STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	R 02/09/2023

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 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 completed an Annual, follow-up survey and a complaint investigation on 02/07/23, 02/08/23 and 02/09/23.	D 000	03/26/23	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of hazards related to an open container of pine oil cleaner and a bottle of hydrogen peroxide in an unlocked shower room on a locked unit with 14 residents with a diagnosis of dementia and improper storage of an oxygen canister. The findings are: 1. Observation of the common shower room in the locked unit on 02/07/23 at 9:44am revealed: -The door to the shower room was unlocked. -There was an open one gallon container of pine oil cleaner on the bottom shelf of a cart. -There was a 12 ounce bottle of hydrogen peroxide in an unlocked cabinet in the shower room.	D 079	① The facility staff will immediately store all open containers in lockable storage. ② The facility management will provide training to the staff of all open containers must be in lockable storage to be free of hazards. ③ The facility management will monitor weekly.	

Reviewed and acknowledged 3/17/23 rm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 079	Continued From page 1 Interview with the housekeeper on 02/07/23 at 9:46am revealed: -The door to the shower room should be locked. -The pine oil cleaner should have been in the locked janitorial closet. Interview with the MA on 02/07/23 at 9:48am revealed: -There were 14 residents in the locked unit all whom had a diagnosis of dementia. -Staff did not always lock the shower room door. -The pine oil cleaner should have been in the janitorial closet. Interview with the Resident Care Coordinator (RCC) on 02/07/23 at 12:02pm revealed: -All the residents in the locked unit had a diagnosis of dementia. -The pine oil cleaner should have been in the locked janitorial closet. -The hydrogen peroxide should not have been left in the shower room. -All staff had been trained on proper storage. Refer to the interview with the Regional Operations Manager (ROM) on 02/08/23 at 2:45pm. 2. Observation of the activity office on 02/08/23 at 12:39pm revealed there was one empty oxygen canister not secured in a container or transport stand. Interview with the Resident Care Coordinator (RCC) on 02/08/23 at 12:29pm revealed the oxygen canister was not supposed to be secured without a container or transport stand and she would remove it. Observation of a hallway in the locked unit on	D 079		

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D 079	Continued From page 2 02/08/23 at 12:53pm revealed an oxygen canister, next to medication cart, not secured in a container or transport stand. Interview with the RCC on 02/08/53 at 12:55pm revealed she had stopped to help a resident in the dining room and had placed the oxygen container on the floor. Refer to the interview with the ROM on 02/08/23 at 2:45pm. Interview with the ROM on 02/08/23 at 2:45pm revealed: -The items in the unlocked shower room should not have been there. -Staff had been trained not to leave cleaning agents or any medications in unlocked areas. -All oxygen canisters should be in secured in a container or transport stand.	D 079		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.	D 238	① The facility Administrator will immediately bring to the attention to RCC and staff that white out is not to be used on FL-2 or any other medical documents that you must strike through and initial with the advice or clarification from the doctor.	

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D 238	Continued From page 3 This Rule is not met as evidenced by: Based on observations and interview, the facility failed to clarify a diet order on the admission FL2 for 1 of 8 sampled residents (Resident #8). The findings are: Review of Resident #8's current FL2 dated 02/07/23 revealed: -Diagnoses included traumatic brain injury with behavioral disturbances, dementia and diabetes. -The area for nutrition status on the FL2 had white out covering the diet information. -There was no dietary information listed on the FL2. Review of the hospital discharge summary for Resident #8 dated 02/07/23 revealed discharge instructions included following a consistent carbohydrate, diabetic diet. Interview with the Resident Care Coordinator (RCC) on 02/07/23 at 4:32pm revealed the FL2 had been received from the hospital with white out covering the diet information. Telephone interview with the hospital Discharge Case Manager on 02/08/23 at 8:12am revealed: -They always keep a copy of discharge FL2 forms. -Resident #8's FL2 dated 02/07/23 had the nutritional status listed as diabetic. -They did not have or use white out at the hospital. -An FL2 would never be sent from the hospital with white out on it. Second review of Resident #8's current FL2	D 238	(2) The facility will get clarification and diet orders from MD for resident FL-2. (3) The RCC and/or Administrator will review all Admission documents and, if needed, contact physician for any clarifications on all admissions. 3/26/23	

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D 238	Continued From page 4 dated 02/07/23 on 02/08/23 at 9:15am revealed: -The nutrition status diet information where the white out had been now had writing on it. -The writing on the white out was "Con Carbs." Interview with the RCC on 02/08/23 at 9:30am revealed: -She had reviewed Resident #8's hospital discharge instructions and had written "Con Carbs" on the FL2. -She had not called the hospital to verify the diet order. Interview with Resident #8 on 02/08/23 at 10:33am revealed: -She had just received five vanilla wafers and Kool-Aid for a snack. -She did not know if she was on a special diet. Interview with the Dietary Manager (DM) on 02/08/23 at 10:43am revealed: -He had not received a diet order for Resident #8 yet. -Resident #8 was admitted to the facility yesterday at lunchtime. -He serves all new residents a regular diet until he receives the diet order. Telephone interview with Resident #8's Guardian on 02/08/23 at 11:16am revealed: -She had received the FL2 dated 02/07/23 from the hospital. -The nutrition status had diabetic listed beside the diet information -There was no evidence of white out on her copy of the FL2. -Resident #8 was on a diabetic diet at the previous facility where she lived.	D 238		

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D 238	Continued From page 5 Observation of Resident #8 during the lunch meal on 02/08/23 at 12:58pm revealed: -She was served a regular diet of meatballs and noodles with gravy, green beans, corn, cake, milk and water for her lunch meal. -She was observed feeding herself cake. -She did not eat any of her lunch meal except for cake. Interview with the DM on 02/09/23 at 8:55am revealed: -He had not received a diet order for Resident #8. -She had meals and snacks consistent with a regular diet before her discharge on 02/08/23. Interview with the Regional Operations Manager (ROM) on 02/09/23 at 9:44am revealed: -He was not sure where the white out came from on Resident #8's FL2. -The RCC told him on 02/08/23 that she had reviewed the hospital discharge instructions and had wrote over the FL2 "Con Carbs." -She should not have written on the FL2. -She should have clarified the diet order.	D 238		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION	D 270		

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D 270	Continued From page 6 Based on observations, record review, and interviews, the facility failed to provide supervision for a newly admitted resident (Resident #8) with a diagnosis of dementia, who attempted to elope from the facility. The findings are: Review of Resident #8's current FL2 dated 02/07/23 revealed: -Diagnoses included dementia and traumatic brain injury with behavioral disturbances. -There was no documentation of history of wandering or exit seeking behaviors. Observation of the outside front of the facility on 02/07/23 at 4:00pm revealed: -Surveyor heard someone yell out "help, help". -Resident #8 was in a ground level open window straddling the window with one leg outside the window and one leg inside the window. -The outside area was surrounded by an approximately 10 foot high fence. -Resident #8 appeared to be unable to get out of the window. -No staff were visible from the outside of the facility. -Resident #8 was wearing only a hospital gown, brief and non-grip socks. -Surveyor went into the facility and informed staff that Resident #8 was in the window. Interview with Resident #8 on 02/07/23 at 4:02pm revealed: -She was "trying to escape" from the facility. -She was a "runaway." Observation of medication aide (MA) and Regional Operations Manager (ROM) on	D 270	① The facility staff will immediately lock storage room doors. ② A storage Lock Check form will be implemented to monitor these areas each shift. ③ Elopement Risk Assessment and Reduction Policy will be revised and training for the facility staff will be implemented. ④ The RCC and Administrator will monitor daily. 03/26/23	

