PRINTED: 01/08/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R-C	
		HAL011262	B. WING		12/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	i	TAIN BROOK R	OAD		
		ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
D 000	Initial Comments		D 000			
	_	sure Section conducted a complaint investigation on				
D 270	10A NCAC 13F .0901 Supervision	(b) Personal Care and	D 270			
		supervision of residents in resident's assessed needs,				
	This Rule is not met a TYPE A1 VIOLATION	·				
	reviews, the facility fa supervision for 2 of 5 physical aggression e	is, interviews and record iled to provide increased sampled residents who had indangering the safety of themselves (#2, and #3) injury (#3).				
	The findings are:					
	10/29/24 revealed: - Resident #2 had diahemiplegia (a medicaparalysis or weaknessmajor depressive discoronary artery diseas	d condition characterized by s on one side of the body), order, restless agitation, se (damage or disease in d vessels), and seizure				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.			В.С	
	HAL011262	B. WING		l l	R-C 2/ <b>12/2024</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
		NTAIN BROOK RO	AD			
CHUNN'S COVE ASSISTED LIVING	ASHEVI	LLE, NC 28805				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
evaluation dated 08/1 personality disorder (remotional, or erratic be antisocial and borderl stimulant use disorder (revealed an admission of Review of Resident # revealed documentatis seen by mental health and verbally abusive of Resident # -On 07/02/24, Reside another residentOn 07/17/24, Reside resident on the armOn 07/26/24, Reside cart because he was threatened to tear the there was nothing stated to -On 08/03/24, Reside bodily harm to another roomOn 08/17/24, Reside demanding breakfast care tasksOn 08/26/24, Reside medicationsOn 09/03/24, Reside having cigarettes and fights that day and for	ented. was Assisted Living.  2's current psychiatric 3/24 revealed diagnoses of cluster b traits (dramatic, behaviors and thoughts), ine personality persists) and r.  Int #2's Resident Register In date of 04/21/22.  2's care plan dated 02/07/24 on that Resident #2 was In for disruptive behaviors behaviors.  2's charting notes revealed: Int #2 made threats to harm  Int #2 slapped a female  Int #2 kicked the medication Int #2 kicked the medication Int #2 threatened to do Int #2 threatened to do Int #2 was cursing	D 270				

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 2 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL011262	B. WING			R-C 2/ <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
	2017 40010777 1 11/11/1	67 MOUN	TAIN BROOK RO	AD		
CHUNN'S	COVE ASSISTED LIVING	ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page		D 270			
	got into an altercation verbally abusive. -On 10/25/24, Reside	ent #2 punched the wall and with another resident, being ent #2 assaulted another in the head with a stick				
	10/25/24 at 6:15am re-Resident #2 stated a his room and he told Resident #2 threater and hit him in the hear resident injured and cemergency room (ER-The Resident Care C	nother resident came into him to get out of his room. ned to kill the other resident ad, which left the other caused him to be sent to the				
	12/11/24 at 10:43am -He was aware Resid causing injury to the omonths ago.	lent #2 hit another resident other resident about 2 d Resident #2 become				
	at 10:34am revealed: -Resident #2 often har residents who were medical shadow witnessed us to being on leave month and a half ago. She was told to obserphysical altercations for that had been put in particular shadow.	nd outbursts toward other nean to staff. ed any physical aggression and came back about a . erve the residents when took place. of any other safety measures place.				
	Telephone interview v	vith a second MA on				

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 3 of 31

DIVISION	n nealth Service Negu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			_			
					R-C	
		HAL011262	B. WING	<del></del>	12/12/	2024
NAME OF PI	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, STA	II E, ZIP CODE		
CHIINNIE	COVE ASSISTED LIVING	67 MOUN	TAIN BROOK R	OAD		
CHUNNS	COVE ASSISTED LIVING	ASHEVIL	LE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 070	0 " 15	•	D 070			
D 270	Continued From page	e 3	D 270			
	12/11/24 at 11:04am	revealed:				
		e very aggressive to other				
	residents.	e very aggressive to other				
		nummer she witnessed				
		summer, she witnessed				
		male resident in the face.				
		ident to the Resident Care				
	Coordinator (RCC) ar	nd to the Assistant				
	Administrator.					
		eyes" on residents, meaning				
	to observe the reside	nts, but was not told to				
	implement any other	safety measures after				
	Resident #2 was phys	sically aggressive with other				
	residents.	, 66				
		mented "laying eyes" on the				
	residents.	monted laying eyes on the				
		sidents every 2 hours.				
	-Triey Check Off all les	sidents every 2 nours.				
	Tolonhono intonvious	with a third MA on 12/11/24				
	•					
	at 11:16am revealed:					
		ent #2 become physically				
	aggressive with other					
		dent he observed happened				
	over the summer whe	en Resident #2 slapped				
	another resident.					
	Interview with the RC	C on 12/12/24 at 2:00pm				l
	revealed:					
	-Staff were trained to	do de-escalation techniques				
		separate the residents.				
		remove the residents from				
	the situation.					l
		o do 15-minute checks on				
		iolent to ensure safety.				
	residents who were v	iolent to ensure salety.				
	Intomious with the Art	ministrator on 12/12/24 at				
		ministrator on 12/12/24 at				
	2:30pm revealed:					l
	•	do 15-minute safety checks				
	on residents who had					
	-He was unsure if 15-	-minute safety checks on				

Division of Health Service Regulation

Resident #2 were ever done.

