

Division of Health Service Regulation STATE FORM

6899

G6PB11

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE COMF	SURVEY
ť						С
		HAL011133	B, WING		12	/14/2018
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		**************************************
		30 DAL	EA DRIVE			
CHASE 5	AMARITAN ASSISTED	LIVING ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	ge 5	D 358			
	Review of Resident	#1's November 2018 MAR				
	revealed:					
		written entry for Fiasp SSI four				
		als, for FSBS <70 = 0 units				
		51-200 = 1 unit, 201-250 = 2				
		units, 301-350 = 4 units,				
	351-400 = 5 units, >	>400 = 6 units, with				
	administration times	s of 8:00am, 12:00pm,				
	4:00pm, and 8:00pr					
		0am, the FSBS was 209 and				
	3 units of insulin wa	is documented as				
	administered.					1
	\$	0pm, the FSBS was 196 and				
	2 units of insulin wa	is documented as				
	administered.	oon the FCDC was 161 and				
	2 units of insulin wa	00pm, the FSBS was 161 and				
	administered.	is documented as				
		0pm, the FSBS was 228 and				
	3 units of insulin wa	•				
	administered.					
	1	0pm, the FSBS was 284 and				
	4 units of insulin wa	•				
	administered.					
		00pm, the FSBS was 247 and				
	3 units of insulin wa	as documented as				
	administered.					
		0am, the FSBS was 236 and				
	3 units of insulin wa	as documented as				
	administered.					
		0pm, the FSBS was 214 and				
	3 units of insulin wa	is ocumented as				
	administered.	0pm, the FSBS was 174 and				
	3 units of insulin wa			·		
	administered.					
	· · ·					
	Review of Resident	#1's December 2018 MAR				
	revealed:					
	-There was a handy	written entry for Fiasp SSI four				

STATE FORM

6899

G6PB11

If continuation sheet 6 of 34

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011133	B. WING		1	2/14/2018
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	. ZIP CODE		*****
MANE OF F	NOVIDER OR GOLT EIER			, <u>,</u>		
CHASE S	AMARITAN ASSISTED L	IVING	LLE, 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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 6	D 358	<u>, and the second se</u>	······································	
	Continued From page 6 times daily after meals, for FSBS $<70 = 0$ units, 70-150 = 0 units, $151-200 = 1$ unit, $201-250 = 2units, 251 - 300 = 3 units, 301-350 = 4 units,351-400 = 5$ units, $<400 = 6$ units, with administration times of 8:00am, $12:00pm$, 4:00pm, and $8:00pm$. -On $12/08/18$ at $4:00pm$, the FSBS was 156 and 0 units of insulin was documented as administered.					
	dated 11/05/18 revea (blood test that meas of blood glucose) leve Diabetes Association A1C target level of le gives you a picture o [blood sugar] control The results give you	ry report for Resident #1 aled a hemoglobin A1C sures a three month average el was 7.3. [The American recommends a hemoglobin ess than 7%. (The A1C test f your average blood glucose for the past 2 to 3 months. a good idea of how well the reatment plan is working).]		·		
	Interview on 12/14/18 at 9:55am with the facility's contracted pharmacy revealed: -The pharmacy had received an order for Fiasp SSI four times daily before meals, FSBS 0-150 give 0 units, 151 -200 give 1 unit, 201-250 give 2 units, 251-300 give 3 units, 301-350 give 4 units, 351-400 give 5 units, >400 give 6 units. -The order was dated 11/05/18. -The pharmacy had no other Fiasp SSI orders.					
	the Resident Care Co Refer to the interview with a first shift Media Refer to the telephon	v on 12/14/18 at 10:10am				

STATE FORM

-

6899

G6PB11

If continuation sheet 7 of 34

1

TATEMENT	f Health Service Regu OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE : COMPI	
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL011133	B. WING		C 12/14/2018	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	MARITAN ASSISTED L	WING 30 DALE	A DRIVE			
SHASE SA	AWARITAN ASSISTED L	ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 358	Continued From pag	e 7	D 358			
	Refer to the interview the Executive Direct	v on 12/14/18 at 1:00pm with or.				
	Refer to the review of Administration Policy	of the facility's Medication and Procedure.				
	01/19/18 revealed: -Diagnoses included complications, hyper pain syndrome, and -There was a physic high blood glucose) three times daily bef Finger Stick Blood S of insulin, FSBS 151 units, 251-300 = 3 u 351-400 = 7 units. Review of Resident	ent #3's current FL2 dated diabetes with neurological dipidemia, seizures, chronic major depressive disorder. ian order for Novolog (treats Sliding Scale Insulin (SSI) fore meals and at bedtime; sugar (FSBS) 0-150 = 0 units -200 = 1 unit, 201-250 = 2 nits, 301-350 = 5 units, #3's October Medication				
	daily before meals a 0 units, 151-200 = 1 251-300 = 3 units, 3	for Novolog SSI three times and at bedtime; FSBS 0-150 = units, 201-250 = 2 units, 01-350 = 5 units, $351-400 = 7$				
	times of 8:00am, 12	scheduled administration :00pm, 5:00pm and 8:00pm. 0pm, the FSBS was 390 and s documented as				
	7 units of insulin wa administered. -On 10/07/18 at 5:0	0pm, the FSBS was 318 and				
	7 units of insulin wa administered. -On 10/09/18 at 12: 1 units of insulin wa administered.	00pm, the FSBS was 149 and				
		0pm, the FSBS was 378 and				

