STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 an annual survey on 09/08/21 to 09/10/21.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#5) was tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. The findings are: Review of Resident #5's current FL-2 dated 07/06/21 revealed diagnoses included dementia, hypertension, and diabetes. Review of Resident #5's Resident Register revealed she was admitted to the facility on 07/19/19. Review of Resident #5's record revealed: -A TB skin test was administered on 05/15/19 and read as 0mm on 05/18/19.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 234	Continued From page 1 -There was a second step TB skin test administered on 05/28/19. -The reading was dated 05/31/19 but no results were noted on the documented provided by the facility. Based on observations and record reviews, Resident #5 was not interviewable. Interview with the Executive Director (ED) on 09/10/21 at 3:45pm revealed: -She knew the residents were supposed to have the 2 step TB skin tests done. -She thought all the residents had their 2 step TB skin tests completed. -She was responsible to ensure the TB skin test was administered upon admission. -She was responsible for ensuring TB skin test requirements were completed. -Resident #5's TB skin tests were both done prior to her admission from another facility. -She was not the ED when Resident #5 was admitted. -She had not realized the second test results were not on the document that the facility was provided. -No further documentation of the second step results were provided prior to survey exit.	D 234		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 317	Continued From page 2	D 317		

exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to provide 14 hours of planned group activities per week for the 31 residents of the assisted living (AL) and 23 residents of the memory care unit (MCU) (54 total residents) living in the facility.

The findings are:

Review of the September 2021 activity calendar revealed:
-The same activity calendar was posted on the AL and MCU.
-There were no activities listed for the weekends.
-There were 17 of the 30 days of the month with activities offered each week.
-There were only 12 of the 30 days with activities listed for the MCU.
-The activities listed a start time for the activities.
-There were no times listed for the end time of the activities.

Review of the September 2021 facility calendar revealed:
-There were no activities scheduled for 09/08/21 .
-The activities for 09/09/21 were exercise at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 317	Continued From page 3 9:30am, music movement at 10:15am for the MCU, out to lunch at 11:45am and at 2:00pm. -The activities for 09/10/21 were Bingo at 10:15am, Walmart /Dollar Tree at 1:15pm, and movie and popcorn at 6:15pm. Interview with the activity director (AD) on 09/10/21 at 1:00pm revealed: -Each activity lasted at least 1 hour. -She did not put an end time as some activities would last longer than one hour. Observations of the MCU living room on 09/09/21 at 1:00pm revealed 17 MCU residents participating in exercise with music being led by one of the MCU personal care aides. Observations of the AL hallway on 09/10/21 at 2:00pm revealed: -Four AL residents walking down the hallway with shopping bags. -One resident stated that "they had just got back from Walmart". Observations of the AL dining room on 09/10/21 at 2:30pm revealed 10 AL residents playing Bingo while the AD called the letters/numbers for the game. Interview with a resident on the AL unit on 09/08/21 at 9:15am revealed: -The resident was not sure of how many hours a week were scheduled but each activity usually lasted about an hour. -The facility had an AD and some of the residents were transported to outings, including shopping trips and eating at restaurants before COVID. -There were not any activities at the facility when the AD was not there on the weekends nor if she was off during the week..	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 317	Continued From page 4 Interview with the AD on 09/10/21 at 3:10pm revealed: -She was responsible for the monthly activity calendar. -The scheduled events usually were one hour each. -She did not post a stop time because there were some activities that would go over one hour. -When they went out to shop or out to eat, it took longer than one hour. -She had scheduled at least 14 hours of activities weekly. -She usually had 3 activities scheduled a day. -She did not have activities scheduled on days she was not in the facility. -She worked Monday through Friday. Interview with the Executive Director on 09/10/21 at 3:45pm revealed: -The AD was responsible for the monthly activity calendar. -The AD was responsible for scheduling at least 14 hours of activities weekly. -The AD knew 14 hours of activities were required. -She would ensure the calendar would have start and stop times for the activities and at least 14 hours per week were scheduled.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 358	Continued From page 5	D 358		

which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents sampled (#3) related to not administering medication to treat cancer.