STATE FORM 9GT411 If continuation sheet 4 of 31

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011262	B. WING		R-C <b>12/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12/12/2027	
CHUNN'S	COVE ASSISTED LIVING	3	AIN BROOK R E, NC 28805	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page -He never initiated inc Resident #2 due to no  2. Review of Resident 06/12/24 revealed: -Diagnoses included diseaseThe resident was and -The resident was control -Recommended level Review of Resident # revealed an admission Review of Resident # resident was discharge 11/27/24.  Review of Resident # hospital discharge surevealed: -An Admission date of -The reason for hospineurocognitive disord under involuntary confacility due to aggress behavior towards resident	creased supervision on bot having enough staff.  It #3's current FL2 dated dementia and Alzheimer's abulatory. Instantly disoriented. In of care was assisted living.  It also record revealed the ged from the facility on the facility of th	D 270			
	Interview with a medi at 11:04am and on 12 revealed: -She witnessed anoth smack Resident #3 in -Staff were supposed checks, document the	cation aide (MA) on 12/11/24 2/12/24 at 10:40am ner resident (Resident #2) 1 the face on 09/04/24.				

Division of Health Service Regulation

-She did not complete 15-minute checks or

STATE FORM 9GT411 If continuation sheet 5 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		HAL011262	B. WING		12/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	3	TAIN BROOK R	OAD		
	Г	ASHEVILI	_E, NC 28805		Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 270	Continued From page	e 5	D 270			
	document the 15-che	cks.				
	-She did not docume	nt any additional supervision				
	checks on either resid	dent.				
	Review of Resident # 09/18/24 revealed:	3's charting notes dated				
	-Resident #3 walked	into the other resident's				
	, ,	nd started kicking and				
	hitting the residentResident #3 was ser	at to the emergency				
		a bloody nose after an				
	altercation with the ot	•				
	Review of Resident # report dated 09/18/24	3's accident and incident revealed:				
	· ·	into the other resident's				
	resident resulting in the	itting and kicking the other he resident receiving a				
	bloody noseEmergency medical	services were called, and				
		sported to the ED for an				
		tation the facility left a rith Resident #3's family				
	-There was documen fax notification to Res	tation that the facility sent a sident #3's PCP.				
	Review of Resident # instructions dated 09/					
	-Reason for ED visit v (nosebleed) and fall.	was due to assault, epistaxis				
	-The resident was sec altercation.	en in the ED due to an				
	Review of Resident # progress note dated (					
	and physical aggress					

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 6 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011262	B. WING			R-C 2/ <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	3	NTAIN BROOK ROA LLE, NC 28805	AD		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	#2) was concerning.  Review of Resident # was no documentation after the 09/18/24 income Review of Resident # 10/05/24 revealed the picked it up and was  Review of Resident # was no documentation after the 10/05/24 income Review of Resident # dated 10/16/24 reveal resident had physical residents.  Review of Resident # dated 10/22/24 reveal and the resident had other residents.  Review of Resident # revealed there was no increased supervision physical altercations.  Review of Resident # 10/25/24 revealed: -Resident #3 was ass (Resident #2) causing transported to the hos	unprovoked physical mother resident (Resident 3's record revealed there in of increased supervision ident.  3's charting notes dated experiments are resident had taken a chair, whitting other residents with it.  3's record revealed there in of increased supervision ident.  3's PCP progress note led documentation the altercations with other  3's PCP progress note led staff reported agitation, physical altercations with  3's record on 12/11/24 of documentation of in after these episodes of a saulted by another resident in good of the saulted by another resident in the s	D 270			

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 7 of 31

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL011262	B. WING		12/12/2024
			l		12/12/2027
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHUNN'S	COVE ASSISTED LIVING	}	AIN BROOK R	OAD	
		ASHEVILLI	E, NC 28805		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 7	D 270		
D 270	Review of Resident # reported dated 10/26/-Resident #3 went into (Resident #2) room would head because he wood-Emergency medical Resident #3 was transevaluation.  There was document voicemail message would message would message would resident #3's Review of Resident #3's Review of Resident # instructions dated 10/-The reason for the Eabrasion and traumat (head injury) with loss -A computed tomograre sident's head at 8:00 chronic right subdural volume of acute hemodaspect of the chronic -CT of the resident's high significant interval chaexamination performed -Unchanged acute on hematoma with a small hemorrhage within the chronic subdural hemodaspect with the subdural hemodaspect with the chronic subdural hem	3's accident and incident /24 revealed: o another resident's //ho hit Resident #3 in the uld not leave the room. services were called, and sported to the ED for an // tation the facility left a // ith Resident #3's family // inentation that the facility sepce. 3's ED discharge // 26/24 revealed: D visit was due to head // ic subdural hemorrhage // so fonsciousness. Apply (CT) scan of the // 18m revealed acute on I hematoma with a small for hage within the posterior subdural hematoma. The ed at 1:46pm revealed no lange from same day ed earlier. The chronic subdural eall volume of acute e posterior aspect of the factoma.  3's charting notes dated served in a female resident's her.	D 270		
	room trying to choke I	her. ent #3 from the room and			