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D 270	Continued From page 7 02/07/23 at 4:04pm revealed: -The MA and ROM attempted to push Resident #8 back into the facility through the storage room window. -They were unable to assist her back inside through the storage room window, so they gave her assistance out the window onto the ground. -Once pulled through the storage room window by the MA and the ROM, Resident #8 was observed kneeling with one knee on the ground. -The MA asked Resident #8 to stand but Resident #8 stated that she could not stand. -The ROM attempted to lift Resident #8 under her arms to a standing position but could not do so. -A personal care aide (PCA) brought a wheelchair outside for Resident #8. -The MA and the ROM assisted Resident #8 by putting their arms under each of hers and lifted her into the wheelchair. -Resident #8 was assisted inside the facility via wheelchair by a PCA. Observation of the route from the common area to the storage room window on 02/07/23 at 4:05pm revealed: -There were 2 unlocked doors leading into a short hallway. -The hallway consisted on one storage room on each side of the hallway. -The storage room on the left side of the hallway was locked. -The storage room on the right side of the hallway was unlocked. -There was a locked via numeric code wall unit to access the exitway to the gated yard. -The exitway to the gated yard was locked. -The unlocked storage room on the right side of the hallway had a window inside the room with an easily opened latch.	D 270		

MONTH:

STORAGE LOCK CHECK

DAY OF MTH	SHIFT 1 (7A/7P)	SHIFT 2 (7P/7A)
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2		
3		
4		
5		
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INITIAL EACH BLOCK

Assisted Living Policy and Procedure

Subject/Title: **Elopement, Risk Reduction Strategies, and Management of Missing Residents**

I. POLICY GUIDELINES

The facility strives to promote resident safety and protect the rights and dignity of the residents.

The facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a coordinated resident search in the event of a missing resident.

II. DEFINITIONS

Elopement is the ability of a cognitively impaired resident, who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way.

Wandering refers to a cognitively impaired resident's ability to move about inside the facility aimlessly, but often with purpose and without an appreciation of personal safety needs and who may enter into a dangerous situation.

Elopers are differentiated from **wanderers** by their overt, and often repeated attempts to leave the facility and premises.

III. PROCEDURAL COMPONENTS

A. Assessment

1. The preadmission evaluation process includes a wandering and elopement history and whether the resident can be safely cared for at the facility
2. An elopement risk evaluation is completed on all residents on admission, and with a change in condition or mental status. The initial resident evaluation is conducted on admission and if not possible, then no later than eight hours from admission
3. A facility-approved risk evaluation tool (or scoring system) is utilized
    a. The evaluation is based on various risk factors that may precipitate an elopement event
    b. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts strategies, as described below
4. The risk evaluation and new resident observation addresses the resident's mobility and psychological, behavioral, physical, and cognitive functions. Specific risk factors include:
    a. An involuntary admission
    b. A history of wandering prior to admission or finding the resident "lost" in the facility after admission. Details of the wandering history may include when the wandering occurs, if more common during daytime or nighttime hours, the usual traffic pattern, if purposeful (e.g. need for food, toileting, exercise), if exit-seeking and other triggers such as pain, noise, and odors
    c. Problems noted in the resident's adjustment to the facility (such as stating a desire to go home, looking for children, attempting to attend functions that are based on a past schedule)
    d. Any cognitive impairment which results in an inability of the resident to appreciate safety risks and an inability to protect himself or herself
    e. A change in the resident's mental status

f. Interference with risk reduction strategies, including an expressed displeasure with a wander bracelet or an attempt to remove it
g. Behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive
h. Actual wandering behaviors, including:
    i. Shadowing (following staff or another resident)
    ii. Self-stimulatory (wandering due to boredom or lack of activity)
    iii. Akathisia (motor restlessness characterized by pacing, standing and sitting, or rocking back and forth, which may be caused by psychotropic and antidepressant medications)
    iv. Exit-seeking (the resident is intent on leaving the unit or facility, looking for exits, and hovering at exits waiting for the opportunity to leave with someone, or pushing on a door)

B. Risk Reduction Measures

1. Interventions that may be used for residents identified as high risk for elopement include:
    a. Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g., every one-half hour check)
    b. Room placement close to common areas such as the nurse's station and away from exits
    c. Promoting activities that are in full view of staff members
    d. Alternative activities to maintain the interest level of the wanderer
    e. Implementation of wander bracelet or other electronic alert systems
    f. Transfer to a more suitable or more secured unit/facility, if necessary
    g. Notification of physician for changes in behavior, such as increasing insistence or attempts to leave
    h. Environmental controls such as:
        i. The physical plant is secured to minimize the risk of elopement through:
            (a.) Functional alarm system for egresses and stairwells
            (b.) Interior courtyards
            (c.) Safety locks or keypad entry that restrict access to dangerous areas
            (d.) Restricted window openings to six inches to allow for ventilation but prevent resident exit
            (e.) Elevator controls
            (f.) Fenced perimeters
            (g.) Camouflaged doors and doorknobs
        ii. Adaptation of the environment with way-finding cues and landmarks
            (a.) Brightly lit, uncluttered paths with many rest areas (indoors/outdoors)
            (b.) Decorations that provide positive distractions and also act as deterrents
2. Additional resident and family involvement and education
3. Verification of control systems
    a. If an electronic surveillance system is in place, door alarms are tested weekly (at a minimum) for proper functioning and the testing is documented
    b. Door alarm codes are changed routinely
    c. Resident electronic monitoring sensors (e.g., bracelets/pendants) are checked every shift for placement and daily for proper functioning and documented in the Resident Record, Treatment Administration Record, Medication Administration Record, or a specifically designed log
    d. A sign-in/-out system is implemented, which requires responsible parties to sign the resident out when leaving and noting an expected return time
    e. Creation of a lost person profile for each resident at risk
        i. Three close-up photographs are taken of each resident on the day of admission
            (a.) The photographs are for identification purposes only

(b.) One photograph is maintained in the Resident Record and the other in his or her Medication Administration Record. A third photograph, with a description of the resident (e.g., height, weight, hair, and eye color), is maintained at the reception desk

(c.) Written consent for photographs is obtained

(d.) Photographs are updated as required to reflect changes in a resident's appearance and at least annually

4. A verification process is conducted to determine the location of each resident after a fire/elopement drill, resident activity, field trip, etc.

