Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPL	
		HAL011262	B. WING		R-	-C <b>24/2019</b>
NAME OF D			DDDEEC CITY CTATE	7/10 0005	1 0172	
NAME OF PI	ROVIDER OR SUPPLIER		IDDRESS, CITY, STATE NTAIN BROOK RO			
CHUNN'S	COVE ASSISTED LIVING	3	LLE, 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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
{D 000}	00) Initial Comments		{D 000}			
	The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow-up survey on 07/23/19 to 07/24/19.					
{D 271}	{D 271} 10A NCAC 13F .0901(c) Personal Care and Supervision  10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.		{D 271}			
	This Rule is not met FOLLOW UP TO TYP Based on these findir Violation was not aba	PE B VIOLATION. ng, the previous Type B				
	reviews, the facility fa related to care and in	ns, interviews, and record hiled to respond appropriately tervention for 1 of 4 sampled (3) who fell and sustained a				
	The findings are:					
	04/04/19 revealed: -Diagnoses included disorder, anxiety, psy	3's current FL2 dated vascular dementia, mood rchosis, and osteoporosis. abulatory and constantly				

disoriented.

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-	С
		HAL011262	B. WING		07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHIINNIS	COVE ASSISTED LIVING	67 MOUNT	AIN BROOK R	OAD		
CHONING	COVE ASSISTED LIVING	ASHEVILL	E, NC 28805			
(X4) ID PREFIX TAG	(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 271}	Continued From page	e 1	{D 271}			
	hallway.  -The resident had a b started at the corner of upwards towards her.  -The skin was yellow of blue and purple at linterview with Reside revealed she did not bruising to her eye and Interview with a perso 07/23/19 at 3:25pm re.  -She found Resident living room on 07/19/-She assisted Reside noticed that she had at that was not present a she reported to the reported to the resident #3 had falle.  Review of the Inciden 07/19/19 at 2:00pm for Resident #3 was lyin room and "stated she -The incident was rep. The name of physicial blank.  -The first aid administ -The person involved section was blank.	anding against the wall in the baseball sized bruise that of her left eye and extended left eyebrow and forehead. colored with a small amount the corner of the left eye.  Int #3 on 07/23/19 at 3:10pm know how she obtained and forehead.  In a loar aide (PCA) on evealed:  #3 lying on the floor in the 19 around 2:00pm.  Int #3 with standing and a "pump knot" on her head at the beginning of her shift. In medication aide (MA) that in and hit her head.  Int/Accident Report dated or Resident #3 revealed:  Ing on the floor in the living if ell".  In orted to the MA.  In an notified section was blank.  In the location of injury as an income and extended of the hospital of the location of injury as an income and extended of the location of injury as an income and extended of the location of injury as an income and extended of the location of injury as an income and extended of the location of injury as an income and extended of the location of injury as an income and extended of the location of injury as an income and extended of the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the location of injury as an income and extended or left with the le				

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 2 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED
					R-C
		HAL011262	B. WING		07/24/2019
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CHIINN'S (	COVE ASSISTED LIVING	67 MOUNT	AIN BROOK R	OAD	
OHOMA	SOVE AGGIOTED LIVING	ASHEVILL	E, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 271}	Continued From page	2	{D 271}		
	Telephone interview v 1:39pm revealed: -The PCA reported to fallen on 07/18/19She did not notify the Resident #3 had falleThe facility did provio procedures for falls di -"I don't know how sh so I didn't call" the PC send Resident #3 to t  Interview with the PC. 8:52am revealed: -She was not at the fa fallenResident #3 falls "qu -The MA should have notified the family and (PCP) that Resident #  Interview with the Adr 10:30am revealed: -The policy and proce falls was to notify the the resident had faller would be taken and re provider would recom resident to the hospita would follow up the ne assess the resident th -He had initiated an h the facility staff that ca to do "if a resident had -The medication aide contacting the physici do for a resident with contact the family.	her that Resident #3 had e provider or family that n. de the policies and uring her orientation. e got the knot on her head CP or for an ambulance to he hospital for evaluation.  A Supervisor on 07/24/19 at acility when Resident #3 had ite a bit or walks into stuff". reported the fall to her and d primary care provider #3 had fallen.  ministrator on 07/24/19 at edure of the facility regarding family and the provider that n. A current set of vital signs eported to the provider. The imend whether to send the fall to be evaluated or they ext day at the facility and hat had fallen.  ourly rounding schedule for contained instructions of what is fallen (found on floor)". on duty was responsible for fan first to determine what to a fall incident, and then to	{D 2/1}		

