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 _____	R-C 12/12/2024

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 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation on 12/10/24 - 12/12/24.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide increased supervision for 2 of 5 sampled residents who had physical aggression endangering the safety of others in the facility and themselves (#2, and #3) and resulting in bodily injury (#3). The findings are: 1. Review of Resident #2's current FL2 dated 10/29/24 revealed: - Resident #2 had diagnoses that included hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body), major depressive disorder, restless agitation, coronary artery disease (damage or disease in the heart's major blood vessels), and seizure disorder. -The resident was semi-ambulatory.	D 270		

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D 270	Continued From page 1 -The resident was oriented. -Current level of care was Assisted Living. Review of Resident #2's current psychiatric evaluation dated 08/13/24 revealed diagnoses of personality disorder (cluster b traits (dramatic, emotional, or erratic behaviors and thoughts), antisocial and borderline personality persists) and stimulant use disorder. Review of the Resident #2's Resident Register revealed an admission date of 04/21/22. Review of Resident #2's care plan dated 02/07/24 revealed documentation that Resident #2 was seen by mental health for disruptive behaviors and verbally abusive behaviors. Review of Resident #2's charting notes revealed: -On 07/02/24, Resident #2 made threats to harm another resident. -On 07/17/24, Resident #2 slapped a female resident on the arm. -On 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 it. -On 08/03/24, Resident #2 threatened to do bodily harm to another resident who was in his room. -On 08/17/24, Resident #2 was cursing demanding breakfast and demanding personal care tasks. -On 08/26/24, Resident #2 was demanding medications. -On 09/03/24, Resident #2 was upset due to not having cigarettes and threatened there would be fights that day and for everyone to be ready. -On 09/04/24, Resident #2 smacked another resident.	D 270		

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-On 09/23/24, Resident #2 punched the wall and got into an altercation with another resident, being verbally abusive.
-On 10/25/24, Resident #2 assaulted another resident, hitting him in the head with a stick causing bodily injury.

Review of Resident #2's incident report dated 10/25/24 at 6:15am revealed:
-Resident #2 stated another resident came into his room and he told him to get out of his room.
-Resident #2 threatened to kill the other resident and hit him in the head, which left the other resident injured and caused him to be sent to the emergency room (ER).
-The Resident Care Coordinator (RCC) and Resident #2's primary care physician (PCP) were notified on 10/25/24.

Interview with a personal care aide (PCA) on 12/11/24 at 10:43am revealed:
-He was aware Resident #2 hit another resident causing injury to the other resident about 2 months ago.
-He had not witnessed Resident #2 become physically aggressive with other residents.

Interview with a medication aide (MA) on 12/11/24 at 10:34am revealed:
-Resident #2 often had outbursts toward other residents who were mean to staff.
-She had not witnessed any physical aggression due to being on leave and came back about a month and a half ago.
-She was told to observe the residents when physical altercations took place.
-She was not aware of any other safety measures that had been put in place.

Telephone interview with a second MA on

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12/11/24 at 11:04am revealed:
-Resident #2 could be very aggressive to other residents.
-Sometime over the summer, she witnessed Resident #2 slap a female resident in the face.
-She reported the incident to the Resident Care Coordinator (RCC) and to the Assistant Administrator.
-She was told to "lay eyes" on residents, meaning to observe the residents, but was not told to implement any other safety measures after Resident #2 was physically aggressive with other residents.
-She had never documented "laying eyes" on the residents.
-They check on all residents every 2 hours.

Telephone interview with a third MA on 12/11/24 at 11:16am revealed:
-He witnessed Resident #2 become physically aggressive with other residents.
-The most recent incident he observed happened over the summer when Resident #2 slapped another resident.

Interview with the RCC on 12/12/24 at 2:00pm revealed:
-Staff were trained to do de-escalation techniques to calm residents and separate the residents.
-She expected staff to remove the residents from the situation.
-She expected staff to do 15-minute checks on residents who were violent to ensure safety.

