STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION			PLE CONSTRUCTION	(X3) DATE SURVEY
		A. BUILDIN	\$1	COMPLETED
۵٫۳۰۰٫۹۵۰٬۳۹ ۲۵۳۵٬۹۹۷ ۲۵۶۵٬۰۰۰	HAL011262	B. WING	n ben han water and with a fill a	R-C 04/12/2023
AME OF PROVIDER OR SUP	<i>Р</i>	STREET ADDRESS, CDY, 8	STATE, ZIP CODE	14-19-7 5 5-6 5-6 5-6 5-6 5-6 5-6 5-6 5-6 5-6 5
HUNNE COVE ASSIST	ET 1 1.04.1/2	57 MOUNTAIN BROOK		
		ASHEVILLE, NC 2680	5	
(X4) ID SU PREFIX (EACH	MMARY STATEMENT OF DEFICIENC DEFICIENCY MUST BE PRECEDED I	15C	PROVIDER'S PLAN OF CO	
	ATORY OR LSC IDENTIFYING INFOR		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	Should be comp Appropriate dat
(D 000) Initial Comm	ents	{D 000}		ne na serie
The Adult Ca	re Licensure Section condu	icled a		
follow-up sur	vey on 04/11/23-04/12/23.			
11 AAA	.		DT. II	Let will
(D 310) 10A NCAC 1 Service	3F .0904(e)(4) Nutrition and	Food (D 310)	O The facil. Contact for	- with
104 NC40 +	3F .0904 Nutrition and Food	i Condon	ant tons	Lenn CR
	Ilic Diets in Adult Care Hom		Contact told Registeral God for Reign norse to	the second
(4) All therap	eutic diets, including nutritic	onal	Decitional	Natition
supplements	and thickened liquids, shall	be	pagi- je a	
served as on:	lered by the resident's phys	ician.	and for Rear	Lacor
			ursi je regr	
			nordento -	-han
			101 - 10	·
			Vitebon St	aft on
	not met as evidenced by:		provide a service of the first	- r .
TYPE B VIOL	ATION		Kitchen St. Huispautic (and property to proper ky to	diets
Based on ohe	ervations, interviews, and n	soord	/ server in C	
reviews the fa	cility failed to serve therape	utic	2nd source	Hem
diets as order	ed for 3 of 3 residents relate	ed to a		~~~ ^
pureed diet (F	tesident #2), and a mechani	ical soft	proper ky te	sr each made h
diet (Resident	s #3 and #4).			·••
The findings a	re:		E a no	
1. Review of F	lesident #2's current FL2 da	Ned	er The facility	r mendicen
03/20/23 reve	aled diagnoses included rigi	ht-sided		6.1 .
	lowing stroke and history of		team will m	onitot
treumatic brain	n mjury.		E The facility team will m therapeutice	15 to las
Review of Res	ident #2 physician's diet or	tor	Karapevse 9	7 1 Octor 1 Mar Angel - Start Contra
dated 03/20/23	revealed a pureed diet.		each meal.	
Parious of the	dief order sheet from the kit	a the action	seconder (
	oler order sneet from the kir 23 revealed Resident #2 wa			
pureed diet.		50 ST 1 S		
of Health Service Regulat	had an ann an an ann an ann ann ann ann a	антан на тако су 1997 г. Алибол и бороло с аконстити на суло (А. 1997 г.). 28 м. – Пана Пана Пана (Пана) и станости и селото с селот	an an an ann an an an an an an an an an	a yang da yang di yang di sana dan kanang
huger a s	WOER/SUPPLIER REPRESENTATA	A >	THE	(X6) DATE
sou u	Drowler	/1 A /	ministrator	412712

Reviewed and Acknowledged Date: 04/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					(X3) DATE SURVEY COMPLETED	
		HAL011262	B. WING	የሆነ በማሪ የት የሚያምለም ነገር ላይ ብር ሲኖሩ ምን ማት አው የሚያም መም አምር ማይም በማሪ በ የተባለ የሚያምለም ነገር ላይ ብር ሲኖሩ ምን ማት አው የሚያም በማሪ የሚያም	R-C 04/12/2023	
Name of P	ROVIDER OR SUPPLIER	STREET	WORESS, CITY, STATE	, ZIP CODE		
C145 (1415)	COVE ASSISTED LIVI	67 MOU	NTAIN BROOK RO	AD		
**************************************		ASHEV	LLE, NC 28805			
(X4) ID PREFIX TAG	(ÉACH DÉFICIEN	ETATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTIN (EACH COHRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DISE COMPLE	
{0 310}	Continued From pag	ge 1	(D 310)		<u></u>	
	Observation of Resi	dent #2's lunch meal in the	:			
		n on 04/11/23 at 12:15pm				
	revealed:				2	
		al tray on the table in front of			í	
	Resident #2.				:	
		ed pureed chicken, pureed) 			
	chocolate pudding.	x with small vegetables) and				
	• •	sted the medication aide			:	
		insistency of the food on	1		×	
	Resident #2's plate.				4	
	مرد مر مرد م					
	Review of the facility	/s menus revealed: ntation the lunch meat on				
		hauon me lunch meal on of mango chicken, fried rice,				
		dinner roll and cream pie.				
		ntation the lunch menu to be				
		diet consisted of pureed				
		, pureed fried rice with a				
	cream pie.	t vegetables and a piece of				
		on 04/11/23 at 12:16pm				
	revealed:	م ال ال				
	-Resident #2 was on -She observed Resid	a pureed diet. Jent #2's lunch meal and				
	stated Resident #2's					
	consistency.					
		nsportation aide on 04/11/23				
	at 12:17pm revealed					
		inch meal Resident #2 was				
	served and realized i -His rice pilat was rer	i was not pureed. gular rice with small bits of				
	vegetables.	Survey, Landor Anteria Deliterati Pallo (1)				
	-She removed his pla	He before Resident #2 ate				
		ook it back to the kitchen.				
	Interview with a laund	dry aide on 04/11/23 at				
	h Service Reputation					