STATE FORM

G6PB11

l

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED
		HAL011133	B. WNG		12	C 2/14/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE	arana an a' alta da da da da da da cana an minana ana air ina chid dha da mendal	
		30 DAL	EA DRIVE			
CHASE \$/	AMARITAN ASSISTED	LIVING	ILLE, NC 28805			
04010	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
D 358	Continued From pa	ge 8	D 358			
	2 units of insulin wa	s documented as				
	administered.					
1	-On 10/14/18 at 8:0	0am, the FSBS was 175 and		•		
	0 units of insulin wa	is documented as				
	administered.					
		0pm, the FSBS was 472 and				
	7 units of insulin wa	is documented as				
	administered.					· · · ·
		0pm, the FSBS was 406 and				
	7 units of insulin wa	is documented as				
	administered.	0am, the FSBS was 410 and				
	7 units of insulin wa					
	administered.	a documented as				
		0pm, the FSBS was 209 and				
	3 units of insulin wa	-				
	administered.					
	-On 10/27/18 at 12:	00pm, the FSBS was 162 and				
	2 units of insulin wa	as documented as				
	administered.					
	1	0pm, the FSBS was 109 and				
	1 unit of insulin was	s documented as				
	administered.	Opm, the FSBS was 169 and				
	2 units of insulin wa					
	administered.					
	1	Opm, the FSBS was 416 and				
	7 units of insulin wa					
	administered.					
	Review of Resident	#3's November 2018 MAR				
	revealed:					1
		ry for Novolog SSI three times				i i
	daily before meals	and at bedtime; FSBS 0-150 =				
	a consideration of the second s second second se Second second s Second second seco	1 units, 201-250 = 2 units,				
		301-350 = 5 units, 351-400 = 7				
		scheduled administration				
		2:00pm, 5:00pm and 8:00pm.				
		00pm, the FSBS was 211 and		с		
	9 units of insulin wa	is documented as				

	OF DEFICIENCIES OF CORRECTION	Ilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED C
		HAL011133	B. WING		12	/14/2018
IAME OF PI	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	ZIP CODE	n de en maneral de l'actuel a mentionem a de trade de la ministra d'actuel de la distribution de la distributio	94103693W24404A-2777#####00000###1280
		30 DALI	EA DRIVE			
HASE SA	AMARITAN ASSISTED L	IVING ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE				(XS) COMPLETE DATE	
D 358	Continued From page	e 9	D 358			
	administered.	om the ESBS was 279 and				
	-On 11/03/18 at 8:00pm, the FSBS was 279 and 0 units of insulin was documented as					- I
	administered.					
		am, the FSBS was 481 and				
	7 units of insulin was					
	administered.					
		pm, the FSBS was 136 and				
	2 units of insulin was					
	administered.					
	-On 11/10/18 at 8:00	am, the FSBS was 372 and				
	6 units of insulin was					
	administered.					
	-On 11/11/18 at 8:00	am, the FSBS was 178 and 2				
		ocumented as administered.				
		0pm, the FSBS was 229 and				
	4 units of insulin was	documented as				
	administered.					
		am, the FSBS was 555 and				
	7 units of insulin was	documented as				
	administered.					
		pm, the FSBS was 154 and				
	2 units of insulin was	s documented as				ł
	administered.	Opm the ESBS was 264 and				
	10 units of insulin wa	Opm, the FSBS was 364 and				
	administered.					
		Opm, the FSBS was 384 and				
	4 units of insulin was]			
	administered.					
		pm, the FSBS was 354 and				
	6 units of insulin was					
	administered.					
		ipm, the FSBS was 55 and 1				
		ocumented as administered.				
a proposition and specific and set of the	and a second state of the second state of the second second second second second second second second second se	pm, the FSBS was 365 and	an 10 م 10	a an ann an a	a parametri na na serie da na na manda na mana na ma	
	5 units of insulin was		1 1			1
	administered.					
		· · · · · · · · · · · · · · · · · · ·	- ··· ·			
	La managemente a gradi e regelse erregel	#3's December 2018 MAR	· · · · · · · · · · · · · · · · · · ·			

Division of Health Service Regulation STATE FORM

6899

G6PB11

If continuation sheet 10 of 34

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011133	B. WING		C 12/14/2018	
NAME OF P	ROVIDER-OR-SUPPLIER-		ODRESS; CITY; STATE;			
			EA DRIVE			
CHASE S.	AMARITAN ASSISTED	LIVING	LLE, NC 28805			
04 D 10	SEMANAADY	· · · · · · · · · · · · · · · · · · ·			ODE OTION	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLE	ETE
D 358	Continued From pa	ge 10	D 358			
	revealed:					
		y for Novolog SSI three times				
		and at bedtime; FSBS 0-150 =				
		1 units, 201-250 = 2 units,				
		301-350 = 5 units, 351-400 = 7				
		scheduled administration				
		2:00pm, 5:00pm and 8:00pm.				
		0pm, the FSBS was 285 and				
	4 units of insulin wa	is documented as				
	administered.	Nom the ESBS was 201 and				
	4 units of insulin wa	0am, the FSBS was 294 and				
	administered.	is documented as				
		0am, the FSBS was 355 and				
	6 units of insulin wa					
	administered.					
	-On 12/09/18 at 12:	00pm, the FSBS was 109 and				
	1 unit of insulin was	documented as				
	administered.					
		0pm, the FSBS was 225 and				
	1 unit of insulin was	documented as	· .			
	administered.					
		0pm, the FSBS was 270 and				
	4 units of insulin wa	is occumented as				
	administered.					
	Refer to the intervie	w on on 12/14/18 at 9:10am				
	with the Resident C					
		w on 12/14/18 at 10:10am				
	with a first shift Mec	lication Aide.				
	Dafor to the tale	no intensious on 10/14/140 of				
	· · · · · · · · · · · · · · · · · · ·	ne interview on 12/14/18 at				
	10.55am with the Pl	hysician's Nurse Practitioner.				
	Refer to the intervie	w on 12/14/18 at 1:00pm with		an a sa sa sa an a ana ana ana ang mananana sa		
	the Executive Direct	•				
	Refer to the review	of the facility's Medication				
	Administration Polic		1		1	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	COME	SURVEY
		HAL011133	B. WING		C 12/14/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE,	ZIP CODE	oof here defined and an and an and an and	ann a mar ann an
		30 DALI	EA DRIVE			
CHASE SA	AMARITAN ASSISTED I	LIVING ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	ge 11	D 358			
	01/21/18 revealed: -Diagnoses included -There was a physic	ent #4's current FL2 dated d dementia and depression. cian order for Refresh tears lrop in each eye three times				
	December 2018 Me Record revealed the as administered thre Observation on 12/*	 #4's October, November, and dication Administration eye drops were documented et times daily. 14/18 at 3:30pm of Resident hand revealed an unopened 				
	11/12/18. Interview on 12/14/ Medication Aide rev -The eye drops had times daily.	with a pharmacy fill date of 18 at 3:30pm with the realed: been administered three but of the last bottle of eye				
	drops this morning Telephone interview the facility's contract -The first bottle of R delivered to the faci -A second bottle was -A third bottle was of -Each bottle was 15 administered three -The doses from the	(12/14/18). y on 11/14/18 at 3:49pm with ted pharmacy revealed: tefresh eye drops was lity on 07/16/18. Is delivered on 08/02/18. lelivered on 11/12/18. iml and was a 50 day supply if times daily. e second bottle of eye drops				
	Based on observati	t by 10/24/18. ons, interviews, and record armined that Resident #4 was		······································		1
	INCLINE TO				-	