Interview with the Administrator on 12/12/24 at 2:30pm revealed:
-He expected staff to do 15-minute safety checks on residents who had violent tendencies.
-He was unsure if 15-minute safety checks on Resident #2 were ever done.

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D 270	Continued From page 4 -He never initiated increased supervision on Resident #2 due to not having enough staff. 2. Review of Resident #3's current FL2 dated 06/12/24 revealed: -Diagnoses included dementia and Alzheimer's disease. -The resident was ambulatory. -The resident was constantly disoriented. -Recommended level of care was assisted living. Review of Resident #3's Resident Register revealed an admission date of 11/14/23. Review of Resident #3's record revealed the resident was discharged from the facility on 11/27/24. Review of Resident #3's behavioral health hospital discharge summary dated 11/13/23 revealed: -An Admission date of 09/14/23. -The reason for hospitalization was for major neurocognitive disorder, presented to hospital under involuntary commitment (IVC) from another facility due to aggressive and hypersexual behavior towards residents. -A discharge diagnosis of severe dementia with behavioral disturbance. Interview with a medication aide (MA) on 12/11/24 at 11:04am and on 12/12/24 at 10:40am revealed: -She witnessed another resident (Resident #2) smack Resident #3 in the face on 09/04/24. -Staff were supposed to initiate 15-minute checks, document the 15-checks were completed and lay eyes on the residents every 15 minutes. -She did not complete 15-minute checks or	D 270		

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document the 15-checks.
-She did not document any additional supervision checks on either resident.

Review of Resident #3's charting notes dated 09/18/24 revealed:
-Resident #3 walked into the other resident's (Resident #2) room and started kicking and hitting the resident.
-Resident #3 was sent to the emergency department (ED) with a bloody nose after an altercation with the other resident.

Review of Resident #3's accident and incident report dated 09/18/24 revealed:
-Resident #3 walked into the other resident's (Resident #2) room hitting and kicking the other resident resulting in the resident receiving a bloody nose.
-Emergency medical services were called, and Resident #3 was transported to the ED for an evaluation.
-There was documentation the facility left a voicemail message with Resident #3's family member.
-There was documentation that the facility sent a fax notification to Resident #3's PCP.

Review of Resident #3's ED discharge instructions dated 09/20/24 revealed:
-Reason for ED visit was due to assault, epistaxis (nosebleed) and fall.
-The resident was seen in the ED due to an altercation.

Review of Resident #3's behavioral health progress note dated 09/20/24 revealed:
-Resident #3 had increased confusion, agitation and physical aggression.
-Resident #3 had periods of agitation when he

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was not redirectable.
-Resident #3's recent unprovoked physical aggression towards another resident (Resident #2) was concerning.

Review of Resident #3's record revealed there was no documentation of increased supervision after the 09/18/24 incident.

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.

Review of Resident #3's record revealed there was no documentation of increased supervision after the 10/05/24 incident.

Review of Resident #3's PCP progress note dated 10/16/24 revealed documentation 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.

Review of Resident #3's record on 12/11/24 revealed there was no documentation of increased supervision after these episodes of physical altercations.

Review of Resident #3's charting note dated 10/25/24 revealed:
-Resident #3 was assaulted by another resident (Resident #2) causing bodily injury and transported to the hospital.
-Resident #3 received sutures to his head from the altercation.

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Review of Resident #3's accident and incident reported dated 10/26/24 revealed:
-Resident #3 went into another resident's (Resident #2) room who hit Resident #3 in the head because he would not leave the room.
-Emergency medical services were called, and Resident #3 was transported to the ED for an evaluation.
-There was documentation the facility left a voicemail message with Resident #3's family member.
-There was no documentation that the facility notified Resident #3's PCP.

Review of Resident #3's ED discharge instructions dated 10/26/24 revealed:
-The reason for the ED visit was due to head abrasion and traumatic subdural hemorrhage (head injury) with loss of consciousness.
-A computed tomography (CT) scan of the resident's head at 8:08am revealed acute on chronic right subdural hematoma with a small volume of acute hemorrhage within the posterior aspect of the chronic subdural hematoma.
-CT 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 small volume of acute hemorrhage within the posterior aspect of the chronic subdural hematoma.