STATEMENT OF DI AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011262		anananan ili ili (119 2) ya ya ya miningan kuwa kuwa kuwa kuwa ja	R-C 04/12/202
NAME OF PROVIDE	TR OR SUPPLIER	林山市(1999)2010年10月1日1日1日1日1日1日1日1日1日1日1日1日1日1日1日1日1日1日1	ADDRESS, CITY, S	たっていたのでは、「こうした」」、 「こここのでは、「こうした」」、 「こここのでは、「こうした」」、	
			INTAIN BROOK		
CHUNK'S COVE	ASSISTED LIVI	1 A P 2	ILLE, NC 28805		
(X4) ID		STATEMENT OF DEFICIENCIES	lD.	PROVIDER'S PLAN OF COM	RECTION
PREFIX TAC		ICY MUST BE PRECEDED BY FOLL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE J DEFICIENCY)	SHOLLO BE COM
(0 310) Con	linued From pag	ge 2	{O 310}	3 Completion May 27	
12:2	1pm revealed:			(A) Constation	which as to
		ed in the dining room before.	,		Print, of K. Williams
-She	neve Resident	#2 his lunch meal tray.	i.	, <i>n</i> ^{gr}	where .
_Sha	did not know w	that kind of diet Resident #2		And a water of the	All and the second second
	Id be served	mat kulu ol diel resident #2		at " inter " and the	fr water
	a contraction of the standard		i i		
*3/1C	ាររថ ១០ ខេរកពេដូ	related to serving meals to	1		
16510	ents on therepe	Pulic diets.		;	
Inter	dimension the the	ietary Manager (DM) on			
0.4/**	1/23 at 12:50pm	recery manager (DM) on	•		
(2442) (24	nzo st izioopit	revealeo:			
-1185	ideni #2 was or	a pureed diet.			
-Kes	ident #2 receive	ed the wrong diet consistency.	1		
-He f	had cooked the	rice pilet for about an hour.		-	
-He a	issumed il was	soft enough, so he did not			
pure	o the rice pilef.				
	ureed Residen 1/11/23.	t #2's food for the lunch meal			
Telep	hope interview	with the Primery Care			
Provi	der (PCP) on 6	4/12/23 at 8:56am revealed:			
-Resi	dent #2 had a s	froke and had dysphagia	1		
	ulty swallowing				
		, a puread diet and was a			
	isk for aspiratio				
		te, he tended to overload his			
	1 with food.	transmithed marginally in the state			
*P\$108	W65 8 1000 108	t could easily cause choking		1	
	omeone on a p				
		ent #2 not receiving a pureed		2	
		, hypoxia (decreased axygen			
		(liquids or foods that enter		f	
the ai	way) prieumon	ia.			
\$ 68.0.mm	retart instance.	with Provident Stars Address			
	Processing Anna Anna Anna Anna Anna Anna Anna An	with Resident #2 on 04/11/23			
atiza	40pm was unsu	icoussio.			
6	dan tanàn ir 👘 🖓	n ≥r 1556 5 4 16 4		N N	
Reier	to interview will	h the Regional Menager on			
04/31/	23 et 12:58pm.				
		h the Corporate Chef on	14/11/14/10/10/14/14/14/14/14/14/14/14/14/14/14/14/14/		
on of Health Servi E FORM	se Regulation		and the second	n na sayan an ana di Julya Calabati Calabati Angin Ya Anji KAN shi ana ata sa sa sa pasara ta kana kana kana s	n film yf nyn inwyn yn nyn manter yn yn yn yn gan gan gan arann arannyn yn mwnyr afar anna arwygymr a
a 31 5 6			6698	ESME 12	Il continuation sheet

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 04/17/2023 FORM APPROVED

(X3) DATE SURVEY

COMPLETED

R-C HAL011262 B. WING 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 67 MOUNTAIN BROOK ROAD CHUNN'S COVE ASSISTED LIVING ASHEVILLE, NC 28805 SUMMARY STATEMENT OF DEFICIENCIES (X4) 83 PROVIDER'S PLAN OF CORRECTION ю (X8) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOLLO HE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (D 310) Continued From page 3 {D 310) 04/11/23 at 1:37pm. Refer to interview with the Administrator on 04/12/23 at 11:29am. 2. Review of Resident #4's current FL2 dated 01/16/23 revealed diagnoses included dysphagia (difficulty swallowing), gastric reflex, dementia and diabetes. Review of Resident #4 physician's diet order dated 03/27/23 revealed a mechanical soft diet (specialized textured foods for people with swallowing problems). Review of the diet order sheat from the kitchen staff on 04/11/23 revealed Resident #4 was on a mechanical soft diet. Observation of Resident #4's lunch meal in the secured dining room on 04/11/23 at 12:18pm revealed: -Staff placed the meal tray on the table in front of Resident#4. -Resident #4 received chopped chicken, pureed carrols, a slice of white bread, rice pilat and chocolate pudding. Review of the facility's menus revealed: -There was documentation the lunch meat on 04/11/23 consisted of mango chicken, fried rice, mixed vegetables a dinner roll and cream ple. -There was documentation the lunch menu to be served for a mechanical soft diet consisted of ground chicken with a sauce, fried rice with a sauce, mixed vegetables, a dinner roll and a piece of cream ple. Interview with a laundry side on 04/11/23 at 12:21pm revealed: Division of Health Service Regulation STATE FORM 肺病 E8ME12 If continuation sheet it of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R-C
		HAL011262	8. WING	1974 and an	04/12/2023
NAME OF P	Rovider or supplier	STREET	DORESS, CITY, STATE), 21P CODE	
CHIMNE	COVE ASSISTED LIVIT	67 MOU	NTAIN BROOK RO.	AD	
		ASHEVI	LLE, NC 28805		
(X4) 10 PREFIX TAC	(EACH DEFICIEN	MATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	íd Prefix Tag	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE
(O 310)	Continued From pag	3e 4	(0 310)	т - такий на	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
	-She had never help	ed in the dining room before.	1		-
	-She gave Resident	#4 her lunch meal tray.			
	-She did not know w	that kind of diet Resident #4	,		•
	should be served.				
	-She had no training	related to serving meals to	4		
	residents on therape	autic diels.	1		
	Coservation during r	me lunch meet on 04/11/23 at			
	12:23pm revealed:				
	-Staff did not acknow	viedge Resident #4 was			
		et instead of a mechanical			
	soft diet.				
		eat the chopped chicken or			
	slice of white bread a				
		difficulties feeding herself.			
	-Resident #4 ste /5%	% of her chocolate pudding,			
	rice pilaf and pureed	carrois.	2		
	Interview with a med	ication aide (MA) on 04/11/23	1		
	at 12:16pm and 1:27	pm revealed;			
		a mechanical soft dist.			
	-Mechanical soft foor	d meant that everything on			
	the plate was chopped	ed.			
	-She did not deliver F	Resident #4's lunch tray.			
	-She did not actually	see Resident #4's lunch			
	meal.				
		dining room at lunch to be			
	present if someone c	hoked.	4		
	Interniews with the Phil.	denne Bånnmaner / 1983 an			
	04/11/23 at 12:50pm	Kary Manager (DM) on revealed:			
	,	a mechanical soft diet.			
		esident #4 received the			
	wrong diet consistent				
	There and and and a second				
	telephone interview v 8:56am revealed:	with the PCP on 04/12/23 st			
	and the second s	a mechanical soft diet.			
		a mechanical son diet. ber why Resident #4 was on			
	e mechanical soft dia	e why resident #4 was on			
	h Service Repulsion	📞 н англание на пакта и пакудола и за пакива (1422-255 Адиа пак пакивила на какивала на какивана на какива пакувила англание на пакива пакива на какива на к	el e ^d al a secola esta com la manar se versión esta el la _{el est} a e		-γ Martin Inde Same Berkanstan (γα γ) π βρίγ βάζοΣος για διαστικό έγαις ματο αποιο κάλη κατο του του συντό το και