Division of Health Service Regulation STATE FORM

6899

G6PB11

If continuation sheet 12 of 34

STATEMENT	f Health Service Rec of DEFICIENCIES of CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011133	B. WING		C 12/14/2018	
	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆᠆	
		30 DAL	EA DRIVE			
CHASE SA	MARITAN ASSISTED	LIVING ASHEV	ILLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE	
D 358	Continued From pa	ge 12	D 358			
	Refer to the review Administration Polic	of the facility's Medication y and Procedure.				
	A Poviow of Resid	ent #2's current FL2 dated				
		liagnoses included chronic				
		ary disease (COPD)				Ì
		ent #2's record revealed a r Resident #2 dated 05/06/18				
		ng take 1 capsule daily before				
	breakfast (used to t					
	Review of Resident	#2's primary care physician's				
	(PCP) visit summar	y dated 10/03/18 revealed:				
	-Resident #2 had a					
		eflux disease (GERD). cian's order to discontinue				
	omeprazole 20mg					
	Review of Resident	t #2's October 2018				
		stration Record (MAR)				
	revealed:					
	-There was a comp	outer generated order for				
	omeprazole 20mg	ake 1 capsule daily before d to be administered at				1
	8:00am.			· .		
		documented as administered				
	daily from 10/01/18					
		t #2's November 2018 MAR				
	revealed:	outer generated order for				Í
		take 1 capsule daily before				
	breakfast schedule	d to be administered at				
aan ay a share ta dhare dhare dhare	8:00am.					
		locumented as administered				
·····	daily from 11/01/18	to 11/30/18.				{
	Review of Residen	t#2's December 2018 MAR				
	alth Service Regulation		<u>I</u>			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY
		HAL011133	B. WING		12	C /14/2018
	OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
NAME OF FI	CONDER OR OUT LER		EA DRIVE			
CHASE S/	MARITAN ASSISTED L	IVING	LLE, NC 28805			
	0.110.000	·····	·····	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 358	Continued From pag	e 13	D 358			
	revealed:					
		ter generated order for				
		ke 1 capsule daily before				
:		to be administered at				1
	8:00am.					
	-Omeprazole was do	ocumented as administered				1
	daily from 12/01/18 1	o 12/13/18.				
	Observation of Resi	dent #2's medication on hand				
		am revealed a medication				
		apsules of omeprazole 20mg				
		18 was available to be				
	administered.	. '				I
	Interview with Resid revealed:	ent #2 on 12/14/18 at 4:35pm				
		supposed to be taking				
	omeprazole.					
	-He did not know on	neprazole had been				
	discontinued in July	2018.				
		with the facility's contracted				
	pharmacy on 12/14/	18 at 10:14am and 4:44pm				
	1	cycled medication for				
		tomatically dispensed				
		omeprazole was dispensed to				
	Resident #2 on 09/2	5/18, 10/24/18, and 11/26/18.				
	-The pharmacy did	not have a discontinuation				
	order for omeprazol					
	-The facility or the p	hysician was responsible for				
	faxing medication or	rders to the pharmacy.				
		Id make corrections on the				
		ceived a signed physician	1	a a name and the second as the second as a second with the second second second second second second second se		aa ahaa ahaa ka ahaa ahaa ahaa ahaa ah
	order. The feeility should l	no ponding corrections to the				
	MAR to the pharma	be sending corrections to the				
		су полизу.			······································	
	Interview with the m	edication aide (MA) on	· · · · · · · · · · · · · · · · · · ·	·····		
	alth Service Regulation			······································		

TATEMENT	f Health Service Regu of DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
,		HAL011133	B. WING		C 12/14/2018	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
HASE SA	MARITAN ASSISTED L	IVING 30 DALE				
		ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTH CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE 1E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 14	D 358			
	12/14/18 at 8:10am r	evealed.				
	-She did not know that					
	discontinuation order					
	Olscontinuation order	tor oneprazole.				
		nt Care Coordinator (RCC)				
		processing new orders.				
		e for faxing medication				
		icy once the orders were				
	received by the facilit					
	the MAR for new me	e for making the changes to				
	The MAR for new me	o for ouditing the modication				
	-Sne was responsible	e for auditing the medication				
1		nonthly when the "cycle fill				
1	was delivered from the	the medication cart were				
	Compared to the MA	Rs during the audit process. zted provider was responsible				
	for sending medication		1			
	summaries to the fac	anty.				
	Interview with the RC revealed:	CC on 12/14/18 at 7:51am				
		re responsible for auditing				
	the medication carts					
		mpared to the previous				
	months MARs at the					ł
		the medication cart were				
		Rs monthly when the	1			
	pharmacy delivered	the medications on "cycle				
	fill."					ļ
	- I ne MA was respor	sible for processing new				
		esidents in the facility.				
		sible for faxing new orders to				
	the pharmacy and u	poaling the MARs.				
		with Resident #2's primary		n a success a second a construction of the second polycology (1997) and for		
	care physician (PCP revealed:) on 12/14/18 at 10:55am				
		ed omeprazole for Resident				
	#2 on 07/26/18.	<u></u>	· · · · · · · · · · · · · · · · · · ·			
		not he taking omeprazole for				