Review of Resident #3's charting notes dated 11/25/24 revealed:
-Resident #3 was observed in a female resident's room trying to choke her.
-Staff removed Resident #3 from the room and took him back to his room.

Review of Resident #3's record revealed there

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was no documentation of increased supervision after the 11/25/24 incident.

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 11/25/24.
-She expected the facility to notify her of Resident #3's aggressive behaviors.
-She expected the facility to initiate increased supervision.

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 room.
-She should have initiated 15-minute checks on Resident #3 but did not.
-She kept an eye on the resident but did not initiate any increased supervision.

Interview with the Administrator on 12/12/24 at 2:33pm revealed:
-Staff should have completed 15-minute checks on any resident displaying aggressive behaviors.
-He did not know if staff had completed 15-minute checks.

Attempted telephone interview with another MA on 12/11/24 at 11:03am and on 12/12/24 at 11:20am was unsuccessful.

Attempted telephone interview with Resident #3's PCP on 12/11/24 at 11:36am and on 12/12/24 at 9:28am was unsuccessful.

_____

The facility failed to ensure supervision was increased for two residents (#2 and #3) who had

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D 270	Continued From page 9 a known history of physically aggressive behaviors towards each other and also towards other residents which resulted in Resident #2 physically assaulting Resident #3 on two occasions causing Resident #3 to be hospitalized for a subdural hematoma (brain bleed) and a head injury that required sutures. The failure of the facility to increase supervision resulted in serious physical harm and injury to residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection on 12/10/24 for this violation in accordance with G.S. 131D-34. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION WILL NOT EXCEED JANUARY 11, 2024.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 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: FOLLOW UP TO TYPE A2 VIOLATION. Non-compliance continues with increased severity resulting in serious physical harm. THIS IS A TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure all residents were free from abuse related to multiple residents being physically assaulted by two residents (#2 and #3).	D 338		

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D 338	Continued From page 10 The findings are: Review of the facility's management of physical aggression or assault policy, Accident or illness policy and emergency/accident policy revealed: -Harassment, physical or verbal abuse of other residents or staff is considered to be inappropriate and unacceptable. -Residents engaging in inappropriate behavior may be subject to behavioral intervention techniques as deeded necessary by the facility and the resident's physician(s). -If a resident is displaying aggressive or inappropriate behavior, contact the supervisor immediately. -Remove resident from immediate danger if possible. -Ask all staff to be alert to inappropriate behaviors. -Report immediately to the supervisor any maladaptive behaviors. -Deescalate the situation as needed. -Report dangerous behaviors to the resident's physicians and/or area mental health authority and implement physician's orders. -Report dangerous behavior to the resident's family/responsible person and seek intervention. -If all other interventions fail, the facility will restrain the resident and call the appropriate law enforcement. -Cooperate with law enforcement. -Assist any victims to obtain medical treatment, relief in the court system, etc., as appropriate. -If a resident was a threat to themselves or others, call 911 immediately. -Any physical altercation must be reported on an incident report. -Completely fill out accident and incident report and notify the local DSS and/or Division of Facility	D 338		

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D 338	Continued From page 11 Services as appropriate. Review of the facility's discharge policy effective 04/01/24 revealed: -It is necessary to discharge residents when the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident as documented by the resident's physician, physician assistant, or nurse practitioner and/or the safely of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or the designee in consultation with the resident's physician, physician assistant, or nurse practitioner. Review of the emergency 911 call event summary from 09/01/24 through 12/11/24 for the facility revealed that there were no calls to local law enforcement. 1. Review of Resident #2's current FL2 dated 10/29/24 revealed: - Resident #2 had diagnoses that included hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body), major depressive disorder, restless agitation, coronary artery disease (damage or disease in the heart's major blood vessels), and seizure disorder. -The resident was semi-ambulatory. -The resident was oriented. -Current level of care was Assisted Living. Review of Resident #2's current psychiatric evaluation dated 08/13/24 revealed diagnoses of personality disorder (cluster b traits (dramatic, emotional, or erratic behaviors and thoughts), antisocial and borderline personality persists) and stimulant use disorder.	D 338		