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 3 of 24

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILDING.		R-C
		HAL011262	B. WING		07/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHUNN'S	COVE ASSISTED LIVING	}	AIN BROOK R	OAD	
	CLIMMADV CT		E, NC 28805	PROVIDER'S PLAN OF CORRECTION	N are
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 271}	Continued From page	2 3	{D 271}		
	11:20am revealed: -The person that finds was responsible for fi -The policy and proces was for the PCA to re -The MA would assess if they needed to be substituted in the process of they needed to be substituted in the process of they needed to be substituted in the process of they needed to be substituted in the process of they needed to be substituted in the process of they needed to responsible for the process of the pro	the physician and family.  we definitely send them r evaluation.  with Resident #3's Nurse 17/24/19 at 1:26pm revealed: at the time of the fall #3. esident #3 had fallen and ry. he health care provider on esident #3's fall. by on 07/22/19 but did not was not notified by staff have been sent to the led for a fall with a head  sident Care Coordinator at 2:10pm revealed: 7/18/19.			
	-"The whole situation for Resident #3.	was not handled correctly"			
	Telephone Interview v	with Resident #3's family			

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 4 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R-0	c
		HAL011262	B. WING		07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	ì	AIN BROOK R	OAD		
044) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	E, NC 28805	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 271}	Continued From page	2 4	{D 271}			
	and noticed the bruisi faceShe did not know tha 07/18/19She did not know if F evaluated by the PCF	dent #3 over the weekending to Resident #3's eye and at Resident #3 had fallen on Resident #3 had been builting.				
	to provide care and in facility's policies and accident involving a resustained a head injustified health, safety, and we constitutes a Type B.	ry was detrimental to the elfare of the resident and Violation.				
	this violation.					
D 418	10A NCAC 13F .1103 Or Payee	(c) Legal IRepresentative	D 418			
	10A NCAC 13F .1103 Payee	Legal Representative Or				
		shall give the resident's proper receipts for any ehalf of the resident				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 5 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		D (	`
		HAL011262	B. WING		R-0 <b>07/2</b> 4	I/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	}	AIN BROOK R	OAD		
		ASHEVILL	E, NC 28805			
(X4) ID PREFIX TAG	(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 418	Continued From page	e 5	D 418			
	Based on interviews and record reviews, the facility failed to provide the payee a receipt for any monies received for 1 of 1 sampled resident who was his own payee (Resident #5).					
	The findings are:					
	revealed a diagnoses	5's FL2 dated 03/11/19 of vascular dementia and of the nervous system.				
	degenerative disease of the nervous system.  Review of Resident #5's record revealed: -A document titled "Resident Financial Information" dated 03/28/18The resident was his own responsible partyThe monthly room and board rate was \$1182.00 -A document titled "Funds Deposit Agreement" dated 03/28/18Resident #5 gave the facility permission to receive his Special Assistance (SA) funds, with no amount documented, toward his monthly room and boardThe Social Security box was checked with a hand-written note beside it that read "Resident would like to pay his own SS/Rent".					
	the facility's contracted: 1:25pm revealed: -Resident #5 had and \$334.60The pharmacy had not from the facility on Resident.					
	revealed: -He paid his own roor lady in the office".	nt #5 on 07/23/19 at 9:25am  m and board in cash "to that  the facility took him to the				

Division of Health Service Regulation

bank so he could withdraw his room and board

STATE FORM 6899 HBOG13 If continuation sheet 6 of 24

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D.C.
			B. WING		R-C
		HAL011262	B. WING	<del></del>	07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		67 MOUNT	AIN BROOK R	OAD	
CHUNN'S	COVE ASSISTED LIVING	}	E, NC 28805	OAD	
			L, NC 20003		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(/
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG			IAG	DEFICIENCY)	
D 418	Continued From page	e 6	D 418		
	money.				
	•	ld him last week that "he			
		and dollars in past rent".			
	•	•			
		nd where that bill came from			
		paying room and board			
	every month.				
		orried because he did not			
		d he did not know how he			
		pay "that much money"			
	back to the facility.				
	•	receipts for his room and			
	board payments prior	to May 2019.			
	Interview with Reside	nt #5 on 07/23/19 at 3:45pm			
	revealed:				
	-Staff took him to the	bank last week.			
	-He paid his room and	d board in cash when he			
	when he returned from	m the bank.			
	-He gave his money t	o "the lady in the office".			
		d him to give all the money			
		as he owed back room and			
	board money.				
	•	p his personal funds of			
	\$66.00 in July 2019.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	•	ıst started giving him a			
	receipt a few months				
	•	his possession dated May			
	2019 and July 2019.	This possession dated May			
	2019 and July 2019.				
	Review of a receipt d	ated 05/14/19 provided by			
		the facility had received a			
		esident #5 in the amount of			
	• •				
	\$821.00 for his" May	ieiit.			
	Davious of a receipt -	atad 07/17/10 presided by			
		ated 07/17/19 provided by			
		the facility received a cash			
		ent #5 in the amount of			
	\$887.00 for "rent".				
			1		