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED R-C	
		UAL 054769	B. WING			
lan sama PA tilkan barkati sar		HAL011262		анан каларыкын каларыкын каларыкын каларыкан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан Алака жана каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан к Алака жана каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан каларыктан к	04/12/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
Chunns	COVE ASSISTED LIVIN	465	NTAIN BROCK RO/ LLE. NC 28805	0		
(X4) ID PREFIX TAG	(EACH DEFICIEN	NATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OPFICIENCY)	N SHOULD BE COMPLE CAPPROPRIATE DATE	
{D 310}	Continued From pag	ye 5	{D 310}	nan an gan an a		
	01/16/23 were read mechanical soft diet -Concerns for Resid	toses from the FL2 dated to the PCP he indicated her was due to her dysphagis. ent #4 not receiving s included choking, hypoxia				
	(decreased oxygen l pneumonia.					
	at 12:43pm was uns	uccessful.				
	Refer to interview wi 04/11/23 at 12:58pm	th the Regional Manager on				
	Refer to interview wi 04/11/23 at 1:37pm,	th the Corporate Chef on				
	Refer to interview wi 04/12/23 at 11:29am	th the Administrator on				
	02/06/23 revealed:	nt #3's current FL2 dated				
	 Diagnoses included kidney injury. 	hyperglycemia and acute				
	-An order for a diabe	tic diet.				
	03/30/23 revealed ar	f3's physician order dated norder for a mechanical soft if (specialized textured foods)				
	for people with swall		:			
		nt diet orders list posted in Resident #3's diet was tanical soft.				
	and 04/12/23 at 11:3 -She was supposed t	o be on a diabetic diet but				
	did not think she rece -She was tried on a g	lived that, round meat dist when she				

Division of Health Service Regulation STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

HAL011262

 (X2) MULTIFLE CONSTRUCTION
 (X3) DATE SURVEY

 A. BUILDING:
 COMPLETED

 B. WING
 R-C

 04/12/2023
 04/12/2023

	COVE ASSISTED LIVING	itreet address, city, s 17 Mountain Brook Asneville, no 2020s	ROAD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ic) Prefix Yag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION BHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) Çompl İjatı
(D 310)	Continued From page 6	(0 310)		
	was in the hospital a few weeks ago but she di	بر		
	not think it was continued when she was	u i i i i i i i i i i i i i i i i i i i		;
	discharged.			
	-She received chopped meal after she was			1
	discharged from the hospital.			×.
	Observation of the lunch meal service on	-		
	04/11/23 st 12:25pm revealed:			
	-Resident #3 was served diced chicken with a			
	sauce, rice pilaf with small pieces of vegetable;	· .		
	ground green beans, a slice of bread and			
	chocolate pudding.			
	-The Regional Manager removed the plate service	ed .		
	to Resident #3, at the surveyor's request, end			
	replaced it with a plate that contained ground			
	meat mixed with ground rice with a sauce on it.			
	Review of the facility's menus revealed:			
	-There was documentation the lunch meal on			
	04/11/23 consisted of mango chicken, fried rice.	, i		
	mixed vegetables a dinner roll and cream pie.			
	-There was documentation the lunch menu to b	e :		
	served for a mechanical soft diet consisted of			
	ground chicken with a sauce, fried rice with a			
	seuce, mixed vegetables, a dinner roll and a			
	piece of cream pie.			
	Interview with the Dietary manager (DM) on			
	04/11/23 at 12:32pm revealed:			
	-Resident #3 was on a mechanical soft diet with			
	chopped meat.			
	-When a resident was ordered a mechanical sof			
	diet, the meat was specified as either chopped of)r	· ·	
	ground and he was told Resident #3 was			
	supposed to receive chopped meat.			
	-The Resident Care Coordinator (RCC) was			
	responsible for informing him of residents' diet			
	orders.			
	-The RCC would tell him when a diet changed b			
	she would also bring an updated diet list to post	in		
	h Service Regulation	and a second	αναστολέξη ΥΥΩΓΙΛΑ αξαστάστατα αυτοποιού ται ταπογιαστάτε του το τη τη τη τη τη τη τη του χιτο του του συστοποιού του τη σύστη για σχιτη ζη στ	a tayanya a aman'ny taong tao amin'ny tao
'E FORM		H009 []	BME12 If contin	nuesion exest 7 d

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER)	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL011262	B. WING	ی محمد او محمد محمد محمد محمد محمد محمد محمد محم	R-C 04/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	UDRESS, CITY, STATE	, ZIP CODE	
CHUNKS	COVE ASSISTED LIVIN	1G 67 MOU	NTAIN BROOK ROA	AD	
		ASHEVI	LLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEPICIEN	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING (NFORMATION)	id Prefix Yag	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTR CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE TE APPROPRIATE DATE
{D 310}	Continued From pag	76 7	{D 310}	۵٬۵۰۰٬۱۹۹۹ میروند میروند میروند میروند با این این این میروند میروند این میروند میروند میروند میروند میروند می مرابع این میروند می	NY MY CHARLEN LA
	the kitchen.		:		
	-He thought the mec	hanical soft menu			
		etable should be ground.	:		
	Interview with the RC revealed:	C on 04/11/23 at 1:00pm			
	-She was responsible residents' diet orders				
	mechanical soft diet.				:
		nen ano icio ene pivi when langed to mechanical soft a new diet order list.			
	12:53pm revealed:	ministrator on 04/11/23 at			
		nsible for taking new diet and informing the DM of			
	-Ground meat should mechanical soft diet.	l always be served for a			
	Interview with the Co. 1:38pm revealed:	rporate Chef on 04/11/23 at			
	-He started coming to	the facility a few weeks			
	ago.		1		
	 me corporate menu: should be served on a 	s documented ground meat e mechanical soft diet.			
		vith Resident #3's Primary			
		on 04-12-23 at 8:56am			
	Realdent #9 was rem	antly antivitian in the honorates			
	to rule out a stoke, at	which time she was treated			
	by speech therapy. -Speech therapy conc	lucted testing and it was			
	documented Resident	t #3 needed a mechanical			
	soft diet with ground n				
	Resident #3 ate quick risk for choking due to	kly which compounded her odysphagia so he changed			