STATE FORM

142

G6PB11

6899

If continuation sheet 15 of 34

-332

	of Health Service Regination of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE : COMPL					
		HAL011133	B. WING			C 14/2018				
NAME OF P	ROVIDER OR SUPPLIER	: STREET	ADDRESS, CITY, STATE	E, ZIP CODE		, T. (C. M. (C. C. C				
		30 DALI	EA DRIVE							
CHASE S	AMARITAN ASSISTED L	ASHEVI	ILLE, NC 28805							
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page 15 an extended period of time.		D 358							
		increased risk of vitamin D								
		osis, and Clostridium Difficile								
	infection (bacterial infection in the intestines that cases severe diarrhea) due to receiving omeprazole for an extended period of time.									
	Refer to interview with the Executive Director on									
	12/14/18 at 11:39am									
1	h Doviou of Posido	nt #2's record revealed a								
	physician's order dated 10/10/18 for doxycycline									
		daily with food and water								
	(used to treat skin in					}				
		#2's record revealed a								
		ed 11/28/18 from Resident								
	#2's dermatologist fo	r doxycycline 1 capsule daily.								
	Boviow of Posident:	#2's November 2018								
		ration Record (MAR)								
	revealed:									
		ter generated entry for								
		apsule twice daily with food								
	and water scheduled	to be administered at				-				
	8:00am and 5:00pm									
		cumented as administered								
	twice daily from 11/0	1/18 to 11/30/18.								
	Dovious of Desidents	#2's December 2018 MAR								
	revealed:	+2 5 DECEMBER 2010 MAR								
		ter generated entry for								
		apsule twice daily with food								
		to be administered at								
	8:00am and 5:00pm				states a signal and the second					
		cumented as administered		annan 197 ann 197 ann 1989 ann 1989 ann 197 ann 197 ann 1970 ann 1970 ann 1970 ann 1970 ann 1970 ann 1970 ann 1						
	twice daily from 12/0					1				
	·									
		lent #2's medication on hand								
	on 12/14/18 at 10:00	am revealed:								

STATE FORM

G6PB11

6899

If continuation sheet 16 of 34

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
				B. WING		C 2/ 14/2018		
an an Alia and a sub-state of the William	and the second	HAL011133				.; 14/2010		
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	FE, ZIP CODE				
			EA DRIVE					
HASE SA	AMARITAN ASSISTED L	ASHEV	ILLE, NC 28805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI		ON SHOULD BE HE APPROPRIATE	(X5) Complete Date
D 358	Continued From pag	e 16	D 358					
0.000								
:	-There was a medication card containing 8							
	capsules of doxycycl	ine dispensed to Resident #2	1 1					
	on 11/14/18 available							
		red writing was attached to						
		I covering the directions with						
	Instructions direction	ns changed refer to chart."				Í		
	Telephone interview	with the facility's contracted						
		18 at 10:14am and 4:44pm						
	revealed:					ļ		
		doxycycline was dispensed to			5.			
	Resident #2 on 10/1	9/18 and 11/14/18 with the						
	directions take 1 cap							
	-A prescription was o	on file but never dispensed	ł					
	11/28/18.	ng take 1 capsule daily dated						
		on was not filled because it						
		insurance to pay for the						
	medication.	humining was represented for						
		hysician was responsible for ders to the pharmacy.						
		Id make corrections on the						
		eived a signed physician						
	order.							
		be sending corrections to the				ļ		
	MARs to the pharma							
		edication aide (MA) on						
	12/14/18 at 8:10am							
		hat Resident #2 had a						
		anging the directions of						
	doxycycline.	i first shift and administered						
	the morning dose of							
		ent Care Coordinator (RCC)						
		r processing new orders.						
		le for faxing medication						
		acy once the orders were		<u> </u>				
	received by the facil	ity.						
	-She was responsib							

......

· · · · · · · · · · · ·

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
					с
	••••••••••••••••••••••••••••••••••••••	HAL011133	B. WING		12/14/2018
NAME OF P	PROVIDER OR SUPPLIER	ашталалын аларыларынын байсанын байсанда түйн түрүнүү байсан түйн түрүүнүү байсан түрүүүү байсан түрүүүүүүүүүү STREET /	ADDRESS, CITY, STATE		ana ang sa kana na sa
CHASE S	AMARITAN ASSISTED) LIVING			}
		ASHEVI	1LLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	BE COMPLETE
D 358	Continued From page	.ge 17	D 358		
1	MARs when a new	medication order was			
ļ	received.				
ţ		the doxycycline should have			
ļ	been changed on th				
1		ble for auditing the medication			
1		monthly when the "cycle fill			
ļ	was delivered from t	the pharmacy."			
1	1	ARs during the audit process.			
ļ		acted provider was responsible			
ļ	for sending medicat				
	summaries to the fa				
	Interview with the Re revealed:	RCC on 12/14/18 at 7:51am			
	-She and the MA we	ere responsible for auditing			
ļ	the medication carts	s and MARs weekly.			
1		ompared to the previous			
!	months MAR at the				
1	1	on the medication cart were ARs monthly when the			
1		d the medications on "cycle			
ļ	fill."				
ļ		onsible for processing new			
1	1	residents in the facility. Disible for faxing new orders to			
ļ	the pharmacy and u				
1		onsible for making changes to			
	the MARs.				
		w with a nurse from Resident			
	#2's dermatology off revealed:	ffice on 12/14/18 at 12:02pm			
		vcycline dose was reduced at			
	an office visit on 11/	• •			
· · · · · · · · · · · · · · · · · · ·	and see a second or interest or an and the second	rescribed to treat Resident	· · · · · · · · · · · · · · · · · · ·	a na an	
ļ	#2's skin rash with ir	infected boils.			
		rash was stable and the			
	-	owered the dose of the			
1	doxycycline.	ار و المحمد ا المحمد المحمد		a en	

f

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		HAL011133	B. WING			C 2/14/2018
AME OF P	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	алтонно оченовного на совется на с ПР ТРР СОДЕ	3	and ware described and a second se
• *			EA DRIVE	-, 21 0000		
CHASE S/	AMARITAN ASSISTED L	LIVING	ILLE, NC 28805			
		·····			·····	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	ge 18	D 358			
	 The dermatologist was going to attempt to discontinue medication if Resident #2 continued to do well. Long term use of antibiotics could increase the 					
		istance to the antibiotic.				
	at 11:39am revealed					
	order changed chang			,		
		cycline should have been change made on the MAR.				
	Refer to interview wi 12/14/18 at 11:39am	vith the Executive Director on n.				
	05/01/18 revealed:	ent #5's current FL2 dated d vitamin D deficiency,				
	anxiety, hypothyroidi disorder.	dism, and major depressive				
	50,000 IU take 1 cap	cian's order for vitamin D3 psule monthly.				
	revealed a discontinu	an's order dated 08/16/18 nuation order for vitamin D2 vitamin D3 5,000 IU take 1				
	physician's order dat	#5's record revealed a ated 08/23/18 to discontinue and start vitamin D3 2,000 IU				
	Review of Resident #			يسي د ۾ اين ان جا جيندن ۽ درگان ان جاني ۾ ۽ پيسنديندي ڪري ڪري ڪري واري واري واري واري واري واري واري	New Sector Control on the Allowed Sector Control of	
	revealed:	tration Record (MAR)				
	vitamin D3 2,000 IU t	take 1 tablet daily scheduled		······	· · · · · · ·	· · · · · ·
		•		· · · · · · · · · · · · · · · · · · ·		