Division of Health Service Regulation

Review of a local bank receipt dated 05/14/19

STATE FORM 6899 HBOG13 If continuation sheet 7 of 24

Division of Health Service Regulation						
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
						_
		1141 044000	B. WING		R-(	
		HAL011262			0/12	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	ΓΕ, ZIP CODE		
		67 MOUN	ITAIN BROOK RO	OAD		
CHUNN'S	COVE ASSISTED LIVING	G	LE, NC 28805			
(Y4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	<u></u>	~E)
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	<u> </u>			DEFICIENCY)		
D 418	Continued From page	2 7	D 418			
5						
	provided by the reside					
		0 and a remaining balance of				
	\$193.90.					
	l					
	Interview with Reside	ant #5 on 07/24/19 at				
	10:07am revealed:	-1				
	-He only had one ban					
	-He had never receive	•				
	months ago".	giving him one a "few				
	_	istrator "always" told him the				
		istrator "always" told him the " and could never give him a				
	-	and could never give min a				
	receipt.	giving him his \$66.00 since				
		ator told him last week that				
	he "owed rent".	ALOI LOIG HIIII IASL WEEK HIAL				
	lle owed icht.					
	Interview with a Perse	onal Care Aide Supervisor				
	on 07/24/19 at 8:50ar					
		to the bank monthly.				
		usually" withdrawal his whole				
	check.					
	Resident #5 would p	pay his "rent" in cash to the				
	previous Administrato	-				
	-Resident #5 would g	ive all the money he				
	received from cashing	g his check, except for the				
	\$66.00.					
		ything about an outstanding				
	room and board balar					
		involved with the financial				
	aspect of the resident					
		ow much money he had in				
	the bank.					
	Interview with the Ad	ministrator on 07/22/40 of				
	3:05pm revealed:	ministrator on 07/23/19 at				
	1 -	ninistrator at the end of April				
	2019 or the first part of	The state of the s				
		ntly become Resident #5's				
ļ	, - The facility flad recei	Tilly become resident #3 3				

payee but had yet to receive any payments.

STATE FORM 6899 HBOG13 If continuation sheet 8 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			A. BOILDING		<sub></sub>	_
		HAL011262	B. WING		R- <b>07/2</b>	4/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	ì	ITAIN BROOK R	OAD		
		ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 418	Continued From page	e 8	D 418			
	-He did not have any 2019He had copies of 'Re-He had two different #5He did not have any Resident #5 prior to F-He had a copy of the Financial' Report.  Review of the July 20 report shows a begin \$1891.52 and two parin the amounts of \$29 in the corporate office balances monthly.	receipt books prior to May esident Trust Ledger' Sheets. ledger sheets for Resident financial records for february 2019. If July 2019 'Population  19 Population Financial pring balance due of fyments towards his account				
	-The receipt book sta -There were four rent Resident #5 ranging i through 07/17/19. -There were two rece Receipt #853417 writ #853418 written for \$ -Receipt #853418 for on it.	receipts written out for n date from 05/14/19 ipts written on 07/17/19; ten for \$891.00 and Receipt 887.00. \$887.00 had "error" written receipt #853417 for \$891.00				
	Review of Resident # Sheets revealed:	5's Resident Trust Ledger				

Division of Health Service Regulation

-There were two different ledger sheets.

STATE FORM 6899 HBOG13 If continuation sheet 9 of 24

	OF DEFICIENCIES		(V0) 1411 775	CONCEDUCTION	(V2) D.TT	LIDVEY.
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
, and I LAIV C	331112011314	.DERTH TO ATTOM NOWIDER.	A. BUILDING: _			
					R-	c l
		HAL011262	B. WING		I	4/2019
		111.12011202			0172	-4/2013
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		67 MOUN	TAIN BROOK R	OAD		
CHUNN'S	COVE ASSISTED LIVING	ASHEVILI	E, NC 28805			
040.15	STIMMADV ST		<del>,</del>	PROVIDER'S PLAN OF CORRECTION	1	0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 440	<del>-</del>	_	D 440			
D 418	Continued From page	9	D 418			
	-The first ledger shee	t had entries from 02/10/19				
	through 05/19.	t flad Charles from 62/10/15				
	•	heet started with an entry				
	•					
	dated 6/19 and ended	d with an entry dated 5/19.				
	D	51- F-h				
		5's February 2019 through				
		rust Ledger Sheet revealed:				
	•	et was dated 02/10/19.				
	-There was a \$1678.3	32 negative beginning				
	balance.					
		now where the beginning				
	negative balance carr					
	-There were nine entr	ries on this ledger sheet.				
	-Entry #5 in April 2019	9 showed a math error which				
	increased Resident #	5's debt by \$700.00.				
	-There was no docum	nentation that the math error				
	had ever been correc	ted.				
	-There was a May 20	19 payment entry, but it did				
	not show the amount.					
	Review of Resident #	5's June 2019 through May				
		Ledger Sheet revealed:				
		entries with a June 2019				
	•	July 2019 date and one				
	entry with a May 2019					
	•	arted 6/2019 and showed a				
	\$1821.52 negative be					
	_	ing balance did not match				
		f the previous ledger sheet.				
		ocumentation that the math				
	error had ever been o					
	•	and June 2019 indicated				
		s in the amounts of 18.01				
		to the previous dates.				
	•	entry for room and board, the				
	negative balance was					
	-The \$891.00 paymer	nt Resident #5 had made in				
	July 2019 had not bee	en credited to his account.				
	•		1			1

