# Adult Care Home Corrective Action Report (CAR)

**I.** Facility Name: Soundview II #4
Address: 30 Smith Graveyard Rd. Asheville, NC 28806
County: Buncombe
License Number: FCL011381

**II.** Date(s) of Visit(s): 08/01/2024
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 09/29/2024

**Instructions to the Provider *(please read carefully)*:**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

| **III (a). Non-Compliance Identified**<br>*For each citation/violation cited, document the following four components:*<br>• *Rule/Statute violated (rule/statute number cited)*<br>• *Rule/Statutory Reference (text of the rule/statute cited)*<br>• *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation*<br>• *Findings of non-compliance* | **III (b). Facility plans to correct/prevent**:<br>*(Each Corrective Action should be cross-referenced to the appropriate citation/violation)* | **III (c). Date plan to be completed** |
|---|---|---|
| Rule/Statute Number: 13G.0901(b) PERSONAL CARE AND SUPERVISION<br>Rule/Statutory Reference:<br>Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br>Level of Non-Compliance: A1 Violation<br>The findings are:<br><br>Based on observations, interviews, and record reviews the facility failed to ensure 1 of 1 sampled resident (#1) was not smoking while wearing oxygen, resulting in a facility fire and injury to the resident (#1).<br><br>Observation of the facility on 08/01/24 at 10:00am revealed:<br>-There were large burn marks on the ground by the side door.<br>-There were large burn marks noted on the side door threshold of the facility.<br>-There were large burn marks about two feet long in the hallway of the facility.<br><br>Review of Resident #1's current FL2 dated 01/18/24 revealed:<br>-Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, depression, shoulder pain, posttraumatic stress disorder (PTSD), mobility impairment, and osteoporosis.<br>-She was ambulatory and utilized a walker.<br>-She was ordered 1 liter of oxygen continuously via nasal cannula.<br>-She was admitted to the facility on 1/17/24.<br><br>Review of Licensed Health Professional Support task form dated | ☒ POC Accepted ERW<br>*DSS Initials* | |

07/23/24 revealed staff competency in oxygen administration and monitoring.

Review of Resident #1's record on 08/01/24 revealed there was no care plan.

Review of facility Tobacco Use Policy dated 01/18/24 revealed:
-Resident #1 signed off on the policy as read in her admission packet.
-The policy included rule that "residents may only smoke outdoors."
- "Smoking in all other areas will be a violation of the policy and will result in immediate discharge notice."
- "When on the grounds of the facility all tobacco products must be disposed of in the proper receptable."
- "Tobacco use of any kind is not permitted in any facility vehicle nor is it permitted in gazeboes or surrounding garden areas. "

Review of the local Fire Marshal's report dated 7/10/24 revealed:
-Resident #1 was sitting outside of an exterior doorway smoking a cigarette while using oxygen via nasal cannula.
-There were no facility staff present while resident was smoking outside.
-The lit cigarette caused the oxygen to ignite, burning the oxygen tubing.
-Evacuation of facility residents and staff appeared to have been complete upon arrival.
-Emergency medical services (EMS) gave aid to Resident #1, for complaint of burn to right finger.
-Resident #1 was not using her oxygen when EMS arrived.
-Resident #1's oxygen saturation was 60% (normal range is 95-100% for a healthy person).
-Resident #1 was placed on oxygen at 4 liters via nasal cannula and her oxygen quickly rose to 95%.
-Resident #1 was transported to the hospital for further treatment.

Review of pictures of the scene provided by the Fire Marshal dated 07/10/24 revealed:
-Resident #1's walker was observed with dark scorch marks surrounding it on the ground.
-Parts of the oxygen tubing were present, and some of the tubing was burned.
-A cigarette butt was observed on the ground next to the scorch marks from the tubing.
-The threshold of the side entrance had a wide burn mark extended through the doorway.
-The burn mark was about two feet into the facility.

Interview with Resident #1 on 08/01/24 at 12:45pm revealed:
-She had smoked while using her oxygen on multiple occasions.
-The Administrator told her to put the tubing on the side of her walker.
-She did not think he had ever told her to turn her oxygen concentrator off while she was smoking.
- "After the fire started, I got up and went inside without telling anybody."