C. Interventions

1. Responding to an actual elopement
   a. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units
   b. Any resident who leaves his/her assigned unit unaccompanied is approached according to accepted guidelines as follows:
      i. Approach in a calm and reassuring manner
      ii. Have one individual approach the resident. Discourage large numbers of staff around the resident
      iii. Avoid arguing with the resident. DO NOT say "You can't" or "You have to"
      iv. Avoid touching the resident if possible
   c. The family and physician are notified of the incident, and notification is documented in the resident's record
   d. If the resident is placed on increased supervision, safety checks are documented in the resident's record each shift for the duration of the increased supervision
2. When a resident is determined to be missing:
   a. The time that the resident is/was determined missing is noted
   b. The staff members assigned to the unit where the resident resides verify that the resident has not been signed out
   c. The staff notify the Administrator that a resident is missing
   d. Staff members, in accordance with the facility's search team plan, conduct a thorough search to locate the resident. If the resident is not located, proceed with the following:
      i. Staff members search the entire facility and grounds. Prior to beginning the search, the resident's photograph is viewed by all staff involved in the search
         (a.) All areas of the building, grounds, and neighboring streets are systematically searched when a resident is missing or has eloped (may use a facility map that is marked off when an area is checked)
         (b.) The Administrator assigns each staff member a sector when searching for a resident to minimize overlapping or overlooking of an area
         (c.) When conducting a search, look under beds and furniture, in closets, showers, under desks, locked rooms/offices, walk-in refrigerators and freezers, and behind doors. When conducting a search in storage rooms look behind boxes, in boxes, and on shelves. The search area also includes stairwells, elevators, and the roof, if there is roof access. A resident who has eloped may be frightened and may be hiding. Being thorough in the search is of extreme importance
         (d.) When finished searching a sector, findings are reported to the Administrator for further instructions
      ii. If the resident has not been found after a period of ten minutes, the Administrator or designee calls the police and reports the resident missing
      iii. When the police arrive, the Administrator provides the officer with a picture and other pertinent information such as:
         (a.) What the resident was wearing

(b.) How the resident was ambulating, with a cane or walker
(c.) The resident's cognitive status, confused, agitated, etc.
(d.) Information as to where resident may be going, if known
(e.) A resident profile, which includes the resident's previous address and family's address, is available in the resident's chart for this purpose

iv. The Administrator notifies the family and attending physician if the resident is not found in the facility or on the grounds

3. When a resident has been found:
   a. The Administrator notifies all staff that the resident has been found
   b. The resident is examined for injuries
   c. The attending physician is notified of the resident's status
   d. The resident's responsible person is contacted and informed of his/her status
   e. The resident's service plan is updated, including:
      i. Additional measures such as a wander bracelet if not in current use
      ii. 15-minute safety checks or continuous observation if transfer to a more secure facility is determined
   f. If the resident is placed on increased supervision, safety checks are documented in the resident record each shift for the duration of the increased supervision
   g. A Missing Resident form is completed, and all staff involved sign the form. The form is forwarded to the Administrator or Resident Services Coordinator
   h. The incident is reported to the state authorities as required

D. Documentation

1. All elopement attempts and events are documented in the resident record, including objective and factual statements regarding:
   a. Circumstances and precipitating factors
   b. Interventions utilized to return the resident to the unit
   c. The resident's response to the interventions
   d. Results of reevaluation upon the resident's return and the condition of the resident
   e. Care rendered
   f. Notification of police, physician, and family
   g. Physician orders following notification
   h. Additional risk reduction strategies implemented
2. Resident-specific safety concerns are noted on the resident care plan and interventions that address his or her needs. Interventions to reduce risk are reviewed by the interdisciplinary team on a quarterly basis, at least, or with a change in condition for effectiveness of risk reduction strategies. These measures include realistic and measurable goals and avoiding statements such as "will have no events or no injuries related to elopement"
3. An Incident Report is completed and forwarded to the Administrator or the Resident Services Coordinator
4. Completion of the Incident Report is **not** noted in the resident's medical record
5. Resident/family education about additional risk reduction strategies is documented

E. Elopement Drills

1. Elopement drills are conducted on a regular basis, at a minimum semiannually
2. Results of the drills are used for staff education
3. Documentation of elopement drills (and actual elopements) are noted on the forms attached to this procedure (see Attachments 1, 2, and 3)

F. Education

1. If possible, family education is conducted on admission or at any time the resident is identified as a high risk for elopement
2. Staff training at orientation and during annual in-services is provided, including the risk factors for elopement and the specific risk reduction measures in place at the facility

3. Elopement risk reduction strategies are reviewed with all staff, including the method and frequency of assessing effectiveness

G. Quality/Risk Management Review

1. Based on compiled incident report data, a periodic trend summary is provided and discussed at the Quality Management/Risk Management Committee meetings
2. Data should include:
   a. The number of residents identified as at risk for elopement
   b. The number of elopement attempts
   c. The number of events
   d. Outcome severity

Elopement
Attachment 1
Elopement Drill or Post-Elopement Follow-up Report

Elopement Drill: _____ Actual Elopement: _____ Date: _____

Missing Resident Name: _____

Staff Person on Duty: _____

Time Started: _____ Time all Clear: _____ Total Time: _____

Supervisor or RSC Notified: _____ Time: _____

Administrator Notified: _____ Time: _____

Police Notified: _____ Time: _____

Family Notified: _____ Time: _____

Resident found: _____ If yes, time: _____

Number of Staff in Participation: _____

Staff Performance Results: Excellent _____ Good _____ Fair _____ Poor _____

Staff did _____/ did not _____ respond in accordance with established procedures.

Comments:

_____

_____

_____

_____

_____

_____

_____

Conductor(s): _____

Elopement
Attachment 2
Resident Elopement Search Drill
Staff Sign-In Log

Signature	Print Name	Department

Elopement
Attachment 3
Elopement Drill or Post-Elopement Checklist

Date: _____ Time: _____

Resident Name: _____ Room #: _____

Resident Missing Time: _____ a.m. p.m.

Resident Found Time: _____ a.m. p.m.

Circle the following Yes or No

1. Did staff verify resident was not signed out?	Y	N
2. Did staff check unit?	Y	N
3. Did staff notify supervisor?	Y	N
4. Was the Administrator notified?	Y	N
5. Was a full search of the facility and grounds implemented?	Y	N
6. Were the police notified?	Y	N
7. Was search called off when resident was located?	Y	N
8. Was resident examined when located?	Y	N
9. Was resident's physician notified when resident was discovered missing?	Y	N
Found?	Y	N
10. Was family and/or responsible party notified when resident was discovered missing?	Y	N
Found?	Y	N
11. Was incident/event report completed?	Y	N
12. Was notation included in the Resident Record?	Y	N
13. Did the alarm system function (if an egress system was in place)?	Y	N

Name of person completing report: _____

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	HAL011262	A. BUILDING: _____ B. WING _____	R 02/09/2023

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 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 270	Continued From page 8 Interview with a PCA on 02/07/23 at 4:07pm revealed: -Resident #8 was a new resident admitted to the facility on 02/07/23. -She saw Resident #8 approximately 10 minutes before in a common living area being alerted that Resident #8 was attempting to elope through a window. -She had not been in the storage room today where Resident #8 was attempting to elope through the window. Observation of Resident #8 on 02/07/23 at 4:09pm revealed: -She was standing in the doorway of the activity/dining room. -She was saying "I want to go outside and smoke" repeatedly. -A PCA assisted her to a seated position in a wheelchair. Observation of Resident #8 on 02/07/23 at 4:12pm revealed: -She was sitting in a wheelchair at the locked exit door attempting to open the door. -The Resident Care Coordinator (RCC) came through the locked door at that time and verbally redirected Resident #8. Interview with a MA on 02/07/23 at 4:17pm revealed: -The storage room where Resident #8 was trying to elope through the window was always kept locked. -She had not been in the storage room today. -There were some briefs kept in the storage room. Interview with the RCC on 02/07/23 at 4:19pm revealed:	D 270		

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D 270	Continued From page 9	D 270		

-The storage room window Resident #8 had attempted to elope through was always kept locked.
-They no longer used this room for storage.
-She thinks a staff member unlocked it looking for something and accidentally forgot to lock it back.