Division of Health Service Regulation

Review of Resident #3's record revealed there

STATE FORM 9GT411 If continuation sheet 8 of 31

	or riealth Service Regu				(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			1		R-C
		HAL011262	B. WING		12/12/2024
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
CHUNN'S	COVE ASSISTED LIVING	<b>3</b>	NTAIN BROOK R	OAD	
		ASHEVII	LE, NC 28805		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	l l
TAG	REGOLATORI ORT	100 IDENTIFY TING IN ORMATION)	TAG	DEFICIENCY)	TAIL -: "-
			<del> </del>		
D 270	Continued From page	e 8	D 270		
	was no documentatio	n of increased supervision			
	after the 11/25/24 inci	•			
	Telephone interview v	vith Resident #3's Mental			
	Health Nurse Practition	oner (NP) on 12/11/24 at			
	3:15pm revealed:				
		otify her of Resident #3's			
	incidents on 10/05/24				
		cility to notify her of Resident			
	#3's aggressive beha				
		cility to initiate increased			
	supervision.				
	Interview with the RC	C on 12/12/24 at 1:59pm			
	revealed:	O On 12/12/24 at 1.00pm			
	-She found Resident	#3 choking a female			
		and immediately removed			
	him from the room.	·			
	-She should have init	iated 15-minute checks on			
	Resident #3 but did n	ot.			
	-She kept an eye on t	he resident but did not			
	initiate any increased	supervision.			
		ministrator on 12/12/24 at			
	2:33pm revealed:	manufata d 45 mains standard			
		mpleted 15-minute checks			
		aying aggressive behaviors. aff had completed 15-minute			
	checks.	an nau completeu 15-minute			
	J. 1001.0.				
	Attempted telephone	interview with another MA			
		am and on 12/12/24 at			
	11:20am was unsucc				
	Attempted telephone	interview with Resident #3's			
		1:36am and on 12/12/24 at			
	9:28am was unsucce	ssful.			
		<del></del>			
		nsure supervision was			
	increased for two resi	idents (#2 and #3) who had			

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 9 of 31

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		(X3) DATE SURVEY COMPLETED
		HAL011262	B. WING		R-C <b>12/12/2024</b>
	ROVIDER OR SUPPLIER  COVE ASSISTED LIVING	67 MOU	ADDRESS, CITY, STATE NTAIN BROOK ROA LLE, NC 28805		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 270	other residents which physically assaulting occasions causing Refor a subdural hemate head injury that requithe facility to increase serious physical harm constitutes a Type A1  The facility provided a 12/10/24 for this viola 131D-34.  THE CORRECTION	ysically aggressive ch other and also towards resulted in Resident #2 Resident #3 on two esident #3 to be hospitalized oma (brain bleed) and a red sutures. The failure of e supervision resulted in a and injury to residents and	D 270		
D 338	all residents guaranted Declaration of Residerand may be exercised.  This Rule is not met FOLLOW UP TO TYP Non-compliance control severity resulting in such as a severity resulting in such a	D Resident Rights hall assure that the rights of hed under G.S. 131D-21, hots' Rights, are maintained d without hindrance.  as evidenced by: PE A2 VIOLATION. hinues with increased herious physical harm.	D 338		

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 10 of 31

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011262	B. WING		R-C <b>12/12/2024</b>	
					12/12/2024	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	ì	NTAIN BROOK RO LLE, NC 28805	OAD		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	÷ 10	D 338			
	The findings are:					
	aggression or assault policy and emergency -Harassment, physical residents or staff is contained in appropriate and unaresidents engaging may be subject to be techniques as deeded and the resident is displated in appropriate behavior immediately.  -Remove resident from possible.  -Ask all staff to be allebehaviors.  -Report immediately the maladaptive behaviors.  -Report dangerous be physicians and/or are and implement physicians and/or are and implement physicians a	acceptable. in inappropriate behavior navioral intervention d necessary by the facility visician(s). ying aggressive or or, contact the supervisor m immediate danger if ent to inappropriate to the supervisor any s. tion as needed. ehaviors to the resident's a mental health authority cian's orders. ehavior to the resident's rson and seek intervention. ons fail, the facility will and call the appropriate law				
		em, etc., as appropriate. reat to themselves or				

incident report.

-Any physical altercation must be reported on an

-Completely fill out accident and incident report and notify the local DSS and/or Division of Facility

STATE FORM 9GT411 If continuation sheet 11 of 31

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILBING.			R-C
		HAL011262	B. WING		l l	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHIINN'S	COVE ASSISTED LIVING	67 MOUN	TAIN BROOK R	OAD		
OHOMI O	COVE ACCIONED EIVING	ASHEVILI	E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	<del>2</del> 11	D 338			
	Services as appropria	ate.				
	04/01/24 revealed: -It is necessary to dis discharge is necessar the resident and the f needs of the resident resident's physician, p practitioner and/or the other individuals in th determined by the fac administrator or the d the resident's physicia nurse practitioner.	charge residents when the ry to protect the welfare of acility cannot meet the as documented by the ohysician assistant, or nurse a safely of the resident or a facility is endangered as cility at the direction of the esignee in consultation with an, physician assistant, or				
	from 09/01/24 through	ency 911 call event summary n 12/11/24 for the facility ere no calls to local law				
	10/29/24 revealed: - Resident #2 had dia hemiplegia (a medica paralysis or weaknes: major depressive disc coronary artery disea the heart's major bloodisorderThe resident was sel-The resident was ori-Current level of care  Review of Resident # evaluation dated 08/1 personality disorder (emotional, or erratic be	I condition characterized by son one side of the body), order, restless agitation, se (damage or disease in ord vessels), and seizure mi-ambulatory. ented. was Assisted Living.  2's current psychiatric 3/24 revealed diagnoses of cluster b traits (dramatic, behaviors and thoughts), ine personality persists) and				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 12 of 31 9GT411

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BUILDING:			
		HAL011262	B. WING	B. WING		R-C 2 <b>/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
		67 MOUN	ITAIN BROOK RO	AD		
CHUNN'S	CHUNN'S COVE ASSISTED LIVING ASHEVIL					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	<del>2</del> 12	D 338			
	Review of the Reside revealed an admissio	nt #2's Resident Register n date of 04/21/22.				
	revealed documentati	2's care plan dated 02/07/24 ion that Resident #2 was n for disruptive behaviors behaviors.				
	Review of Resident #2's charting notes revealed: -On 07/02/24, Resident #2 made threats to harm another residentOn 07/17/24, Resident #2 slapped a female resident on the armOn 07/26/24, Resident #2 kicked the medication cart because he was mad about cigarettes and threatened to tear the place apart and stated there was nothing staff could do about itOn 08/03/24, Resident #2 threatened to do bodily harm to another resident who was in his room.					
	care tasksOn 08/26/24, Reside medicationsOn 09/03/24, Reside having cigarettes and fights that day and for -On 09/04/24, Reside residentOn 09/23/24, Reside got into an altercation verbally abusiveOn 10/25/24, Reside	and demanding personal  Int #2 was demanding  Int #2 was upset due to not Ithreatened there would be If everyone to be ready. Int #2 smacked another  Int #2 punched the wall and If with another resident, being  Int #2 assaulted another In the head with a stick				
	causing bodily injury.	2's incident report dated				