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 10 of 24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-	C
		HAL011262	B. WING		ı	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	ì	TAIN BROOK R	OAD		
		ASHEVILL	.E, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 418	Continued From page	e 10	D 418			
	for monies received for board resulting in a pubalance of \$3088.50. provide the resident vof his payments result of resident monies and upset and worried over board debt which was and welfare of the resident monies and welfare of the resident monies and welfare of the resident with the second monies and welfare of the resident monies and welfare of the resident monies.  The facility provided a accordance with G.S. this violation.  CORRECTION DATE VIOLATION SHALL No. 7, 2019.	131D-34 on 07/24/19 for FOR THE TYPE B IOT EXCEED SEPTEMBER				
D 421	10A NCAC 13F .1104 Resident's Personal F	Funds	D 421			
	Personal Funds (c) A record of each of the resident's personal Faragraph (b) of this resident, legal repressibly the resident, if not with two witnesses' silverifying the accuracy	transaction involving the use onal funds according to Rule shall be signed by the entative or payee or marked adjudicated incompetent, gnatures at least monthly of the disbursement of record shall be maintained as evidenced by:				

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 11 of 24

	or riealth Service Regu						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED	
AIND FLAIN	J. GOMMEGHON	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMPLI	_,_,	
					R-	С	
		HAL011262	B. WING	<del></del>	1	4/2019	
			I				
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
CHIINNIS	COVE ASSISTED LIVING	67 MOUN	ITAIN BROOK R	OAD			
CHONING	COVE ASSISTED LIVING	ASHEVIL	LE, NC 28805				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE	
				BEI IGIEROT)			
D 421	1 Continued From page 11		D 421				
		ns, interviews, and record					
		iled to ensure a record of					
	each transaction invo						
		nds was maintained and					
		t or legal representative at					
	least monthly verifying	-					
	disbursement of person						
	sampled residents (R	esident #1, #2, #5, and #6).					
	The findings are:						
		t #6's current FL2 dated					
		agnoses included dementia,					
	diabetes mellitus type	e II, hypertension, and					
	neuropathy.						
		nt #6 on 07/23/19 at 9:30am					
	revealed:						
	-He had lived at the fa						
		ing his personal funds					
	money.						
	_	and the remaining amount					
	went to pay his pharn	nacy co-pays.					
		nt #6 on 07/23/19 at 3:25pm					
	revealed:						
		oney at the last facility I					
	lived."						
		Administrator and she said I					
	owed \$5400.00 here.						
	- "Sometimes I get my						
		ed them where my money					
	was going."						
	- "I was given \$40.00						
		money this month in July."					
		were taking my money for					
	room, board and pres						
	- "They showed me a	prescription bill for \$14.00					
	and that was the last						

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 12 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
JUNE 1 EART OF GOTTLESTION IDEATH IONITION NO.		A. BUILDING: _	A. BUILDING:		TED	
					R-0	2
		HAL011262	B. WING		07/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
CLILININIO	COVE ACCIOTED I IVINI	67 MOUN	ITAIN BROOK R	OAD		
CHUNN 5	COVE ASSISTED LIVING	ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 421	Continued From page	e 12	D 421			
D 421	- "I sign my name whe- "I asked about this r was told that I got it." - "They told me, "your and I said "no I didn't - "I never get \$66.00." - "They take care of r - "I don't know where  Review of Resident # 07/24/19 revealed: - Resident #6 had che Resident's Personal I "I authorize the mana manage my entire pe account following pro accordance with licer - Resident #6 had sig Home Contract on 04 -The former Administr the Home Contract on Review of Resident # revealed: -There was a hand w for \$40.00 cash paid of \$5340.75 and sign -There was a hand w for \$40.00 cash paid of \$4141.75 and sign -There was a hand w for \$40.00 to the phale	en they give me money." month of July's money and r paper has been signed" sign it." " my money." my money is going."  6's Home Contract on ecked the 4th block under Funds Agreement showing, gement of (the facility) to rsonal spending funds cedures outlined in using rules." ned and dated the facility's /17/19. rator had signed and dated in 04/17/19. 6's Trust Ledger Sheet ritten entry dated 12/10/18 out, leaving a balance owed ed only by Resident #6. ritten entry dated 01/10/19 out, leaving a balance owed ed only by Resident #6. ritten entry dated 02/10/19 rmacy, leaving a balance	D 421			
	#6There was a hand w for \$40.00 cash paid of \$5302.75 and sign prior staff member.	d signed only by Resident  written entry dated 02/14/19 out, leaving a balance owed ed by Resident #6 and a  ritten entry dated 03/11/19				