Interview with Resident #8 on 02/08/23 at 10:33am revealed:
-She remembered trying to leave the facility on 02/07/23.
-She had been wandering around the hall trying to get directions.
-She got lost and was trying to get out through the window.

Review of the Incident/Accident report for Resident #8 dated 02/07/23 revealed:
-There were no recent medical changes, illness or medication changes.
-"Resident went in diaper room, was trying to climb out the window to escape."
-Resident was checked for injury but none were found.

Review of a Resident Service Note for Resident #8 dated for 02/07/23 revealed:
-"Resident upon moving in, attempted to elope out a window."
-"Resident brought back in facility."
-A full body assessment was completed with "no marks, bruises, or skin tears" noted on Resident #8.

Interview with the ROM on 02/08/23 at 3:44pm revealed:
-A PCA informed him on 02/07/23 there was a resident trying to elope out a window.
-He went to observe the situation.
-He and the MA tried to assist Resident #8 back

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D 270	Continued From page 10 into the building through the window in the storage room unsuccessfully. -He and the MA assisted Resident #8 through the window in the storage room unto the ground outside. -Resident #8 had been very agitated and was focused on smoking on 02/07/23. -Resident #8's Guardian had given them instructions not to let her smoke. -He thought a staff member must have gotten something out of the storage room and forgot to lock the exterior door to the storage room. -The door to the storage room should have been locked. -They did not have a policy regarding any type of supervision or additional monitoring for new residents. _____ The facility failed to provide supervision for 1 of 1 sampled residents (Resident #8) who attempted to elope from a secured unit within the facility through a window in an unlocked storage room. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/07/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 26, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure the Primary Care Provider (PCP) was notified of ongoing issues in obtaining medications for 2 of 5 sampled residents (#1 and #2) related to a medication used to treat increased pressure in the eyes (#1) and a medication used to manage Chronic Obstructive Pulmonary Disease (COPD) (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 12/27/22 revealed diagnoses included diabetes, neurocognitive disorder, heart failure, and sleep apnea.

Review of Resident #1's Resident Register revealed an admission date of 01/03/23.

Review of physician's orders for Resident #1 dated 01/09/22 revealed Levobunolol (a medication that lowers the pressure in the eyes that is caused by glaucoma, a disease of the optic nerve) 0.5% eye drops, 1 drop into both eyes every morning.

Review of Resident #1's January 2023 and February 2023 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for Levobunolol 0.5% eye drops, 1 drop into both eyes every morning with an administration time of 8:00am.
-There was documentation that the Levobunolol eye drops was administered 01/04/23 - 01/31/23, 02/01/23 - 02/04/23, and 02/06/23 - 02/07/23.

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D 273	Continued From page 12 Observations of Resident #1's medications available for administration on 02/07/23 at 12:45pm revealed there was not any Levobunolol eye drops available. Interview with the Medication Aide (MA) on 02/07/23 at 12:48pm revealed: -She documented she administered the Levobunolol eye drops to Resident #1 in error. -There was not any Levobunolol eye drops to administer. -She did not order anymore eye drops via the eMAR because she had been distracted. -She did not know when the eye drops were last available. -The MAs would notify the Resident Care Coordinator (RCC) if there were issues with medications -It was the responsibility of the RCC to notify the Nurse Practitioner (NP) regarding issues with medications. Interview with a second MA on 02/07/23 at 12:55pm revealed: -She knew that Resident #1 was admitted with an order to administer Levobunolol eye drops. -She did not know when the eye drops ran out. -The MAs would notify the RCC regarding medication related issues. -The RCC was responsible for contacting the NP about the eye drops. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/07/23 at 1:00pm revealed: -The pharmacy received a signed physician's order for Resident #1 via fax on 12/27/22 for Levobunolol eye drops. -The pharmacy was unable to obtain the	D 273	① The facility Med Aide will order the medicine immediately, getting a new order for a new eye drop from MD. ② RCC will document and make sure that new eye drop will be added to the MAR, accurately. ③ RCC will monitor med cart and MAR monthly. 03/26/23	

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Levobunolol eye drops and did not dispense them.
-The pharmacy notified the RCC via telephone on 01/04/23 that they were unable to obtain the Levobunolol eye drops and requested a new order for a different eye drop.
-The pharmacy did not receive any other orders or any other communication from the RCC regarding eye drops for Resident #1.

Interview with the RCC on 02/07/23 at 2:30pm and on 02/08/23 at 10:10am revealed:
-Resident #1 was admitted from a local hospital with the Levobunolol eye drops.
-The local hospital pharmacy was suppose to dispense the Levobunolol eye drops.
-She had contacted the local hospital pharmacy about the eye drops but did not remember when.
-She notified the facility's contracted NP that the facility's contracted pharmacy could not provide the Levobunolol eye drops but did not remember when.
-The facility's policy was to notify the NP within 3 days if there were issues with medications.
-She did not have any documentation that she had notified the NP.
-She did not have any documentation that she had contacted the local hospital pharmacy or the facility's contracted pharmacy about the eye drops.
-She did not have any documentation of medications Resident #1 was admitted with.

Telephone interview with the facility's contracted NP on 02/07/23 at 1:20pm revealed:
-He was not notified by any staff at the facility that the facility's contracted pharmacy could not dispense the Levobunolol eye drops for Resident #1 and that the resident had gone without his medication.

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-The resident was at risk of increased pressure in his eyes leading to a progression of glaucoma without the medication.
-The resident would need to have an evaluation by an ophthalmologist as soon as possible.

Interview with the ROM on 02/07/23 at 2:45pm revealed:
-The RCC was responsible for notifying the NP with any medication related issues.
-He knew Resident #1 had been admitted from a local hospital with medications and he was "pretty sure" the eye drops were included.
-He did not know the facility's contracted pharmacy could not obtain the eye drops.
-The RCC should have notified the NP that the facility's contracted pharmacy could not obtain the Levobunolol eye drops.

Interview with Resident #1 on 02/08/23 at 7:44am revealed:
-Staff had not administered any eye drops to him since he was admitted to the facility.
-He knew the eye drops were for pressure in his eyes.

Attempted telephone interview with the local hospital pharmacy on 02/08/23 at 10:58am was unsuccessful.

2. Review of Resident #2 's current FL-2 for dated 09/26/22 revealed:
-Diagnoses included schizoaffective disorder and bipolar disorder.
-The resident was intermittently disoriented and ambulatory.