#054 P.010/026

	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	NSTRUCTION	(X3) DATE SURVEY COMPLETED
	₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩	HAL011262	B. WING		R-C 04/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DORESS, OTY, STATE, 3	ZIP OODE	
CLEI MAPS	COVE ASSISTED LIVIN	67 MOUI	NTAIN BROOK ROA	0	
***************************************		ASHEVE	LLE, NC 20805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	NATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY PULL R LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE COMPLE E APPROPRIATE DATE
{D 310}	Continued From pag	ye 8	(0 310)	해가 가려 있다. 이 가 가 가 가 가 가 가 가 가 가 가 가 가 가 가 가 가 가	₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩
	her to a mechanical	soft diet with ground meat for			
	her safety as the so	sech therapist recommended			
	upon her hospital di				
		e a mechanical soft diet with			
		as at risk for choking which			
	could result in hypor	da (decreased oxygen lavel)			
	or aspiration pneum				
	The Face on Induced Sec.	the share provide the state			
		th the Regional Manager on			
	04/11/23 at 12:58pm	ł.	-		
	Refer to interview wi	th the Corporate Chef on			
	04/11/23 at 1:37pm.				
	Refer to interview wi 04/12/23 at 11:29am	th the Administrator on			
	. As the control of the product of the transmission of tr	/p=/m1m1			
	at 12:58pm revealed		4		
		ility of the DM to ensure the			
	the physician's order		-		
		lesident #2, #3 and #4 were			
	not receiving the pre-	scribed therapeutic diets.			
		oporate Chef on 04/11/23 at	ļ		
	1:37pm revealed:				
		e DM prepare pureed and			
		ly and had no concerns	1		
	about the consistency				
	He had not observed		4		
		1#2, #3 and #4 on 04/11/23.			
		for the DM not to prepare the			
	mear according to the the physician.	e therapeutic diet ordered by			
	tenteren sizerra realite etcan dans.	nínistrator on 04/12/23 at			
	interview with the Aot 11:29am revealed:	initialization on the lated bl			
	The DM knew which	residents were on	:		
	h Service Regulation	ски парти и разли тали с ла ъргани и и во во на тали и и во на			

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 04/17/2023 FORM APPROVED

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BURDING: R-C 8. WING HALG11262 64/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **67 MOUNTAIN BROOK ROAD** CHUNN'S COVE ASSISTED LIVING ASHEVILLE, NC 26805 SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 PROVIDER'S PLAN OF CORRECTION ID: (XS) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 7AG DEFICIENCY) (D 310) Continued From page 9 (D 310) therapeutic diets, -There was a therapeutic diet list posted in the kitchen that the Resident Care Coordinator kept updated. -She was not aware the residents were not being served the diet ordered by the PCP. The facility failed to serve therapeutic diets as ordered to Resident #2 related to a pursed diet, and to Resident #3 and Resident #4 related to a mechanical soft diet., which increased the risk of choking, hypoxia (decreased oxygen level) and aspiration pneumonia. This failure was detrimental to the residents health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 27. 2023. (D 319) 10A NCAC 13F .0905 (f) Activities Program (D 319) 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: Based on interviews and record review, the Division of Health Service Regulation STATE FORM ñóùv E8ME12 If continuation sheet 10 of 25

	of Health Service Re-	(X1) PROVIDER/SUPPLIER/CLIA	I /statistics		
	OF CORRECTION	IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREE	ADDRESS, CITY, S	TATE. ZIP CODE	28 200 2012012 0000 0000 00000 0000000000
PL211675374	COVE ASSISTED LIVI	27 N. H.	UNTAIN BROOK		
4457144FKP8 47	COVE ASSISTED LIVE	×1.	/ILLE, NC 28805		
(X4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL S LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IDLALD BE COM
(D 319)	Continued From pag	ze 10	{O 319}	۵۳۶۶۹۶۶۶۶ (۱۹۹۹) بخر میزمین سیسی می بین اور ۱۹۹۵ (۱۹۹۵) بخرهای از ۲۰۱۹ می بین اور اور اور اور اور اور اور اور ا ۱۹۹۶ (۱۹۹۹) با اور اور اور اور اور اور اور اور اور او	۱۳۰۰، ۱۳۵۰ میک میکند. ۱۳۵۰ میک میکند (۱۳۵۰ میک
		re each resident in the facility		10 mg 11. 11	and the second sec
	had the poportionity	to participate in at least one		O The Activitie	s regrom
	tating crange attack w	nne perior freigeren ere ret der treiten der bereiten nammeren Anne erete		port of the re	منتظر المراجع المواجع المراجع ا
			-	eren e o transfer e c	
	The findings are:		1	the opportuni	i han mha
	Ranian of the block	2023 activity calendar		Francis Of Life Contraction	
	presented by the Ad	ministrator revealed there		pordin factor in	- Sum Lize carta
	were no outings sch			and the second	No. of the second s
				one outing er	a prese the for the second
	Observation of the A	pril 2023 activity calendar			
		coms revealed there were no		north. Est	lander will
	outings scheduled.				
	Interviews with 6 res	idents during the facility initial		Se encourage	al when when the
	tour on 04/11/23 bety	ween 9:10am-9:65am		per checker of the	a pres service a
	revealed:				
	-Residents had not b	een taken on any outings		@ Admin is had	n an the
	since the start of CO			· · · ·	
		nt anywhere for activities.		manifet pasis	at a shafter and
	-one resident had no her admission a few	If gone on any outlings since	*	Anone Toler Press	E CLAN S
		as bored because no one		outings at A	V 12 Colam
	was ever taken on ar			Court of a transfer dama of the	and the second
		to "beg" staff to be taken to		proceeding (4)	
	the store.	-			
	-A fourth resident had	I lived at the facility for 2 1/2			
		emember being taken on			no har i
	outings by the facility occasions.	on more than two		(2) Completion a	Conde Partie Sec.
·	un un un vergen sonne d'half s			where we have a set of the	
í	Interview with the tran	sportation aids (TA) on		© Completion a May 27, 2	
(04/11/23 at 9:31am n	ivealed:		NAM ZT, Z	with the second
×	She was responsible	for transporting residents to			
t	nedical appointments	and for activities.			
-	I ne residents on the	secured unit were not taken			
		nvities. At check off list to ensure			
		ven the opportunity to go on	:		
	in outing every other				
	Service Regulation	алан тараалан br>Тараалан тараалан тар	annan marina sa		

AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		HAL011262	B. WING	unandi ju ju de aveza na lan ana ta de ana ana ana ana ana ana ana ana ana an	R-C 04/12/2023
NAME OF	PROVIDER OR SUPPLIER	STREET,	ODRESS, CITY, STATE	, ZIP CODE	
CHUNN	S COVE ABSISTED LIVIN	\$\$	ntain brook ro. Lle. NC 28805	AD	
(X4) (D		FATEMENT OF DEFICIENCIES	ici	PROVIDER'S PLAN OF CORR	
TAO	REGULATORY OR	LEO IDENTIFYING INFORMATION)	Piterta TAG	CROSS-REFERENCED TO THE AP DERCIENCY)	TOTALO BE COMPLE
{D 319]	Continued From pag	e 11	(D 319)	VII MARKANNEN EINEN EINEN EINEN EINEN EINEN EINEN KANNE KANNEN EINEN EINEN EINEN EINEN EINEN EINEN EINEN EINEN	ηση τριγόλου (Αλβαλλαβους του Ρουτικό αυτοποιοποιοποιοποιοποιοποιοποιοποιοποιοπο
	activity calendar. -She was not sure wi providing activities fo Activity Director was Interview with the Re at 9:48am revealed h 2023 activity calenda or the Assisted Living Interview with the Add 10:36am and 11:29ar -There should be an a residents outside the month. -The residents on the going on any commun- -There were no commun- March and April 2023	evealed: of what was listed on the no was responsible for r the residents when the not working. gional Manager on 04/11/23 e had not reviewed the April rs posted in the secured unit (AL) unit. ninistrator on 04/12/23 at n revealed: activity available for facility at least every other secured unit had not been hity outings. unity outings planned for on the activity calendars.			
() 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358		
	(a) An adult care horr preparation and admin prescription and non-p by stelf are in accorda (1) orders by a licensi which are maintained	Medication Administration w shall assure that the instration of medications, rescription, and treatments now with: ad prescribing preclitioner in the resident's record; and n and the facility's policies			

	of Health Service Rec				
STATEMEN AND PLAN	FOF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
// JP 1.50 _ PP 100000 100000 1000000000000000000	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	HAL011262	B, WING		R-C 04/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
Par Brass	4"P3122, 6.4"8"92""""""""""""""""""""""""""""""""""		WTAIN BROOK	ROAD	
runni 9	COVE ASSISTED LIVIN				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPL
D 358	Continued From pag	10 12	D 358	στου διατώστη την αγγατηρημένη την μαγγγγα την διατό το ματά την του στου του που του του του του του του του τ Αγγατηρία του	ατι τη του στο το τ
	This Rule is not met TYPE B VIOLATION			Q The facility contract Ph	1 will somery
	reviews, the facility fa medications as order residents with Insuli	ns, interviews, and record alled to administer red for 1 of 2 sampled n orders (Resident #4) g insulin ordered to treat high		and/or keg. nurse to pr	istered nucle med Aides
	The findings are:				
	02/27/23 revealed:	4's current FL2 deted		on administ	enny inavin
	disorder and dement			Increasing a to	est-au g
	fast-acting insulin use	for Humalog Kwikpen (a ed to treat high blood sugar)	÷	insulin for th	reat high
	100wmi check fingen	stick blood sugar (FSBS)		bland compared	Da
	follows: loss than 70	e sliding scale insulin as treat low blood sugar; less	:	prose segure	- FE-
	than 180=0 units; 18 units; 251-300=3 unit	1-200=1 unit; 201-250=2		blood sugars will follow h	ip with
		ater than 400=6 units.		mo to revié	w residents
	Medication Administra 03/26/23 to 03/31/23		:	mo to revie charts white	vl.h orders.
	There was an entry f				
		sugar before meals and		And the second s	the second second
1	reat low blood sugar; 181-200=1 unit; 201-2	lin as follows: less than 70 less then 181=0 units; 250=2 units; 251-300=3 s; 351-400=5 units; greater		@ File will . Mud Techs à	nol res. del
1		s, 351-400-5 units; greater aduled at 8:00am, 12:00pm,		w/ insulin or	ders daily
-	Humalog Kwikpen wa	as documented as Ily for 9 occurrences out of		,	ž
and the second sec	Service Regulation				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MLATIPLE C		(X3) DATE SURVEY COMPLETED
Mc4Mathinelling Websharefore commensus	त्र न स्वर्थनान अन्यपुर्वत् मृत्युं मृत्युं मृत्युं मृत्युं प्रदेश द्वर्थना न स्वत्या स्वरण्यात्र स्वरण्या जाया	HAL011262		a a sa sa sa sa sa sa managang pangang ng sa sa sa sa sa sa sa sa	R-C 04/12/2023
NAME OF PI	ROWDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZM CODE	
CHUNN'S	COVE ASSISTED LIVIN	2	intain brook ro. Lle, nc 26805	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of deficiencies Y must be preceded by full .SC identifying information)	ið Prefix Tag	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPL EAPPROPRIATE DAT
	03/31/23 was 140-49 -On 3/29/23 at 8:00ar documented as admir required. -On 03/26/23 at 12:00 were documented as required. -On 03/26/23 at 5:00p documented as admir required. -On 03/27/23 at 12:00 were documented as admir required. -On 03/27/23 at 5:00p documented as admir required. -On 03/28/23 at 12:00 were documented as admin required. -On 03/28/23 at 5:00p documented as admin required. -On 03/28/23 at 5:00p documented as admin required. -On 03/31/23 at 5:00p -On 03	<ul> <li>I FSBS's from 03/26/23 to 3.</li> <li>a, FSBS 235, 1 unit was histered, 2 units were</li> <li>ipm, FSBS 285, 2 units administered, 3 units were</li> <li>imm, FSBS 345, 3 units were</li> <li>istered, 4 units were</li> <li>pm, FSBS 305, 3 units were</li> <li>istered, 4 units were</li> <li>pm, FSBS 375, 4 units were</li> <li>istered, 5 units were</li> <li>pm, FSBS 375, 4 units were</li> <li>istered, 5 units were</li> <li>pm, FSBS 375, 4 units were</li> <li>istered, 5 units were</li> <li>pm, FSBS 375, 4 units were</li> <li>pm, FSBS 319, 3 units administered, 4 units were</li> <li>pm, FSBS 448, 5 units were</li> <li>pm, FSBS 413, 5 units were</li> <li>pm, FSBS 413, 5 units were</li> <li>pm, FSBS 413, 5 units were</li> <li>stered, 6 units were</li> <li>stered, 6 units were</li> <li>stered, 6 units were</li> <li>administered, 4 units were</li> <li>thumalog Kwikpen</li> <li>ugar before meals and</li> <li>n as follows: less than 70</li> </ul>	D 358	2 Complation . Min 27	1945 - Maria Maria Managara, ang kanang k
	محمد العراج	uled at 8:00am, 12:00pm,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				$\pi^{2}/4$ ) by propagation of the strain processing of the physical physic	(X3) DATE SURVEY COMPLETED R-C
		HAL011262	B. WING	and the second second second and the second s	04/12/2023
NAME OF PROVIDER OR SI	UPPLEA	BTREET	DDRESS, CITY, STATE	, ZIP CODE	annan an a
CULLING COMPANY	The states	e7 mou	NTAIN BROOK RO.	AD	
CHUNW'S COVE ASSIS	- 1 KILI LI ( 1963)	ASHEVI	LLE, NC 28805		
PREFIX (EAC	H DÉPICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S FLAN O (EACH DORRECTIVE AC CROSS REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DATE
D 358 Continued	From page	14	D 358	nn fan 'n en en in de en	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
and 5:00pn	<b>A</b>				
		s documented as			
-ritoriinintory r	VVHSERSET VER VVHSERSET VER	s oocumenteo as			
		y for 9 occurrences out of			
32 opportui		CORCUS			
· me range	or premea	FSBS's from 04/01/23 to			
04/11/23 w					
		n, FSBS was 252, 2 units			
	nenied as a	dministered, 3 units were			
required.	المراجع والمراجع				
-UKI UH/UZ/2	23 81 5:0000	n, FSBS was 512, 9 units			
	nemeo as s	dministered, 6 units were	1		
required.	M				
		m, FSBS was 397, 4 units			
	nemed as a	dministered, 5 units were			
required.		Private and the second s			
-On U4/04/2	:5 at 8:00ar	n, FSBS was 108, 5 units	1		
	nenteo as a	dministered, 0 units were			
required.					
-Un U4/04/2	:3 at 12:00p	m, FSBS 315, 3 units			
	ienieo as a	dministered, 4 units were			
required.		No. 10 Aug. 10. 10. 1			
		n, FSBS 351, 4 units were			
	i as aommi	itered, 5 units were			
required.	1	and the second			
		m, FSBS 233, 4 units			
	ienteo 28 20	Iministered, 2 units were			
required.	റ് പറോത്തം പം	و به المراجع ا	:		
		, FSBS 354, 2 units were			
	1 85 80MINIS	itered, 5 units were			
required.	3	and the second			
		, FSBS 180, 4 units were			
	i as agimens	tered, 0 units were			
required.					
() how man in the	nt Kienisten	t #4's medications on			
		t #4 s medications on 52am revealed Humalog			
		or administration.			
e ne extendente anali	U UVANGUAG I	w wwannergugt			
Interview wit	h e medica	ion aide (MA) on 04/11/23	÷		
at 12:35pm r		and a second of more as is a summer	1		
ion of Health Service Regu		ر از در خور ۱۹۹۲ میکند. میکند ده با میکند میکند میکند در در میگرد کرد این این این این این این این میکند بیکند م	At tailing 2 an ann ann ann ann an 1960 agus e tart ann an taing an e sig said	ty in Refs (M. 1977) and " A functional contention for a state of the content of the	