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 13 of 31

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	≣TED
					R-	C
		HAL011262	B. WING		1	2/2024
		TIALUTIZUZ			12/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHIMNIE	COVE ASSISTED LIVING	67 MOUN	TAIN BROOK R	OAD		
CHUNNS	COVE ASSISTED LIVING	ASHEVILI	LE, NC 28805			
(X4) ID	SUMMARY ST.	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			+	,		
D 338	Continued From page	e 13	D 338			ı
	-Resident #2 stated a	another resident came into				ı
		him to get out of his room.				ı
		ned to kill the other resident				ı
		ad, which left the other				1
		caused him to be sent to the				ı
	emergency room (ER					1
		Coordinator (RCC) and				1
		y care physician (PCP) were				ı
	notified on 10/25/24.	, ,, ( )				ı
						1
	Interview with a resid	lent on 12/11/24 at 3:01pm				ı
	revealed:	·				ı
	-He had witnessed R	esident #2 cursing at				ı
	women.	-				ı
	-He physically heard	fights, but he was unsure				ı
	exactly what took place	ce during the fights.				ı
		nd resident on 12/11/24 at				ı
	3:20pm revealed:					ı
	-She witnessed Resid	dent #2 twisting her				ı
	roommate's arm.					ı
	-	ay to a male resident in her				1
	roommate's bed.					1
	-She did not feel safe	<b>).</b>				I
		D : 1 1 40/44/04 1				I
		Resident on 12/11/24 at				1
	3:29pm revealed:	the feelih e couple weeks				1
		the facility a couple weeks				1
	ago.	violent behaviors between				1
	residents since her a					1
		dent in a wheelchair grab a				1
	paddle brush to hit ar	S S				1
	l -	illy threatened by another				I
	resident, but was uns					1
		are of mo name.				1
	Interview with a perso	onal care aide (PCA) on				1
	12/11/24 at 10:43am	, ,				1
	,,	dent #2 hit another resident				1

causing injury to the other resident about 2

STATE FORM 6899 9GT411 If continuation sheet 14 of 31

Division of fleath Service Regulation			1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					l R-	C
		UAL 044262	B. WING		1	_
		HAL011262			12/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		67 MOUN	TAIN BROOK R	OAD		
CHUNN'S	COVE ASSISTED LIVING	3	E, NC 28805			
		ASHEVILI	-E, NC 20005			T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
ind		,	IAG	DEFICIENCY)		
D 338	Continued From page	e 14	D 338			
	months ago.					
		any safety measures that				
		protect Resident #2 or any of				
	the other residents.					
		cation aide (MA) on 12/11/24				
	at 10:34am revealed:					
		nd outbursts toward other				
	residents.					
		ed any physical aggression				
	•	and came back about a				
	month and a half ago					
		n told to keep her eye on				
		e them when physical				
	altercations had taker					
	-She was not aware of	of any other safety measures				
	that had been put into	place.				
	Telephone interview v	with a second MA on				
	12/11/24 at 11:04am					
		e very aggressive to other				
	residents.	o very aggressive to earle.				
		summer, she witnessed				
		male resident in the face.				
	•	ident to the Resident Care				
	Coordinator (RCC) ar					
	Administrator.	id to the Assistant				
	Administrator.					
	Telephone interview v	with a third MA on 12/11/24				
	at 11:16am revealed:					
	-He had witnessed R					
	physically aggressive					
		dent he observed happened				
		en he slapped another				
	resident.					
	Telephone intonvious	with the local Department of				
		Home Specialist (AHS) on				
	12/11/24 at 10:04pm					
	- i nere was a 30-day	notice of discharge for				1

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 15 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	<del></del>	D.C	
		HAL011262	B. WING		R-C <b>12/12/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	67 MOUNT	AIN BROOK R	OAD		
		ASHEVILL	E, NC 28805			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 15	D 338			
D 338	Resident #2 issued of not been given to the the resident on 11/05, -On 11/04/24, the faciteam for Resident #2Resident #2 would not teamOn 11/13/24, the RC not to discharge Resident #2 would take Resident #2.  There was no docume Commitment (IVC) (a medical professional judge order mental heteratment for someon paperwork completed Interview with the facit Practitioner (NP) on 1He was aware Resident physical aggressionHe was aware Resident physical aggressionHe would expect state were having violent or power of attorney's (Feservices involvedIf eliminating violent or obtainedThe facility had appredischarging Resident	n 10/25/24, but a copy had resident when she spoke to /24.  Illity requested a discharge of consent to the consent to the discharge of consent to the	D 338			
	•	him copies of Resident #2's ner facilities about a month				
		Resident #2 did not get n the RCC had not received				

