Adult Care Home Corrective Action Report (CAR)

I. Facility Name: CHUNNS COVE ASSISTED LIVING
Address: 67 Mountainbrook Road Asheville, NC 28805
County: Buncombe
License Number: HAL011262

II. Date(s) of Visit(s): 11/20/2023, 11/27/2023, 12/13/2023, 01/04/2024
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 01/16/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.0901(b) PERSONAL CARE AND SUPERVISION Rule/Statutory Reference: Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Level of Non-Compliance: A1 Violation This rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision of residents in a secured unit resulting in an altercation between two residents (#1 and #2) during which one resident (#2) hit another resident (#1) with a walker. The findings are: Observation of the hallway to the secured unit where Resident #1 and Resident #2 resided on 12/13/23 at 10:30am revealed: - The doors to enter and exit the unit were locked and required the social worker to enter a code to open. - No staff present on the unit. - A Medication Aide (MA) came onto the unit after approximately five minutes. Review of the current FL-2 for Resident #1 dated 03/20/23 revealed: - A diagnosis of dementia. - The resident was ambulatory and constantly disoriented with wandering behaviors.	☐ POC Accepted_____ *DSS Initials*	

Review of the current FL-2 for Resident #2 dated 06/14/23 revealed:
- Diagnoses included dementia with mood disturbance.
- The resident was ambulatory and intermittently disoriented.

Review of an incident report completed by a MA dated 11/12/23 revealed:
- Resident #1 was pushed to the floor with a walker by another resident.
- The MA observed a cut and a "pump knot" on the resident's left temple.
- Resident #1 also "hit her left hand."
- Resident #1's Power of Attorney (POA) was notified.
- The Primary Care Provider (PCP) was not notified.
- First aid was not administered.
- The resident was not send to the Emergency Department (ED).

Observations, interviews, and record reviews revealed Resident #1 was not interviewable.

Interview with Resident #2 on 11/20/23 at 11:00am revealed:
- Resident #1 kept wandering into her room.
- She told Resident #1 to leave, but the resident would not leave.
- She called for a staff member to get Resident #1 out of her room.
- No staff members came to help.
- She pushed Resident #1 with her walker to make the resident leave her room.
- Resident #1 fell the ground when she pushed her.
- A staff member came after Resident #1 had fallen.
- It was not unusual for there to be no staff on the unit.

Interview with another resident on the secured unit on 11/27/23 at 2:45pm revealed:
- He witnessed the altercation between Resident #1 and Resident #2.
- No staff had been on the unit to assist until after Resident #1 was hit.
- There was occasionally no staff on the unit, but this usually happened at night.

Interview with a third resident on the secured unit on 12/13/23 at 12:00pm revealed:
- Sometimes there were no staff on the unit.
- If a resident needed help with something when no staff were present, the resident would just have to be patient.
- If there was an emergency, residents would have to bang on the door to the outside hallway to get someone's attention.

Interview with a community provider on 11/29/23 at 12:30pm revealed:
- She visited a resident on the secured unit on 11/21/23.
- A staff member entered the code to let her onto the unit.
- After finishing her visit with the resident, she attempted to find a staff member to help her leave the locked unit.
- She checked resident rooms and common areas, but did not find any staff.

- There were no staff on the unit for at least five minutes.
- During this time, a resident was walking down the hall with his pants falling down asking for help finding toilet paper.
- She also heard two residents have a verbal altercation and there were no staff available to supervise or intervene.
- She eventually saw a staff member through the window of the door to the main hallway and knocked to get her attention.
- The staff member said she was about to "make rounds" on the unit.

Interviews with a MA on 11/20/23 at 11:15am and 12/13/23 at 11:45am revealed:
- He responded to the incident between Resident #1 and Resident #2 on 11/12/23.
- He was working on a different unit and ran onto the secured unit when he heard yelling.
- He found Resident #1 with a "red knot" on her forehead and Resident #2 standing over her with a walker.
- Resident #2 told him that Resident #1 was bothering her by wandering into her room.
- No staff were on the unit when the incident occurred.
- A Personal Care Aide (PCA) was supposed to be on the unit, but she had left the unit without telling anyone.
- The PCA was supposed to tell him if she was leaving the hall, but she did not.
- He did not know how long she had been gone before the incident occurred.
- Staff were supposed to remain on the unit at all times.
- If there was not enough staff for someone to be on the unit at all times, then staff were supposed to round on the unit as often as possible.
- Resident #2 had a history of anger and aggression.