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D 338	Continued From page 12 Review of the Resident #2's Resident Register revealed an admission date of 04/21/22. Review of Resident #2's care plan dated 02/07/24 revealed documentation that Resident #2 was seen by mental health for disruptive behaviors and verbally abusive behaviors. Review of Resident #2's charting notes revealed: -On 07/02/24, Resident #2 made threats to harm another resident. -On 07/17/24, Resident #2 slapped a female resident on the arm. -On 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 it. -On 08/03/24, Resident #2 threatened to do bodily harm to another resident who was in his room. -On 08/17/24, Resident #2 was cursing demanding breakfast and demanding personal care tasks. -On 08/26/24, Resident #2 was demanding medications. -On 09/03/24, Resident #2 was upset due to not having cigarettes and threatened there would be fights that day and for everyone to be ready. -On 09/04/24, Resident #2 smacked another resident. -On 09/23/24, Resident #2 punched the wall and got into an altercation with another resident, being verbally abusive. -On 10/25/24, Resident #2 assaulted another resident, hitting him in the head with a stick causing bodily injury. Review of Resident #2's incident report dated 10/25/24 at 6:15am revealed:	D 338		

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-Resident #2 stated another resident came into his room and he told him to get out of his room.
-Resident #2 threatened to kill the other resident and hit him in the head, which left the other resident injured and caused him to be sent to the emergency room (ER).
-The Resident Care Coordinator (RCC) and Resident #2's primary care physician (PCP) were notified on 10/25/24.

Interview with a resident on 12/11/24 at 3:01pm revealed:
-He had witnessed Resident #2 cursing at women.
-He physically heard fights, but he was unsure exactly what took place during the fights.

Interview with a second resident on 12/11/24 at 3:20pm revealed:
-She witnessed Resident #2 twisting her roommate's arm.
-She woke up one day to a male resident in her roommate's bed.
-She did not feel safe.

Interview with a third Resident on 12/11/24 at 3:29pm revealed:
-She was admitted to the facility a couple weeks ago.
-She had witnessed violent behaviors between residents since her admission.
-She observed a resident in a wheelchair grab a paddle brush to hit another resident.
-She had been verbally threatened by another resident, but was unsure of his name.

Interview with a personal care aide (PCA) on 12/11/24 at 10:43am revealed:
-He was aware Resident #2 hit another resident causing injury to the other resident about 2

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months ago.
-He was not aware of any safety measures that were put in place to protect Resident #2 or any of the other residents.

Interview with a medication aide (MA) on 12/11/24 at 10:34am revealed:
-Resident #2 often had outbursts toward other residents.
-She had not witnessed any physical aggression due to being on leave and came back about a month and a half ago.
-She had always been told to keep her eye on residents and observe them when physical altercations had taken place.
-She was not aware of any other safety measures that had been put into place.

Telephone interview with a second MA on 12/11/24 at 11:04am revealed:
-Resident #2 could be very aggressive to other residents.
-Sometime over the summer, she witnessed Resident #2 slap a female resident in the face.
-She reported the incident to the Resident Care Coordinator (RCC) and to the Assistant Administrator.

Telephone interview with a third MA on 12/11/24 at 11:16am revealed:
-He had witnessed Resident #2 become physically aggressive with other residents.
-The most recent incident he observed happened over the summer when he slapped another resident.

Telephone interview with the local Department of Social Services Adult Home Specialist (AHS) on 12/11/24 at 10:04pm revealed:
-There was a 30-day notice of discharge for

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Resident #2 issued on 10/25/24, but a copy had not been given to the resident when she spoke to the resident on 11/05/24.
-On 11/04/24, the facility requested a discharge team for Resident #2.
-Resident #2 would not consent to the discharge team.
-On 11/13/24, the RCC stated the facility decided not to discharge Resident #2 and were no longer looking for placement because no other facilities would take Resident #2.