-She had burns on her hands, but no burns on her face.
-The Administrator knew she smoked while using her oxygen, "he told me if he caught me again, he would kick me out."
-She does not recall being checked on by the staff while she was outside smoking.

Interview with a resident on 08/01/24 at 10:45am revealed:
-She had observed Resident #1 smoking while using her oxygen concentrator on multiple occasions.
-She had asked Resident #1 not to smoke with her oxygen on in the past.
-She had informed the staff and Administrator Resident #1 was observed smoking with her oxygen on.

Interview with a second resident on 08/01/24 at 10:16am revealed:
-Resident #1 smoked outside while using her oxygen "all the time."
-He asked the resident to stop smoking with her oxygen on and she refused.
-The staff tried to intervene, but the resident ignored them too.
-He did not want Resident #1 to return as to the facility from the hospital, "it's not safe with her here."

Interview with a third resident on 08/01/24 at 11:00am revealed:
-He had observed Resident #1 smoking while using her oxygen once.
-He was unsure if staff knew she smoked while using her oxygen.

Interview with the Supervisor-in-Charge (SIC) on 08/01/24 at 11:10am revealed:
-Resident #1 should have turned off the oxygen concentrator, left it in her room, and removed the cannula before smoking.
-She had spoken with the resident almost every day since Resident #1 was admitted in January regarding smoking outside with the oxygen on.
-She had informed the Administrator the resident had been smoking with the oxygen on multiple occasions since January.
-She had informed the Administrator about the most recent incident on 07/28/24.
-The Administrator came to the facility and spoke with Resident #1 to remind her of the rules regarding smoking.
-There were no additional safety precautions put in place.
-After the fire started, the resident ran into the house and didn't tell anyone.
-She was not asked by the Administrator to provide any extra supervision to Resident #1.

Interview with the Administrator on 08/01/24 at 1:40pm revealed:
-Resident #1 was observed by staff to be smoking while using oxygen when she moved into the facility.
-He told Resident #1 smoking while using oxygen was unsafe, and to stop smoking with oxygen multiple times including the last time on 07/28/24.
-He decided to give Resident #1 another chance to stop smoking while using oxygen.
-The facility did not initiate any additional checks or measures for

| | | |
|---|---|---|
| Resident #1 to prevent further smoking while using oxygen.<br><br>The facility failed to ensure a resident was not smoking while wearing oxygen. The facility's failure resulted in serious injury to resident who sustained burns to her hands when using oxygen while smoking which constitutes a Type A1 violation.<br><br>The facility provided a plan of protection in accordance with G.S. 111D-14 on 08/01/24 for this violation.<br><br>DATE OF CORRECTION FOR THE A1 VIOLATION SHALL NOT EXCEED 10/29/2024 | | |

| | | |
|---|---|---|
| **IV. Delivered Via:** Email | **Certified Mail #:** | Date: 11/07/2024 |
| **DSS Signature:** Emily R. Weinstein | | Return to DSS By: 12/03/2024 |

| | |
|---|---|
| **V. CAR Received by:** | Administrator/Designee (print name): Jose Ortiz |
| | Signature: Date: |
| | Title: Administrator |

| | |
|---|---|
| **VI. Plan of Correction Submitted by:** | Administrator (print name): Jose Ortiz |
| | Signature: Date: 12/03/2024 |

**VII. Agency's Review of Facility's Plan of Correction (POC)**

| | | |
|---|---|---|
| ☐ ***POC Not Accepted*** | By: | Date: |
| Comments: | | |
| ☒ ***POC Accepted*** | By: Emily R. Weinstein | Date: 12/03/2024 |
| Comments: | | |

| | | |
|---|---|---|
| **VIII. Agency's Follow-Up** | By: Emily R. Weinstein | Date: 12/04/2024 |
| | Facility in Compliance: ☒ Yes ☐ No | Date Sent to ACLS: 12/23/2024 |
| Comments: | | |

** For follow-up to CAR, attach Monitoring Report showing facility in compliance.*