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D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey and complaint investigation on 07/23/24-07/26/24 and 07/29/24. The complaint investigation was initiated on 07/19/24 by the Buncombe County Department of Social Services.	D 000		
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. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 8 sampled residents (#6) who missed 2 of 4 scheduled rabies vaccinations for a raccoon bite and to provide a referral to a menntal health provider for 1 of 5 sampled residents (#1) which resulted in an escalation of verbal and physical aggression. The findings are: Upon request during the survey, no policy or procedure for health care referral and follow-up was provided. 1. Review of Resident #6's current FL2 dated 07/08/24 revealed: -Diagnoses included encephalopathy (a disturbance in brain function), dementia, diabetes mellitus type 2, chronic obstructive pulmonary disease, history of repeated falls, and	D 273		

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hypotension.
-Recommended level of care was documented as assisted living facility.
-There was no documentation regarding orientation.

Review of Resident #6's current FL2 dated 06/18/24 revealed:
-Recommended level of care was documented as domiciliary.
-Orientation was documented as intermittently disoriented.

Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 11/02/23.

Interview with Resident #6 on 07/25/24 at 9:38am revealed:
-He was bitten by a raccoon 2-3 months ago.
-He was sitting outside one evening in a covered area in the courtyard smoking and both his hands were hanging down beside the chair when a raccoon "snuck" up on him and bit him on the hand.
-Other residents were feeding 5 or 6 raccoons at night around 10:00pm.
-He could not remember which staff he reported the raccoon bite to, but he was sent to the local hospital to get a "shot".

Review of Resident #6's Incident and Accident (I/A) report dated 05/23/24 revealed:
-The Resident Care Coordinator (RCC) documented Resident #6 reported being bitten by a raccoon in the courtyard at 8:51pm.
-There was documentation of no apparent injury and Resident #6 was transported to the local hospital emergency department (ED) for treatment.

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D 273	Continued From page 2 Review of Resident #6's chart notes revealed: -On 05/23/24 at 8:31am, there was documentation by the RCC that Resident #6 was "supposedly" bitten after trying to feed a raccoon and was transported to the local hospital for a rabies vaccination, with a second dose scheduled for 05/26/24 at the local hospital, 3rd dose set for 05/30/24 at the local county health department, and 06/06/24 for the final dose of the rabies vaccination. -On 05/28/24 at 1:25pm, there was documentation by the RCC that Resident #6 received the 2nd dose of the rabies vaccination with "3rd set Friday and last set following Friday". -On 05/30/24 at 1:00pm, the RCC documented "2nd round rabies vaccination". -On 06/06/24 at 1:24pm, there was documentation by the RCC that Resident #6 was sent out for the "last round of rabies vaccination". Review of Resident #6's ED discharge instruction report dated 05/28/24 revealed: -Resident #6 was seen in the ED for an animal bite. -Resident #6 received an initial dose of rabies vaccine on 05/28/24 in the right upper arm. -Follow-up instructions included to return to the ED on 05/30/24 for a third rabies vaccine. -The rabies vaccine schedule was documented as day 0= 05/23/24, day 3= 05/26/24, day 7= 05/30/24, and day 14= 06/06/24. Review of Resident #6's North Carolina Immunization Registry revealed: -Resident #6 received a rabies vaccination at a local hospital on 05/23/24. -Resident #6 received a 2nd rabies vaccination at a local hospital on 05/28/24. -There was no documentation Resident #6	D 273		

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D 273	Continued From page 3 received a 3rd or 4th dose of the rabies vaccinations. Review of an email from the local health department (LHD) communicable disease (CD) registered nurse (RN) to the local Department of Social Services (DSS) adult home specialist (AHS) revealed: -On 05/24/24, a report was received at the LHD related to Resident #6 being bitten by a raccoon. -The CD RN called the RCC and explained the schedule for the remaining rabies vaccinations with the second dose due on 05/26/24 and would have to be obtained at the local hospital ED since it fell on a Sunday and the rest of the series could have been obtained at the local health department or ED. -On 05/28/24, the CD RN telephoned the RCC to follow-up because Resident #6 missed the second rabies vaccine on 05/26/24 as scheduled. -The RCC reported Resident #6 was visiting family over the weekend and she planned on taking Resident #6 for the vaccination on 05/28/24. -The CD RN advised the RCC the administration dates for the 3rd and 4th doses fell on a Saturday and Resident #6 would have to be administered the vaccinations at the local hospital ED and the RCC verbalized understanding. -On 07/26/24, the CD RN reported to the AHS she could not find documentation of the administration of the remaining 2 doses of Resident #6's rabies vaccination series in the state immunization registry and the electronic patient health record system that links all key medical information from all health care providers, or the local hospital computer system. Interview with the RCC on 07/26/24 at 10:15am revealed:	D 273		

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-Resident #6 was bitten by a raccoon on 05/23/24.
-She did not know why Resident #6 did not receive 2 of the 4 scheduled rabies vaccinations.
-She did not know why she documented in the chart notes Resident #6 received all 4 rabies vaccinations when Resident #6 only received the first 2 vaccinations.

Telephone interview with the CD RN Supervisor at the LHD on 07/19/24 at 2:30pm revealed:
-She had limited access to the computer system due to worldwide software issues and could not check to see if she received a post-exposure report for Resident #6.
-Any humans potentially exposed to rabies must have a rabies vaccine on day zero, day 3, day 7, and day 14 after exposure and a 5th vaccine on day 28 if the person was immunocompromised.
-Anyone potentially exposed to rabies must complete all 4 vaccinations because the incubation period for rabies in humans ranged from one week to one year and if any doses of vaccines were missed, rabies was 100 percent fatal in humans.

Telephone interview with Resident #6's primary care provider (PCP) on 07/29/24 at 12:03pm revealed:
-She was informed by the facility staff that Resident #6 was feeding and bitten by a raccoon on 05/23/24.
-Resident #6 was sent to the local hospital ED to be administered the first rabies vaccination.
-She knew Resident #6 received a second rabies vaccination on 05/28/24.
-She was not notified by the facility that Resident #6 did not receive a 3rd and 4th rabies vaccination to complete the series.
-If Resident #6 was bitten by a raccoon infected

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with rabies and did not receive the full series of vaccinations, it would be fatal to Resident #6.