There was no documentation of any Involuntary Commitment (IVC) (a legal process that allows a medical professional or layperson to request a judge order mental health or substance use treatment for someone against their will) paperwork completed for Resident #2.

Interview with the facility's contracted Nurse Practitioner (NP) on 12/11/24 at 2:35pm revealed:
-He was aware Resident #2 had a history of physical aggression.
-He was aware Resident #2 hit another resident for being in his room.
- He would expect staff to send residents who were having violent outbursts to the ER, notify the power of attorney's (POA) and get psychiatric services involved.
-If eliminating violent outbursts could not be resolved, placement at another facility should be obtained.
-The facility had approached him about discharging Resident #2 in the past.
-The facility informed him copies of Resident #2's FL2 were faxed to other facilities about a month ago.
-He was unsure why Resident #2 did not get discharged other than the RCC had not received an acceptance for admission for the resident from

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other facilities.
-He expected IVC paperwork to be filled out for residents who were a danger to themselves and/or others.
-He expected to be notified of any violent behaviors that occurred with residents.

Interview with the facility's contracted psychiatric provider on 12/12/24 at 9:29am revealed:
-She was aware Resident #2 could get verbally and physically aggressive.
-She received numerous complaints about Resident #2 for behaviors by staff.
-She expected to be notified of any violent behaviors.
-She would expect the facility to IVC residents for behaviors that would put themselves and/or others at risk if they refuse services.
-She was unsure if resident #2 had ever had IVC paperwork filled out.

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 placement.
-On 08/02/24, they were able to find placement for Resident #2, but he refused to go.
-They had never requested an IVC for Resident #2 because it had not worked in the past for whom they had requested an IVC.
-She tried to find placement in November for Resident #2, but it was unsuccessful because no other facilities would admit Resident #2.
-Staff were trained to do de-escalation techniques to calm residents and separate the residents.
-She expected staff to remove the residents from the situation.
-She expected staff to do 15-minute checks to ensure safety.

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D 338	Continued From page 17 Interview with the Assistant Administrator on 12/10/24 at 5:10pm revealed: -Involuntary Commitment (IVC) paperwork was not completed on Resident #2 because it had failed with other residents in the past. -He was told by law enforcement that if other residents or families did not press charges, there was nothing that could be done. Interview with the Administrator 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 obtain paperwork to request an IVC for a previous resident. -He was unaware of Resident #2 being accepted at any facilities. -Resident #2 had always refused to be discharged. -He expected staff to separate violent residents from the other residents. -He expected staff to complete 15-minute safety checks on residents who had violent tendencies. -He was unsure if 15-minute safety checks on Resident #2 were ever done. -He never initiated supervision on Resident #2 due to not having enough staff. 2. Review of Resident #3's current FL2 dated 06/12/24 revealed: -Diagnoses included dementia and Alzheimer's disease. -The resident was ambulatory. -The resident was constantly disoriented. -Recommended level of care was assisted living. Review of Resident #3's Resident Register revealed an admission date of 11/14/23.	D 338		

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D 338	Continued From page 18 Review of Resident #3's record revealed the resident was discharged to a hospice facility on 11/27/24. Review of Resident #3's behavioral health hospital discharge summary dated 11/13/23 revealed: -An Admission date of 09/14/23. -The reason for hospitalization was for major neurocognitive disorder, presented to hospital under involuntary commitment (IVC) from another facility due to aggressive and hypersexual behavior towards residents. -A discharge diagnosis of severe dementia with behavioral disturbance. Review of Resident #3's accident and incident report dated 09/18/24 revealed: -Resident #3 walked into another resident's (Resident #2) room and started hitting and kicking the other resident resulting in the Resident #3 receiving a busted nose. -Resident #3 was sent to the emergency department (ED) with a bloody nose after an altercation with the other resident. Review of Resident #3's accident and incident report dated 09/18/24 revealed: -Resident #3 had walked into another resident's room, hitting and kicking the other resident. -The other resident gave Resident #3 a bloody nose which resulted in Resident #3 being sent to ED. Review of Resident #3's ED discharge instructions dated 09/20/24 revealed: -Reason for ED visit was due to assault, epistaxis (nosebleed) and fall. -Resident #3 was seen in the ED due to an altercation.	D 338		