Division of Health Service Regulation

an acceptance for admission for the resident from

STATE FORM 9GT411 If continuation sheet 16 of 31

STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		R-C	
		HAL011262	B. WING	B. WING		:024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
011111110	00//E 400/0TED   15//15/	67 MOUN	TAIN BROOK R	OAD		
CHUNN'S	COVE ASSISTED LIVING	ASHEVIL	LE, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 338	Continued From page	e 16	D 338			
	residents who were a and/or othersHe expected to be no behaviors that occurr.  Interview with the fac provider on 12/12/24 -She was aware Resi and physically aggres -She received numer. Resident #2 for behaviorsShe would expect the behaviors that would others at risk if they resident #2 for behaviors that would others at risk if they resident #2 for behaviors.	ed with residents.  ility's contracted psychiatric at 9:29am revealed: dent #2 could get verbally sive.  ous complaints about viors by staff. notified of any violent  e facility to IVC residents for put themselves and/or				
	Interview with the RCC on 12/11/24 at 10:01 am and on 12/12/24 at 2:00pm revealed: -Resident #2 refused to have assistance from anyone who could help find placementOn 08/02/24, they were able to find placement for Resident #2, but he refused to goThey had never requested an IVC for Resident #2 because it had not worked in the past for whom they had requested an IVCShe tried to find placement in November for Resident #2, but it was unsuccessful because no other facilities would admit Resident #2Staff were trained to do de-escalation techniques to calm residents and separate the residentsShe expected staff to remove the residents from the situationShe expected staff to do 15-minute checks to ensure safety.					

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 17 of 31

DIVISION	n Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1			
			B. WING		R-C	.
		HAL011262			12/12/2024	•
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		67 MOUN	TAIN BROOK R	OAD		
CHUNN'S	COVE ASSISTED LIVING	3 ASHEVILI	_E, NC 28805			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (V	(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	,	PLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DA	ATE
				DEFICIENCY)		
D 338	Continued From page	e 17	D 338			
	Interview with the Ass	sistant Administrator on				
	12/10/24 at 5:10pm re	evealed:				
	-Involuntary Commitm	nent (IVC) paperwork was				
	not completed on Res	sident #2 because it had				
	failed with other resid	ents in the past.				
	-He was told by law e	nforcement that if other				
	residents or families of	did not press charges, there				
	was nothing that could	d be done.				
	Interview with the Adr	ministrator on 12/12/24 at				
	2:30pm revealed:					
	-He tried to discharge	Resident #2 from the				
	facility for over a year	· .				
	-It was difficult to obta	ain paperwork to request an				
	IVC for a previous res	sident.				
	-He was unaware of F	Resident #2 being accepted				
	at any facilities.					
	-Resident #2 had always	ays refused to be				
	discharged.					
	-He expected staff to	separate violent residents				
	from the other resider					
		complete 15-minute safety				
		vho had violent tendencies.				
		minute safety checks on				
	Resident #2 were eve					
		pervision on Resident #2				
	due to not having end	ough staff.				
	2. Review of Residen	t #3's current FL2 dated				
	06/12/24 revealed:					
		dementia and Alzheimer's				
	disease.					
	-The resident was am	nbulatory.				
	-The resident was cor	•				
		of care was assisted living.				
	Review of Resident # revealed an admissio	3's Resident Register n date of 11/14/23.				

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 18 of 31

DIVISION	n Health Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
						_
		1141 044 000	B. WING		R-(	
		HAL011262	B: Wilto		12/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		67 MOUN	TAIN BROOK R	OAD		
CHUNN'S	CHUNN'S COVE ASSISTED LIVING			OAD		
		ASHEVIL	LE, NC 28805		1	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
1710		,	1710	DEFICIENCY)		
D 338	Continued From page	e 18	D 338			
	Review of Resident #	3's record revealed the				
		ged to a hospice facility on				
	11/27/24.	ged to a mospice facility off				
	11/21/24.					
	Review of Resident #	3's hohavioral hoalth				
	revealed:	mmary dated 11/13/23				
	-An Admission date o	£ 00/14/22				
		italization was for major				
	_	ler, presented to hospital				
	-	nmitment (IVC) from another				
	facility due to aggress					
	behavior towards resi					
		is of severe dementia with				
	behavioral disturbanc	e.				
	Review of Resident #	3's accident and incident				
	report dated 09/18/24					
	•	into another resident's				
	(Resident #2) room a					
	kicking the other resid					
	Resident #3 receiving					
	-Resident #3 was ser					
		a bloody nose after an				
	altercation with the ot	-				
	altereation with the of	rici resident.				
	Review of Resident #	3's accident and incident				
	report dated 09/18/24					
	•	ked into another resident's				
		ing the other resident.				
		ave Resident #3 a bloody				
		n Resident #3 being sent to				
	ED.	Tradical tro boiling sont to				
	LD.					
	Review of Resident #	3's FD discharge				
	instructions dated 09/	_				
		was due to assault, epistaxis				
	(nosebleed) and fall.	Tac ado to docadit, opicianis				
	,	en in the ED due to an				
	TOSIGOTIL TO Was Sec	m m dio LD ddo to dii	1			

Division of Health Service Regulation

altercation.

STATE FORM 9GT411 If continuation sheet 19 of 31

DIVISION	n nealth Service Negu	lation				_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		1141 044 000	B. WING		R-C	
		HAL011262	B: Willo		12/12/2024	4
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		67 MOUN	TAIN BROOK R	OAD		
CHUNN'S	COVE ASSISTED LIVING	3	LE, NC 28805	OND		
		ASHEVIL	LE, NC 20005			$\dashv$
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
						┪
D 338	Continued From page	e 19	D 338			
	Review of Resident #	3's hehavioral health				
	progress note dated (					
		reased confusion, agitation				
	and physical aggress					
		iods of agitation when he				
	was not redirectable.	lous of agitation when he				
	-Resident #3's recent	unprovoked physical				
	aggression towards a					
	concerning.	illottlet residerit was				
	concerning.					
	Review of Resident #	3's charting notes dated				
		e resident had taken a chair,				
	picked it up and hit ot					
	picked it up and thit of	TICI TCSIGCITIS WITH IT.				
	Review of Resident #	3's PCP progress note				
	dated 10/16/24 revea					
	physical altercations					
	priyologi ditorogilorio	with other residents.				
	Review of Resident #	3's PCP progress note				
		lled staff reported agitation,				
		physical altercations with				
	other residents since					
		F 1.000				
	Review of Resident #	3's staff charting notes				
	dated 11/25/24 reveal	3				
		served in a female resident's				
	room trying to choke I	her.				
		sident from the room and				
	took him back to his r					
	Interview with a reside	ent on 12/12/24 at 3:10pm				
		had grabbed her by the arm				
		rled her around causing her				
	to fall to the ground in					
		1				
	Interview with a medic	cation aide (MA) on 12/11/24				
	at 11:04am and on 12					
	revealed:					

