PRINTED: 08/15/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MALC11282		34 (1987) 10846 3080 (1988)	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING					
		B. WING						
VAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	ATE, ZIP CODE				
RMHUMB	COVE ASSISTED LIVING	67 MOUI	vtain brook f	ROAD				
	OCCUPATION CONTRACTOR	ASHEVI	LE, NC 28205					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE OF THE APPROPRIATE DEFICIENCY)				SE COMPLET			
D 000	Initial Comments		D 000					
	The Adult Care Licens Buncombe County De conducted a follow-up through 07/26/23.	partment of Social Services						
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310					
	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: FOLLOW UP TO TYPE B VIOLATION  Based on these findings, the previous Type B Violation was not abated.  Based on observations, interviews, and record reviews, the facility failed to serve therapautic diets as ordered for 2 of 2 sampled residents related to nectar thickened liquids (Resident #2 and #3).			The facility corporate chef will be ordering thickener packets from our food vendor to measure the liquid or drink for proper thickness.  Training has been provided immediately by the chef for dietary staff and additional training wife				
				## provided on 08/01/2023.  Training will be provided by RN to all 08/22/2023 for measuring the liquid for proper thickness.	staff on d or drink			
				The facility corporate chef will continue thickening packets from our food vent residents that have difficulty with swand /or diagnosed with dysphagia. A will be trained immediately in measure or drink for proper thickness.	dor for the allowing Il new staff			
	The findings are:	#2lo aumont FLC 3-4-1		Completion date: 08/22/2023				
	3/20/23 revealed diagonal hemiplegia following control of the cont	#3's current FL2 dated moses included depression, erebral infraction affecting sumatic brain injury, senile ee nectar thickened liquids. or a restorative feeding or speech therapy (ST).	!	The Administrator will monitor q	uarterly.			
	Review of Resident#3	's Resident Register	ė					

Reviewed and acknowledged with revisions per telephone call with the Administrator on 08/22/23

Julio Grooms, RN 08/22/23

Division	of Health Service Requ	lation				FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPI AND PLAN OF CORRECTION DENTIFICATIONAL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING:			OMPLETED
		HAL011262	B. WING			R 07/26/2023
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING		ntain brook roa			
	<del></del>	ASHEVII	LE, NC 28805	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	1	D 310		<del></del>	
	revealed an admission	n date of 10/25/22.	i			į.
	Danden of Death and the	01 0 01 11				r
	Review of Resident #: 10/25/22 revealed:	3's Care Plan dated				i
	-Additional diagnoses	included traumatic brain				t. V
	Injury, frontal tempora	l dementia, right hip				
	fracture, hemiplegia o	i the right side. I puree diet with nectar				1
	thick liquids.	2 barco diet mitt Hectal	1			
	Davinus of Davidson de		İ			ı.
	6/2/23 revealed:	3's physician orders dated	ŗ,			11
	-There was a referral t	for ST, physical therapy				) E
	(PT), and occupationa	I therapy (OT) for			4	1
	swallowing.	rs, balance, cognition, and				
	Review of Resident #3	s's physician's order dated				п
	5/15/23 and signed by	the facility's contracted				, ]
	Nurse Practitioner (NF	) on 5/20/23 revealed ncluded aphasia (the loss of	4			
	ability to understand or	r express speech, caused				
	by brain damage), and	i dysphasia- oropharyngeal				*
	phase (swallowing pro mouth and/or the threa	blems occurring in the				
	moder eliator nie fillos	at <i>y</i> .	i			Į
	Review of ST Plan of (	Care dated 1/20/23				
	revealed: -Resident #3 was refer	rred to ST services due to	1			
		ne in verbal expression and	ľ			
	swallowing abilities.		*			
	-The Resident was cho meals and the primary	oking and coughing during	Ì			ļ
3	ordered pureed solids					1
	iquids.					
•	-vviinout therapy for dy at risk for genication (w	sphagia, Resident #3 was hen something enters your				
	airway or lungs by acci	dent), weight loss,				1
	dehydration, pneumoni					
						į