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D 338	Continued From page 19 Review of Resident #3's behavioral health progress note dated 09/20/24 revealed: -Resident #3 had increased confusion, agitation and physical aggression. -Resident #3 had periods of agitation when he was not redirectable. -Resident #3's recent unprovoked physical 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 hit other residents with it. Review of Resident #3's PCP progress note dated 10/16/24 revealed Resident #3 had physical altercations with other residents. Review of Resident #3's PCP progress note dated 10/22/24 revealed staff reported agitation, and Resident #3 had physical altercations with other residents since previous PCP visit. Review of Resident #3's staff charting notes dated 11/25/24 revealed: -Resident #3 was observed in a female resident's room trying to choke her. -Staff removed the resident from the room and took him back to his room. Interview with a resident on 12/12/24 at 3:10pm revealed Resident #3 had grabbed her by the arm and aggressively swirled her around causing her to fall to the ground in the past Interview with a medication aide (MA) on 12/11/24 at 11:04am and on 12/12/24 at 10:40am revealed: -The RCC had been seeking placement for	D 338		

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Resident #3 due to his aggressive behaviors such as yelling at other residents, wandering into other residents' rooms and being physically aggressive towards other residents.
-She witnessed another resident smack Resident #3 in the face when Resident #3 would not leave the other resident's room.

Telephone interview with the local Department of Social Services Adult Home Specialist (AHS) on 12/11/24 at 10:04pm revealed:
-The RCC discussed discharging Resident #3 to a dementia unit due to his aggressive behaviors.
-The RCC stopped looking for placement for Resident #3 when he was admitted to the care of hospice services.

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 11/25/24.
-She expected the facility to notify her of Resident #3's aggressive behaviors.
-She felt it was reasonable for the facility to seek IVC due to resident's aggressive behaviors.
-She 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 room.
-She kept an eye on Resident #3 but did not complete any additional supervision of Resident #3.
-The facility did not call local law enforcement or seek Involuntary Commitment.
-The facility did not notify Resident #3's PCP or

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D 338	Continued From page 21 family member. -The facility never issued a discharge notice. Interview with the Administrator on 12/12/24 at 2:33pm revealed: -He was aware of Resident #3's aggressive behavior towards other residents. -The facility had never issued a discharge notice to Resident #3 due to the facility experiencing issues with a different resident over the summer who had aggressive behaviors. Attempted telephone interview with another MA on 12/11/24 at 11:03am and on 12/12/24 at 11:20am was unsuccessful. Attempted telephone interview with Resident #3's PCP on 12/11/24 at 11:36am and on 12/12/24 at 9:28am was unsuccessful. _____ The facility failed to protect residents from abuse and physical harm when Resident #2 and Resident #3 physically assaulted each other and physically assaulted other residents. Issuance of discharge, filing for IVC and notification of law enforcement was not completed by the facility.This failure of the facility to protect residents from abuse resulted in serious physical harm and injury and constitutes a Type A1 Violation. _____ The facility provided a plan of protection on 12/10/24 for this violation in accordance with G.S. 131D-34. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION WILL NOT EXCEED JANUARY 11, 2024.	D 338		

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D 378	Continued From page 22	D 378		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. 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: Observation of a hallway on 12/10/24 at 9:58am revealed: -There was a medication cart in the hall unlocked and with the keys hanging from the lock. -There was no staff on the hall. -At 10:00am a medication aide (MA) came out of a resident's room 4 doors away from the medication cart, approached the medication cart, and locked it. Interview with the MA on 12/10/24 at 10:01am revealed she was trained to never leave the medication cart unlocked when not in view but she just forgot. Interview with the Resident Care Coordinator (RCC) on 12/12/24 at 10:18am revealed: -Medication carts were to be locked at all times and the keys should be with the MA. -She did not know why the medication cart was	D 378		