Division of Health Service Regulation

for \$40.00 cash paid out, leaving a balance owed

STATE FORM 6899 HBOG13 If continuation sheet 13 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	COMPLETED
	5.0
D WING	R-C
HAL011262 B. WING	07/24/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CHUNN'S COVE ASSISTED LIVING 67 MOUNTAIN BROOK ROAD	
ASHEVILLE, NC 28805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE
SEL GENETY	
D 421 Continued From page 13 D 421	
of \$5241.75 and signed only by Resident #6.	
-There was a hand written entry dated 05/14/19	
for \$40.00 cash paid out, leaving the balance	
owed blank and signed only by Resident #6.	
-There were no entries for cash paid out in the	
months of February 2019, April 2019 or July 2019	
to Resident #6.	
-None of the payments made to the pharmacy in	
2019 for Resident #5 had been deducted from	
the balance owed to the facility.	
Telephone interview with a representative at the	
contracted facility pharmacy on 07/24/19 at	
1:25pm revealed:	
-The pharmacy began service for Resident #6 on	
04/17/18.	
-There had been no facility payments to the	
pharmacy for Resident #6 in 2018.	
-On 01/11/19, the facility made a \$5.00 payment	
to the pharmacy for Resident #6.	
-On 03/08/19, the facility made a \$40.00 payment	
to the pharmacy for Resident #6.	
-On 03/28/19, the facility made a \$61.00 payment	
to the pharmacy for Resident #6.	
-On 05/30/19, the facility made a \$5.00 payment	
to the pharmacy for Resident #6.	
-The current balance owed on Resident #6's	
account was \$3,403.57.	
Interview with the Administrator on 07/23/19 at	
3:00pm revealed:	
-Resident #6's admission date was 04/17/18.	
-A family member had been "doing the books for	
the last three months."	
-The family member had signed the Resident	
Trust Ledger Sheet for June and July 2019.	
-Resident #6's funds had gone directly to him until	
"I'm not sure of date."	
-Resident #6 had lived at another facility and "it	
took us three months to figure out the	

STATE FORM 6899 HBOG13 If continuation sheet 14 of 24

DIVISION	n nealth Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			_			_
				R-C		
		HAL011262	B. WING	<del></del>	07/2	4/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET ADI	ORESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN					
CHUNN'S	COVE ASSISTED LIVING	<b>3</b>	TAIN BROOK R	OAD		
		ASHEVILL	.E, NC 28805			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 421	Continued From page	<u>.</u> 14	D 421			I
J	Continued From page	, 14				I
	accounting."				ļ	1
	-"I don't know what wa	as happening with the last			ļ	1
	Administrator."				ļ	1
						I
	Interview with Adminis	strator on 07/24/19 at				I
	11:25am revealed:				ļ	1
	-"Unfortunately, we ov	wn several buildings and I				ı
	•	nanage their own records."				ı
		or didn't communicate these				I
	issues to him.	or didn't communicate these				1
		ents go three or four months				I
	without paying.	ents go timee or loar months				1
		do avery six months				I
	-He audited the record					I
	-	opriety did or didn't happen."				I
	-	for the Administrator to call				I
		tch over the payee within				I
		mission of new residents.				I
	-"We do have to docu					I
	reports at the corpora					I
		s sent from the corporate				I
		ce with the highlighted areas				I
	of residents having ur	npaid balances.				1
	-The local facilities we	ere responsible for follow up				I
	with the residents of t	he highlighted areas on the				I
	financial reports.					1
	-The facility had a dep	posit cover sheet every				1
	Friday that has itemiz	ed resident funds and which				I
	payor source the fund	ds come from.				ı
		t #1's current FL2 dated				1
	07/04/19 revealed:					ı
	-Diagnoses included	vascular dementia,				
		e heart failure, and atrial				I
	fibrillation.					
		ermittently disoriented.				
	THE RESIDENT WAS THE	ommeditiy disonemed.				
	Paview of Posidost #	1's Resident Register				
	signed 02/22/12 reveal					
	<ul> <li>The resident was add</li> </ul>	milled UZ/ZZ/TZ.	1			ı

blank.

Division of Health Service Regulation

-The responsible person section of the form was

STATE FORM 6899 HBOG13 If continuation sheet 15 of 24

AND DUAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011262	B. WING		R-C <b>07/24/2019</b>
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 01124/2019
		67 MOUNT.	AIN BROOK R		
CHUNN'S	COVE ASSISTED LIVING	ASHEVILLI	E, NC 28805		
(X4) ID PREFIX TAG	(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 421	Continued From page	e 15	D 421		
	·	with Resident #1 on 07/24/19 e to the resident being out of			
	02/22/12 revealed:	1's Home Contract signed be managed by the home,			
	resident, family, or re- -Personal funds giver	sponsible party.			
	by the residentPersonal funds will b	e managed by the			
	no other means are p				
		ent or responsible party. b. y transaction (receipts or rds will be signed by			
	resident. c. All or any	portion of funds will be legal guardian or his/her			
		business hours as long as			
	Review of a Resident Resident #1 revealed	Trust Ledger Sheet for :			
	starting on 01/10/19.	ng balance of \$248.64			
	each month from Jan	arged for room and board uary 2019-May 2019 in the			
		funds in the amount of n from January 2019-May			
	2019 for Resident #1.	-			
	~	ledger was dated 04/19/19			
		d an ending balance of \$0. dger dated "5/19, and 4/19"			
	were not signedResident #1 had not	signed the Resident Trust			