133

	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED C 12/14/2018	
		HAL011133	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE	1914W - 1997 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977	anaan ahaa ahaa ahaa ahaa ahaa ahaa aha
CHASE S	AMARITAN ASSISTED	LIVING	EA DRIVE LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	ge 19	D 358	<u> </u>	<u></u>	
	discontinued on 08/2	J was documented as 24/18 and no vitamin D3 was iinistered from 10/01/18 to				
	revealed: -There was a compl	#5's November 2018 MAR Iter generated entry for take 1 tablet daily scheduled				
	-Vitamin D3 2,000 II discontinued on 08/2	J was documented as 24/18 and no vitamin D3 was inistered from 11/01/18 to				
	revealed: -There was a compu- vitamin D3 2,000 IU to be administered a -Vitamin D3 2,000 II discontinued on 08/2	#2's December 2018 MAR Iter generated entry for take 1 tablet daily scheduled at 8:00am. J was documented as 24/18 and no vitamin D3 was inistered from 12/01/18 to				
	on 12/14/18 at 3:00	dent #5's medication on hand om revealed no vitamin D3 ole to be administered to				
	from the facility's con 12/14/18 at 4:44pm	with a pharmacy technician ntracted pharmacy on revealed vitamin D3 2,000 IU o Resident #5 for a 30 day's				
	12/14/18 at 8:10am	edication aide (MA) on revealed: e for processing medication				
		e residents and the RCC was		······································		

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COM	SURVEY	
						с	
		HAL011133	B. WING		12	12/14/2018	
VAME OF P	ROVIDER OR SUPPLIER	๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛	ADDRESS, CITY, STATE	;ZPCODE	1099/109 <u>1091010101010000000000000000000</u>		
CHASE S	AMARITAN ASSISTED		EA DRIVE				
			1LLE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From pa	age 20	D 358				
ĺ	responsible for the	male residents.					
	-She was responsible for faxing medication						
		nacy once the orders were					
	received by the fac	cility.					
		he correction on the MAR for					
ł		ders to take effect the following					
		ation had been delivered from					
	the pharmacy.	on order took effect when the					
		ailable for administration.					
		ble for auditing the medication				1	
		monthly when the "cycle fill					
	was delivered from						
		on the medication cart was					
		AR during the audit process.					
		acted provider was responsible					
	summaries to the f	tion orders and visit					
	summanes to the h	aomy.					
	Interview with the F	Resident Care Coordinator					
		at 7:51am revealed:					
[Resident #5 was supposed to					
	be taking vitamin D	-					
		ntinue vitamin D3 5,000 IU					
		3 2,000 IU for Resident #5 was					
	never processed.	ere responsible for auditing					
		s and MARs weekly.					
		onsible for faxing new orders to					
	the pharmacy and i						
		ompared to the previous					
		end of each month.					
1		n the medication cart were					
		ARs monthly when the					
	•	I the medications on "cycle					
	····						
		xecutive Director on 12/14/18					
		d:					
	The order to discor	ntinue vitamin D3 5,000 IU					

STATE FORM

6899

G6PB11

If continuation sheet 21 of 34

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPL	
		HAL011133	8. WING		C 12/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET.	ADDRESS, CITY, STATE			
			EA DRIVE			
CHASE S	AMARITAN ASSISTED I	LIVING	ILLE, NC 28805			
2/4/15	SHAMADV S	TATEMENT OF DEFICIENCIES				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	le 21	D 358			
	missed and never pr	2,000 IU for Resident #5 was ocessed. hould be comparing the				
	previous MAR to the medications are adm	current MAR to make sure inistered correctly.				
		e interview with Resident #5's an on 12/14/18 at 4:28pm				
	Refer to interview wi 12/14/18 at 11:39am	th the Executive Director on				
	05/31/18 revealed: -Diagnoses included of falls, and coronary -There was a physici	an's order for vitamin D2 sule every Thursday				
	(PCP) visit summary -There was a physici vitamin D2 50,000 IU					
	-There was a physici 2,000 IU take daily o	an's order to start vitamin D3 nly.				
		n's order dated 10/05/18 2,000 IU take 2 capsules				
	Review of Resident # Medication Administr revealed:	ation Record (MAR)				
	vitamin D3 2,000 IU t scheduled to be adm	inistered at 8:00am.				
	-Vitamin D3 2,000 IU administered daily fro	was documented as m 10/01/18 to 10/08/18				

,

ł

l

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		LETED	
		HAL011133	B. WING			C 12/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	disaturation of the second and the second and the second statement of the second s	DDRESS, CITY, STATE	ZIP CODE			
			A DRIVE				
CHASE S	AMARITAN ASSISTED L	IVING	LLE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 22	D 358				
	-Vitamin D3 2,000 IU	was documented as					
	discontinued on 10/0			1			
		ritten entry for vitamin D3					
		cheduled to be administered					
	at 8:00am.						
	-Vitamin D3 2,000 IU	was documented as					
	1	om 10/09/18 to 10/31/18.					
		ter generated entry for					
		take 1 capsule weekly on					
		to be administered at					
	8:00am.	to be administered at					
	· ·	U was documented as					
	, ,	04/18, 10/11/18, 10/18/18,					
	and 10/25/18.						
	and 10/20/10.	<i>,</i>					
	Review of Resident #	#6's November 2018 MAR					
	revealed:						
	-There was a compu	ter generated entry for					
	vitamin D3 2,000 IU I						
	scheduled to be adm	•					
	-Vitamin D3 2,000 IU	was documented as					
	administered daily fro	om 11/01/18 to 11/30/18.				ĺ	
		ter generated entry for					
		take 1 capsule weekly on					
		to be administered at					
	8:00am.						
	-Vitamin D2 50,000 1	U was documented as				}	
	administered on 11/0	01/18, 11/08/18, 11/15/18,					
	11/22/18, and 11/29/	18.					
i	Review of Resident #	#6's December 2018 MAR					
	revealed:						
		ter generated entry for					
	vitamin D3 2,000 IU 1						
	scheduled to be adm	•					
	-Vitamin D3 2,000 IU	A set Products for each depression in the set of the set of the depression of the set of the set of the set of	14 - Margan - C. 1997 Alicence (1997 - 1997	n an an tao amin' amin' ao amin'	n an ann an a	19 19 19 19 19 19 19 19 19 19 19 19 19 1	
		om 12/01/18 to 12/14/18.					
	•	ter generated entry for					
		take 1 capsule weekly on		······································			
		to be administered at					