Review of a physician progress note for Resident #2 dated 09/13/22 revealed additional diagnoses of Chronic Obstructive Pulmonary Disease

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D 273	Continued From page 15 COPD) and asthma. Review of the Resident Register for Resident #2 revealed an admission date of 10/07/20. Review of a hospital discharge summary for Resident #2 dated 01/03/23 revealed an order for Budesonide-Formoterol 80mcg-4.5mcg, 2 puffs inhalation twice per day. Review of a physician order form for Resident #2 dated 01/27/23 revealed that Budesonide-Formoterol 80mcg-4.5mcg was discontinued due to the medication not being covered by insurance. Observation of Resident #2's medications on hand on 02/08/23 at 9:55am revealed no Budesonide-Formoterol 80mcg-4.5mcg was available for administration. Review of Resident #2's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Budesonide-Formoterol 80-4, 2 puffs by mouth 2 times a day for shortness of breath. -The medication was documented as administered twice daily on 01/05/23, 01/06/23, 01/07/23, 01/08/23, 01/09/23, 01/10/23, 01/11/23, 01/13/23, 01/14/23, 01/15/23, 01/18/23, 01/29/23, 01/21/23, 01/24/23, 01/25/23, and 01/27/23, and documented as administered at 8:00am at 01/12/23, 01/16/23,01/17/23, 01/20/23, and 01/26/23. -The medication was documented as not administered on 01/03/23 at 8:30pm, 01/04/23 at 8:30am and 8:00pm, 01/12/23 at 8:00pm, 01/16/23 at 8:00pm, 01/17/23 at 8:00pm, 01/20/23 at 8:00pm, and 01/26/23 at 8:00pm.	D 273		

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D 273	Continued From page 16 -The listed exception for the medication not being administered on the above dates was "awaiting rx/md prior auth." Review of Resident #2's record revealed there was no documentation of the facility's contracted NP was notified prior to 01/27/23 the Budesonide-Formoterol could not be filled. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/23 at 9:34am revealed: -The pharmacy had received the order for Budesonide-Formoterol 80mcg-4.5mcg on 01/02/23. -The medication was never filled due to nonpayment issues related to insurance. Telephone interview with Resident #2's facility's contracted NP on 02/08/23 at 10:31am revealed: -He did not recall if he was notified the Budesonide-Formoterol could not be filled prior to discontinuing it on 01/27/23. -He could not recall why it was prescribed. Interview with the RCC on 02/08/23 at 10:05am revealed: -She recalled trying to get that medication filled and was aware the pharmacy had been unable to fill it. -The facility's contracted NP should be notified if a medication could not be filled after three days. -It was her responsibility to notify the physician of any issues with medications. -She had notified the facility's contracted NP but she did not have any documentation to show she had contacted him. Based on interviews and record reviews it was determined that Resident #2 was not available to	D 273		

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D 273	Continued From page 17 be interviewed. _____ The facility failed to ensure the NP was contacted for a different eye drop medication when the facility's contracted pharmacy was unable to obtain Levobunolol eye drops, (Resident #1). This failure put Resident #1 at risk of increased eye pressure and progression of glaucoma which was detrimental to the resident's health and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/07/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 26, 2023.	D 273		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident at meal time in addition to other beverages. The findings are:	D 306		

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D 306	Continued From page 18 Review of the facility's menu for regular diets revealed: -Milk was listed on the menu at breakfast and dinner. -"Beverage" was listed on the menu at lunch. -Water was not listed on the menu. Observation of the noon meal service on 02/07/23 beginning at 12:25pm revealed: -There were 8 residents in the secured unit dining room in the secured unit for the noon meal. -Residents were not asked if they wanted water. -Residents were served coffee, tea and/or milk. Interview with two residents in the secured unitl dining room on 02/07/23 between 12:35pm-12:58pm revealed: -They liked water and would like to have some. -She wanted a glass of water. -They could not remember if staff had asked them or if they had asked staff for water. Observation of the noon meal service on 02/07/23 beginning at 12:36pm revealed: -There were 29 residents present in the main dining room for the noon meal. -Residents were not asked if they wanted water. -Residents were served coffee, tea and/or milk. Interview with three residents on 02/07/23 between 1:03pm and 1:09pm revealed: -The staff never offered the residents water at any meal. -"I would like to have water at lunch and dinner." -"I do not get offered water at meals." -The staff will give the residents water but the residents have to ask for it. Interview with a personal care aide (PCA) on 02/07/23 at 12:37pm revealed:	D 306	① The dietary staff will make available Pitchers of Water in both dining areas to offer to residents at mealtimes. ② The facility management team will monitor at mealtimes. ③ Signs will be posted to remind staff to offer water to residents at meals. 03/26/23	

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D 306	Continued From page 19 -They did not serve water at each meal but staff usually asked each resident if they wanted water at the beginning of a meal and at times throughout the meal. -She had forgotten to ask the residents if they wanted water. Interview with a dietary aide (DA) on 02/07/23 at 1:12pm revealed: -When she was trained, she was told by the Dietary Manager (DM) what beverages the residents drank at meal times. -She was trained by the DM to give water to the residents if they asked for it. -She was not aware she should offer water to the residents at each meal. -She had delivered the meal tray for breakfast to the residents on 02/07/23 and had not offer them water. -She had delivered the meal tray for lunch to the residents on 02/07/23 and had not offered them water. Interview with the DM on 02/07/23 at 3:23pm revealed: -He had been training the DA since she started working three weeks ago. -Water was provided to residents at mealtimes if they requested it. -He had not trained the DA to offer water to every resident at each meal. Interview with the Regional Operations Manager (ROM) on 02/07/23 at 3:39pm revealed: -The residents can ask if they want water at mealtimes. -He always thought if the residents were able to ask, water did not have to be offered. -He took full responsibility for the dietary staff not being aware to offer water to every resident at	D 306		

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D 306	Continued From page 20 each meal.	D 306	(D) The dietary staff and management team will come together and review and/or revise the therapeutic diet list. (E) After reviewing and/or revising the Therapeutic List, dietary staff will carry out and serve diets as ordered by the resident's MD. 03/26/23	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered for 2 of 5 residents related to a pureed diet with a nutritional supplement (Resident #5) and a diabetic diet (Resident #8). The findings are: 1. Resident #5's current FL2 dated 10/24/22 revealed: -Diagnoses included right-sided hemiplegia following stroke and history of traumatic brain injury. -Limited assistance was required with eating. -Diet was listed as pureed with nectar thickened liquids. a. Review of the physician's orders for Resident #5 revealed: -There was an order dated 01/30/23 for a Pureed diet with nectar thickened liquids.	D 310		

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	HAL011262	A. BUILDING: _____ B. WING _____	R 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

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D 310	Continued From page 21 Review of the diet order sheet (contained meal and supplement orders) provided by the RCC on 02/07/23 at 9:18am revealed: -There was a column listing the names of residents, and an x marking those residents on a regular or mechanical soft diet, pureed and Thickened liquids for nectar/honey thick liquids. -Resident #2 was listed as being on a pureed diet with thickened liquids. Observation of Resident #5's lunch meal service in the secured dining room on 02/07/23 at 12:30pm revealed: -Resident #5 received ground, dry, breadcrumbs, pureed barbeque pork in gravy in the middle of a large bed of dry bread crumbs, pureed greens and pureed pinto beans, vanilla pudding and nectar thickened milk. -Resident ate one bite of the puree barbeque, and his vanilla pudding and drank his nectar thickened milk. Observation of Resident #5's lunch meal service on 02/08/23 at 12:31pm revealed: -The RCC observed Resident #2's lunch meal before it was served to him. -She told the personal care aide (PCA) it was not pureed. -She instructed the PCA to take it back to the kitchen. Second observation of Resident #5's lunch meal service on 02/08/23 at 12:45pm revealed: -His plate consisted of pureed corn, pureed green beans, pureed cake, meatballs and noodles with visible small portions of meat and noodles with gravy. -The surveyor requested the RCC observe the observed consistency of the food on Resident #5's plate.	D 310		