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S, DITY, STATE, ZIP CODE BROOK ROAD C 28805 ID PROVIDER'S PLAN OF CORRECTION (XS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
C 28805 ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
C 28805 ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
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## #054 P.018/026

PRINTED: 04/17/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: K-C 8. WING HAL011262 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 67 MOUNTAIN BROOK ROAD CHUNN'S COVE ASSISTED LIVING ASHEVILLE, NC 28805 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 05 (X5) PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREEXX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 16 D 358 administer sliding scale Insulin. -She and the RCC stressed the importance to staff of being very careful with insulin dosages. Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/12/23 at 11:50am revealed: -Inaccurate cosing of fast acting insulin could have short term and long term effects for Resident #4. -Kesident #4 would experience high blood sugars If staff were not giving the prescribed amount of insulin. -Resident #4 could experience low blood sugars if staff gave too much sliding scale insulin. -Long term effects of poor blood sugar control included damage to every organ in the body. -Kidney damage and damage to the eyes were usually the first areas to show signs of the long term effects of poor blood sugar control, -The insulin needed to be administered as it was ordered to control Resident #4's blood sugar. Review of the facility's medication administration policy revealed medications will be administered in accordance with the prescribing practitioner's orders. The facility failed to administer sliding scale ŝ insulin to Resident #4 as It was prescribed increasing the resident's risk of developing damage initially to the kidneys and eyes, and eventual damage to every organ in the body. This failure was detrimental to Resident #4's health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/23 for this violation. Division of Health Service Regulation STATE FORM 6500 E8ME12 If continuation shoot 17 of 25

**Division of Health Service Regulation** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R-C HAL011262 5. WING 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 67 MOUNTAIN BROOK ROAD CHUWN'S COVE ASSISTED LIVING ASHEVILLE, NC 28805 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D 673 PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFX **(EACH CORRECTIVE ACTION SHOULD BE** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 368 Continued From page 17 D 358 () RCC Will review CORRECTION DATE FOR THE TYPE B MAR W/ RN to ensure Keenares are accorate for VIOLATION SHALL NOT EXCEED MAY 27. 2023. (0 367) 10A NCAC 13F .1004(j) Medication {D 367) Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration resistants with record (MAR) shall be accurate and include the following: it sull orders. (1) resident's name; (2) name of the medication or treatment order: (3) strength and dosage or quantity of medication Bric will manuter med Ades dily for seconde Mare. 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 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 these initials is to be 3 Completion Date: Muy 27, 2023 documented and maintained with the medication administration record (MAR), This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the electronic Medication Administration Records (eMARs) were accurate for 2 of 2 sampled residents with insulin orders (#3 and #4) related to documentation of premeal Division of Hashh Service Regulation STATE FORM 69664 EBME12 If continuation shoet 18 of 25