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 16 of 24

Division	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						0
			B. WING		R-	
		HAL011262	B. WING		07/2	24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
CHUNN'S	<b>COVE ASSISTED LIVING</b>	3	TAIN BROOK R	OAD		
		ASHEVIL	_E, NC 28805			1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGOLATORY ORT	EGO IDENTII TING INI GRAMATION)	TAG	DEFICIENCY)	WAI E	
			+			
D 421	Continued From page	e 16	D 421			
	Ladrar Chast					
	Ledger Sheet.					
	Daview of a second F	Desident Tweet Ladge Cheet				
		Resident Trust Ledger Sheet				
	revealed:	f 06/20/19 for Resident #1				
		a basississ balance of				
	_	e beginning balance of				
	\$27.93.	arged for room and board for				
		arged for room and board for				
	June 2019 and July 2					
	-	funds in the amount of				
	\$1203.60 in June 201					
		dated 04/19/19 for "Rx" in				
	the amount of \$21.60					
	-The last entry had no					
		mented as "credit wrong Rx				
		s documented in the deposit				
	_	for Resident #1 with no				
	ending balance.	dd-td-110/0040 4/4011				
		dger dated "6/2019, 4/19"				
	_	t dated were not signed.				
		signed the Resident Trust				
	Ledger Sheet.					
	D					
	_	s contracted pharmacy				
	account record for Re					
		e was documented as				
	\$797.02 for April 2019					
		ions in April 2019 were				
	documented as \$37.0	ions in May 2019 were				
	documented as \$73.4					
		ions in June 2019 were				
		18 with a payment of \$21.60.				
	documented as \$927	due in June 2019 was				
	uocumenteu as \$927	.40.				
	Intoniou with Admini	otrotor on 07/24/40 of				
		strator on 07/24/19 at				
	11:25am revealed:	um acuaral buildings and l				
		wn several buildings and I				
	uust each facility to m	nanage their own records."				

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 17 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D MINO		R-C
		HAL011262	B. WING		07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHUNN'S	COVE ASSISTED LIVING	67 MOUN	TAIN BROOK R	OAD	
		ASHEVIL	_E, NC 28805		
(X4) ID PREFIX TAG	(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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 421	Continued From page	e 17	D 421		
	-The past Administratissues to himHe wouldn't let reside without payingHe audited the recorder and the audited and the aud	ents go three or four months  ds every six months. opriety did or didn't happen." for the Administrator to call tch over the payee within mission of new residents. Iment on the financial Inte office." Is sent from the corporate It ewith the highlighted areas Inpaid balances. It ere responsible for follow up the highlighted areas on the Inposit cover sheet every ted resident funds and which tals come from.  It #2's current FL2 dated Ingnoses included chronic Ty disease, degenerative joint Threnia.  It is Resident Register In date of 09/03/04.  It is Home Contract dated The facility had been authorized			
	01/10/19 to 05/2019 r -There was an entry f 01/10/19 for \$20.00 a Resident #2.	_			

Division of Health Service Regulation

02/10/19 for \$20.00 and the entry was signed by

STATE FORM 6899 HBOG13 If continuation sheet 18 of 24

DIVISION	n nealth Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					D 0
			B. WING		R-C
		HAL011262	B. WING		07/24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		67 MOUN	TAIN BROOK R	OAD	
CHUNN'S	COVE ASSISTED LIVING	<b>3</b>	E, NC 28805		
	OLIMANA DV OT		<del>.</del>	DDO//DEDIO DI ANI OF CODDECTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
D 421	Continued From page	. 10	D 421		
D 421	Continued From page	: 10	D 421		
	Resident #2.				
	-There was an entry f	or a pharmacy payment on			
	03/06/19 for \$20.00 a	nd the entry was signed by			
	Resident #2.				
	-There was an entry f	or a pharmacy payment on			
	04/12/19 for \$10.00 a	nd the entry was signed by			
	Resident #2.				
	-There was an entry f	or a pharmacy payment on			
	04/2019 for \$81.00 w	hich was not signed by the			
	resident.				
	-There was an entry f	or a pharmacy payment on			
	05/2019 for \$24.31 w	hich was not signed by the			
	resident.				
		n 01/10/19 to 05/2019			
	totaled \$175.31.				
	Telephone interview v	vith a representative at the			
		narmacy on 07/24/19 at			
	1:25pm revealed:	lamacy on orre-ris at			
	•	had been received for			
	Resident #2 on 01/11				
		had been received for			
	Resident #2 on 03/08				
		had been received for			
	Resident #2 on 03/28				
	-A payment of \$20.00	had been received for			
	Resident #2 on 04/29				
	-A payment of \$10.00	had been received for			
	Resident #2 on 05/30	/19.			
	-A payment of \$182.0	0 had been received for			
	Resident #2 on 06/21	/19.			
	-The current balance	owed on Resident #2's			
	account was \$185.53				
	-The pharmacy did no	ot "cut anybody off" with their			
	medication supply as				
	insurance source pay	ing on the medications.			
		ministrator on 07/24/19 at			
	10:05am revealed:				