STATE FORM

6899 G6PB11

If continuation sheet 23 of 34

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING;		(X3) DATE S COMPLE	TED
		HAL011133	B. WING		C 12/1	4/2018
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		9552854900-4694 64289955426884844444444946999449995
	AMARITAN ASSISTED L	MINC 30 DALL	EA DRIVE			
AASE 3	AMANTAN ASSISTED L	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
		······································				
D 358	Continued From page	e 23	D 358			
	8:00am.					ł
	+	U was documented as				ł
	administered on 12/0					ſ
	autimistered off 12/0	$\frac{1}{10} \frac{1}{10} \frac$				
	Observation of Resid	lent #6's medications on				
	hand on 12/14/18 at					
		tion card with 4 capsules of	1		í	1
		dispensed on 12/01/18				1
		histered to Resident #6.				1
		ation card with 60 tablets of				1
		dispensed on 12/01/18				-
		nistered to Resident #6.				
	avanable to be autilit					
ļ	Telephone interview	with a pharmacist from the				
		harmacy on 12/14/18 at				
	4:44pm revealed:	hamady on the to at				
		ast filled a 30 day supply of				
	vitamin D3 2,000 IU t					
	08/22/18.					
		ysician was responsible for				
	faxing medication or					
		d make corrections on the				
		eived a signed physician				
	order.	and a signed prijoroterr				
F		e sending corrections to the	l Í			
	MARs to the pharma	-				
	the rest of the priorities	ey menany.				
	Interview with the me	dication aide (MA) on				
ļ	12/14/18 at 8:10am n					
		e for processing medication				
		residents and the RCC was				
ĺ	responsible for the m					
	•	e for auditing the medication				
		onthly when the "cycle fill				
	was delivered from th					
		he medication cart were				
		lications listed on the MARs.				
	-	ted provider was responsible				
	for sending medicatio					
. 1	summaries to the fac					

STATE FORM

-

6899

G6PB11

If continuation sheet 24 of 34

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011133	B. WING		C 12/14/2018	
	ROVIDER OR SUPPLIER		ODRESS, CITY, STATE		میں اور میں میں میں کر میں	an a
	No HELL ON OUT LIEN					
CHASE S	AMARITAN ASSISTED I	LIVING	LE, NC 28805			
			1			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
D 358	Continued From pag	e 24	D 358			
	orders to the pharma received by the facili -She was responsibl	e for faxing medication acy once the orders were ty. e for making corrections to medication orders were				
	received.					
	(RCC) on 12/14/18 a					
	most mornings. -She knew Resident	edications on the female hall #6 was being administered				
	administered vitamin	esident #6 should only be D 2,000 IU.				
	the medication carts	re responsible for auditing and MARs weekly. sible for faxing new orders to				
	the pharmacy and up -The MARs were cor	odating the MARs. npared to the previous				
		and of each month. the medication cart were Rs monthly when the				
		the medications on "cycle				
	care physician (PCP) revealed:	with Resident #6's primary) on 12/14/18 at 10:55am				
	50,000 IU at a visit o dose to 2,000 IU dail					
		esident #6 was receiving 50,000 IU and the vitamin D3				
	-She did not know Re order for vitamin D2 {		· hange an er er an ander er en er		ana na ana ang mang mang mang mang mang	
,	because of all the vita	risk for vitamin D toxicity amin D she had received.				
	-Vitamin D toxicity co	uld result in constipation,			10001	

.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011133	B. WING	44	C //14/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
		30 DALE	A DRIVE			
CHASE S	AMARITAN ASSISTED	LIVING	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	ge 25	D 358	· · · · · · · · · · · · · · · · · · ·		
	and calcification of s -The facility should i but by the physician to determine a resid	not go by the signed MARs orders and visit summaries ent's correct medications. ith the Executive Director on				
	Resident Care Coor -The MAs had atten 12/07/18 from the pl	ded an insulin class on				
	Medication Aide reve -She always compar MAR "about three tin -The MAs had receiv week in December.	ed her medication to the				
	Physician's Nurse Pr -Receiving the wrong resident at risk of hy hyperglycemia.	g dose of insulin put the poglycemia or d have received the correct				
	at 11:39am revealed: -The RCC and MA w new medication orde	ere responsible for faxing	· · ·			ne (* 1. 2011) (1. 2012) (1. 2012) (1. 2012)
	the MARs with medic	ation changes. ere responsible for auditing				

Division of Health Service Regulation STATE FORM

6899

G6PB11

If continuation sheet 26 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011133	B. WING		C 12/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	aanaan waxaa waxaa ahaa ahaa ahaa waxaa ahaa ah	DORESS, CHTY, STATE	, ZP-00BE	TERRITORIA CONTRACTOR CONTRACTOR CONTRACTOR	
CHASE S	AMARITAN ASSISTED	LIVING	EA DRIVE LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	ge 26	D 358			
ĺ	or correcting any pro order.	oblems with a medication				
	Executive Director n -The staff had attend the pharmacy nurse Review of the facility Policy and Procedur -Medications, prescr and treatments will b	ded "diabetic training" from the first week of December. 's Medication Administration e revealed: iption and non-prescription.				
	orders. The facility failed to a ordered, including in Resident #1 which p or high blood glucos reflux and an antibio of antibiotic resistand doses of insulin to Re the risk of high or low drops for Resident # eyes, a vitamin supp deficiency for Resided supplements for low The facility's failure to ordered was detriment of the residents and of Violation.	administer medications as correct doses of insulin for ut the resident at risk of low e levels, medications for tic, which increased the risk esident #3 which increased v blood glucose levels, eye 4 to prevent dry, irritated lement for vitamin D int #5, and vitamin blood levels for Resident #6 o administer medications as intal to the health and welfare				
	accordance with G.S	. 131D-34 on 12/14/18.				
1		OT EXCEED JANUARY 31,		• • • · · · · · · · · · · · · · · · · ·		n for a second
						· · · · · · · · · · · · · · · · · · ·