ND PLAN OF CORRECTION IDENTIFICATIO	IPPLIER/CLIA IN NUMBER!	A. BUILDINIS;	ONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
HALC11262		e. wing	04/12/2023	
Me of provider or supplier	STREETA	UDRESS, CITY, STATE	, ZIP CODE	
Hunn's cove assisted living		HTAIN BROOK ROJ LLE, NC 28805	LD	
(X4) ID SUMMARY STATEMENT OF DEFICIE	****	-	۱۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ - ۲۹۹۵ -	Щ (б. =), <mark>//</mark>
TAG REGULATORY OR LSC (DENTIPYING INF	D BY FULL	K) Prefix Tag	FROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	NON SHOULD BE COMPLET HE APPROPRIATE DATE
(D 367) Continued From page 18		{D 367}		and a second
sliding scale (#3 and #4) and promeal insulin (#3 and #4).	scheduled			
The findings are:		₩ <b>4</b> 97 ₩ 4 ₩		
<ol> <li>Review of Resident #3's current FL: 02/06/23 revealed diagnoses included kidney injury and hyperglycemia.</li> </ol>				
Review of Resident #3's physician's or dated 03/06/23 revealed: -There was an order for Humalog Kwił				
to treat high blood sugar) 100u/mi che fingerstick blood sugar (FSBS) before	ck meals and			
et bedtime and give sliding scale insul follows: less than 70 treat low blood su than 180≏0 units; 181-200=1 unit; 201	igar; less -250=2			
units; 251-300=3 units; 301-35D=4 unit 351-400=5 units; greater than 400=6 u -There was an order for Humalog Kwik	nks.			
100u/ml 5 units three times a day with				
Review of Resident #3's March 2023 e Medication Administration Record (eM.				
03/26/23 to 03/31/23 revealed: -There was an entry for Humalog Kwik 180u/mi check fingerstick blood sugar	pen /FSRS1			
before meels and at bedtime and give scale insulin as follows: less than 70 tru	sliding set low			
blood suger; less then 180=0 units; 18 unit; 201-250=2 units; 251-300=3 units 301-350=4 units; 351-400=5 units; gree	;			
400=6 units scheduled at 8:00am, 12:0 5:00pm, and 8:00pm.	Opm,			
<ul> <li>There was an entry for Humalog Kwikj 100u/ml 5 units three times a day with r scheduled at 8:00am, 12:00pm, and 5:t</li> </ul>	meals	:		
-On 03/29/23 at 12:00pm, FSBS 253, 5	units	1		
documented as administered for sliding units required), 3 units documented for a of Hoelih Service Regulation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SLPPLIER/CLIA IDENTIFICATION NUMBER:	ş	XONSTRUCTION	(X3) OATE SURVEY
		BOOM TO REACTION FOR MARKE	A BUILDING:	nden alar har har 1,4 n,0 m, an	COMPLETED
		HALOTT262	B. WING		R-C 04/12/2023
NAME OF P	ROVEDER OR SUPPLIER	STREET	ODRESS, CITY, STATI	- 787 0000	₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩₩
			NTAIN BROOK RO		
CRUMN'S	COVE ASSISTED LIVE	4 <b>C</b> #	LLE, NC 28805	~~ ~	
(X4) (D		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	RECTION (X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL NEC IDENTIFYING INFORMATION	PREFIX YAG	(Each corrective action 5 cross-referenced to the a deficiency)	SHOLLO BE COMPL
(D 367)	Continued From pag	ye 19	(D 367)	zu Szakan de az a a a a a a a a a a a a a a a a a a	એ / પંચે અર્થ કરી કરી કરી કરી અર્થ અન્ય નાંગ પ્રતા કરવા કરવા કરવા છે. આ ગામ આ ગામ આ ગામ આ ગામ વાલ્ય પ્રતા સુધા
	(5 units required).				
		0pm, FSBS 400, 5 units			
		inistered for sliding scale (6			
		its documented for scheduled			
	(5 units required).	its documented for scheduled			
	(or osnica responses).				
	Review of Resident	#3's April 2023 eMAR from			
	04/01/23 to 04/11/23	revealed:			
		for Humslog Kwikpen			
		before meals and at			
		ding scale insulin as follows:			
		v blood sugar; less than			
		0=1 unit; 201-250=2 units;			
		1-350=4 units; 351-400=5			
	units' greater than 40	00=6 units scheduled at			
	8:00am, 12:00pm, 5:				
		for Humalog Kwikpen			
	100u/ml 5 units three	times a day with meals			
		, 12:00pm, and 5:00pm.			
		Opm, FSBS 262, 5 units			
	documented as adm	inistered for sliding scale (3			
		Is documented for scheduled			
	(5 units required).				
		am, FSBS 189, 5 units			
	documented as somi	inistered for sliding scale (0			
		is documented for scheduled			
	(5 units required).	وهويهو يعونه والمراسي والمراجب المراجب معارفتها والمعارية والمراجب والمراجب			
		0pm, FSBS 290, 5 units			
		nistered for sliding scale (3			
		is documented for scheduled			
	(5 units required).				
		am, FSBS 171, 5 units			
		nistered for sliding scale (0			
		s documented for scheduled			
	(5 units required).				
		om, FSBS 310, 5 units			
	documented as admit	nistered for sliding scale (4			
•					
1					
;	units required), 4 unit	s documented for scheduled			
1	units required), 4 unit (5 units required).				

(X4) (D

PREFIX

TAG

Division of Health Service Regulation

PRINTED: 04/17/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES (C1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLEMED A BUILDING: R-C 8. WING HAL011262 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **67 MOUNTAIN BROOK ROAD** CHUNN'S COVE ASSISTED LIVING ASHEVILLE, NC 28805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 2X63 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFix (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {0.367}

(D 367) Continued From page 20 documented as administered for sliding scale (4 units required), 4 units documented for scheduled (5 units required). -On 04/08/23 at 12:00pm, FSBS 285, 5 units documented as administered for sliding scale (3 units required), 3 units documented for scheduled (5 units required). -On 04/09/23 at 12:00pm, FSBS 212, 5 units documented as administered for sliding scale (2 units required), 2 units documented for scheduled (5 units required). -On 04/10/23 at 8:00am, FSBS 228, 5 units documented as administered for sliding scale (2 units required), 2 units documented for scheduled (5 units required). -On 04/10/23 at 12:00pm, FSBS 434, 5 units documented as administered for stiding scale (6 units required), 6 units documented for scheduled (5 units required). -On 04/11/23 at 8:00am, FSBS 422, 5 units documented as administered for stiding scale (6 units required), 6 units documented for scheduled (5 units required). Interview with the Resident Care Coordinator (RCC) on 04/11/23 at 12:50pm revealed: -She administered Resident #3's Humalog Kwikpen sliding scale and scheduled insulin at 8:00am that morning. -She administered 11 units total of Humalog Kwikpen to Resident #3 which included 5 scheduled and 6 sliding scale units. -She had mislakenly "flipped" the documentation of the number of units given for the sliding scale and scheduled on the eMAR. -She may have documented the wrong amount of sliding scale and scheduled premeat insulin in the eMAR system. Refer to the interview with the Resident Care Division of Health Service Regulation STATE FORM 6622 E8MB42 If continuation shout 21 of 26