Second interview with the RCC on 07/29/24 at 3:25pm revealed:
-Resident #6 was bitten by a raccoon a "couple" of months ago.
-Resident #6 reported the bite to a former night shift medication aide (MA).
-Resident #6 received the 1st and 2nd rabies vaccinations but missed the 3rd and 4th vaccinations because he fell, was sent to the local hospital, and then went to a rehabilitation center before being readmitted to the facility (Resident #6's 3rd vaccination was scheduled for 05/30/24 and 4th vaccination was scheduled on 06/06/24 and the fall with admission to the local hospital did not occur until 06/20/24).
-She did not recall Resident #6 was bitten by a raccoon until it was brought to her attention on 07/26/24.
-She was responsible for reviewing all orders and discharge instructions when a resident was sent to the local hospital ED.
-If a follow-up was required, she gave the facility's transportation person a copy of the order and they were responsible for setting up all follow-up visits and taking the resident for the appointments.
-The Administrator's Assistant was responsible for making sure all health care referrals and follow-ups were completed.

Interview with the Administrator's Assistant on 07/29/24 at 4:13pm revealed:
-The facility's transportation person was responsible for scheduling all the residents' appointments and gave him a copy of the appointments to keep in a notebook.
-He did not have a record of any appointments

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set up for Resident #6 to receive a 3rd and 4th rabies vaccination.
- "We dropped the ball" and missed taking Resident #6 for the 3rd and 4th rabies vaccinations.

Interview with the Administrator on 07/29/24 at 4:21pm revealed:
-He was not aware Resident #6 missed 2 of the 4 scheduled rabies vaccinations.
-He thought Resident #6 received the vaccinations at a rehabilitation facility after experiencing a fall.
-He did not know when the scheduled rabies vaccinations were due.
-The facility's transportation person was responsible for setting up appointments for the residents.
-His Assistant was responsible for making sure all heath care referral and follow-up for residents were completed.
-He expected staff to make sure the rabies vaccinations for Resident #6 were completed as scheduled.

Attempted telephone interview with Resident #6's responsible person on 07/26/24 at 3:58pm was unsuccessful.

2. Review of the facility's policy for the "management of physical aggression or assault by a resident" revealed:
-Report dangerous behaviors to the residents' physicians and/or area mental health authority and implement physician's orders.
-Report dangerous behaviors to the resident's family/ responsible persons, an seek intervention.
-Cooperate with law enforcement.

Review of Resident #1's current FL2 dated

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06/13/24 revealed:
-Diagnoses included recurrent depression, chronic obstructive pulmonary disease.
-Recommended level of care was documented as assisted living facility.
-There was no documentation regarding orientation to time, place or situation.

Review of Resident #1's care plan dated 02/22/24 revealed:
-Resident #1 had a tendency to "be belligerent" to staff and other residents when he doesn't get his way over his medications.
-Resident #1 would continuously request medications before they were scheduled and would argue with staff that he could have it.

Review of Resident #1's initial psychiatric visit dated 01/16/24 revealed diagnoses of somatic complaints (significant focus on physical symptoms to the level it results in major distress), chronic pain and antisocial personality disorder.
-There was documentation Resident #1 remained irritable and had multiple somatic complaints.
-There was documentation psychiatric nurse practioner (NP) had observed Resident #1 being rude and curt with staff and had accused staff of taking his belongings.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 08/31/23.

Review of Resident #1's Incident/Accident Report for 04/14/24 at 8:55pm revealed:
-Resident #1 insisted staff give him medication not on his medication administration record (MAR) for his bedtime medications.
-Resident #1 tried to reach into the medication

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cart and take his medication out of the cart.
-Resident #1 then pushed staff and grabbed her arms demanding she give him his medicine, insulting her ability to do her job, while inhibiting her ability to complete her medication pass.
-Resident Care Coordinator (RCC) was contacted on 04/14/24 at 9:00pm.
-Resident#1's family was notified on 04/14/24 at 8:47pm and the primary care physician (PCP) was notified on 04/15/24 at 8:50am

Review of Resident #1's chart notes revealed:
-There was no documentation of any incident on 04/14/23 or 04/15/24..
-On 05/01/24 at 10:37am Resident #1 pulled a "bed" into the backyard of the facility for him to sleep on.
-Residents #1's room was a fall hazard and Administrator and Maintenance told staff to clean room.
-On 05/01/24 at 10:45am Resident #1 was yelling at staff to leave his room alone.
-The Administrator was present and told him the room would be cleaned.
-On 05/01/24 at 1:02pm Resident #1 was screaming in the Administrators face; Resident #1 started pulling trash out of his trash can stating his PCP had told him he could keep his medications and cleaning chemicals in his room.
-On 05/06/24 at 1:17pm Resident #1 was sleeping outside with staff explaining to Resident #1 it was not safe for him to sleep outside the facility and refused to come inside after staff explained to him that sleeping outside would affect his pulmonary issues.
-On 05/09/24 at 10:38am Resident #1 was sleeping outside the facility in the fenced in courtyard.
-On 05/12/24 at 12:00am, Resident #1 approached a female resident and asked her if

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she was a mother; she replied no and he ask her if she "wanted to go make one real quick".
-On 05/14/24 at 12:00am a knife was found in Resident #1's belongings outside, reported to management and staff made aware.
-On 05/15/24 at 1:00pm Resident #1 was argumentative and refused to let housekeeping clean his room
-On 05/16/24 at 12:11am Resident #1 refused for his room to be cleaned again.
-On 05/17/24 at 1:59pm staff attempted to clean resident's room; he refused and insisted they leave his room.
-On 05/18/24 at 9:34am Resident #1 was demanding another resident's medication because his had not arrived from the pharmacy.
-Resident #1 approached a female resident, raising his voice and arguing and asking her to trade out her medication.
-On 05/15/24 at 1:00pm Resident #1 was argumentative and refused to let housekeeping clean his room.
-On 05/20/24 at 12:00am Resident #1 was yelling at the housekeeper about cleaning his room.
-On 05/20/24 at 1:55pm PCP was with Resident #1 when he began screaming and yelling at the PCP due to the PCP decreasing pain medication, resulting in a referral for pain management.
-On 05/20/24 at 2:40pm Resident #1 poured a liquid substance on the floor in his room and refused for housekeeping to clean it up
-On 05/20/24 at 3:36pm Resident #1 told staff and Administrator he could keep his medications in his room.
-The PCP was notified and denied he had told Resident #1 he could keep medication in his room.
-On 05/21/24 at 2:23pm Resident #1 refused to get up at noon for his pain medication; Resident #1 was arguing about wanting his medications