Division of Health Service Regulation

-Prior to May 2019, the previous Administrator

STATE FORM 6899 HBOG13 If continuation sheet 19 of 24

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
	A. BUILDING:					
		HAL011262	B. WING			R-C // <b>24/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		67 MOUI	NTAIN BROOK RO	AD		
CHUNN'S	COVE ASSISTED LIVING	ASHEVII	LLE, 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 ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 421	Continued From page	e 19	D 421			
	fundsPrior to May 2019, h financial records "abo -In May 2019, he and looking over the resid -Discrepancies had b the Trust Ledger She -They had not yet bed the Trust Ledger She corrections.	ging residents personal  e would audit the residents but every six months."  a family member began lents' Trust Ledger Sheets. een discovered in some of ets. en able to get through all of				
		#2 was not interviewable.				
	revealed a diagnoses	nt #5's FL2 dated 03/11/19 s of vascular dementia and e of the nervous system.				
	Interview with Reside revealed:	nt #5 on 07/23/19 at 9:25am				
	bank so he could with moneyThe Administrator to	the facility took him to the ndraw his room and board  Id him last week that "he				
	-He did not understar because he had beer every month.	and dollars in past rent".  nd how that was possible  n paying room and board				
	money and did not kr able to pay "that muc	se he did not have extra now how he would ever be h money" back to the facility. receipts for his room and to May 2019.				
	revealed: -Staff took him to the	ont #5 on 07/23/19 at 3:45pm bank last week. d board in cash when he				

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 20 of 24

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		,		R-(	c	
		HAL011262	B. WING		1	4/2019
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	ì	AIN BROOK R	OAD		
	CLIMMA DV CT		E, NC 28805	DROWDENIC DI ANI OF CODDECTION	.	
(X4) ID PREFIX TAG	(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 SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 421	Continued From page	20	D 421			
D 421	when he returned from the gave his money to the administrator took that he just withdrew aboard money.  He did not get to kee \$66.00 in July 2019.  The Administrator "jureceipt a few months the had 2 receipts in 2019 and July 2019.  Interview with Reside 10:07am revealed: He had never receive Administrator began of months ago".  The previous Administrator began of months ago".  The facility stopped of the current Administrator he "owed rent".  Interview with the Peron 07/24/19 at 8:50ar she took Resident #5 would previous Administrator he "esident #5 would greceived from cashing \$66.00.  She did not know any room and board balar she had never been	on the bank. on the lady in the office. d him to give all the money as he owed back room and ap his personal funds of list started giving him a lago. This possession dated May are are are a receipt until the lagiving him one a few lateral are always told him the land could never gave him last week that are always. The bank monthly lasually withdrawal his whole lay his "rent" in cash to the lar. The lateral are always to the lateral are always told him the last week that are always told him the last week that are always told him last week that are always told him last week that are always to the bank monthly lasually withdrawal his whole lay his "rent" in cash to the lar. The lateral are always told him the last week that are always to the bank monthly lasually withdrawal his whole lay his "rent" in cash to the lar. The lateral are always to the lateral are always	D 421			
	-She did not know and room and board balar	nce. involved with the financial				

Division of Health Service Regulation

Interview with the Administrator on 07/23/19 at

STATE FORM 6899 HBOG13 If continuation sheet 21 of 24

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7 50.25 10		R-C	
	HAL011262	B. WING		07/24/2019	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OUUNNIA OOME AOOMETED LIMING	67 MOUNTA	AIN BROOK R	OAD		
CHUNN'S COVE ASSISTED LIVING	ASHEVILLE	E, NC 28805			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 421 Continued From page	21	D 421			
3:05pm revealed: -He took over as Admii 2019 or the first part of The facility had recent payee but had yet to resolve the gave receipts to the payments they made, in the did not have any receiptsHe did not have any first ledger sheet they are was a \$1678.32 balanceThe ledger did not show any first ledger sheet they are was a \$1678.32 balanceThe ledger did not show any first ledger did not show and they are was a first ledger sheet they are nine entriesEntry #5 in April 2019 increased Resident #5 -There was no docume had ever been corrected. There was a May 201 not show the amount.  Review of Resident #5 2019 Resident Trust Lester was a May 2019 resident Trust Lester was a May 2019This ledger had four edate, one entry with a sentry with a May 2019This ledger sheet stare \$1821.52 negative beginning the ending balance of the There was no docume had ever been corrected.	nistrator at the end of April f May 2019. tly become Resident #5's eceive any payments. he residents for any including Resident #5. eceipt books prior to May inancial records for ebruary 2019.  It's February 2019 through ust Ledger Sheet revealed: was dated 02/10/19. It's negative beginning by where the beginning er from. He so not his ledger sheet. He showed a math error which he's debt by \$700.00. Hentation that the math error edd. He payment entry, but it did  It's May 2019 through July edger Sheet revealed: Horizontal not match the do/2019 and showed a ginning balance. He do/2019 and showed a ginning balance did not match the previous ledger sheet. He not match the math error that the math err	D 421			

