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	HAL011133	A. BUILDING: _____ B. WING _____	01/23/2020

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 an annual and follow up survey and complaint investigation on 01/22/20 - 01/23/20.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure the wall heater in the women's shower room was in working order. The findings are: Interviews with seven residents on 01/22/20 and 01/23/20 at various times from 9:30am on 01/22/20 to 10:45am on 01/23/20 revealed: -The shower room heater has been broken for a few months. -It was very uncomfortable to take a shower because there was no heat. -It was mentioned to the Administrator during a recent resident council meeting but nothing had been done about the heat in the shower room. -It would be nice to have heat in the shower room, the last few days it had been cold when getting in and out of the shower. -It had been a while since there had heat in the shower room. -The last few days the shower room had been cold when showering. -Recently it had been too cold to shower in the	D 105		

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D 105	Continued From page 1	D 105		

early morning and the resident had to wait until later in the day when the shower room was not as cold, the resident preferred early morning showers.

Observation of the women's shower room on 01/22/20 at 8:40am revealed:
-There was a heater in the right wall of the shower room.
-The heater was cold when touched.
-There were no knobs or buttons visible to turn the heater on or off.
-A thermometer was placed on a shelf in the shower room at 8:45am.

Observation of the thermometer on 01/22/20 at 9:30am revealed the temperature to be 65.7 degrees Fahrenheit (F).

Interview with the Maintenance Staff on 01/22/20 at 9:30am revealed:
-He was not aware the heater was not working in the women's shower room.
-There had not been any previous problems with the heater.
-He would check the heater and try to repair the heater if necessary.

A second interview with the Maintenance Staff on 01/23/20 at 10:05am revealed:
-The heater was not working.
-He had notified the Administrator and she was going to contact the owner.

Interview with the Administrator on 01/22/20 at 10:10am revealed:
-She had contacted the owner about a month or so ago when she was notified by the local department of social services worker that residents had mentioned the heater needed to be

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D 105	Continued From page 2 checked. -The owner was supposed to contact a repairman at that time to come and check the heater. -There had not been any reports from residents concerning the shower room being too cold. Interview with two Personal Care Aides on 01/22/20 at 1:30pm revealed: -Neither had noticed the women's shower room being cold when assisting with showers. -No one had complained to either of them about being cold. -They were not aware the heater was not working in the women's shower room. Observation of the women's shower room on 01/22/20 at 3:40pm revealed a new heater had been installed. Observation of the women's shower room on 01/23/20 at 8:35am revealed: -The heater was turned on in the women's shower room. -The room was very warm.	D 105		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.	D 131		

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D 131	Continued From page 3 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) was tested upon hire for tuberculosis (TB) disease. The findings are: Review of Staff C's, Housekeeper/Maintenance, personnel record revealed: -Staff C was hired on 09/13/19. -Staff C was hired as an independent contractor. -There was no documentation of TB skin testing. Interview with the Business Office Manager on 01/23/20 at 9:50am revealed: -Staff C was a contracted employee who performed housekeeping and maintenance duties in the facility. -Staff C routinely worked four days a week in the facility. -TB skin testing had not been performed for Staff C upon hire because he was a "contracted" employee. Interview with Staff C, Housekeeper/Maintenance, on 01/23/20 at 10:10am revealed: -He had worked in the facility since September 2019 in housekeeping and maintenance. -He was hired as an independent contractor and was not an employee of the facility. -He routinely worked in the facility Monday through Friday 8:00am to 4:30pm. -He had not received a TB skin test upon hire nor did he remember ever having had a TB skin test. Interview with the Executive Director on 01/23/20 at 10:14am revealed:	D 131		

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D 131	Continued From page 4 -They had recently completed an audit of all of their personnel records on 01/20/20. -Staff C was hired as an independent contractor in September 2019. -She was unaware independent contractors were required to have TB skin testing. -The Business Office Manager was responsible for maintaining the personnel files.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 12/09/19 as a Personal Care Aide (PCA) and a Medication Aide (MA). -There was no documentation of a HCPR check in Staff B's personnel record. Interview with the Administrator on 01/23/20 at 10:05am revealed:	D 137		

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D 137	Continued From page 5 -The Business Office Manager (BOM) was primarily responsible for ensuring all qualifications for staff were met. -She thought she had seen the new HCPR for Staff B but could not locate the verification. -She had completed a HCPR but could not locate it. Interview with the BOM on 01/23/20 at 10:15am revealed: -She had been trying to get personnel files organized. -She had not run a HCPR on Staff C. -Staff B was a rehire and the Administrator had actually rehired Staff B while she (BOM) was out on leave. Review of the HCPR for Staff B dated 02/23/20 revealed there were no substantiated findings listed.	D 137		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to implement an activity program that	D 315		

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promoted the active involvement of the residents.

The findings are:

Interviews with 16 residents during the initial tour on 01/22/20 from 8:50am to 10:00am revealed:
-The facility offered activities "sometimes."
-Bowling was an example of an activity "sometimes" offered at the facility.
-The only activity offered by the facility was bingo on Friday nights.
-Activities posted on the calendar were not conducted.
-The residents would like something other than to play bingo.
-The residents would watched TV, color, and talk to other residents to pass the time.
-The residents went shopping if they had money.
-There were not enough activities.
-The residents would sometimes we get their nails painted.
-Residents had not been asked what kind of activities they would like.

Review of the January 2020 activity calendar on 01/22/20 at 10:53am revealed:
-It was on a white board posted on a wall beside the dining room.
-The scheduled activity for 01/22/20 was singing from 10:00am to 12:00pm.

Observation of the facility on 01/22/20 from 10:00am to 12:00pm revealed no singing activity or any other activity occurred.