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A. DUALMAG:	an an a guir a fa an	
ቀሳ በቀሳ በተዋና የም ታይሯ በ1 ዓመር መንሸመን የመመን የመንሸማ በተማ በማይ የተያያዘር የትር ዓመር የትር ዓመር የትር ዓመር የትር ዓመር በታይ የተያያዘር የትር ዓመር የ የተኛ የም ታይ		HAL011262	8. WING		R-C 04/12/2023
WAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	. ZIP CODE	nanna ar ann ganna, ann ga (1945) an ga Allan Anna an San San San San San San San San S
mass shifting	COVE ASSISTED LIVING	67 MOU	NTAIN BROOK RO	40	
0730166× 0*	CONC HISSINICO LIVING		LLE, NC 28805		
(X4) ID PREFIX TAB	(EACH DEPICIENC	ATEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE COMPLE E APPROPRIATE DATE
(D 367)	Continued From pege	5 21	(D 367)	**************************************	
	Coordinator (RCC) or	1 04/11/23 at 12:55pm.			
	Refer to the telephon pharmacist from the f pharmacy on 04/11/2	acility's contracted			
	Refer to the interview 04/12/23 at 11:35am.	with the Administrator on			
	Refer to the interview at 11:45am.	with the RCC on 04/12/23	-		
	02/27/23 revealed: -Diagnoses included r disorder and dementia -There was an order fi to treat high blood sug fingerstick blood suga	a. pr Humalog Kwikpen (used			
	treat low blood sugar; 181-200=1 unit; 201-2	less than 180=0 units; 50=2 units; 251-300=3 ; 351-400=5 units; greater			
		imes a day with meals.			
1	Medication Administrat 03/26/23 to 03/31/23 n				
:	give sliding scale insul	ugar before meals and in as follows: less than 70			
1	units; 301-350=4 units;	less than 181=0 units; 50=2 units; 251-300=3 ; 351-400≈5 units; greater ≄uled at 8:00am, 12:00pm,			
: -	and 5:00pm. There was an entry fo	r Humalog Kwikpen			
	100u/ml 4 units three 6	interaction on address consistent was an active			

	f Health Service Reg of Deficiencies	(AI) PROVIDERODOPPLIEROCIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1	" ^{an} y of a the grad you want and and party and the spectra of the state of the sta	COMPLETED R-C 04/12/2023	
		HAL011262	B. WING	11. 9. 1. 15. 47. or de literatur un estan un februit, la glas contra un te		
NAME OF PR	ovider or supplier	STREET	ADDRESS, CITY, STATE	. ZP CODE	and the second	
~131 131310 F	OVE ASSISTED LIVIN	و بنایا جو بر بنایا اور	NTAIN BROOK RO			
	OVE ASSISTED LIVIR	N.C.	ALE, NC 28805	1er		
(X4) IO PREFIX TAG	(EACH DEPICIENC	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE CONPI	
(D 367)	Continued From page	e 22	{D 367)	an a		
	scheduled at 8:00am There were no docu	, 12:00pm, and 5:00pm. mentation errors.				
l t	Review of Resident # 04/01/23 to 04/11/23	4's April 2023 eMAR from revealed:				
-	There was an entry t	or Humalog Kwikpen	4 1 1 1			
,	100u/ml check blood	sugar before meals and	7 5 4 4			
ç,	give sliding scale insu	In es follows: less than 70				
•.	181-200=1 Unit: 201.1	; less than 181=0 units; 250=2 units; 251-300=3				
Ĺ	inits: 301-350=4 unit	s; 351-400=5 units; greater				
ŧ	han 400=6 units sch	eduled at 8:00am, 12:00pm,				
÷	and 5:00pm.					
	There was an entry f	or Humalog Kwikpen				
۲ م	00u/mi 4 units three	times a day with meals				
		12:00pm, and 5:00pm. pm, FSBS 233, 4 units				
		histered for sliding scale (2				
L)	nits required), 2 units	s documented for scheduled				
(*	4 units required).		\$			
R	tefer to the Interview	with the Resident Care				
C	coordinator (RCC) on	04/11/23 at 12:55pm.				
R	efer to the telephone	interview with a				
	harmacist from the fa					
	hamacy on 04/11/23					
R	efer to the interview	with the Administrator on				
	4/12/23 at 11:36am.	with the Plantiniso (tip) off				
R	efer to the interview	with the RCC on 04/12/23				
	11:45am.	an ann an 1977 an 1980 ann ann a 1977 a' Bull Bull				
In	terview with the Resi	dent Care Coordinator				
(6	ICC) on 04/11/23 at 1	12:65pm revealed:				
-1	he date input ereas a	of the eMAR for Humalog				
sli	ding scale and sched	tuled premeal Humelog				
		ch other in the eMAR				
	siem.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
ana ang ang tanggang	8:44 stanson san ar san amammuna samamangangagangayanga gayas	HAL011262	B. WING		R-C 04/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE	
ALITHIANO	COVE ASSISTED LIVI	67 MOUI	NTAIN BROOK RO.	AD	
633661626 KS	OWAE WOORLED FIAH	ashevii Ashevii	LLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL S LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH OORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE HE APPROPRIATE DATE
{D 367}	Continued From page	3e 23	{D 367}	στι τη δελαγγαρία ματά τη δεί τη ματά τη παρά τη	۵۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰
	«There was no way	to distinguish which input area			
		cale units administered or for			
	the scheduled units				
		was confusing as to where to			
	document the sliding	scale insulin when there			
	was also an order fo	r a premeal scheduled dose			
	of insulin.	· • • • • • • • • • • • • • • • • • • •			
			1		
	<b>Telephone Interview</b>	with a pharmacist from the			
		pharmacy on 04/11/23 at			
	3:00pm revealed:				
		responsible for entering			
	medication and treat	ment orders into the			
	residents eMARs.				
	-In the eMAR, preme	al sliding scale insulin and			
		nsulin orders were grouped			
	together.				
		sulin option was not applied			
	to those eMAR entrie	es, one could not distinguish			
		o enter the number of units			
		nistered and the number of			
	units of scheduled in				
		sulin option was applied, a			
		the right of the data entry			
		d directions to the user for			
	the sliding scale and	premeal scheduled insulin.			
		siled to activate the sliding			
		sulin orders when they had			
	entered the order.				
	- the stan person at t	he facility who approved			
		vas able to activate the			
:	sliding scale option o	n the insulin orders.			
	Interview with the Ad	ministrator on 04/12/23 at	:		
	11:35am revealed;	an a			
		nsible for ensuring the			
(	MAR documentation	Was accurate.			
		itered medications in the			
	acility.				
	•	ding scale and premeal			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUCTIFLE C		(X3) DATE SURVEY	
		INTERACTORY CONSTRUCTS	A BUILDING:	administrative for the product and address to the first and output and output and output and output and output a	COMPLEYED R-C 04/12/2023	
		HAL011262	B. WING	uning (11) of the second s		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIF CODE		
CHIMMER	COVE ASSISTED LIVIN	67 KOU	NTAIN BROOK ROA	AD.		
	COVAR MOREOTERS CLARK	(C)	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLE	
(0 367)	Continued From pag	e 24	(0 367)	το το διαδομάτιας ματογραφικά το που που το που το το το διαδομάτου το το που το που το που το που το που το π Το το το διαδομάτισται το ποι το που το πο	landenaman an a	
	input areas where to acale administered a scheduled insulin adi -She looked at a prin discovered, she had administered incorrec Interview with the RC revealed: -She reviewed eMAR all residents. -She did review the d and they "looked righ -She looked at the en not print them out dur	b discern from the eMAR document the units of sliding ind the units of premeal ministered, ted eMAR on 04/11/23 end documented the insulin she ctly on the eMAR. CC on 04/12/23 at 11:45em CC on 04/12/23 at 11:45em				