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two and a half hours after the administration time..
-On 05/21/24 at 2:44pm Resident #1 was being argumentative with RCC and the Administrator regarding medications being removed from his room and safety issues discussed
-On 05/27/24 at 10:30am RCC spoke with Resident #1 about THC Delta products (look like marijuana products having a similar mood-altering effect) being brought into the facility.
-On 06/05/24 at 3:30pm staff were attempting to get residents out of the facility for a fire alarm(not a drill) when Resident #1 pushed by medication aide (MA) going back into the facility.
-Staff explained to Resident #1 it was not a fire drill and he told staff to shut up he would go wherever he wanted.
-The RCC and the Maintenance Director attempted to talk with Resident #1 about leaving the facility related to a fire alarm and that building must be cleared but Resident #1 refused, stating it was his right to do what he wanted to.
-On 06/18/24 at 3:52pm Resident #1 started altercation with another male resident gave a female resident a piece of pizza.
-Resident #1 was yelling and cursing at male resident and told the other male resident he had to ask him (Resident #1) stated the other male resident had to ask Resident #1 for permission to give female resident a piece of pizza.
-On 07/03/24 at 1:29pm there was documentation Resident #1 attempted to punch a "wheelchair bound hemiplegia resident" in the face.
-On 07/06/24 at 2:02pm there was documentation Resident #1 attempted to slap another resident who told him he needed to come in the facility.
-On 07/10/24 at 9:59am Resident #1 told to MA that he had a pocket knife and had been self medicating with vitamin c and Pepto Bismol.

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D 273	Continued From page 11 Interview with the MA on 07/26/24 at 10:05am revealed: -Resident #1 wanted medication when it was not time for it, tried to trade his medications with other residents, "rides you all day long" when staff are trying to work or deal with other residents, tries to intimidate new staff or other residents. -When Resident #1 became upset, he would curse, flips residents and staff with his middle finger, tell residents and staff their worthless, makes fun of residents and staff appearances and try to intimidate them. -She observed Resident #1 "throw" a male resident out of his wheelchair after accusing the male resident of inappropriate behavior with a female resident because he gave the female resident a piece of pizza. -Resident #1 threatened another male resident to hit him but she stepped in front Resident #1, and he backed down. -Resident #1 had tried several times to "physically" and aggressively get into the medication cart to obtain medications. -Resident#1 had been agitated and intimidating since January 2024 since she began working at the facility but had become increasingly worse over the past three to four months. Interview with the RCC on 07/25/24 at 11:10am revealed: -Resident #1 did not have any other Incident/Accident Report for 2024. -Resident #1 frequently became agitated over his medications. -Resident #1 had been in a physical altercation with a staff member on 04/14/24 over medications. -There were no interventions put in place at this time for Resident #1 as they were focused on the	D 273		

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staff member.
-Resident #1 had also been involved in bringing alcohol and THC Delta products into the facility and sharing it with two other residents at the end of May, keeping over-the-counter medication in his room without a physician's order, had thrown another male resident in the floor because the male resident had sat down beside a female resident that Resident #1 was interested in, and had put his hands on another male resident for interacting with the same female resident.
- Resident #1 attempted to interfere with care when the female resident received a heart monitor and attempted to stop the nurse who was trying to assist the female resident with the heart monitor.
-Staff informed Resident #1 that he could not interfere with the care of another resident and Resident #1 became angry and belligerent.
-On 05/29/24 an intervention was put in place for Resident #1 to be redirected from the female resident and Resident #1 was to talk with the Administrator about the facility rules.
-Resident #1 signed a statement that THC products and alcohol were not allowed to be in the facility and if he brought it in again it would result in a discharge from the facility.
-Resident #1 received a 30-day discharge notice on 06/04/24 after he brought in alcohol and TCH products into the facility and gave it to the same female resident.
-On 06/22/24 Resident #1 became agitated and drew back to hit the Administrator, but the Administrator had stepped back.
-The Administrator called the local sheriff's department for assistance and Resident #1 was sent to the local emergency department for evaluation.
-The facility tried to redirect Resident #1.
-They had to take the curtains down in the living

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	HAL011262	A. BUILDING: _____ B. WING _____	07/29/2024

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
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room so staff would be able to monitor the courtyard related to Resident #1's behaviors.
-Third shift staff were to monitor Resident #1 hourly because he was up most of all night and slept late in the day.
-Resident #1 had exhibited and increase in his behaviors for the last three months.
-The PCP for Resident #1 was aware of his behaviors.

Interview with the PCP on 07/26/24 at 2:55pm for resident #1 revealed:
-He was familiar with Resident #1 and had followed him since he was admitted to the facility. and other residents and staff.
-Resident #1 was verbally aggressive with him.
-He had attempted to decrease Resident #1's pain medication and Resident #1 became verbally aggressive and belligerent.
-He made a referral to a pain management clinic.

Interview with the mental health provider for Resident #1 on 07/26/24 at 3:25am revealed:
-She provided mental health services one time monthly for the facility.
-She recalled seeing Resident #1 only one time on 06/18/24.
-She followed Resident #1 for depression and the fact his room was so messy.
-She had not been notified that Resident #1 was exhibiting verbal or physical aggression behaviors.
-She would have wanted to known about any increase or change in Resident #1's behaviors.

Interview with the Administrator and Administrator Assistant on 07/29/24 at 11:15pm revealed:
-Resident #1's behaviors had escalated beginning in April with the main agitation being related to Resident #1's medication.

