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 _____	R-C 09/29/2023

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 a follow-up survey and state involved complaint investigation on September 27, 2023 through September 29, 2023.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: 0305 (h) (4) Physical Environment Standard Based on observations, interviews, and records reviews, the facility failed to ensure each exit door accessible by residents was equipped with a sounding device that was activated when the door opened for the safety of residents known to be disoriented (#3, #6). The findings are: Observation of an exit door for the smoking area/courtyard off the 200 hallway on 09/29/23 at 1:00 pm revealed:	D 067		

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 _____	R-C 09/29/2023

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 067	Continued From page 1 -There was not an audible alarm on the door that sounded when the door was opened. -The exit door was to the side of the building and open to a parking lot and wooded area. Observation of the front door on 09/29/23 at 12:55 pm revealed: -There was not an audible alarm on the door that sounded when the door was opened. -The exit door was at the front of the building and opened to a parking lot and a neighborhood. -There were no staff monitoring the door. Observation of the second exit door for the smoking area/courtyard located off the main hallway/across from the activity room on 09/29/23 at 12:50 pm revealed: -There was not an audible alarm on the door that sounded when the door was opened. -The exit door was located at the back of the building and opened to a parking lot and wooded area. Observation of the exit door located between laundry and the kitchen on 09/29/23 at 12:40 pm revealed: -There was not an audible alarm on the door that sounded when the door was opened. -The exit was located at the side of the building and opened to a parking lot and neighborhood. Review of Resident #3's FL-2 dated 08/16/23 revealed: -Diagnoses included vascular dementia, post 4 strokes, parkinson disease, and diabetes mellitus. -The resident was intermittently disoriented. Interview with a resident on 09/29/23 at 9:30 am revealed:	D 067		

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 _____	R-C 09/29/2023

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 067	Continued From page 2	D 067		

-She felt unsafe at night because the doors were left unlocked.
-The front door and the doors to the smoking area are not locked at night.
-Residents enter and exit all hours during the night.

Interview with another resident on 09/29/23 at 10:10 am revealed:
-The doors do not lock.
-There was a resident at the facility that ran away when she got a chance.
-Staff had to watch the resident.

Review of Resident #6's FL-2 dated 08/21/23 revealed:
-Diagnoses included dementia and major depressive disorder.
-The resident was intermittently disoriented.

Interview with Resident #6 on 09/29/23 at 10:35 am revealed:
-She walked outside with staff and sometimes walked by herself.
-She walked outside by herself.

Interview with a Personal Care Assistant (PCA) on 09/29/23 at 10:35 am revealed she was keeping an eye on Resident #6 today, so she did not wander.

Interview with the Maintenance Director on 09/29/23 at 10:15 am revealed:
-All doors were locked at night except the two doors that opened to the smoking area.
-Not all doors have alarms.

Interview with the Resident Care Coordinator (RCC) on 09/29/23 at 11:45 am revealed:
-The front door was locked at night or could be

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 _____	R-C 09/29/2023

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 067	Continued From page 3 locked. -The front door does not have an alarm. -The two doors to the smoking area were unlocked and did not have an alarm. Interview with the Administrator on 09/29/23 at 5:05 pm revealed: -He was not sure if the front door was locked at night, but it could be. -The front door did not have an alarm. -The two exits going to the smoking area were not locked and did not have an alarm. -There were no residents with exit seeking behaviors and there were no elopements. Intermittent observations from 09/27/23-09/29/23 revealed no monitoring of the unlocked and unalarmed front door.	D 067		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to ensure that a call bell system was in place for residents that needed assistance. The findings are: Interview with a resident on 09/28/23 at 9:10 am revealed:	D 105		

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 _____	R-C 09/29/2023

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 105	Continued From page 4 -The call bell for room 215 had been illuminated for about 6 weeks. -Her call bell had not worked since she had been there. -The call bell did not work at the desk. -She did not feel safe here with no way to call for help. -Staff was not at the desk at night when help was needed. -She yelled for help when it was needed or called her sister. -She did not have a hand bell to carry, and no one had asked if she wanted one. Interview with the Resident Care Coordinator (RCC) on 09/28/23 at 9:33 am revealed: -The call light for room 215 would not cut off for couple of weeks. -The resident had a hand bell. -Call bells do not sound at the desk. -The Administrator was getting estimates for a new call bell system. -She had worked there since 2016 and the call bell system had not worked since she was hired. -Staff was located on floor when residents needed help. Interview with the Administrator on 09/28/23 at 9:38 am revealed: -He did not know how long room 215 call light had not worked. -He did not know if the call bell system ever made a sound at the desk. -The infrastructure of the building would not allow for the system to be repaired. -He had contacted a contractor about replacing the system but did not have the estimate. -Residents had hand bells to call for help. Interview with two Residents that were	D 105		

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 _____	R-C 09/29/2023

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 105	Continued From page 5	D 105		

roommates on 09/28/23 at 9:55 am revealed:
-The call bell system had not worked in years.
-They did not have a hand bell to carry, and no one had asked if they wanted one.
-One resident called her brother for help and the other resident would call 911.