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D 310	Continued From page 22 -The RCC stated the meatballs and noodles were not a pureed consistency for Resident #5. -The RCC removed the plate and told Resident #5 it was the wrong diet. -The RCC took the plate back to the kitchen. Interview with a PCA on 02/07/23 at 12:40pm revealed: -Resident #2 was on a puree diet. -She looked at Resident #5's plate that he had barely touched and stated the bread crumbs on the plate were not pureed. Interview with the dietary manager (DM) on 02/08/23 at 3:20pm revealed: -He had prepared the bread for Resident #5 on 02/07/23 by placing 1 piece of bread in the food processor. -He did not place any liquid in with the bread. -He had cut the noodles up in smaller pieces on 02/08/23 for Resident #5's noon meal. -He was aware that pureed bread required liquid in order to get the right consistency. -He was aware chopping noodles in smaller pieces was not a pureed consistency. -He did not think he needed to puree the noodles as they were soft. -He was aware Resident #5 was served a therapeutic diet that did not follow the physician's order. -He had worked at the facility for 4 years and had been trained in diet consistencies. -He was aware the diet was not prepared as a pureed consistency. -He did not put the liquid in the bread or puree the noodles as he did not want to give the resident a "blob of starch", it was his "judgement call". -The RCC was responsible for letting him know when there are any new orders or order changes regarding a resident's diet.	D 310		

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D 310	Continued From page 23 Interview with personal care aide/medication aide (PCA/MA) on 02/08/23 at 4:10pm revealed: -The RCC was responsible for processing the physician orders for new diets and changes in their orders. -She would place them on the eMAR and give a list to the DM. Interview with the ROM on 02/08/23 at 4:45pm revealed: -The RCC was responsible for notifying the kitchen regarding new diet orders and changes in diet orders. -The kitchen was to ensure the residents received the meals as the physician had ordered them -He was not aware Resident #5 had not received pureed diet. -He worked with and trained the dietary manager regarding therapeutic diets especially on consistencies. Interview with the RCC on 02/08/23 at 3:28pm and 02/09/23 at 9:55am revealed: -She had observed the 1st lunch plate for Resident #5. -The meal was not pureed consistency so she sent it back to the kitchen. -The second plate she observed when it was brought to her attention by the surveyor, -The meatballs and noodles were not pureed consistency. -She took the second plate to the kitchen and told the cook it was not pureed consistency. -She pureed the meatballs and noodles herself. -She brought the third plate of food with the correct pureed consistency back to Resident #5. -She was responsible for for updating the diet order sheet and giving the updates to the DM and	D 310		

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D 310	Continued From page 24 floor staff for all resident diets. -If the meal was not the correct diet ordered or the consistency was not right the staff should return it to the kitchen for the correct diet order and then inform the RCC. b. Review of the physician's orders for Resident #5 revealed: -There was an order dated 11/07/22 for two, 4 ounce cartons of nutritional supplement three times daily with meals. Review of the diet order sheet (contained meal and supplement orders) provided by the RCC on 02/07/23 at 9:18am revealed there was no mention of any supplement ordered for Resident #5. Observation of Resident #5's lunch meal in the secured unit dining room on 02/07/23 at 12:30pm revealed there was no nectar thickened supplement served. Observation of Resident #5's lunch meal on 02/08/23 at 12:31pm revealed there was no supplement served. Second observation of Resident #5's lunch meal on 02/08/23 at 12:45pm revealed there was no supplement served. Interview with a PCA on 02/07/23 at 12:40pm revealed: -She did not recall seeing the supplements on the dietary cart. -She did not give Resident #5 a supplement during the lunch meal. Interview with a PCA on 02/07/23 at 12:40pm revealed:	D 310		

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D 310	Continued From page 25 -Resident #2 was on a puree diet. -She looked at Resident #5's plate that he barely touched and stated the bread crumbs on the plate were not pureed. Interview with the medication aide (MA) on 02/08/23 at 4:05pm revealed: -The RCC entered the supplements on the EMAR record after she received the order from the physician. -The supplement would be flagged at mealtime, so the MA's knew who received a supplement. -The DM sent several supplements on the meal cart and then she would pass them out to the residents. Interview with the DM on 02/08/23 at 3:20pm revealed: -He counts the number of supplements from his list, placed them on the meal cart and sent them to the secured unit dining room. -He does not place the supplement on the residents tray. -He thought he had placed all the supplements on the cart when the cart went to the secured unit dining room on 02/07/23. -He did not place the supplement on Resident #5's tray as he placed all the supplements on the cart and the floor staff handed them out to whomever gets one. -He was not aware Resident #5 had not received his supplement as ordered. -He was not aware Resident #5 was not on his list for supplements in the kitchen. -The RCC is responsible for letting him know when there are any new orders or order changes regarding a resident's supplements. Interview with PCA/MA on 02/08/23 at 4:10pm revealed:	D 310		

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D 310	Continued From page 26 -The RCC processed the new orders or changes in orders for nutritional supplements. -The DM sent the residents their supplements on the meal cart from the kitchen. -The eMAR would trigger for those residents with a supplement so staff knew who to give the supplements to. -The MA's would then document on the eMAR when the supplement was given. -Resident #5 did not get a supplement on 02/07/23. -She was not sure if Resident #5 received a supplement or not as she had not checked the eMAR. Interview with the ROM on 02/08/23 at 4:45pm. -The DM was to ensure the residents received the meals and their supplements as the physician had ordered them -He was not aware Resident #5 had not received his supplements. Interview with the RCC on 02/08/23 at 3:28pm and 02/09/23 at 9:55am revealed: -She was responsible for updating the diet order sheet and giving the updates to the DM and floor staff for all nutritional supplement orders. -The DM was responsible to put the supplements on the meal cart with the resident meals. -She did not recall if Resident #5 had a supplement ordered or not. -If the supplement was not on the cart the staff should go to the kitchen and get a supplement for the resident and then inform the RCC. 2. Resident #8's current FL2 dated 02/07/23 revealed: -Diagnoses included traumatic brain injury with behavioral disturbances, dementia and diabetes. -There was no dietary information listed on the	D 310		

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D 310	Continued From page 27 FL2. Observation of Resident #8's lunch meal on 02/07/23 at 12:30pm revealed: -Resident #8 was served a regular diet of barbeque pork on a bun, greens, pinto beans, vanilla pudding, and tea. -Resident #8 left the dining room and did not eat any of the noon meal. Observation of Resident #8's lunch meal on 02/08/23 at 12:58pm revealed: -She was served a regular diet of meatballs and noodles with gravy, green beans, corn, cake with frosting, milk and water for her lunch meal. -She was observed feeding herself cake. -She did not eat any of her lunch meal except for cake. Review of the hospital discharge summary for Resident #8 dated 02/07/23 revealed discharge instructions included following a consistent carbohydrate, diabetic diet. Second review of Resident #8's current FL2 dated 02/07/23 on 02/08/23 at 9:15am revealed the nutrition status diet information on the FL-2 now had "Con Carbs" listed for the diet. Telephone interview with the hospital Discharge Case Manager on 02/08/23 at 8:12am revealed: -They always keep a copy of the discharge FL2 at the hospital. -Resident #8's FL2 dated 02/07/23 had the nutritional status listed as diabetic. Interview with the Resident Care Coordinator (RCC) on 02/08/23 at 9:30am revealed: -She reviewed Resident #8's hospital discharge instructions.	D 310		