Interview with another MA on 12/13/23 at 10:45am revealed:
- She was trained to never leave the unit unattended.
- If a staff member was working on the unit and needed to step out, that staff member was supposed to get someone to cover the unit.
- Resident #1 needed a lot of supervision because she wandered into other residents' rooms.

Interview with a third MA on 01/02/23 at 3:30pm revealed:
- The facility tried to keep staff on the secured unit at all times, but there was not always enough staff for that to happen.
- Resident #2 had a history of aggression.
- Resident #2 had hit and pushed at least two other residents on the unit.
- Resident #2 seemed to be triggered by residents that wandered the halls and could be aggressive towards them.

Interview with a PCA on 12/13/23 at 11:15am revealed:
- When she worked on the secured unit, she never left it unattended.
- The residents on the unit needed a lot of supervision.
- Resident #1 needed supervision because she wandered into other residents' rooms.
- Resident #1 would also climb into other resident's beds and upset

them.
- If she needed to leave the unit, she would ask the MA to come watch the unit.

Interview with another PCA on 12/13/23 at 11:45am revealed:
- Residents on the secured unit needed a lot of supervision.
- Resident #2 had a history of aggression and of targeting and "bullying" Resident #1.
- Resident #1 wandered into other residents' rooms.

Interview with a third PCA on 01/02/24 at 1:24pm revealed:
- There were not always staff on the secured unit.
- Staff were supposed to do rounds on the secured unit as often as possible, but they did not have to remain on the unit.

Interview with the Resident Care Coordinator (RCC) on 12/13/23 at 12:00pm revealed:
- The secured unit was never supposed to be left unattended.
- If a staff member needed to leave the unit, they should contact another staff member to provide supervision for the unit.
- They did not train staff to leave the unit and then round, staff are trained to stay on the unit.

Interview with the Administrator on 11/20/23 at 10:30am revealed:
- There were no staff on the unit when the incident between Resident #1 and Resident #2 occurred.
- There was a PCA who was supposed to be on the unit, but she left the unit without notifying anyone.
- Staff were trained to never leave the secured unit unattended.

The failure of the facility to provide supervision of residents on a secured unit resulted in an altercation between Resident #1 and Resident #2 during which Resident #1 was hit with a walker and sustained a head injury. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/13/23 for this violation.

DATE OF CORRECTION FOR THE A1 VIOLATION SHALL NOT EXCEED 02/22/2024

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.0901(c) PERSONAL CARE AND SUPERVISION	☐ POC Accepted_____ *DSS Initials*	

Rule/Statutory Reference:
Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

Level of Non-Compliance: A2 Violation

This rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to respond immediately and appropriately to an incident involving 2 of 5 sampled residents (Resident #1 and Resident #2), resulting in Resident #1 not receiving timely medical care after being hit with a walker.

The findings are:

Observation of the hallway to the secured unit where Resident #1 and Resident #2 resided on 12/13/23 at 10:30am revealed:
- The doors to enter and exit the unit were locked and required the social worker to enter a code to open.
- No staff present on the unit.
- A Medication Aide (MA) came onto the unit after approximately five minutes.

Review of the current FL-2 for Resident #1 dated 03/20/23 revealed:
- A diagnosis of dementia.
- The resident was ambulatory and constantly disoriented with wandering behaviors.

Review of the current FL-2 for Resident #2 dated 06/14/23 revealed:
- Diagnoses included dementia with mood disturbance.
- The resident was ambulatory and intermittently disoriented.

Review of an incident report completed by a Medication Aide (MA) dated 11/12/23 revealed:
- Resident #1 was pushed to the floor with a walker by another resident.
- The MA observed a cut and a "pump knot" on the resident's left temple.
- Resident #1 also "hit her left hand."
- Resident #1's Power of Attorney (POA) was notified.
- The Primary Care Provider (PCP) was not notified.
- First aid was not administered.
- The resident was not send to the Emergency Department (ED).

Review of an incident report completed by another MA dated 11/13/23 revealed:
- When the MA entered the building, she heard Resident #1 screaming in pain.
- The resident was involved in an incident the day before on 11/12/23 and had been hit with a walker.
- The resident had been hit on the left side of her head and knocked down to the floor.
- The resident was in severe pain and had wounds on her knees.
- The resident was in such pain that she could not stand.

