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 04/09/2019

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
{D 000}	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow up survey on 04/09/19.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 13 residents (#6) observed during the medication pass related to an antibiotic.	{D 358}		

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{D 358}	Continued From page 1 The findings are: The medication administration error rate was 5% evidenced by the observation of 1 error out of 18 opportunities during the 12:00pm medication pass on 04/09/19. Review of Resident #6's current FL2 dated 12/03/18 revealed diagnoses included schizophrenia, obsessive compulsive disorder, diabetes, and intellectual disability. Review of signed physician's orders for Resident #6 revealed a medication order dated 04/08/19 to begin clindamycin (an antibiotic used to treat various types of infections) 150mg oral capsule take 2 capsules by mouth four times a day for 5 days. Observation of the 12:00pm medication pass on 04/09/19 at 11:26am revealed the medication aide (MA) administered one clindamycin HCL 150mg capsule (used to treat skin infection) to Resident #6. Review of Resident #6's April 2019 medication administration record (MAR) revealed: -There was an entry for clindamycin 150mg two capsules by mouth four times a day for 5 days scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation to begin clindamycin 150mg, 2 capsules by mouth four times a day for 5 days beginning 04/09/19. -There was documentation the two 150mg capsules of clindamycin were administered for the 12:00pm medication pass dated 04/09/19. Observation of Resident #6's medications on hand on 04/09/19 at 11:29am revealed:	{D 358}		

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{D 358}	Continued From page 2 -A bubble pack with 40 capsules of clindamycin 150mg with a dispense date of 04/08/19. -Review of the label for clindamycin 150mg capsules, take 2 capsules by mouth four times a day for 5 days. -There were 37 capsules of clindamycin remaining in the bubble pack after the MA administered her 12:00pm dose on 04/09/19. Telephone interview with the facility's contracted pharmacy on 04/09/19 at 3:40pm revealed: -The pharmacy dispensed 40 capsules of clindamycin HCL 150mg on 04/08/19 for Resident #6. -The clindamycin for Resident #6 was delivered by the pharmacy to the facility on 04/08/19 after 6:30pm. Interview with the first shift MA on 04/09/19 at 2:50pm revealed: -She administered 1 capsule of clindamycin instead of 2 capsules during the 12:00pm medication pass. -She knew that she was supposed to administer 2 capsules of clindamycin to Resident #6 at 12:00pm. -She "just got nervous from being watched" during medication pass. Interview with the Executive Director on 04/09/19 at 2:55pm revealed: -Resident #6's medication orders had changed since he was discharged from the hospital and returned to the facility on 04/08/19. -Resident #6 had a previous order for clindamycin 300mg capsule, take 1 capsule by mouth four times a day for 7 days. -The MA was nervous and made a mistake. Observation of the Executive Director on	{D 358}		

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{D 358}	Continued From page 3 04/19/19 at 2:55pm revealed: -She checked the clindamycin pills remaining in the bubble pack on the medication cart for Resident #6. -She popped one clindamycin 150mg capsule into a medication cup and administered it to Resident #6 at 2:55pm. Telephone interview with Resident #6's Nurse Practitioner on 04/09/19 at 3:26pm revealed: -Resident #6 had a mental health disorder that caused him to constantly pick at his skin. -Resident #6 had frequent skin infections and excoriated skin from picking. -Clindamycin had been prescribed multiple times to Resident #6 for skin infection. -Resident #6 had been sent to the emergency room multiple times for skin infection.	{D 358}		