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D 378	Continued From page 23 not locked. -All the MAs were trained to lock the medication carts when not in view. Interview with the Assistant Administrator on 12/12/24 at 10:22am revealed: -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 378		
D 457	10A NCAC 13F .1212 (h) Reporting Of Accidents And Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interview and record reviews, the facility failed to immediately notify local law enforcement regarding physical assault of residents including 2 of 5 sampled residents (#2 and #3) when Resident #2 assulted Resident #3 resulting in a head injury and Resident #3 attempted to choke another resident. The findings are: 1. Review of Resident #2's current FL2 dated	D 457		

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D 457	Continued From page 24 10/29/24 revealed: - Resident #2 had diagnoses that included hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body), major depressive disorder, restless agitation, coronary artery disease (damage or disease in the heart's major blood vessels), and seizure disorder. -The resident was semi-ambulatory. -The resident was oriented. -Current level of care was Assisted Living. Review of Resident #2's current psychiatric evaluation dated 08/13/24 revealed diagnoses of personality disorder (cluster b traits (dramatic, emotional, or erratic behaviors and thoughts), antisocial and borderline personality persists) and stimulant use disorder. Review of the Resident #2's Resident Register revealed an admission date of 04/21/22. Review of Resident #2's care plan dated 02/07/24 revealed documentation that Resident #2 was seen by mental health for disruptive behaviors and verbally abusive behaviors. Review of Resident #2's charting notes revealed: -On 09/04/24, Resident #2 smacked another resident. -On 10/25/24, Resident #2 assaulted another resident, hitting him in the head with a stick causing bodily injury. Review of Resident #2's incident report dated 10/25/24 at 6:15am revealed: -Resident #2 stated another resident came into his room and he told him to get out of his room. -Resident #2 threatened to kill the other resident and hit him in the head, which left the other	D 457		

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resident injured and caused him to be sent to the emergency room (ER).
-Resident Care Coordinator (RCC) and Resident #2's primary care physician (PCP) were notified on 10/25/24.
-There was no documentation law enforcement was notified.

There was no documentation that Law Enforcement was notified on 09/04/24 or 10/25/24.

Interview with a medication aide (MA) on 12/12/24 at 10:41am revealed:
-On 09/04/24, Resident #2 went into another resident's room and slapped the other resident.
-She did notify the Resident Care Coordinator (RCC) of the incident.
-She had no training to call police when assaults occur.
-She was only aware of keeping the residents separated.

Interview with a second MA on 12/11/24 at 11:16am revealed:
-When incidents occurred, he documented and reported to supervisors, the RCC and Assistant Administrator.
-He would only call law enforcement if he felt he could not handle the situation.
-He had never called law enforcement before.

Interview with the RCC at 10:01am revealed:
-She thought the MA called law enforcement on 10/25/24, but she could not locate any documentation of it.
-Staff notified her of incidents/accidents.
-She expected staff to call law enforcement for any assaults.

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Interview with the Assistant Administrator on 12/10/24 at 5:10pm revealed:
-He thought law enforcement had been called for assaults.
-He had been told by law enforcement that there is nothing the police could do if other residents or resident's families did not press charges.
-He expected staff to call law enforcement for all assaults.

Interview with the Administrator on 12/12/24 at 2:30pm revealed:
-He expected staff to call law enforcement in any violent situation.
-He did not know if law enforcement was called when Resident #2 caused bodily injury to another resident on 10/25/24 and sent the other resident to the ER.
2. Review of Resident #3's current FL2 dated 06/12/24 revealed:
-Diagnoses included dementia and Alzheimer's disease.
-The resident was ambulatory.
-The resident was constantly disoriented.
-Recommended level of care was assisted living.

Review of Resident #3's Resident Register revealed an admission date of 11/14/23.

Review of Resident #3's record revealed the resident was discharged to a hospice facility on 11/27/24.

Interview with a medication aide (MA) on 12/11/24 at 11:04am and on 12/12/24 at 10:40am revealed:
-She had witnessed another resident smack Resident #3 in the face on 09/04/24.
-She did not document the incident in the staff charting notes for Resident #3.