STATE FORM

6899

G6PB11

If continuation sheet 27 of 34

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S		
	OF CORRECTION	IDENTIFICATION NOMBER:	A. BUILDING:		COMPL	COMPLETED	
		HAL011133	B. WNG		C 12/14/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	with the first of the the theorem is the transmission of the tran		harona mayakishi "koandara Wiving	
CUARE C.	AMARITAN ASSISTED	N/INC 30 DALE	A DRIVE				
CHASE 3/	AMARIAN ASSISTED	ASHEVIL	LE, NC 28805				
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORR		(X5)	
Prefix Tag		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETE DATE	
D 371	Continued From pag	je 27	D 371				
D 371	10A NCAC 13F .100 Administration	4(n) Medication	D 371				
		4 Medication Administration					
	administered in acco	assure that medications are ordance with infection control o prevent the development		Facility will ensure that all me	dications are		
	and transmission of	disease or infection, prevent and provide a safe and	administered in accordance with Infection Control Policy. The appropriate use of gloves and hand sanitation reviewed at staff meeting				
		t for staff and residents.					
ĺ	This Rule is not met as evidenced by: Based on observations, interviews, and record				at staff meet	ing	
	reviews, the facility f	ailed to assure proper		on 12/29/18.			
		sures were used for 1 of 10 #7) observed during a		1/9/1	9		
		pass related to administering					
	eye drops without we hands before and af	earing gloves and washing er administration.					
	The findings are:						
	Observation of the m 12/14/18 at 7:51am	orning medication pass on					
	-Resident #7 receive	d 5 oral medications and 1					
	eye drop. -The Resident Care	Coordinator (RCC) popped					
		edications into a medication					
		e bottle of eye drops in her					
l	bare hand along with	the medication cup					
1		edications into Resident #7's				ľ	
	room.	od Docidont #7% ave dropp		an ya manana ka manana ka manana ka manana manana manana ka mana ka manana ka manana ka manana ka ka ka mana ka		مسابق السراب وولا والارتباط والاردار	
	without wearing glove	ed Resident #7's eye drops					
		ding her eyes closed and the					
		s to hold Resident #7's eyelid	· · [· · · · · · · · · · · · · · ·				
	open to administer th						

ND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	······································	HAL011133	B. WING		C 12/14/2018	
ME OF F	ROVIDER OR SUPPLIER	SIREEL	ADDRESS, CITY, STATE	-212-0005		
IASE S	AMARITAN ASSISTED L	IVING	EA DRIVE ILLE, NC 28805			
X4) ID REFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
D 371	Continued From pag	e 28	D 371			
	Continued From page 28 -The RCC put on gloves and checked Resident #7's fingerstick blood sugar (FSBS) after she administered the eye drops. -The RCC did sanitize her hands with an alcohol based gel after she checked Resident #7's FSBS. -The RCC did not wash her hands with soap and water before she administered medications to Resident #7, including eye drops. Observation of the medication cart on 12/14/18 at 8:01am revealed gloves were available for the RCC to wear for medication administration. Interview with Resident #7 on 12/14/18 at 2:30pm revealed: -The MAs usually wear gloves when they administered her eye drops. -The eye drops were prescribed for her dry eyes. -She was administered her eye drops every morning.					
	revealed: -She had forgotten to administered Residen -She knew she was si administer eye drops. -She usually wore glo	C on 12/14/18 at 9:27am put gloves on before she t #7's eye drops. upposed to wear gloves to ves to administer eye drops. ninistrator on 12/14/18 at				
1	-The facility staff had r control procedures. -Training in infection c completed yearly. -The medication aides to administer eye drop -The MAs should use I	(MA) should wear gloves				
	each resident.					

STATE FORM

10000

6899

G6PB11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		SURVEY PLETED	
		HAL011133	B. WING		C 12/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	enversion and an an and an and an	DDRESS, CITY, STATE	мало на на предокта на пред Т. ZIP CODE	un na merina da serve un annaberar das dasses das s	ni ani mangalan dalam mengalan kana in
CHASE S	AMARITAN ASSISTED L	IVING 30 DALE	A DRIVE			
		ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 371	Continued From pag	e 29	D 371			
	Policy and Procedure	's Medication Administration e revealed the facility staff will ons in accordance with usures.				
D912	G.S. 131D-21(2) Dec	claration of Residents' Rights	D912			E C
	Every resident shall I 2. To receive care as adequate, appropriat	ration of Residents' Rights have the following rights: nd services which are te, and in compliance with state laws and rules and		Refer to response for D35	58	
	reviews, the facility fa received care and se	as evidenced by: ns, interviews, and record ailed to ensure resident rvices which are adequate, ompliance with relevant		Refer to response for D9	935	
	federal and state law related to medication qualifications of medi	s and rules and regulations administration and				
	The findings are:					
	A. Based on observa reviews, the facility fa medications as order					
	residents related to ir omeprazole and doxy					
	vitamin D3 (Resident vitamin D3 (Resident	#5), and vitamin D2 and #6). [Refer to Tag 0358, 10A				
	13F .1004(a) Medicat Violation).]	tion Administration (Type B		·		

STATE FORM

G6PB11

6899

If continuation sheet 30 of 34

ł

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED			
		HAL011133	B. WING		C 12/14/2018			
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE ZIP CODE		nin zwasta in the second state of the second s		
		30 DAL	EA DRIVE	····, -····				
HASE SA	AMARITAN ASSISTED	LIVING	ILLE, NC 28805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE		
D912	Continued From page	ge 30	D912					
	facility failed to ensu aides (Staff B and S the written exam wit completing the skills							
D935	G.S.§ 131D-4.5B(b) Training and Compe	ACH Medication Aides; tency	D935	Facility will ensure that all s	staff			
	G.S. § 131D-4.5B (b Medication Aides; Tr Evaluation Requirem	aining and Competency		administering medications				
				successfully passed the stat	te med exam			
	home is prohibited fr	er 1, 2013, an adult care om allowing staff to perform edication aide duties unless		within the appropriate time				
	that individual has p	reviously worked as a ng the previous 24 months in		All Med Techs are signed up	o for the exam			
		or successfully completed all		immediately after completi	ng the require	d .		
		ng program developed by the udes training and instruction		training. Due to the minima	al amount of			
	in all of the following a. The key principles			testing sites and dates, the facility does not				
		rs for Disease Control and		always receive test dates w	ithin the windo	ow.		
	applicable, safe inject			However those staff membe	ers awaiting te	st		
1		oring or testing in which le potential for bleeding		dates will not be allowed to	administer			
	(2) A clinical skills ev	aluation consistent with 10A	nan man	medications if the date is ou	tside the allot	ed ·····		
	(3) Within 60 days fro individual must have	om the date of hire, the completed the following:		time frame. Any staff memb	per that does n	ot		
	a. An additional 10-h	our training program						