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D 273	Continued From page 14 -The Administrator was not aware Resident #1 had only been seen by psychiatry once in January and once in June and the mental health provider was not aware of Resident #1's verbal or physically aggressive behaviors. -The Administrator Assistant stated he had discussed Resident #1 with a mental health provider and the more pressure put on Resident #1 to conform to the facility rules resulted in Resident #1's behaviors becoming worse. Attempted interview with Resident #1 on 07/26/24 at 11:21am and 07/29/24 at 1:11pm he declined to be interviewed. Attempted interview with a family member for Resident #1 on 07/25/24 at 3:52 and 3:58pm was unsuccessful. _____ The facility failed to obtain the last 2 doses of a 4-dose series of rabies vaccinations for Resident #6 who was bitten by a raccoon on 05/23/24 or notify the primary care provider (PCP) of the missed doses which could result in death if Resident #6 contracted rabies and the facility failed to notify a mental health provider for Resident #1, who had a diagnoses of anti-social personality disorder and exhibited verbal and physically aggressive behaviors towards staff and residents, who pulled another resident out of a wheelchair, attempted to hit other residents, and interfered with another resident's health care when a nurse placed a heart monitor on a female resident and Resident #1 became beligerent. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/29/24 for this violation.	D 273		

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D 273	Continued From page 15 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 28, 2024.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the reach in ice machine in the kitchen was clean and free of contamination related to build up of a pink and black residue inside the ice machine. The findings are: Observation of the reach-in ice machine located in the kitchen on 07/24/24 at 10:15am revealed: -There was pink and black residue across the	D 283		

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D 283	Continued From page 16 interior of the reach-in ice machine. -The cook used a cloth she dropped on the floor while walking toward the reach-in ice machine to clean the interior where the pink and black residue was observed. -There was pink and black residue observed on the cloth used to clean the interior or the reach-in ice machine. Interview with the cook on 07/24/24 at 10:15am revealed: -She did not know how often the ice machine was cleaned. -She did not know if there was a cleaning schedule for the ice machine. -She observed the Maintenance Director clean the ice machine twice in the past few months. Interview with the Maintenance Director on 07/24/24 at 10:25am revealed: -The kitchen staff were responsible for cleaning the reach-in ice machine monthly. -The interior of the reach-in ice machine had a pink and black residue visible on the plastic ice distribution tube that was in contact with the ice. -The ice was contaminated and needed to be discarded and the ice machine sanitized immediately. Interview with the Administrator on 07/24/24 at 10:30am revealed: -The reach-in ice machine was cleaned monthly. -He personally cleaned the reach-in ice machine last week. -He did not know why there was a pink and black residue along the plastic ice distribution tube. -He was responsible for ensuring the reach-in ice machine was sanitary.	D 283		

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D 338	Continued From page 17	D 338		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

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.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on interviews and record reviews, the facility failed to ensure the health and safety of all residents related to residents feeding wild raccoons resulting in 6 of 6 sampled residents (#1, #3, #7, # 6, #5, #8) being bitten by the raccoons that were on the facility's property.

The findings are:

1. Review of Resident #1's current FL2 dated 06/13/24 revealed:
-Diagnoses included recurrent depression, chronic obstructive pulmonary disease.
-Recommended level of care was documented as assisted living facility.
-There was no documentation regarding orientation.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 08/31/23.

Interview with Resident #1 on 07/26/24 at 11:21am revealed he did not want to discuss feeding the raccoons, being bitten or his vaccinations.

Review of Resident #1's Incident and Accident

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report revealed:
-There was no documentation of the 06/28/24 incident of Resident #1 being bitten by a raccoon.
-There was no documentation Resident #1 was transported to the local hospital emergency department (ED) for treatment of a raccoon bite.

Review of Resident #1's chart notes revealed:
-There was no documentation of Resident #1 reporting he had been bitten by a raccoon prior to 07/01/24.
-On 07/01/24 at 12:00am there was documentation Resident #1 had received 2nd dose of rabies vaccination as a family member had taken him to the local ED for the vaccine.

Review of Resident #1's local hospital discharge instruction report dated 06/28/24 revealed:
-Resident #1 was seen in the ED for an animal bite.
-Follow-up instructions included if there were any changes or worsening of symptoms to return to the ED right away.

Review of Resident #1's North Carolina Immunization Registry dated 07/24/24 revealed there was documentation Resident #1 received 4 doses of the rabies vaccinations with a 5th dose due on 07/26/24.

Interview with the RCC on 07/23/24 at 11:39pm revealed:
-Resident #1 had two small red areas where he stated he had been bitten.
-She was not aware if had had the rabies vaccinations or not as she had not called the local health department or ED to find out.

Refer to the telephone interview with the communicable disease (CD) registered nurse

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D 338	Continued From page 19 (RN) supervisor at the local county health department on 07/19/24 at 2:30pm. Refer to the interview with the RCC on 07/29/24 at 3:25pm. Refer to the interview with the Administrator on 07/29/24 at 4:50pm. 2. Review of Resident #3's current FL2 dated 03/06/24 revealed diagnoses included vascular dementia and traumatic brain injury. Review of Resident #3's Resident Register revealed an admission date of 07/29/19. Review of Resident #3's current care plan dated 06/06/24 revealed Resident #3 only required supervision with all activities of daily living. Interview with Resident #3 on 07/24/24 at 9:51am revealed: -He frequently sat outside where the kitchen door opens to the back yard when he smoked. -He used to volunteer in the kitchen and would throw food out for the bears and the raccoons in the woods behind the facility. -The raccoons were not aggressive, and he most recently saw one raccoon close to the kitchen door on 07/23/24. -He did not feed the raccoon he saw on 07/23/24, but that was only because he didn't have any food to give it. -He hated to throw away food, so he always gave anything he had left over to the wildlife outside. -He did not hand feed the raccoons. -A few weeks ago, he was outside the kitchen smoking when a raccoon came up to him and bit him on his left wrist.	D 338		

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-He had to get a series of shots in case the raccoon was sick.
-There were signs posted inside and outside not to feed the wildlife.
-After he was bitten, the Administrator told him not to feed the raccoons anymore or he would have to discharge him from the facility.
-A representative from the Wildlife Commission had spoken to him and the other residents about the dangers of feeding the wildlife, including the possibility of rabies, sometime in July 2024.
-He knew the risks but planned on continuing to feed the raccoons.

Review of the incident/accident report dated 06/21/24 revealed:
-Resident #3 was sitting outside at 10:00pm and a raccoon came up beside him and bit his left wrist.
-The type of injury Resident #3 received was documented as a "skin tear" on his left wrist.
-Initial actions taken included checking for injury, applying first aid, notifying management, the emergency contact and the PCP, called 911 and sent to the emergency room (ER) for evaluation and treatment.