Division of Health Service Regulation

-The RCC had been seeking placement for

STATE FORM 9GT411 If continuation sheet 20 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _				
		HAL011262	B. WING	B. WING		R-C <b>12/12/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CHUNN'S	COVE ASSISTED LIVING	3	AIN BROOK R E, NC 28805	OAD			
040.45	CLIMMADY CT			DROVIDER'S DI AN OF CORRECTION	<u> </u>	0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 338	Continued From page	e 20	D 338				
	as yelling at other res residents' rooms and towards other resider -She witnessed anoth	ner resident smack Resident Resident #3 would not leave					
	Social Services Adult 12/11/24 at 10:04pm -The RCC discussed a dementia unit due to -The RCC stopped lo	with the local Department of Home Specialist (AHS) on revealed: discharging Resident #3 to o his aggressive behaviors. oking for placement for was admitted to the care of					
	Telephone interview with Resident #3's Mental Health Nurse Practitioner (NP) on 12/11/24 at 3:15pm revealed: -The facility did not notify her of Resident #3's incidents on 10/05/24 or on 11/25/24She expected the facility to notify her of Resident #3's aggressive behaviorsShe felt it was reasonable for the facility to seek IVC due to resident's aggressive behaviorsShe felt Resident #3 was not safe to reside in the facility if he had been assaulting other residents.  Interview with the RCC on 12/12/24 at 1:59pm revealed: -She found Resident #3 choking a female resident on 11/25/24 and immediately removed him from the roomShe kept an eye on Resident #3 but did not						
	#3The facility did not ca seek Involuntary Com	nal supervision of Resident all local law enforcement or nmitment. otify Resident #3's PCP or					

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 21 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R-C	
		HAL011262	B. WING		12/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHUNN'S	COVE ASSISTED LIVING	3	AIN BROOK R	OAD		
			E, NC 28805	PROVIDER'S PLAN OF CORRECTION	l over	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	e 21	D 338			
	family member.					
	-The facility never iss	ued a discharge notice.				
	Interview with the Adr 2:33pm revealed:	ministrator on 12/12/24 at				
	-He was aware of Re	sident #3's aggressive				
	behavior towards other	er residents. er issued a discharge notice				
		the facility experiencing				
	issues with a differen	t resident over the summer				
	who had aggressive b	pehaviors.				
		interview with another MA				
	on 12/11/24 at 11:03a 11:20am was unsucc	am and on 12/12/24 at				
	11.20am was unsucc	essiui.				
		interview with Resident #3's				
	PCP on 12/11/24 at 1 9:28am was unsucce	1:36am and on 12/12/24 at				
	9.20am was unsucce					
		rotect residents from abuse				
	and physical harm wh	y assaulted each other and				
	physically assaulted of	other residents. Issuance of				
		/C and notification of law				
	enforcement was not facility. This failure of					
	residents from abuse	resulted in serious physical				
	harm and injury and dividual violation.	constitutes a Type A1				
	violation.					
		a plan of protection on				
	12/10/24 for this viola 131D-34.	ition in accordance with G.S.				
	THE CORRECTION	DATE FOR THE TYPE A1				
		OT EXCEED JANUARY 11,				
	2024.					

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 22 of 31

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED		
		HAL011262	B. WING			R-C 2/12/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE				
CHUNN'S	COVE ASSISTED LIVING	G	NTAIN BROOK ROA	AD				
		ASHEVI	LLE, NC 28805					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
D 378	Continued From page	e 22	D 378					
D 378	10A NCAC 13F .100	06 (b) Medication Storage	D 378					
	requiring refrigeration	nd non-prescription y the facility, including those n, shall be maintained under ot when under the direct of staff in charge of						
	This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored securely when a medication aide left a medication cart unlocked and unattended.							
	The findings are:							
	revealed: -There was a medica and with the keys had -There was no staff of -At 10:00am a medica a resident's room 4 d	on the hall. ation aide (MA) came out of						
	revealed she was tra	A on 12/10/24 at 10:01am ined to never leave the cked when not in view but						
	(RCC) on 12/12/24 a -Medication carts we and the keys should	re to be locked at all times						

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 23 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
	OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		COMPLETED	
			A. BUILDING: _			
					R-C	
		HAL011262	B. WING		12/12	2/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			AIN BROOK R			
CHUNN'S	COVE ASSISTED LIVING	3	E, NC 28805			
0(0)15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
D 378	Continued From page	e 23	D 378			
	not locked.	ined to lock the medication				
	carts when not in view					
	carts when not in viev	w.				
	Interview with the Ass	sistant Administrator on				
	12/12/24 at 10:22am					
	-The MA was trained	to lock the medication cart				
	at all times when not	in view.				
	-He did not know why the MA left the medication					
cart unsecured.						
D 457	10A NCAC 13F .1212	2 (h) Reporting Of Accidents	D 457			
	And Incidents					
		Reporting Of Accidents				
	And Incidents					
	(b) The facility shall i	mmodiately report any				
		mmediately report any arm to a resident or other				
	•	to the local law enforcement				
	authority.	o the local law emoreement				
	addionty.					
	This Rule is not met					
	TYPE A1 VIOLATION	I				
	Dood on interview	nd record reviews the				
		nd record reviews, the				
	facility failed to immediately notify local law enforcement regarding physical assault of					
	_	of 5 sampled residents (#2				
		ent #2 assulted Resident #3				
	resulting in a head inj					
	attempted to choke a					
	•					
	The findings are:					
			1	1		