Interview with the Resident Care Coordinator on 01/23/20 at 8:36am revealed:
-She did not know if there was a dedicated staff for activities.
-She knew the residents played bingo on Fridays

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D 315	Continued From page 7 during second shift. -The facility offered nail painting, coloring, movies, and pet therapy for the residents. -She did not know why the scheduled activity had not occurred on 01/22/20. Interview with the Housekeeper/Maintenance Staff on 01/23/20 at 8:42am revealed: -He had been working in the facility for about three months. -He had seen the residents bowling and playing a "corn hole" game in the afternoons. -He had only seen the activities "a couple of times" since he had been in the facility. Interview with the Executive Director on 01/23/20 at 8:46am revealed: -The Activity Director had resigned two months ago and had not been replaced. -She was responsible for completing the activity calendar. -The residents played bingo and went shopping on Fridays and watched movies on Saturdays. -Pet therapy was offered on Thursdays. -The singers that had been scheduled for 01/22/20 had called in sick.	D 315		
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.	D 358		

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D 358	Continued From page 8 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 5 sampled residents (Resident #1) related to an order for an antibiotic and a steroid. The findings are: Review of Resident #1's current FL-2 dated 09/19/19 revealed diagnoses included schizoaffective disorder and schizophrenia. Interview with Resident #1 on 01/22/20 at 8:58am revealed: -She was having shortness of breath on 01/18/20 and went to the Emergency Room (ER) from the facility. -The ER physician told her she would be prescribed medication to treat her breathing problems. -She returned to the facility in the early morning on 01/19/20. -She had not started the medication to help her breathe better and she did not know why. -She had been feeling worse in the last day or two and she was worried she would have to go back to the ER. -She had asked one of the nursing staff why she had not started her breathing medication on 01/21/20 and was told that it had been ordered from the wrong pharmacy. Review of Resident #1's resident record revealed: -Resident #1 had an ER visit on 01/18/20. -Resident #1 returned to the facility in the early	D 358		

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morning of 01/19/20.
-She was seen in the ER for a "COPD (Chronic Obstructive Pulmonary Disease) exacerbation" as detailed in her discharge summary.
-Two new medications, doxycycline and prednisone, were listed on her discharge paperwork from the hospital.
-Doxycycline was classified as an antibiotic to be taken as one capsule twice a day for seven days to help treat or prevent infections.
-Prednisone was classified as a steroid to be taken as two tablets once a day for four days to help with inflammation and swelling.

Review of Resident #1's Medication Administration Record (MAR) for January 2020 revealed the doxycycline and prednisone were not listed.

Observation of Resident #1's medication on hand on 01/22/30 revealed the doxycycline and prednisone was not available for administration.

Interview with a Pharmacist from the facility's contracted pharmacy on 01/22/20 at 3:03pm revealed:
-They had not received the prescription for the doxycycline or the prednisone prior to this afternoon when it was received by fax.
-The hospital usually sent the prescriptions to the pharmacy, but the facility was also responsible to verify the right pharmacy was sent the prescription.

Interview with the Medication Aide (MA) on 01/22/20 at 3:30pm revealed:
-Whoever the MA was on shift when someone returned from the hospital was responsible to fax any paperwork with prescriptions to the pharmacy.

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-When she came to work on 01/20/20 she saw the discharge paperwork with prescription information for Resident #1 and realized it had been faxed from the hospital to a pharmacy that was not the facility's contracted pharmacy.
-She recognized this was the wrong pharmacy and then faxed the paperwork to the facility's contracted pharmacy.
-She did not remember getting a confirmation that the fax was received and she did not follow up with a phone call to the facility's contracted pharmacy.

Interview with Resident #1's Nurse Practitioner on 01/22/20 at 4:05pm revealed:
-Without the medications prescribed for her COPD exacerbation, her symptoms would continue and the original problem causing her ER visit would not be corrected.
-She would be at risk for a rehospitalization due to respiratory failure.

Interview with a second MA on 01/23/20 at 9:34am revealed:
-He was on duty when Resident #1 returned from the hospital on 01/19/20.
-He faxed the paperwork to the facility's contracted pharmacy with the new prescriptions to be started for Resident #1.
-Medications usually were delivered to the facility within 24 hours.
-He did not get a confirmation that the pharmacy had received the paperwork.
-He did not follow up with the pharmacy by phone to verify the prescription information had been received.
-He passed on the discharge paperwork to the other MA when his shift ended on 01/19/20.

Interview with the Executive Director on 01/23/20

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D 358	Continued From page 11 at 9:45am revealed: -She was not aware the medication for Resident #1 was not available. -When a resident returned from the hospital the MA on duty was expected to fax any new orders to the pharmacy. -She would have expected the Resident Care Coordinator or the MA to follow up with the pharmacy to ensure the prescription information was received. -There was no follow up with the pharmacy to verify they had received the new medication orders for Resident #1 after her ER discharge on 01/19/19. The facility failed to administer medications as ordered to 1 of 5 sampled residents related to not administering doxycycline and prednisone and to treat an exacerbation of COPD diagnosed in the ER for Resident #1. This failure resulted in Resident #1 feeling worse and fearing she might have to return to the ER and increased her risk for rehospitalization for respiratory failure. This failure was detrimental to the health and welfare of Resident #1 and constitutes a Type B Violation. A Plan of Protection was requested from the facility in accordance with G.S. 131 D-34 on 01/22/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEEC MARCH 8, 2020.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912		

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D912	Continued From page 12 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration. The findings are: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 5 sampled residents (Resident #1) related to an order for an antibiotic and a steroid. [Refer to Tag 0358, 10A 13F .1004(a) Medication Administration (Type B Violation).]	D912		