- The resident was sent to the ED on 11/13/23 at 7:15am.
- The PCP and POA were notified.

Observations, interviews, and record reviews revealed that Resident #1 was not interviewable.

Interview with Resident #2 on 11/20/23 at 11:00am revealed:
- Resident #1 kept wandering into her room.
- She told Resident #1 to leave, but the resident would not leave.
- She called for a staff member to get Resident #1 out of her room.
- No staff members came to help.
- She pushed Resident #1 with her walker to make the resident leave her room.
- Resident #1 fell the ground when she pushed her.
- A staff member came after Resident #1 had fallen.

Interview with a resident on the secured unit on 11/27/23 at 2:45pm revealed:
- He witnessed the altercation between Resident #1 and Resident #2.
- No staff had been on the unit to assist until after Resident #1 was hit.
- There were occasionally no staff on the unit, but this usually happened at night.

Interview with a MA on 11/20/23 at 11:15am revealed:
- He responded to the incident between Resident #1 and Resident #2 on 11/12/23.
- He was working on a different unit and ran onto the secured unit when he heard yelling.
- He found Resident #1 with a "red knot" on her forehead and Resident #2 standing over her with a walker.
- No staff were on the unit when the incident occurred.
- A Personal Care Aide (PCA) was supposed to be on the unit, but she had left the unit without telling anyone.
- He "thought" he called the PCP.
- He did not send the resident to the ED because the POA instructed him not to.
- He thought he could not send the resident to the ED in this case because the POA said not to.
- He had not received any training about how to respond to incidents or when to send someone to the ED.

Interviews with another MA on 11/29/23 at 1:00pm and 01/02/24 at 3:30pm revealed:
- She heard Resident #1 yelling in pain when she arrived to work on the morning of 11/13/23.
- The MA working on the unit at the time told her the resident had been yelling for about an hour.
- The MA also told her the resident was having trouble walking, and that she had wanted to send the resident to the ED but did not know the procedure to do so.
- When she assessed the resident, she found the resident seemed to have pain in her arms.
- She also observed scratches on the resident's arms and a "spot" on

her head from the incident on 11/12/23, a small open wound that did not appear to have been cleaned or covered.
- She observed open, bleeding wounds on both of the resident's knees from the incident on 11/12/23 that did not appear to have been cleaned or covered.
- None of these wounds appeared to have had any basic first aid attention.
- She called Emergency Services (EMS) and had the resident transported to the ED.
- She notified the POA and the PCP.
- If a resident had a visible head injury, the POA and PCP should be notified and the resident should be sent to the ED for evaluation.
- She did not know why the resident was not sent out when she was originally injured on 11/12/23 because she was not working that shift.
- She did not know why the resident's wounds were not treated with basic first aid after the incident on 11/12/23 because she was not working that shift.
- She did not know why the resident was not assessed immediately when the other MA heard her start yelling the morning of 11/13/23.

Interview with a third MA on 12/5/23 at 12:00pm revealed:
- She was working the morning of 11/13/23.
- Resident #1 started screaming in pain around 5:30 or 6:00 that morning.
- She seemed to be in more pain when the MA attempted to help her change into a clean shirt.
- She called the MA coming on shift that morning and told her about the screaming.
- The MA told her to wait until she arrived so she could assess the resident.
- The MA arrived around 6:30 that morning.
- She did not send the resident to the ED herself because she was a fairly new employee and did not know the procedure.
- Resident #1 was expressing pain for about an hour before being sent to the ED.
- The MA had not received any training about responding to incidents.

Interview with the Resident Care Coordinator (RCC) on 12/13/23 at 12:00pm revealed:
- She was supervising the day of the incident between Resident #1 and Resident #2.
- She was not aware of any specific protocol in the facility for responding to resident falls, but thought that usually residents were sent to the ED if they had head injuries.
- Resident #1 was not sent to the ED in this instance because the RCC made a judgment call due to the resident seeming like her "normal self" and being able to walk around after the incident.