The findings are:

Review of Resident #3's current FL-2 dated 08/12/21 revealed:
-The diagnosis of cancer was not documented on the FL-2.
-There was documentation of Erivedge 150mg (used to treat advance basal cell carcinoma skin cancer) was to be administered 1 capsule once daily.

Review of Resident #3's July 2021 eMAR revealed there was not an entry documented for Erivedge 150mg.

Review of Resident #3's August 2021 eMAR revealed there was not an entry documented for Erivedge 150mg.

Review of Resident #3's August 2021 eMAR revealed there was not an entry documented for Erivedge 150mg.

Review of Resident #3's medication on hand on 09/10/21 at 2:56pm revealed:
-There were two medicine bottles labeled with Erivedge 150mg with 28 capsules.
-The two medicine bottles of the Erivdege 150mg were labeled with Resident #3's name.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 358	Continued From page 6 -The Erivdege 150mg was to be administered 1 capsule once daily. Interview with a Medication Aide (MA) on 09/10/21 at 2:45pm revealed: -She had not administered the Erivdege 150mg to Resident #3. -The Erivdege 150mg was not listed on the eMAR. Telephone interview with the Nursing Director of Services at the discharging nursing home on 09/10/21 at 10:53am revealed: -She had completed the FL2 for Resident #3 while at the nursing home. -The FL2 was faxed to the facility with a face sheet. -The Erivdege 150mg was listed on the FL2. -The face sheet listed all of the conclusive diagnosis. -Resident #3 diagnosis of basal cell carcinoma was present upon his arrival to the nursing home. -Resident #3 was discharged from the nursing on 08/12/21. Attempted telephone interview with Resident #3's Primary Care Physician (PCP) on 09/10/21 at 11:18am was not successful. Interview with the Resident Care Coordinator (RCC) on 09/09/21 at 12:03pm revealed: -Resident #3 had been readmitted to the facility on 08/12/21 from the nursing home. -Resident #3's medications were attached the FL2 dated 08/12/21. -She had reviewed the FL2 and listing of the medications. -She had not noticed Ervidege 150mg on the medications list that was attached to Resident #3's FL2.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 358	Continued From page 7 -She was the person responsible for reviewing the FL2 for accuracy and comparing all medications listed against the eMAR. -She was the person responsible for completing chart audits. -She completed 5 chart audits randomly on a weekly basis. -She had not completed chart audits in the past few weeks. Interview with the Administrator on 09/10/21 at 11:31am revealed: -The RCC was responsible for reviewing FL2s and eMARs for accuracy. -The RCC was responsible for completing chart audits. -The Administrator did not require a written report of chart audits.	D 358		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 463	Continued From page 8	D 463		

and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled residents residing in the Memory Care Unit (MCU) had a pre-admission screening (Resident #2) and regarding the policies and procedures in the MCU.

The findings are:

Review of Resident #2's current FL2 dated 08/19/20 revealed:
-Diagnoses included, dementia, hypertension, coronary heart disease and chronic obstructive pulmonary disease.
-The level of care was documented as other MCU.
-His admission date was 08/19/20.
-Resident #2 was constantly disoriented.

Review of Resident #2's Resident Register revealed:
-There was no documentation of a pre-admission screening prior to admission to the MCU.
-There was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the MCU.
-There was no documentation of a disclosure statement regarding policies and procedures in the MCU.
-The Executive Director (ED) provided a blank copy of the disclosure statement without facility staff or designee or Resident #2's Power of Attorney (POA) signatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 463	Continued From page 9 -The ED provided a Pre-Admission Assessment Screening Form which was dated 08/05/20, the information was hand written in the noted areas, and was not signed by Resident #2s POA nor by any facility staff or designee. Based on observations, interviews, and record reviews, Resident #2 was not interviewable. Attempted telephone interview with Resident #2's Power of Attorney (POA) member on 09/09/21 at 2:09pm was unsuccessful. Interview with the ED on 09/10/21 at 3:45pm revealed: -She was not the ED when Resident #2 was admitted. -She was not sure why the disclosure form nor the pre-screening forms were not signed by the staff completing the form nor the POA for Resident #2.	D 463		