Interview with the RCC on 07/29/24 at 3:25pm revealed:
-She was not present at the facility when Resident #7 was bitten by a raccoon.
-A representative from the Wildlife Commission came to the facility in July 2024 to educate the residents about the importance of not feeding the wildlife.
-She had spoken to Resident #3 after he was bitten and told him not to feed the raccoons.

Interview with the Administrator on 07/29/24 at 4:50pm revealed:

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D 338	Continued From page 21 -Resident #3 had been feeding the raccoons prior to being bitten. -He thought the residents were taking their daily snacks and feeding the raccoons. -He spoke with Resident #3 after he was bitten about not feeding any wildlife on the property and that if he continued to do so, it could jeopardize his placement at the facility. 3. Review of Resident #7's current FL2 dated 04/17/242/29/22 revealed diagnoses included high blood pressure, stroke, anxiety and depression. Review of Resident #7's Resident Register revealed an admission date of 12/29/22. Interview with Resident #7 on 07/25/24 at 5:10pm revealed: -She had been bitten by a racoon twice but could not remember the date. -The first bite was about three days before the second bite. -She had been feeding the raccoon and was bitten. -She did not tell staff when the raccoon bite occurred but told her primary care provider (PCP). -She had gone to the local emergency room for a rabies vaccination. Review of the incident/accident report dated 06/26/24 revealed: -Resident #7 had an unwitnessed raccoon bite on her left wrist. -Resident #7 did not tell staff when the raccoon bite occurred but told her PCP during their visit three days after the first bite occurred. -The type of injury Resident #7 received was documented as a "bite" to her left wrist.	D 338		

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D 338	Continued From page 22 -Initial actions taken included notifying management, the emergency contact and the PCP, and sent to the emergency room (ER) for evaluation and treatment. Review of the charting notes for Resident #7 revealed: -Resident #7 told the PCP on 06/27/24 that she had previously been bitten on the hand by a raccoon. -The PCP verified Resident #7 had not made staff aware of the raccoon bite. -The PCP notified the RCC. Interview with the RCC on 07/29/24 at 3:25pm revealed: -Another resident had convinced Resident #7 that the raccoon was actually a cat they were feeding. -Resident #7 did not tell staff after she was bitten by the raccoon. -She did not think Resident #7 told staff because she did not want the animals relocated or killed. -Resident #7 told her PCP three days after she was bitten by the raccoon. -She spoke to Resident #7 after she was bitten and told her not to feed the raccoons anymore. -She was only aware of Resident #7 being bitten once by a raccoon. -A representative from the Wildlife Commission came to the facility in July 2024 to educate the residents about the importance of not feeding the wildlife. Interview with the Administrator on 07/29/24 at 4:50pm revealed: -Resident #7 had been feeding the raccoons prior to being bitten. -He thought the residents were taking their daily snacks and feeding the raccoons. -He had difficulty communicating with Resident	D 338		

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#7, but he knew the RCC had spoken to her about not feeding the raccoons anymore.

4. Review of Resident #6's current FL2 dated 07/08/24 revealed:
-Diagnoses included encephalopathy (a disturbance in brain function), diabetes mellitus type 2, chronic obstructive pulmonary disease, history of repeated falls, and hypotension.
-Recommended level of care was documented as assisted living facility.
-There was no documentation regarding orientation.

Review of Resident #6's current FL2 dated 06/18/24 revealed:
-Recommended level of care was documented as domiciliary.
-Orientation was documented as intermittently disoriented.

Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 11/02/23.

Interview with Resident #6 on 07/25/24 at 9:38am revealed:
-He was bitten by a raccoon 2-3 months ago.
-He was sitting outside one evening in a covered area in the courtyard smoking and both his hands were hanging down beside the chair when a raccoon "snuck" up on him and bit him on the hand.
-Other residents were feeding 5 or 6 raccoons at night around 10:00pm.
-He could not remember which staff he reported the raccoon bite to, but he was sent to the local hospital to get a "shot".

Review of Resident #6's Incident and Accident

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report dated 05/23/24 revealed:
-The Resident Care Coordinator (RCC) documented Resident #6 reported being bitten by a raccoon in the courtyard at 8:51pm.
-There was documentation of no apparent injury and Resident #6 was transported to the local hospital emergency department (ED) for treatment.

Refer to the telephone interview with the communicable disease (CD) registered nurse (RN) supervisor at the local county health department on 07/19/24 at 2:30pm.

Refer to the interview with the RCC on 07/29/24 at 3:25pm.

Refer to the interview with the Administrator on 07/29/24 at 4:50pm.

5. Review of Resident #5's current FL2 dated 04/17/24 revealed:
-Diagnoses included vascular dementia, anxiety, bipolar disorder, schizoaffective disorder, chronic obstructive pulmonary disease, hypertension, and nicotine dependence.
-There was documentation she was intermittently disoriented.

Review of Resident #5's Resident Register revealed an admission date on 10/07/20.

Review of Resident #5's Care Plan dated 04/12/24 revealed:
-Resident #5 had a decline in cognition.
-Resident #5 had an increased need for assistance with all activities of daily living.

Interview with Resident #5 on 07/24/24 at 11:36am revealed:

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-Other residents were feeding raccoons nightly outside.
-She was sitting outside one evening when a raccoon ran up and when she kicked the raccoon away with her foot it bit her right big toe.
-She could not remember if she was wearing shoes when she was bitten.
-She did not report the bite to staff, but she saw her primary care provider (PCP) the next day and was sent to the local hospital emergency department (ED) to get a vaccination.
-Staff told her and other residents to not feed the raccoons anymore after several of the residents were bitten.

Telephone interview with Resident #5's primary care provider (PCP) on 07/29/24 at 12:03pm revealed:
-She saw Resident #5 for a routine visit on 06/26/24 and Resident #5 told her she was bitten by a raccoon.
-She bandaged Resident #5's foot and spoke to the RCC who reported she was not aware Resident #5 was bitten.
-She had the facility send Resident #5 to the local hospital ED to get a rabies vaccination.
-The risk Resident #5 could experience from a raccoon bite was develop a local or systemic infection or contract rabies which is fatal to humans without a series of rabies vaccinations.