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: B. WING HAL011262 07/26/2023 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 310 Continued From page 2 D 310 Review of ST Progress and Discharge Summery dated 3/3/23 revealed: -Resident #3 had difficulty chewing, had moderately impaired swallowing, and required thickened liquids. -Resident #3 was at risk of aspiration and may need cueing and intermittent supervision during meals. -Without therapy for dysphagia, Resident #3 was at risk for aspiration, weight loss, dehydration, pneumonia, and hospitalization. Review of the facility's therapeutic diet list dated 7/11/23 posted on the kitchen wall revealed Resident #3 should be served nectar thick liquids. Observation of the breakfast meal service on 7/26/23 at 8:06am revealed: -The personal care aide (PCA) served 8 ounces of regular consistency orange Juice to Resident #3 then walked away. -When prompted by the surveyor, the PCA returned with a container of thickening powder and added two scoops with the small scoop [2] teaspoons (tsp)] of the powder in the cup and stirred it. Observations of the container of thickening powder on 7/26/23 at 8:10am revealed: -A 36-ounce container of thickening powder was on a table near the door in the dining room. -The directions on the label for nectar thickened liquids were to mix 3 to 3 1/2 tsp per 4 ounces of orange juice (8 ounces would have required 6-7 -There was a double-sided scooper in the container. -The small end of the scoop was the labeled 5cc (1 tsp) and the large end of the scoop labeled 14.8cc (1 tablespoon).

Division	of Health Service Requ	ulation			FORM APPROVE
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(Va) DATE SUBJECT
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING:		(X3) DATE SURVEY COMPLETED	
		1	-		2
		HAL011262	B. WING		R
NAME OF	ROVIDER OR SUPPLIER	<u> </u>			07/28/2023
TOTAL OF F	WOAIDER OK SONATIEK		ADDRESS, CITY, STATE,		
CHUNN'S	COVE ASSISTED LIVING		INTAIN BROOK ROA	AD.	
	· · · · · · · · · · · · · · · · · · ·		ILLE, NC 28805		
(X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORR	ECTION (X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	BOULD RE COMPLETE
		<u> </u>		DEFICIENCY)	PROPRIATE DATE
D 310	Continued From page	9.3	D 310	· · · · · · · · · · · · · · · · · · ·	
	<b>Fog</b>		D 210		
	Investigate with the DO	II Tinning to se	5.		
	revealed:	A on 7/26/23 at 8:08am	1		
		#3 was to be served nectar			
	thick liquids and she l	had walked away to retrieve	1		
	the thickening powde	г.			
	-She only put 2 scoop	os of thickening powder in	l,		
	the orange juice beca	use if she put in any more it			
	was too thick, and the	resident would choke.	j		
	-Sne stated they alwa	ys served 2 scoops to			
	thicken the liquids.	dalam Barda E., O	. 1		
	-She was trained to the resident by another P	iicken iiquias tor the			
	tonical in by another (	OA.			
	interview with the spe	ech therapist on 7/26/23 at	1		
	9:52am revealed:				
	-Resident #3 was orde	ered nectar thickened			
	ilquids because he wa	as at risk for aspiration.			
	-he could aspirate if n	ot given thickened liquids			
	hospitalization.	nto pneumonia resulting in			
	nospitalization,				
	Interview with facility's	contracted NP on 7/26/23			
	at 10:38am revealed in	f Resident #3 not given	1		
	thickened liquids, he o	ould aspirate, get			
	pneumonia and requir	e hospitalization.			
	L-1				
	interview with the Adm 9:42am revealed:	ninistrator on 07/26/23 at			
		on hire on the process to			
	thicken thin liquids.	of fille off title process to			
		sed to follow the directions			
	on the container of thic	ckening powder.			
	The orange juice shou	uld not have been served to			
	the residents before th				
		aff to use the big scoop			
	which would have been	п о шавроопѕ.	81 24		
1	Based on observations	s, interviews, and record			
	review, Resident #3 wa				
	,			A-100/20	

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 B. WING HAL011262 07/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **67 MOUNTAIN BROOK ROAD** CHUNN'S COVE ASSISTED LIVING ASHEVILLE, NC 20905 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY D 310 Continued From page 4 D 310 2. Review of Resident #2's current FL2 dated 03/13/23 revealed: -Diagnoses included primary progressive aphasia (inability to comprehend or formulate language). -Regular diet. Review of Resident #2's Resident Register revealed an admission date of 04/01/22. Review of Resident #2's Swallowing Assessment and Treatment Swallow Study dated 06/07/23 revealed: -It was signed by a Speech-Language Pathologist and initialed by the facility's contracted Primary Care Provider (PCP). -Resident #2 had a history of esophageal stricture (abnormal narrowing of the esophagus) and dementia. -Resident #2 had moderate-severe dysphagia (difficulty swallowing), swallowing safety was impaired evidenced by silent aspiration observed with thin liquids via a cup. -Resident #2 was at high risk for aspiration pneumonia (infection of the air sacs in the lungs which may fill with fluid). -Resident #2 was at a moderate risk for malnutrition and dehydration. -Diet to consist of nectar thick liquids. Review of Resident #2's Recommendations for Safe Swallowing form dated 06/07/23 revealed: -Nectar thick liquids was circled on the form. -Handwritten on the form was "Aspiration Precautional She silently aspirates thin liquidal". -It was signed by a Speech-Language Pathologist (SLP) and initialed by the facility's contracted Primary Care Provider (PCP). Review of the facility's therapeutic diet list posted