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D 310	Continued From page 28 -She had wrote "Con Carbs" on the FL2 under nutritional status per the hospital discharge instructions. -She did not call the hospital to verify the diet order. -She did not inform dietary staff that Resident #8's had a special diet order. Interview with Resident #8 on 02/08/23 at 10:33am revealed: -She had just received five vanilla wafers and Kool-Aid for a snack. -She did not know if she was on a special diet. Interview with the Dietary Manager (DM) on 02/08/23 at 10:43am revealed: -He had not received a diet order for Resident #8 yet. -Resident #8 was admitted to the facility on 02/07/23 at lunchtime. -He served all new residents a regular diet until he received the diet order. -He expected to know diets of new residents as soon as possible after they were admitted to the facility. -The RCC was responsible to let him know about new residents diet orders. Telephone interview with Resident #8's Guardian on 02/08/23 at 11:16am revealed: -Resident #8 was a diabetic. -She had been Resident #8's Guardian for 8 months. -Resident #8 was on a diabetic diet at the previous facility where she lived. Interview with the DM on 02/09/23 at 8:55am revealed: -He had not received a diet order for Resident #8. -Resident #8 had all meals and snacks consistent	D 310		

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D 310	Continued From page 29 with a regular diet before her discharge on 02/08/23. Interview with the Regional Operations Manager (ROM) on 02/09/23 at 9:44am revealed: -The RCC told him on 02/08/23 that she had reviewed the hospital discharge instructions and had written "con carbs" on the FL2 since there was no dietary information listed. -The kitchen staff should know dietary orders as soon as possible if not before a new resident is admitted to the facility. -He was not aware Resident #8 was being served the wrong diet.	D 310		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Bason on interviews and record review, the facility failed to ensure each resident in the facility had the opportunity to participate in at least one outing every other month. The findings are: Review of the acitivity calendar for February 2023 revealed there were no outings scheduled.	D 319	(1) The facility will provide each resident at least one outing every other month. Outings will be posted on Activity Calendar for each month.	

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D 319	Continued From page 30 Interview with a resident on 02/07/23 at 9:16am revealed: -She participated in some of the activities offered at the facility, but she would like to go on an outing. -She had not been able to leave the building in a long time. -She wished someone would at least take her and "drive around" for a while so she could experience a different environment. Interview with a second resident on 02/07/23 at 9:23am revealed: -She enjoyed the activities at the facility but wished she could get out of the building sometimes. -She would like to go to the store because she needed to purchase some hygiene items and snacks. -She did not know who to talk to about going to the store. Interview with a third resident on 02/07/23 at 9:30am revealed: -She had not been anywhere other than medical appointments in a long time. -Facility staff used to take residents to a local variety store or a grocery store, but that stopped a long time ago. -She was not sure who she should ask to take her to the store. Telephone interview with a resident's guardian on 02/08/23 at 9:00am revealed she thought that it would be "nice" if the facility would take the resident out of the facility "once in awhile". Interview with an medication aide (MA) on 02/07/23 at 2:40pm revealed: -She was responsible for activities while the	D 319	(2) The facility management team will monitor calendar and outings documentation monthly. 3/26/23	

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D 319	Continued From page 31 activity director was on leave. -She took residents to the store every week or every other week. -She took three to four residents at a time. -She rotated which residents she took so that all residents had the opportunity to go out. -The facility had a COVID outbreak recently which disrupted this rotation, so some residents had been waiting longer than usual. -Residents on the secured unit who were diagnosed with dementia were not included in the rotation. -To her knowledge, those residents were not taken on outings. -Those residents were sometimes taken on walks on the facility grounds. Interview with the Regional Operations Manager on 02/08/23 at 10:20am revealed: -The MA took residents to the store every other week. -She took 3 to 4 residents at a time. -Residents could sign up to be taken to the store. -There was not currently any list to make sure every resident was offered the opportunity to go to the store or any other outing every two months. -Residents on the secured unit who were diagnosed with dementia were not offered any outings right now. -Staff used to take these residents to local parks for walks, and they may start doing that again.	D 319		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 32 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed ensure the health and safety of all residents related to staff feeding wild bears that were on the property grounds. The findings are: Interview with the Resident Care Coordinator (RCC) on 02/09/23 at 8:20am revealed: -There were wild black bears that came onto the property grounds. -She fed the bears and one bear would eat out of her hand. -The bear would lay outside up against the back wall of the facility directly across from the facility dumpster. -Sometimes the bear would get into her vehicle. -The facility had been feeding one of the bears since it was a baby. -The bear was "sweet as she can be". Telephone interview with the local Wildlife Interaction Biologist on 02/09/23 at 8:41am revealed: -Feeding bears was unsafe for both the animal and humans. -It was dangerous for facility staff to feed the bears. -Staff feeding the bears could result in the bears coming on the property more frequently. -Feeding bears could cause the bears to lose their natural fear of humans and to begin approaching people they saw in search of food. -The bears could become aggressive if the food they expected was not available. -Bears that were accustomed to being fed by	D 338	① The facility will immediately implement training for staff on the danger of feeding bears or any other wildlife. Training will be provided by management team and Wildlife Commission officer to the staff of the facility. ② The facility management will monitor the grounds of the facility daily. 03/26/25	

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D 338	Continued From page 33	D 338		

humans were dangerous bears.
-Bears have become aggressive before in similar situations and people have been injured.
-He recommended the facility take steps to discourage the bears from returning to the property.

Interview with the RCC on 02/09/23 at 9:10am revealed she had never been instructed not to feed the bears.

Interview with a resident on 02/09/23 at 9:00am revealed he saw bears on the property "once in awhile".

Interview with a second resident on 02/09/23 at 9:15am revealed:
-He was a resident at the facility for several years.
-Bears were on the property several times a month.
-He saw a bear one week ago.
-Residents were also feeding the bears.

Interview with the Dietary Manager (DM) on 02/09/23 at 9:02am revealed:
-He saw bears on the property several times a week.
-He often saw bread outside at the back of the facility where the bears came to eat.
-The two dumpsters have plastic locks on them that have been effective in keeping the bears out of the trash.
-He was not sure whether staff and/or residents were feeding the bears.