Refer to the telephone interview with the communicable disease (CD) registered nurse (RN) supervisor at the local county health department on 07/19/24 at 2:30pm.

Refer to the interview with the RCC on 07/29/24 at 3:25pm.

Refer to the interview with the Administrator on

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D 338	Continued From page 26 07/29/24 at 4:50pm. 6. Review of Resident #8's current FL2 dated 06/12/24 revealed: -Diagnoses included schizoaffective disorder, major neurocognitive disorder, diabetes mellitus type 2, hypertension, chronic obstructive pulmonary disease, and bipolar disorder. -There was documentation she was intermittently disoriented. Review of Resident #8's Care Plan dated 02/22/24 revealed Resident #8 needed assistance from staff with all activities of daily living. Interview with Resident #8 on 07/19/24 at 11:00 revealed: -She was feeding the raccoons one night and was bitten around 9:00pm. -Other residents were also bitten and they were not feeding the raccoons. -Staff told her and the other residents to not feed the raccoons anymore. -She was no longer feeding the raccoons. Review of Resident #8's primary care provider (PCP) progress note dated 06/28/24 revealed: -Resident #8 was assessed for an animal bite wound with documentation "bitten by raccoon 3 days ago. No signs of infection today. Raccoons are known vectors for rabies." -There were orders to send Resident #8 to the local hospital emergency department (ED) for the 1st shot of the rabies vaccination series, complete the rabies vaccine series through the local health department, and report any muscle cramping, muscle rigidity, difficulty swallowing or breathing.	D 338		

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D 338	Continued From page 27 Interview with the RCC on 07/26/24 at 9:15am revealed: -She did not think to ask other residents that went outside at night about being bitten by raccoons when a resident was confirmed as being bitten. -She found out Resident #8 was bitten by a raccoon when Resident #8's primary care provider (PCP) made the weekly routine visit to see Resident #8. Telephone interview with Resident #8's primary care provider (PCP) on 07/29/24 at 12:03pm revealed: -Resident #8 reported being bitten by a raccoon on the elbow during a routine visit. -She had the facility send Resident #8 to the local hospital ED to get a rabies vaccination. -The risk Resident #8 could experience from a raccoon bite was develop a local or systemic infection or contract rabies which is fatal to humans without a series of rabies vaccinations. Refer to the telephone interview with the communicable disease (CD) registered nurse (RN) supervisor at the local county health department on 07/19/24 at 2:30pm. Refer to the interview with the RCC on 07/29/24 at 3:25pm. Refer to the interview with the Administrator on 07/29/24 at 4:50pm. _____ Telephone interview with the communicable disease (CD) registered nurse (RN) Supervisor at the local county health department on 07/19/24 at 2:30pm revealed: -She received a post exposure report for several residents residing at the facility that were all bitten by raccoons.	D 338		

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D 338	Continued From page 28 -She visited the facility with the CD nurse and environmental health food and lodging supervisor after receiving the post exposure report and saw a wildlife trap on the property that was not set, and the door was closed. -She asked the facility's Maintenance Director about the closed wildlife trap and was told he left the trap closed because he was letting the raccoon get used to the cage and then he would open it put peanut butter in the trap to try to capture the raccoon. -She had limited access to the computer system due to worldwide software issues and could not look up the details of the residents residing at the facility bitten by raccoons. -Any humans potentially exposed to rabies must have a rabies vaccine on day zero, day 3, day 7, and day 14 after exposure and a 5th vaccine on day 28 if the person was immunocompromised. -Anyone potentially exposed to rabies must complete all 4 vaccinations because the incubation period for rabies in humans ranged from one week to one year and if any doses of vaccines were missed, rabies was 100 percent fatal in humans. Interview with the RCC on 07/29/24 at 3:25pm revealed: -Several residents were feeding raccoons and were bitten. -A representative from the Wildlife Commission came to the facility in July 2024 to educate the residents about the importance of not feeding the wildlife. -Some of the residents continued to feed the wildlife. Interview with the Administrator on 07/29/24 at 4:50pm revealed: -After the first resident was bitten by a raccoon,	D 338		

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D 338	Continued From page 29 they placed signs inside and outside the building indicating that no one was supposed to feed the wildlife. -After the second resident was bitten by a raccoon, they placed more signs inside and outside the building along with settings traps, getting a bear horn and a sling shot. -Within the last 45 days, a representative from the Wildlife Commission had come to the facility and talked with the residents about the importance of not feeding the wildlife. -The residents were also informed they would have to pay a fine of up to $5,000.00 if they were caught feeding the wildlife. -Staff had been informed to contact him or the RCC if they saw any residents feeding the raccoons and they would give the staff instructions on what to do. -He thought the residents were taking their daily snacks and feeding the raccoons. _____ The facility failed to ensure 6 residents received the appropriate care and services related to allowing the residents to feed wild raccoons, who became habituated to human food and resulted in the residents being bitten requiring rabies vaccinations to prevent them from acquiring rabies that could be deadly. This failure placed all the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/19/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 28, 2024.	D 338		

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D 358	Continued From page 30	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#4) observed during the medication pass including errors with lubricant eye drops and an inhaler to treat shortness of breath and wheezing. The findings are: The medication error rate was 6.6% as evidenced by observation of 2 errors out of 30 opportunities during the 8:00am medication pass on 07/24/24. Review of Resident #4's current FL2 dated 01/10/24 revealed diagnoses included chronic obstructive pulmonary disease. a. Review of a physician's order dated 02/12/24 revealed an order for albuterol hydrofluoroalkane (HFA) (compressed gases in an inhaler to propel the medication) inhaler (a short-acting rescue inhaler to treat shortness of breath and wheezing) 90 mcg inhale 2 puffs twice daily. Observation of the morning medication pass on	D 358		