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CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

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D 457	Continued From page 27 -She did not notify local law enforcement. Review of Resident #3's charting notes dated 09/18/24 revealed: -Resident #3 walked into another resident's (Resident #2) room and started kicking and hitting the other resident. -Resident #3 was sent to the emergency department (ED) with a bloody nose after an altercation with the other resident. Review of Resident #3's accident and incident report dated 09/18/24 revealed: -Resident #3 walked into another resident's (Resident #2) room and started hitting and kicking the other resident resulting in the Resident #3 receiving a busted nose. -Emergency medical services (EMS) were called, and Resident #3 was transported to the ED for an evaluation. -There was no documentation that local law enforcement was notified. -Review of Resident #3's record revealed there was no documentation that local law enforcement was notified. Review of Resident #3's ED discharge instructions dated 09/20/24 revealed: -Reason for ED visit was due to assault, epistaxis (nosebleed) and fall. -The resident was seen in the ED due to an injury sustained during an altercation. Review of Resident #3's behavioral health progress note dated 09/20/24 revealed: -Resident #3 had increased confusion, agitation and physical aggression. -Resident #3 had periods of agitation where he was not redirectable. -Resident #3 recent unprovoked physical	D 457		

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 _____	R-C 12/12/2024

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 457	Continued From page 28 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. Review of Resident #3's record revealed there was no documentation that local law enforcement was notified. 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. Review of Resident #3's charting note dated 10/25/24 revealed: -Resident #3 was assaulted by another male causing bodily injury and transported to the hospital. -Resident #3 had received sutures to his head from the altercation. Review of Resident #3's accident and incident reported dated 10/26/24 revealed: -Resident #3 went into another resident's (Resident #2) room who hit Resident #3 in the head because he would not leave the room. -There was no documentation that local law enforcement was notified. -Review of Resident #3's record on 12/11/24 revealed there was no documentation that local law enforcement was notified.	D 457		

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 _____	R-C 12/12/2024

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CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

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D 457	Continued From page 29	D 457		

Review of Resident #3's ED discharge instructions dated 10/26/24 revealed:
-The reason for the ED visit was due to head abrasion and traumatic subdural hemorrhage (head injury) with loss of consciousness.
-A computed tomography (CT) scan of the resident's head at 8:08am revealed acute on chronic right subdural hematoma with a small volume of acute hemorrhage within the posterior aspect of the chronic subdural hematoma.
-CT 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 small volume of acute hemorrhage within the posterior aspect of the chronic subdural hematoma.

Review of Resident #3's staff charting notes dated 11/25/24 revealed:
-Resident #3 was caught in a female resident's room trying to choke her.
-Staff removed Resident #3 from the room and took him back to his room.

Review of Resident #3's record revealed there was no documentation that local law enforcement was notified.

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 room.
-She did not notify local law enforcement.

Interview with the Administrator on 12/12/24 at 2:33pm revealed:
-He expected staff to call local law enforcement for residents who have displayed aggressive

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 _____	R-C 12/12/2024

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D 457	Continued From page 30 behaviors. -He did not know if local law enforcement had been called when Resident #3 had been aggressive towards other residents. Attempted telephone interview with another MA on 12/11/24 at 11:03am and on 12/12/24 at 11:20am was unsuccessful. Attempted telephone interview with Resident #3's PCP on 12/11/24 at 11:36am and on 12/12/24 at 9:28am was unsuccessful. _____ The facility failed to ensure law enforcement was contacted on several occasions when two residents who had a known history of physically aggressive behaviors assaulted each other (Resident #2 and #3) and other residents. Resident #3 attempted to choke another resident and sustained a head injury that required sutures after being assaulted by Resident #2. The facility's failure resulted in delayed reporting and prevention of further physical assaults which resulted in serious injury, harm and physical abuse which constitutes a Type A1 Violation. _____ The facility provided a plan of protection on 12/10/24 for this violation in accordance with G.S. 131D-34. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION WILL NOT EXCEED JANUARY 11, 2024.	D 457		