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Division	of Health Service Requ	ulation			FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	INSTRUCTION	NO DATE OUR -	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
					1000 XAA000000000
į		HAL011262	B. WING		R
MANEGER	ROVIDER OR SUPPLIER	<u> </u>			07/26/2023
TENANE OF F	KONIDEK OK SUPPLIER		address, City, State,		
CHUNN'S	COVE ASSISTED LIVIN		intain brook roa ILLE, NC 28805	.D	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF CORRECTIO	N am
TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RF COUNTER
D 310	Continued From page	95	D 310	DEFIDICACT)	
	on a kitchen wall date	ed 07/11/23 revealed nectar			
	thick liquids for Resid	ent#2.			
	Observation of the mo	orning meal on 07/26/23 at			
	8:06am revealed:		ì		
	-The parsonal care at	de (PCA) served 8 ounces	ž.		
		Resident #2 then walked			
	away.				
	<ul> <li>When prompted by the surveyor, the PCA returned with a container of thickening powder and put two scoops with the small scoop (2</li> </ul>				
	teaspoons) of the pov	der in the cup and stirred it.			
	Observations of the co	ontainer of thickening			
	powder on 07/26/23 at 8:10am revealed:				
	-A 35 ounce container	of thickening powder was			
	on a table near the do	or in the gining room. label for nectar thick liquids			
	were to mix 3 to 3 1/4 to	easpoons per 4 ounces of			
	orange juice (8 ounce	s would have required 6 - 7	8		
	teaspoons).  -There was a double sided scoop in the				
	container.				
	-On the bottom of the	small scoop was the			
	tableances) was well	1 teaspoon) and 14.8 cc (1			
	larger scoop.	en on the bottom of the	×		
	anger soop,				
	Interview with the PCA	on 07/26/23 at 8:08am			
	revealed:	we see your way to			
	-She knew Resident #2 was to be served nectar thick liquids and she had walked away after putting the cup of thin orange juice on the table				
	next to the resident to	orange juice on the table retrieve the thickening			
	powder.	ionieve uie unoteiniy			ļ
		nickening powder in the			1
	orange juice because l	f she put in any more it			Ì
	was too thick and the r				
	-That was the way the	liquids were always			
100	serven.				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R B. WING HAL011262 07/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **67 MOUNTAIN BROOK ROAD** CHUNN'S COVE ASSISTED LIVING ASHEVILLE, NC 28805 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY D 310 Continued From page 6 D 310 -She had received her training from another PCA. Telephone interview with the facility's contracted PCP on 07/26/23 at 10:36am revealed: -He could not recell why Resident #2 was ordered nectar thick liquids. -Drinking thin liquids put Resident #2 at risk of aspiration pneumonia possibly leading to hospitalization. -The staff should be following all orders whether from the PCP or SLP. Interview with the Administrator on 07/26/23 at 9:42am revealed: -Staff were trained upon hire on the process to thicken thin liquids. -The staff were supposed to follow the directions on the container of thickening powder. -The orange juice should not have been served to the residents before thickening it. -She had instructed staff to use the big scoop which would have been 6 teaspoons. It would be easier if the facility had individual packets of thickener to put on each meal tray. Based on observations, interviews, and record review, Resident #2 was not interviewable. Attempted telephone interview with the SLP on 07/26/23 at 8:50am was unsuccessful. The facility failed to serve therapeutic diets as ordered to Resident #2 and #3 related to nectar thick liquids, which increased the risk of aspiration pneumonia and hospitalization. This failure was detrimental to the residents' health and welfare and constitutes a Type B Violation. The facility provided a plan of protection on

Division	of Health Service Rep	ulation			FORM APPROVE	
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
		HAL011262	B. WING		R 07/20/2000	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	700 0000	07/26/2023	
			NTAIN BROOK ROA			
CHUMA'S	COVE ASSISTED LIVIN		LLE, NC 28805	<b></b>		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F			מו	PROVIDER'S PLAN OF CORRECTION	CORRECTION (X5)	
TAG	REGULATORY OR	CT MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COURTER	
D 310	Continued From pag	je 7	D 310		·	
	07/26/23 for this viol 131D-34.	ation in accordance with G.S.				
	1010-04.		1			
			E.			