Division of Health Service Regulation

1. Review of Resident #2's current FL2 dated

STATE FORM 9GT411 If continuation sheet 24 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
THE TENNO CONTENT OF THE TENNO		A. BUILDING: _				
		HAL011262	B. WING		R-C <b>12/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHIINNIS	COVE ASSISTED LIVING	67 MOUNT	AIN BROOK R	OAD		
ASHEVILLE			E, NC 28805			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
D 457	Continued From page	e 24	D 457			
D 45/	10/29/24 revealed: Resident #2 had dia hemiplegia (a medica paralysis or weaknes major depressive disc coronary artery disea the heart's major blood disorder. The resident was sei. The resident was ori. Current level of care  Review of Resident # evaluation dated 08/1 personality disorder (emotional, or erratic thantisocial and border stimulant use disorder stimulant use disorder revealed an admission Review of Resident # revealed documentat seen by mental healthand verbally abusive  Review of Resident # -On 09/04/24, Resident # -On 10/25/24, Resider resident, hitting him in causing bodily injury.  Review of Resident # 10/25/24 at 6:15am re-Resident #2 stated at his room and he told	Ignoses that included all condition characterized by son one side of the body), order, restless agitation, se (damage or disease in od vessels), and seizure mi-ambulatory.  ented.  was Assisted Living.  2's current psychiatric  3/24 revealed diagnoses of cluster b traits (dramatic, behaviors and thoughts), line personality persists) and r.  nt #2's Resident Register in date of 04/21/22.  2's care plan dated 02/07/24 ion that Resident #2 was in for disruptive behaviors behaviors.  2's charting notes revealed:  ent #2 smacked another in the head with a stick  2's incident report dated evealed:  inother resident came into thim to get out of his room.	D 457			
	Review of Resident # -On 09/04/24, ResideresidentOn 10/25/24, Resideresident, hitting him in causing bodily injury.  Review of Resident # 10/25/24 at 6:15am re-Resident #2 stated a his room and he told-Resident #2 threater	2's charting notes revealed: ent #2 smacked another ent #2 assaulted another in the head with a stick  2's incident report dated evealed: evealed: event #2 assaulted another in the head with a stick				

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 25 of 31

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	, ,	E SURVEY PLETED
		HAL011262	B. WING			R-C 2/12/2024
	ROVIDER OR SUPPLIER  COVE ASSISTED LIVING	67 MOU	DDRESS, CITY, STAT NTAIN BROOK RO LLE, NC 28805			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 457	emergency room (ER-Resident Care Coord #2's primary care phy on 10/25/24.  -There was no docume was notified.  There was no docume Enforcement was not 10/25/24.  Interview with a media 12/12/24 at 10:41am -On 09/04/24, Reside resident's room and sended resident's room and sended with the sended with the sended with the work of the incident sended with the sended w	dinator (RCC) and Resident sician (PCP) were notified mentation law enforcement entation that Law ified on 09/04/24 or cation aide (MA) on revealed: nt #2 went into another lapped the other resident. It is ident Care Coordinator is call police when assaults of keeping the residents of keeping the residents and MA on 12/11/24 at the RCC and Assistant we enforcement if he felt he situation. It is identification is a situation of the called law enforcement on identification in the called law enforcement on identification.	D 457			

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 26 of 31

Division o	of Health Service Regu	ilation	_			
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		D MINO		R-C		
		HAL011262	B. WING	<del></del>	12/1	2/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR SOLT LIER		, ,	,		
CHUNN'S	COVE ASSISTED LIVING	G	TAIN BROOK R	OAD		
		ASHEVILL	.E, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG REGULATORY OR		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
				DEI IOIENOT)		
D 457	Continued From page	26	D 457			
2 .0.	Continued i form page	3 20				
	Interview with the Ass	sistant Administrator on				
	12/10/24 at 5:10pm re	evealed:				
	-He thought law enfor	rcement had been called for				
	assaults.					
	-He had been told by	law enforcement that there				
		could do if other residents or				
	resident's families did					
		call law enforcement for all				
	assaults.	can law emorcement for an				
	assaults.					
	l4					
	Interview with the Administrator on 12/12/24 at					
	2:30pm revealed:					
	•	call law enforcement in any				
	violent situation.					
	-He did not know if la	w enforcement was called				
	when Resident #2 ca	used bodily injury to another				
	resident on 10/25/24	and sent the other resident				
	to the ER.					
	2. Review of Residen	nt #3's current FL2 dated				
	06/12/24 revealed:					
		dementia and Alzheimer's				
	disease.					
	-The resident was am	nbulatory				
	-The resident was con	•				
		l of care was assisted living.				
	-i (Coommended icvei	Tor care was assisted living.				
	Pavious of Pasidont #	t2's Posident Posister				
		43's Resident Register				
	revealed an admissio	on date of 11/14/23.				
	D : (D :   (#	101				
		43's record revealed the				
	•	ged to a hospice facility on				
	11/27/24.					
	Interview with a medi	cation aide (MA) on 12/11/24				
	at 11:04am and on 12	2/12/24 at 10:40am				
	revealed:					
	-She had witnessed a	another resident smack				
	Resident #3 in the fac	ce on 09/04/24.				

Division of Health Service Regulation

-She did not document the incident in the staff

charting notes for Resident #3.