Interview with a Personal Care Aide (PCA) on 09/28/23 at 10:08 am revealed:
-The call lights did not work,
-Residents would have to yell for help.
-Call lights have not worked since she was hired 2 years ago.

Interview with the Maintenance Director on 09/28/23 at 10:14 am revealed:
-The call bell system has malfunctioned since returning to work 2 years ago.
-Call lights was turned on and would not turn off.
-This was reported to the Administrator before leaving the facility two years ago.
-All residents were given hand bells 4 years ago when the call bell system had started malfunctioning.
-There had been no reports of any issues with the call bell system since he returned 2 years ago.

Interview with a second PCA on 09/28/23 at 10:35 am revealed:
-Some of the call bells worked.
-She did not know which ones did not work.
-Residents did not have any other way to call for help if the call bell system did not work.

Interview with a fourth resident on 09/28/23 at 11:45 am revealed:
-She had fallen trying to sit in her recliner and landed on the floor on 09/12/23.
-She had no way to call for help.
-She had tried yelling, and no staff member

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 _____	R-C 09/29/2023

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 105	Continued From page 6	D 105		

came.
-She was able to get her roommate to go get help.
-She felt scared lying on the floor with no way to call for help.
-She did not feel like she knew what was happening.
-She did not have a hand bell to carry, and no one had asked if she wanted one.

Interview with a fifth resident on 12/29/23 at 10:50 am revealed:
-The resident's roommate had called out for help, she had fallen on the floor.
-The resident was scared and upset, she had yelled for help, then got out of bed and walked into hall and yelled for help.
-She did not have a hand bell to carry, and no one had asked if she wanted one.

Observation of all the resident rooms on the 200 hall on 09/28/23 at 12:30 pm revealed:
-Rooms 201-202 had nonfunctioning call lights.
-Rooms 203-204 had functioning call lights, across the hall from each other close to the nurse's desk.
-Rooms 205-218 had nonfunctioning call lights.
-Shower rooms did not have call lights.
-There were no visible had bells in any of the resident rooms.

Second interview with Administrator on 09/28/23 at 2:25 pm revealed:
-He contacted a company for call bell replacement on 08/15/23 and the estimate was $42,000.00.
-He did not know how long the call bell system has not worked.
-He did not know when the hand bells were handed out to the residents.

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 _____	R-C 09/29/2023

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 105	Continued From page 7 Observation of room 215 on 09/27/23 at 2:12 pm revealed the call light was illuminated but non-functioning. Observation of room 215 on 09/28/23 at 9:10 am revealed the call light was illuminated but non-functioning. Observation of room 215 on 09/28/23 at 12:30 am revealed the call light was illuminated but non-functioning. _____ The facility failed to provide a working call system over a period of several years that was accessible to all the residents in the facility to use to call for staff assistance when needed resulting in at least one resident sustaining a fall in her room and unable to call for staff assistance, residents reported having to call family or the local 911 emergency number for help and residents yelling for assistance and at time staff did not respond causing residents to feel unsafe in the facility. The failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/29/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2023.	D 105		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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 _____	R-C 09/29/2023

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 273	Continued From page 8 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Noncompliance continues. Based on observations, record reviews, and interviews, the facility failed to provide referral in a timely manner to meet the routine healthcare needs of 1 of 5 sampled residents (#1) related to a hand sprain identified 4 days after a fall. The findings are: Review of Resident #1's current FL-2 dated 05/31/23 revealed diagnoses included Parkinson's disease, type 2 diabetes, anxiety disorder and arthropathy. Review of Resident #1's Resident Register revealed an admission date of 08/04/22. Review of Resident #1's progress notes dated 09/23/23 3-11 revealed: -Around 6:50pm on 09/23/23, the resident was outside trying to help another resident up off the ground and fell against the wall. -There were skin tears and lacerations on his right arm, knee, hand, and shoulder. -Staff cleaned and dressed all of them. -An incident report was filled out and left for the Resident Care Coordinator (RCC). -The resident stated he was "sore a little" after his 8:00pm medications, charted and reported. Review of Resident #1's Incident/Accident report	D 273		

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 _____	R-C 09/29/2023

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 273	Continued From page 9	D 273		

dated 09/23/23 at 6:50pm revealed:
-Resident was helping another resident.
-He tripped over and hit a wall.
-Lacerations and skin tears were documented on the right shoulder, right upper arm, and knee.
-Vital Signs were documented as refused.
-First aid was documented as administered by the medication aide (MA), but the type of care was not documented.
-There was fax confirmation that the Incident/Accident report was faxed to the Primary Care Provider (PCP) at 7:39am on 09/24/23.