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D 358	Continued From page 31 07/24/24 at 8:10am revealed: -The medication aide (MA) removed a box containing an albuterol HFA 90mcg inhaler labeled with a sticker with Resident #4's name and instructions to inhale 2 puffs twice daily. -Resident #4 was sitting on the seat of a rolling walker in the community living room and the MA handed the albuterol HFA inhaler to Resident #4 and said only take 2 puffs. -Resident #4 pressed the inhaler 3 times and inhaled 3 puffs of the albuterol and said, "well, I did three". -The MA returned to the medication cart and documented albuterol HFA 90mcg inhaler 2 puffs were administered to the resident. Review of Resident #4's July 2024 electronic medication administration record (eMAR) from 07/01/24 through 07/24/24 revealed: -There was an entry for albuterol HFA 90mcg inhaler inhale 2 puffs twice daily. -There was documentation albuterol HFA 90mcg inhaler inhale 2 puffs were administered at 10:00am from 07/01/24 through 07/15/24. -There was documentation albuterol HFA 90mcg inhaler inhale 2 puffs were administered at 4:00pm from 07/01/24 through 07/15/24. -There was documentation albuterol HFA 90mcg inhaler inhale 2 puffs were administered at 7:00am from 07/16/24 through 07/24/24. -There was documentation albuterol HFA 90mcg inhaler inhale 2 puffs were administered at 7:00pm from 07/16/24 through 07/23/24. -There was no documentation albuterol HFA 90mcg inhaler 3 puffs were administered at 7:00am on 07/24/24. Interview with a day shift MA on 07/24/24 at 11:50am revealed: -Resident #6 preferred to administer the albuterol	D 358		

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inhaler to herself and would "often" administer extra doses.
-She always reported the extra doses that Resident #4 self-administered to the Resident Care Coordinator (RCC) or the MA supervisor.

Interview with the RCC on 07/24/24 at 11:59am revealed:
-She was aware that Resident #4 sometimes administered extra doses of the albuterol inhaler to herself.
-Resident #4 preferred to administer the albuterol inhaler herself.
-Resident #4 also inhaled 3 puffs of the albuterol inhaler on 07/23/24.
-The MA reported the incorrect dosage of the albuterol inhaler that Resident #4 self-administered for the morning medication pass on 07/24/24.
-She always communicated the incorrect doses of inhaler with Resident #4's primary care provider (PCP) by either sending the PCP an email or documenting in a notebook which was reviewed by the PCP on a weekly basis.
-She could not find documentation where Resident #4's PCP was notified of the albuterol inhaler medication errors administered on 07/23/24.

Telephone interview with Resident #4's PCP on 07/26/24 at 2:45pm revealed:
-Resident #4 was ordered albuterol HFA 90mcg inhaler take 2 puffs twice daily for chronic obstructive pulmonary disease to treat shortness of breath and wheezing.
-He was not notified by the facility that Resident #4 was administered an incorrect dosage of the albuterol inhaler.
-Resident #4 receiving extra doses of the albuterol inhaler could cause tachycardia

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(increased heart rate) short term, and taken long term it could cause the lungs to become damaged and scarred with stiffness.
-He expected the facility to administer Resident #4's medications as ordered and notify him of any medication errors.

Interview with the Administrator on 07/29/24 at 4:21pm revealed:
-He expected the MA to administer the albuterol inhaler to Resident #4 as ordered.
-Resident #4's PCP should have been notified of the medication error.

b. Review of Resident #4's physician's order dated 01/10/24 revealed an order for artificial tears (a lubricant eye drop for the relief of dry eyes) instill 1 drop into the left eye twice daily for dry eye.

Observation of the morning medication pass on 07/24/24 at 8:10am revealed:
-The medication aide (MA) removed a bottle of Resident #4's artificial tears labeled with the directions apply 1 drop into the left eye twice daily.
-The MA donned gloves and approached Resident #4 and instilled 1 drop of artificial tears into each of Resident #4's eyes.
-The MA returned to the medication cart and documented artificial tears 1 drop was instilled to Resident #4's left eye.

Review of Resident #4's July 2024 electronic medication administration record (eMAR) from 07/01/24 through 07/24/24 revealed:
-There was an entry for artificial tears instill 1 drop into the left eye twice daily for dry eye.
-There was documentation artificial tears 1 drop was instilled into the left eye at 10:00am from

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07/01/24 through 07/15/24.
-There was documentation artificial tears 1 drop was instilled into the left eye at 4:00pm from 07/01/24 through 07/08/24 and 07/10/24 through 07/15/24.
-There was documentation artificial tears 1 drop was instilled into the left eye at 7:00am from 07/16/24 through 07/24/24.
-There was documentation artificial tears 1 drop was instilled into the left eye at 7:00pm from 07/15/24 through 07/23/24.
-There was no documentation that a second dose of Resident #4's artificial tears were administered on 07/09/24 at 4:00pm and no documented reason why the dose was not administered.

Interview with a day shift MA on 07/24/24 at 11:50am revealed:
-She did not realize the order for Resident #4's artificial tears were to instill 1 drop in the left eye.
-She instilled one drop of artificial tears into each of Resident #4's eyes because she was nervous.

Interview with the RCC on 07/24/24 at 11:59am revealed the MAs were trained to compare the order on the eMAR to the label attached to the medications and administer the correct dosage according to the directions on the eMAR.

Telephone interview with Resident #4's PCP on 07/26/24 at 2:45pm revealed:
-He ordered the artificial tears to be instilled into Resident #4's left eye for dry eye relief.
-He expected the facility to administer Resident #4's medications as ordered.

Interview with the Administrator on 07/29/24 at 4:21pm revealed:
-MAs were trained to compare medications to the eMAR, administer medications as ordered on the

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D 358	Continued From page 35 eMAR, and accurately document the medications as administered. -He expected the MAs to administer and accurately document medications as they were ordered by the PCP.	D 358		
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 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 electronic medication administration records (eMARs) were accurate for 1 out of 5 sampled residents (Resident #4) related to a medication needed for wheezing and shortness of breath.	D 367		

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D 367	Continued From page 36 The findings are: Review of the facility's undated Medication Management Policy revealed: -The facility must maintain a medication administration record for all residents who self-administer. -The administration of as needed medications must be documented on the resident's medication administration record and include the date, time, dose, reason, and effectiveness. Review of Resident #4's current FL2 dated 1/10/24 revealed: -Diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, tobacco use, chronic pain, constipation and insomnia. -She was intermittently oriented. -There was an order for albuterol sulfate 1.23mg/3ml solution, inhale contents of 1 vial via nebulizer every 4 hours as needed for wheezing and shortness of breath. Review of Resident #4's May 2024 eMAR revealed: -There was an entry for albuterol sulfate 1.23mg/3ml solution, inhale contents of 1 vial via nebulizer every 4 hours as needed for wheezing and shortness of breath. -There was documentation the resident was out of the facility from 5/8/24 until 5/13/24. -There was no documentation albuterol sulfate was administered from 5/01/24 until 5/31/24. Review of Resident #4's June 2024 eMAR revealed: -There was an entry for albuterol sulfate 1.23mg/3ml solution, inhale contents of 1 vial via nebulizer every 4 hours as needed for wheezing	D 367		

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and shortness of breath.
-There was documentation the resident was out of the facility from 6/12/24 until 6/16/24.
-There was documentation albuterol sulfate was administered on 06/27/24 at 12:49pm and 06/29/24 2:13am.