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 22 of 24

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED
		_		
	HAL011262	B. WING		R-C <b>07/24/2019</b>
ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
00\/E 400 0TED    \/	67 MOUNT	AIN BROOK R	OAD	
COVE ASSISTED LIVING	ASHEVILLI	E, NC 28805		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
Continued From page	e 22	D 421		
-The \$891.00 payment Resident #5 had made in July 2019 had not been credited to his account.				
The facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and verification of the accuracy of disbursements of personal funds for 4 of 4 sampled residents (Resident #1, #2, #5, and #6) which resulted in the facility using residents' personal funds allowance to pay room and board debt and pay pharmacy bills without their consent and residents feeling upset because of their inability to decide how their personal funds were spent. This failure of the facility to provide residents access to their personal funds resulted in misappropriation of residents funds which was detrimental to the health and welfare of the residents and constitutes a Type B Violation.				
G.S. 131D-21(4) Dec	laration of Residents' Rights	D914		
Every resident shall h 4. To be free of menta	ave the following rights: al and physical abuse,			
	COVE ASSISTED LIVING  SUMMARY ST.  (EACH DEFICIENC' REGULATORY OR LE  Continued From page -The \$891.00 paymer July 2019 had not bee  The facility failed to e involving the use of p maintained in the faci accuracy of disburser 4 of 4 sampled reside and #6) which resulte residents' personal fu and board debt and p their consent and resi of their inability to dec funds were spent. Th provide residents acc resulted in misapprop which was detrimenta of the residents and of Violation.  The facility provided a accordance with G.S. this violation.  CORRECTION DATE VIOLATION SHALL N 7, 2019.  G.S. 131D-21(4) Dec  G.S. 131D-21 Declar Every resident shall h 4. To be free of menta	The \$891.00 payment Resident #5 had made in July 2019 had not been credited to his account.  The facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and verification of the accuracy of disbursements of personal funds for 4 of 4 sampled residents (Resident #1, #2, #5, and #6) which resulted in the facility using residents' personal funds allowance to pay room and board debt and pay pharmacy bills without their consent and residents feeling upset because of their inability to decide how their personal funds resulted in misappropriation of residents funds which was detrimental to the health and welfare of the residents and constitutes a Type B Violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/19 for this violation.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  ROVE ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22  The \$891.00 payment Resident #5 had made in July 2019 had not been credited to his account.  The facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and verification of the accuracy of disbursements of personal funds for 4 of 4 sampled residents (Resident #1, #2, #5, and #6) which resulted in the facility using residents' personal funds allowance to pay room and board debt and pay pharmacy bills without their consent and residents feeling upset because of their inability to decide how their personal funds were spent. This failure of the facility to provide residents access to their personal funds resulted in misappropriation of residents funds which was detrimental to the health and welfare of the residents and constitutes a Type B  Violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/19 for this violation.  CORRECTION DATE FOR THE TYPE B  VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2019.  G.S. 131D-21(4) Declaration of Residents' Rights  Every resident shall have the following rights:  4. To be free of mental and physical abuse,	ROVIDER OR SUPPLIER  THALO11262  STREET ADDRESS, CITY, STATE, ZIP CODE  67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805  SUMMARY STATEMENT OF DEFICIENCES  (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  COntinued From page 22  The \$891.00 payment Resident #5 had made in July 2019 had not been credited to his account.  The facility failed to ensure each transaction involving the use of personal funds was maintained in the facility using residents' personal funds will without their consent and residents feeling upset because of their inability to decide how their personal funds were spent. This failure of the facility to provide residents access to their personal funds resulted in misappropriation of residents funds which was detrimental to the health and welfare of the residents and constitutes a Type B Violation.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2019.  G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse,

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 23 of 24

PRINTED: 08/07/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HA	AL011262	B. WING		R-C <b>07/24/2019</b>
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
CHUNN'S COVE ASSISTED LIVING		AIN BROOK R E, NC 28805	OAD	
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE I TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
This Rule is not met as evider Based on observations, intervireviews, the facility failed to as were free of neglect and exploicompliance with federal and st and regulations related to Pers Supervision, Legal Payee, and Residents' Personal Funds.  The findings are:  1. Based on observations, interviews, the facility failed to reviews, the facility failed to reviews, the facility failed to reviews, the facility failed to review (Resident #3) who fe head injury.[Refer to Tag 271, .0901(c) Personal Care and St (Unabated Type B Violation)].  2. Based on interviews and refacility failed to provide the pay any monies received for 1 of 1 who was his own payee (Residang 418, 10A NCAC 13F .1103 Representative or Payee (Type 3. Based on interviews and refacility failed to ensure each trathe use of personal funds was facility and verification of the adisbursements of personal funds was facility and verification of the adisbursements of personal funds sampled residents (Resident # {Refer to Tag 421, 10A NCAC Accounting for Residents' Personal B Violation)].	ews and record sure residents itation in ate laws and rules conal Care and Accounting for erviews, and record spond appropriately in for 1 of 4 sampled ell and sustained a 10A NCAC 13F approvision cord reviews, the yee a receipt for sampled resident dent #5). [Refer to 8(c) Legal e B Violation)]. cord reviews, the ansaction involving maintained in the ccuracy of ds for 4 of 4 e1, #2, #5, and #6). 13F .1104(c)	D914		

Division of Health Service Regulation

STATE FORM 6899 HBOG13 If continuation sheet 24 of 24