Division of Health Service Regulation STATE FORM

6699

G6PB11

If continuation sheet 31 of 34

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING;	CONSTRUCTION		SURVEY
		HAL011133	B. WING		с	
	ROVIDER OR SUPPLIER	······································			12	/14/2018
	NOVIDER OR SOLITIER		ADDRESS, CITY, STATE EA DRIVE	E, ZIP CODE		
CHASE S	AMARITAN ASSISTED L	IVING	ILLE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D935	Continued From page	e 31	D935			
	developed by the De	partment that includes	pa	ss the state exam will be pu		
ļ	training and instruction	eveloped by the Department that includes aining and instruction in all of the following:				
	1. The key principles	of medication	fro	m med administration and	signod up to	
	administration.					
	2. The federal Centers of Disease Control and		the	exam along with review an	d additional	mod
	Prevention guidelines	s on infection control and, if				
	applicable, safe inject		adn	ninistration training. Staff r	nembers will	not be
		oring or testing in which e potential for bleeding				
	exists.	e potential for bleeding	allo	wed to administer med s ur	ntil passing	l
	b. An examination de	veloped and administered		exam.	Ū	
i i	by the Division of Hea	alth Service Regulation in		exam,		
	accordance with subs	section (c) of this section.		1/0/40		-
1			1	1/9/19	I	
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION					
	Based on interviews a	and record reviews, the				
	facility failed to ensure	e 2 of 3 sampled medication				
	aides (Staff B and Sta	aff C) successfully passed				
	the written exam withi	n 60 days of successfully				
	completing the skills v	alidation competency				
	evaluation.					
	The findings are:					
	1 Review of Staff Dia	porpoppol filo re				
	-She was hired on 04/	personnel file revealed:				
		ion Clinical Skills Validation				
	dated 09/06/18					
	-There was no docum	entation that Staff B had		an ann an		n nama an marat para an part a sa munang
	successfully passed th	ne medication				1
	administration examination	ation.				
	Interview.on 12/14/19	at 2:50pm with Staff B				
	th Service Regulation	ar z. ovprir with otall B				· · · · -

STATE FORM

6699

G6PB11

If continuation sheet 32 of 34

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:			E SURVEY PLETED
··· ··		HAL011133	B. WING		C 12/14/2018	
VAMEOFI	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE	والجارية والمستحد مستخدما والمواتع والمتعادية	1913-00-00-00-00-00-00-00-00-00-00-00-00-00
CHASE S	AMARITAN ASSISTED	LIVING	A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	DI	PROVIDER'S PLAN OF CO	PRECTION	
PREFIX TAG	(EACH DEFICIEN REGULATORY O	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From page	ge 32	D935			
	revealed;					
	-She had started as	a medication aide (MA) about				
	six months ago.					
	-She had taken the	MA test on 12/04/18.				
		istered medications to				
	residents on second	some 12/10/18.				
	Review of a Decem	per 2018 Medication		4		
	Administration Reco					
İ	documented the adm	ninistration of medications on				
	12/07/18, 12/09/18,	and 12/12/18.				
	Refer to the interview	v with the Resident Care				
	Coordinator on 12/14					
	Refer to the interview on 12/14/18 at 3:15p	v with the Executive Director m.				
	2. Review of Staff C -Staff C had a hire da	's personnel file revealed: ate of 08/22/18				
		tion Clinical Skills validation				
	-There was no docur	nentation that Staff C had				
	successfully passed	the medication				
	administration examination	nation.				
	Interview on 12/14/18 revealed:	at 3:30pm with Staff C				
	-She was hired 08/25	/18.				
	-She had taken the M	A test on 12/04/18 and				
	failed it.					
	-She did not know if the	he test had been				
	rescheduled. -She had last adminis	fered medications to	}			
	residents on 12/10/18	and 12/11/18.				
······	Review of a Decembe	n 2019 Modionie -	·····	an an ann an	······································	
	Administration Record				,	
		nistration of medications on		anna tan art t transmanation tan ta statunga		
	12//10/18 and 12/11/1	8				

STATE FORM

G6PB11

6699

If continuation sheet 33 of 34

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	· · · · · · · · · · · · · · · · · · ·	HAL011133	B. WING		C 12/14/2018	
IAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	TAR CODE		ana ang ang ang ang ang ang ang ang ang
CHASE S	SAMARITAN ASSISTED	LIVING	EA DRIVE ILLE, NC 28805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	1
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	Hould be	(X5) COMPLETE DATE
D935	Continued From page	ge 33	D935	······································		
	Refer to the intervie Coordinator on 12/1	w with the Resident Care 4/18 at 1:50pm.				
	Refer to the interview on 12/14/18 at 3:15p	w with the Executive Director om.				
	12/14/18 at 1:50pm -Staff B and Staff C I administration exam -She did not know S	had failed the medication				
	12/14/18 at 3:15pm i -She had been on lea facility 12/14/18. -She was told by stat B and Staff C had fai administration exam. -She knew Staff B an	ave and returned to the ff today (12/14/18) that Staff led the medication				
	were qualified to adm residents. This failur	nsure all medication aides ninister medications to all e placed all residents at risk to the health, safety, and es a Type B Violation.				
	accordance with G.S. CORRECTION DATE	a Plan of Protection in 131D-34 on 12/14/18. FOR THE TYPE B				
	VIOLATION SHALL N	IOT EXCEED JANUARY 31,		n na shi man a maara amaaya ah aha ahaan ahaan ay ahaan a	1996 - 1996 - Sangara na pananga panganan na pa	· · · · · · · · · · · · · · · · · · ·
				······		
	th Service Regulation				· · ·	

,