Review of Resident #4's July 2024 eMAR revealed:
-There was an entry for albuterol sulfate 1.23mg/3ml solution, inhale contents of 1 vial via nebulizer every 4 hours as needed for wheezing and shortness of breath.
-There was documentation the resident was out of the facility from 7/9/24 until 7/10/24.
-There was documentation albuterol sulfate was administered on 07/17/24 at 11:17am and 07/20/24 at 11:46am.

Observation of Resident #4 's room on 7/24/24 at 9:00am revealed there was a nebulizer machine and a cup containing four unopened, liquid-filled vials on the bedside table.

Interview with Resident #4 on 7/29/24 at 9:05am revealed she self-administered her nebulizer treatments four times per day.

Interview with a medication aide (MA) on 7/24/24 at 9:20am revealed the vials in Resident #4's room contained albuterol for the nebulizer.

Interview with another MA on 7/25/24 at 10:00am revealed:
-Resident #4 self-administered nebulizer treatments 3 times a day.
-She forgot to document the frequency of the nebulizer treatments on the eMAR.

Interview with Administrator on 7/29/24 at

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D 367	Continued From page 38 11:09am revealed the RCC was responsible for ensuring the MAs were documenting nebulizer treatments.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure the medication aide (MA) observed administration of medications for 1 of 1 resident (Resident #4) related to nebulizer treatments. The findings are: Review of the facility's undated Medication Management Policy revealed: -In order for a resident to self-administer medications, a physician must write a specific order indicating that the resident is capable of self-administration of medications.	D 375		

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 _____	07/29/2024

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 375	Continued From page 39 -All residents will be assessed by a licensed nurse using the self-administration of medications assessment to determine the ability to self-medicate and is completed upon admission, quarterly, with a change of condition, and at any time that is deemed unsafe for the resident to self-administer medications. -The administration of as needed medications must be documented on the resident's medication administration record and include the date, time, dose, reason, and effectiveness. -Medications that are self-administered by residents and kept in the resident's room must be stored in a locked cabinet or lock box. The resident's door must remain locked while the resident is away. -All medications are administered in accordance to the physician's order. -The resident's care plan must be updated to include the resident's ability to self-administer their medications. Review of Resident #4's current FL2 dated 1/10/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation, tobacco use, chronic pain, constipation, insomnia. -She was intermittently disoriented. -There was an order for albuterol sulfate 1.23mg/3ml solution, inhale contents of 1 vial via nebulizer every 4 hours as needed for wheezing and shortness of breath. Observation of Resident #4 's room on 7/24/24 at 9:00am revealed: -There was a bedside table next to her bed. -There was a nebulizer machine and a cup containing four unopened, liquid filled vials on the bedside table.	D 375		

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D 375	Continued From page 40 Interview with Resident #4 on 7/24/24 at 9:00am revealed: -She administered the nebulizer treatments on her own without assistance from a MA. -She always administered her own treatments. -She would go to the medication cart and get several albuterol vials from the MA when she ran out. -The plastic vials in her room contained medication for her nebulizer. -She administered herself 4 treatments per day. Interview with primary care provider (PCP) on 7/25/24 at 1:31pm revealed: -He was not aware that Resident #4 was self-administering nebulizer treatments. -Resident #4 may be able to self-administer nebulizer treatments but the facility is first required to give the resident a test to prove that she was alert and she knows how to self-administer. -He would then need to have a conversation with Resident #4 to ask questions to see if she responded appropriately and gave clear answers. -He would consider Resident #4's cognition, age and level of activity before writing an order. -If treatments were taken too close together it could cause temporary tachycardia for 10-15 minutes and long term effects may be stiffening of the lungs and abnormal breathing. -He was last at the facility on 7/22/24 and was not aware that the facility had prepared an order dated for 7/8/24 for him to sign for Resident #4 to self-administer nebulizer treatments. Interview with a MA on 7/24/24 at 9:20am revealed: -She identified the vials in Resident #4's room as albuterol for the nebulizer. -She supervised Resident #4 putting the albuterol	D 375		

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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 375	Continued From page 41	D 375		

in the nebulizer, but then left the room and returned when Resident #4 completed her nebulizer treatment.

Interview with a second MA on 7/24/24 at 9:25am revealed:
-Resident #4 had albuterol vials in her room.
-She supervised Resident #4 putting the medication in her nebulizer.

Interview with Resident Care Coordinator (RCC) on 7/24/24 at 9:51am revealed:
-The MAs were responsible for preparing the albuterol nebulizer treatment and then Resident #4 would administer the treatment on her own.
-She had an unsigned medication order dated 7/8/2024 for the doctor to sign stating that Resident #4 could self -administer nebulizer treatments.

Interview with RCC on 7/29/24 at 10:00am revealed:
-Resident #4 had been self-administering nebulizer treatments for at least the past two years.
-The RCC was responsible for following up with the PCP to obtain self-administration medication orders for residents.
-Albuterol vials should not have been left in Resident #4's room.
-She was not aware that the MAs gave several vials of albuterol to Resident #4 to self-administer.

Interview with Administrator on 7/29/24 at 11:09am revealed:
-He was not aware that Resident #4 was self-administering the nebulizer treatments without a self-administration order.
-The RCC was responsible for ensuring

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D 375	Continued From page 42 medication orders were followed. -The RCC was responsible for obtaining any self-administration orders from the PCP.	D 375		