Interview with Resident #1's POA on 11/28/23 at 4:30pm revealed:
- She was notified on 11/12/23 of the altercation.
- She did not say the resident should not be sent to the ED.
- She would want the resident sent to the ED for evaluation if that

was the safe thing to do. Interview with Resident #1's PCP on 12/05/23 at 2:15pm revealed: - She was first notified of the altercation between Resident #1 and Resident #2 on 11/13/23 when Resident #1 was sent to the hospital. - There was no record in her practice's system of any contact from the facility about Resident #1 or #2 on the day of the incident. - If there was a fall with a visible head injury it was safest to sent the resident to the ED for evaluation. - Risks of such an injury could include a brain bleed. Interviews with the Administrator on 11/20/23 at 10:30am and 12:30pm and 01/04/24 at 10:40am revealed: - She did not know that Resident #1 had not been immediately sent to the ED for evaluation after her injury. - She did not know that Resident #1 had an open wound on her head or knees. - She did not know if the facility had a specific policy about responding to unwitnessed falls, but in her opinion it was best for a resident to be sent to the ED if there was any suspicion of injury. - She would also send any resident with a visible head injury to the ED. - Resident #1 should have had a full assessment to see if there were injuries anywhere else on her body. Interview with the Regional Director on 12/13/23 at 1:00pm revealed: - The Administrator was responsible for training staff on responding to incidents and accidents. - If staff were unsure what to do, they should have called him or the Administrator. - A resident with a visible head injury should have been sent the ED for evaluation. The failure of the facility to respond immediately and appropriately to an incident involving 2 of 5 sampled residents (Resident #1 and Resident #2) resulted in Resident #1 not receiving timely medical care after being hit with a walker. This failure put Resident #1 at substantial risk of harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/13/23 for this violation. DATE OF CORRECTION FOR THE A2 VIOLATION SHALL NOT EXCEED 02/22/2024		
III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**

Rule/Statute Number: 13F.1205 HEALTH CARE PERSONNEL REGISTRY	☐ POC Accepted_____ *DSS Initials*	
Rule/Statutory Reference: The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .1001 and .1002.		
Level of Non-Compliance: Standard Deficiency		
This rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to comply with G.S. 131E-256 and supporting rules related to reporting allegations of neglect by a caregiver to the Healthcare Personnel Registry (HCPR). The findings are: Review of an incident report completed by a Medication Aide (MA) dated 11/12/23 revealed: - Resident #1 had been pushed to the floor with a walker by another resident. - The MA observed a cut and a "pump knot" on the resident's left temple. - It was documented Resident #1 also "hit her left hand." - Resident #1's responsible party was notified. - The Primary Care Provider (PCP) was not notified. - First aid was not administered. - The resident was not send to the Emergency Department (ED). Interview with Resident #2 on 11/20/23 at 11:00am revealed: - Resident #1 kept wandering into her room. - She told Resident #1 to leave, but the resident would not leave. - She called for a staff member to get Resident #1 out of her room. - No staff members came to help. - She pushed Resident #1 with her walker to make the resident leave her room. - Resident #1 fell the ground when she pushed her. - A staff member came after Resident #1 had fallen. Interview with another resident on the secured unit on 11/27/23 at 2:45pm revealed: - He witnessed the altercation between Resident #1 and Resident #2. - No staff had been on the unit to assist until after Resident #1 was hit. Interviews with a MA on 11/20/23 at 12:15pm and 12/13/23 at 11:45am revealed: - He responded to the incident between Resident #1 and Resident #2 on 11/12/23. - He was working on a different unit and ran onto the secured unit when he heard yelling. - He found Resident #1 with a "red knot" on her forehead and Resident #2 standing over her with a walker. - Resident #2 told him that Resident #1 was bothering her by wandering into her room.		

- No staff were on the unit when the incident occurred. - The PCA was supposed to tell him if she was leaving the hall, but she did not. - He did not knowhow long she had been gone before the incident occurred. Interview with the Administrator on 11/20/23 at 10:30am revealed: - There had not been any staff on the unit when the incident between Resident #1 and Resident #2 occurred. - There was a PCA who was supposed to be on the unit, but she left the unit without notifying anyone. - She did not report this to the HCPR. - She did not report it because she did not think it would do any good. Interview with the Regional Director on 12/13/23 at 1:00pm revealed: - The PCA should not have left that unit unattended. - No one had completed an HCPR investigation or report. - He would ask the Administrator to complete and submit the report.		

IV. Delivered Via: Email	**Certified Mail #:**	Date: 01/23/2024
DSS Signature: Susannah D. Yost		Return to DSS By: 02/13/2024

V. CAR Received by:	Administrator/Designee (print name):
	Signature: Date:
	Title:

VI. Plan of Correction Submitted by:	Administrator (print name):
	Signature: Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		
VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

** For follow-up to CAR, attach Monitoring Report showing facility in compliance.*