Interview with a personal care aide (PCA) on 02/09/23 at 9:10am revealed:
-She most recently saw one large bear on the property about three weeks ago.
-About six months ago, bears were seen on the

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	HAL011262	A. BUILDING: _____ B. WING _____	R 02/09/2023

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 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 338	Continued From page 34 property daily. -The bears would come in the parking lot and walk around. -The bears would walk around outside the back of the building outside the kitchen and close to the dumpsters. -She has seen 2 or 3 bears on the porch at the entranceway to the facility. -There was a trash can at the entranceway to the facility. -The entranceway to the facility was through an unlocked door during the daytime. Observation of the property grounds near the resident smoking area on 02/09/23 at 9:20am revealed there were three slices of white bread on the ground near a bird feeder inside a fenced area. Observation of the property grounds on 02/09/23 at 11:45am revealed there was a tall trash can on the front porch next to the facility's front entrance. Interview with the Regional Operations Manager (ROM) on 02/09/23 at 8:45am revealed: -Wild bears would walk from the woods behind the facility to the back of the facility and sometimes onto the parking lot. -He was walking to the parking lot and there was a bear there at which point he had thrown fire crackers on the ground near the bear and made a lot of noise to scare the bear away. -He was concerned for the staff walking to their cars with the bears on the property. -Usually it was one bear with one or two cubs that came onto the property. -The residents had fed the bears in the past. -A representative from a wildlife organization came to the facility in October 2022 and spoke to the prior Administrator about the bears.	D 338		

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D 338	Continued From page 35 -Staff was instructed not to feed the bears. -The RCC was instructed when she was hired in September 2022 not to feed the bears. The facility failed to ensure the health and safety of all residents related to staff feeding wild bears, that can become very dangerous when habituated to human food, on the property grounds. This failure placed the residents at risk of injury from the bears and was detrimental to the health and safety and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 26, 2023.	D 338		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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D 367	Continued From page 36 medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic Medication Administration Records (eMAR) were accurate for 2 of 5 sampled residents (#1 and #2) related to inaccurate documentation of a medication to treat increased pressure in the eyes (#1), and a medication to manage Chronic Obstructive Pulmonary Disease (COPD) (#2). The findings are: 1. Review of Resident #1's current FL2 dated 12/27/22 revealed diagnoses included diabetes, neurocognitive disorder, heart failure, and sleep apnea. Review of Resident #1's Resident Register revealed an admission date of 01/03/23. Review of physician's orders for Resident #1 dated 01/09/22 revealed Levobunolol (a medication that lowers the pressure in the eyes that is caused by glaucoma, a disease of the optic nerve) 0.5% eye drops, 1 drop into both eyes every morning. Review of Resident #1's January 2023 and February 2023 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Levobunolol 0.5% eye drops, 1 drop into both eyes every morning with	D 367	(1) The facility med Aide will order the medicine immediately by getting a new order for a new eye drop from the MD. (2) RCC will document and make sure that the new eye drop will be added to the MAR accurately. (3) The RCC will monitor med cart and MAR monthly. 03/26/23	

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D 367	Continued From page 37	D 367		

an administration time of 8:00am.
-There were documentation Levobunolol eye drops were administered 01/04/23 - 01/31/23, 02/01/23 - 02/04/23, and 02/06/23 - 02/07/23.
-There was documentation on 02/05/23 at 8:00am Levobunolol was not administered without a reason why documented.

Observations of Resident #1's medications available for administration on 02/07/23 at 12:45pm revealed there was not any Levobunolol eye drops available.

Interview with the Medication Aide (MA) on 02/07/23 at 12:48pm revealed:
-She had documented she had administered the Levobunolol eye drops to Resident #1 in error.
-There was not any Levobunolol eye drops to administer.
-She did not know when the eye drops were last available.

Interview with a second MA on 02/07/23 at 12:55pm revealed:
-She knew that Resident #1 had been admitted with an order for Levobunolol eye drops.
-She did not know when the eye drops ran out.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/07/23 at 1:00pm revealed:
-The pharmacy had received a signed physician's order for Resident #1 via fax on 12/27/22 for Levobunolol eye drops.
-The pharmacy was unable to obtain the Levobunolol eye drops and the eye drops were never dispensed.
-The pharmacy notified the Resident Care Coordinator (RCC) on 01/04/23 that they were unable to obtain the Levobunolol eye drops and

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D 367	Continued From page 38 requested a new order for a different eye drop. -The pharmacy had not received any other orders or any other communication from the RCC regarding eye drops for Resident #1. Interview with the RCC on 02/07/23 at 2:30pm and 02/08/23 at 10:10am revealed: -Resident #1 was admitted from a local hospital with the Levobunolol eye drops. -The local hospital pharmacy was supposed to dispense the Levobunolol eye drops but could not obtain them. -The MAs should not have documented they had administered the eye drops when they had not. -She reviewed residents' eMAR on a daily basis. Interview with the Regional Operations Manager (ROM) on 02/07/23 at 2:45pm revealed: -He did not know the facility's contracted pharmacy could not obtain the eye drops. -The MAs had been trained to document administration only after they had administered the medications. Interview with Resident #1 on 02/08/23 at 7:44am revealed staff had not administered any eye drops to him since he was admitted to the facility. 2. Review of FL-2 for Resident #2 dated 09/26/22 revealed: -Diagnoses included schizoaffective disorder and bipolar disorder. -The resident was intermittently disoriented and ambulatory. Review of a medical progress note for Resident #2 dated 09/13/22 revealed additional diagnoses of chronic obstructive pulmonary disease and asthma.	D 367		

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D 367	Continued From page 39 Review of a hospital discharge summary for Resident #2 dated 01/03/23 revealed an order for Budesonide-Formoterol 80mcg-4.5mcg, 2 puffs inhalation twice per day. Review of a physician order form for Resident #2 dated 01/27/23 revealed: -The Budesonide-Formoterol 80mcg-4.5mcg was discontinued due to the medication not being covered by insurance. -There was no other documentation prior to the 01/27/23 order of the Budesonide-Formoterol 80mcg-4.5mcg not being covered by insurance. Review of Resident #2's electronic Medication Administration Record (eMAR) dated 01/01/23-01/31/23 revealed: -There was a computer-generated entry for Budesonide-Formoterol 80-4, 2 puffs by mouth 2 times a day for shortness of breath. -The medication was documented as administered twice daily on 01/05/23, 01/06/23, 01/07/23, 01/08/23, 01/09/23, 01/10/23, 01/11/23, 01/13/23, 01/14/23, 01/15/23, 01/18/23, 01/29/23, 01/21/23, 01/24/23, 01/25/23, and 01/27/23, and documented as administered at 8:00am at 01/12/23, 01/16/23,01/17/23, 01/20/23, and 01/26/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/23 at 9:34am revealed: -The pharmacy had received the order for Budesonide-Formoterol 80mcg-4.5mcg 2 puffs inhalation twice per day on 01/03/23. -The medication was never filled due to nonpayment issues related to insurance. Based on interviews and record reviews it was	D 367		

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D 367	Continued From page 40 determined that Resident #2 was not available to be interviewed. Interview with a MA on 02/08/23 at 9:48am revealed: -She did not know why she had documented that she had administered the Budesonide-Formoterol when it had not been available for administration. -She may have been confused because the resident was ordered another inhaler. -She probably signed off on the Budesonide-Formoterol when she had actually administered the other inhaler. Interview with a second MA on 02/08/23 at 9:55am revealed: -She did not recall why she had documented the Budesonide-Formoterol as administered when it was not available. -The resident had another inhaler ordered and she may have gotten the two confused. -She had been trained to check medications she administered against the MAR to make sure the medications and documentation were correct. Interview with the RCC on 02/08/23 at 10:05am revealed: -She could not say why the medication was being documented as administered when it was not available for administration. -All staff had been trained to document when medication was not available and she did not know why that was not being done consistently. Interview with the ROM on 02/08/23 at 10:20am revealed he could not say why the medication was being documented as administered when it was not available for administration.	D 367		