STATE FORM 9GT411 If continuation sheet 27 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
	HAL011262 B. WING			12/12/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHIINNIS	COVE ASSISTED LIVING	67 MOUNT	AIN BROOK R	OAD		
ASHEVILLE			E, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 457	Continued From page	27	D 457			
	-She did not notify loo	cal law enforcement.				
	09/18/24 revealed: -Resident #3 walked (Resident #2) room a hitting the other resid -Resident #3 was ser department (ED) with altercation with the ot Review of Resident # report dated 09/18/24 -Resident #3 walked (Resident #2) room a kicking the other resid Resident #3 receiving -Emergency medical	at to the emergency a bloody nose after an her resident.  3's accident and incident revealed: into another resident's and started hitting and dent resulting in the				
	-There was no documentation that local law enforcement was notifiedReview of Resident #3's record revealed there was no documentation that local law enforcement was notified.					
	Review of Resident # instructions dated 09/-Reason for ED visit (nosebleed) and fall.	20/24 revealed: was due to assault, epistaxis en in the ED due to an injury				
	Review of Resident #3's behavioral health progress note dated 09/20/24 revealed: -Resident #3 had increased confusion, agitation and physical aggressionResident #3 had periods of agitation where he					

Division of Health Service Regulation

-Resident #3 recent unprovoked physical

STATE FORM 9GT411 If continuation sheet 28 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		R-C		
		HAL011262	B. WING		12/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
CHUNN'S	COVE ASSISTED LIVING	ì	AIN BROOK R	OAD		
	OLUMBA DV OT		E, NC 28805		.	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 457	7 Continued From page 28		D 457			
	aggression towards another resident was concerning.					
	Review of Resident #3's charting notes dated 10/05/24 revealed the resident had taken a chair, picked it up and was hitting other residents with it.					
		3's record revealed there n that local law enforcement				
	Review of Resident #3's PCP progress note dated 10/16/24 revealed the resident had physical altercations with other residents.					
	Review of Resident #3's PCP progress note dated 10/22/24 revealed staff reported agitation, and the resident had physical altercations with other residents.					
	10/25/24 revealed: -Resident #3 was ass causing bodily injury a hospital.	3's charting note dated saulted by another male and transported to the eived sutures to his head				
	reported dated 10/26/ -Resident #3 went into (Resident #2) room we head because he wood	o another resident's ho hit Resident #3 in the uld not leave the room. nentation that local law				
		#3's record on 12/11/24 o documentation that local notified.				

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 29 of 31

DIVISION	n nealth Service Negu	lation	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		The Boilebirton_				
				R-C		
HAL011262		B. WING		1	2/2024	
		117 (2011202			1 12/12	., 2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		67 MOUN	TAIN DDOOK D	OAD		
CHUNN'S COVE ASSISTED LIVING 67 MOUNTAIN BROOK ROAD						
		ASHEVILI	E, NC 28805			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 457	Continued From page	29	D 457			
	Di	01- FD disabanna				
	Review of Resident #					
	instructions dated 10/	26/24 revealed:				
	-The reason for the E	D visit was due to head				
	abrasion and traumat	ic subdural hemorrhage				
	(head injury) with loss					
	-A computed tomogra					
		8am revealed acute on				
		hematoma with a small				
	volume of acute hemo	orrhage within the posterior				
	aspect of the chronic subdural hematomaCT of the resident's head at 1:46pm revealed no significant interval change from same day					
	examination performed earlier.					
	-Unchanged acute on chronic subdural					
	hematoma with a sma	all volume of acute				
	hemorrhage within the	e posterior aspect of the				
	chronic subdural hem	atoma.				
	Povious of Posidont #	3's staff charting notes				
		<del>-</del>				
	dated 11/25/24 reveal					
		ight in a female resident's				
	room trying to choke I	her.				
	-Staff removed Reside	ent #3 from the room and				
	took him back to his r	oom.				
	Paviow of Pacident #	3's record revealed there				
		n that local law enforcement				
		n that local law enforcement				
	was notified.					
	Interview with the RC	C on 12/12/24 at 1:59pm				
	revealed:					
	-She found Resident	#3 choking a female				
		and immediately removed				
		and infinediately femoved				
	him from the room.					
	-She did not notify loc	al law entorcement.				
	Interview with the Adr	ninistrator on 12/12/24 at				
	2:33pm revealed:					
		call local law enforcement				
-He expected staff to call local law enforcement		1				

Division of Health Service Regulation

for residents who have displayed aggressive

STATE FORM 9GT411 If continuation sheet 30 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		R-C
		HAL011262	B. WING		12/12/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
CHUNN'S	COVE ASSISTED LIVING	}	AIN BROOK R	OAD	
	OLIMAN DV OT		E, NC 28805	DDOWNERS DIAM OF CORRECT	ON.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 457	Continued From page	e 30	D 457		
D 457	behaviorsHe did not know if lobeen called when Reaggressive towards of Attempted telephone on 12/11/24 at 11:03a 11:20am was unsucce.  Attempted telephone PCP on 12/11/24 at 19:28am was unsucce.  The facility failed to econtacted on several residents who had a laggressive behaviors (Resident #2 and #3) Resident #3 attempte and sustained a head after being assaulted facility's failure resulted facility's failure resulted in serious injabuse which constituted. The facility provided a 12/10/24 for this viola 131D-34.  THE CORRECTION	cal law enforcement had sident #3 had been ther residents.  interview with another MA am and on 12/12/24 at essful.  interview with Resident #3's 1:36am and on 12/12/24 at ssful.  Insure law enforcement was occasions when two known history of physically assaulted each other and other residents. In the control of the con	D 457		

Division of Health Service Regulation

STATE FORM 9GT411 If continuation sheet 31 of 31