Observation of Resident #1's right hand on 09/27/23 at 9:00am revealed:
-There was a large band-aid on the back of his right hand.
-His right hand was swollen and reddened.
-He had a wrap-type dressing on his right upper arm.

Interview with Resident #1 on 09/27/23 at 9:10am revealed:
-He fell in the evening on Saturday (09/23/23).
-Another resident fell, and he was trying to help him up and was pulled down.
-He cut his right upper arm and hit his hand.
-He told staff he needed to go to the hospital, but staff would not send him.

Second interview with Resident #1 on 09/27/23 at 10:42am revealed:
-Another resident knocked over the cigarette butt can, and a second resident was helping her pick them up.
-The second resident lost his balance and he tried to help him, but he was pulled down with the other resident.
-There were no staff present when he fell.
-Staff came out and helped him up and brought

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 _____	R-C 09/29/2023

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 273	Continued From page 10	D 273		

him in cleaned him up.
-He went to the nurse's desk a little later the same evening and reported pain on the top of his hand.
-The staff at the desk asked him to open and close his hand and said he did not need to go to the hospital.
-His hand still hurt some but not as bad as it was.
-He was told he would see the PCP today.

Third interview with Resident #1 on 09/29/23 at 9:31am revealed:
-He did not have pain in his right hand on Saturday (09/23/23) after he fell.
-He had some pain in the right hand on Sunday (09/24/23) but did not tell anyone.
-He thought his right hand was swollen on Sunday (09/24/23) but no one looked at it Sunday (09/24/23) or Monday (09/25/23).
-The MA noticed swelling in his right hand on Tuesday (09/26/23) and he saw the PCP on Wednesday (09/27/23).
-He had an x-ray late Wednesday evening 09/27/23 and was told late Thursday 09/28/23 that the x-ray showed a fracture of his right hand and was sent to the Emergency Department (ED) on Thursday 9/28/23.
-A splint was placed on the 4th finger at the ED.

Interview with the third shift MA on 09/28/23 at 7:10am revealed:
-She noticed Resident #1's right hand was swollen on Tuesday night (09/26/23) and placed Resident #1 on schedule to see the PCP on Wednesday (09/27/23).

Interview with the 2nd shift MA on 09/28/23 at 3:38pm revealed:
-She was working as an MA on 09/23/23.
-Residents were sent to the Emergency

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 _____	R-C 09/29/2023

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 273	Continued From page 11	D 273		

Department (ED) after a fall if they hit their head, had a lot of bleeding, or complained of pain.
-Resident #1 was helping another resident on 09/23/23 when he fell against a concrete wall.
-Resident #1 had skin tears on right hand, shoulder, arm, and right knee after the fall on 09/23/23.
-Resident #1 did not have swelling at the time of the fall and did not complain of swelling in the right hand on Saturday (09/23/23) or Sunday (09/24/23).
-Resident #1 did not want to be sent out to the ED.
-She thought Resident #1 complained of arm pain later to the day shift MA and she gave him acetaminophen.
-She checked on Resident #1 every 2 hours after his fall and he went to bed,

Attempted telephone interview with the 1st shift MA on 09/29/23 at 10:33am was unsuccessful.

Review of the Resident #1's September 2023 electronic Medication Administration Record revealed:
-There was an entry for acetaminophen 325mg tablets, take 2 tablets by mouth every 6 hours as needed for pain.
-There was no documentation that acetaminophen was administered to Resident #1 in September 2023.

Review of Resident #1's skin assessment dated 09/26/23 revealed skin tears on both arms and right hand swollen signed by the RCC.

Review of facilty's Hot Box charting revealed:
-There was an entry on 09/23/23 with no time or shift noted that Resident #1 fell while helping another resident pick up cigarettes,

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 _____	R-C 09/29/2023

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 273	Continued From page 12 -There was an entry on 09/24/23 7:00pm to 7:00am that Resident #1 had skin tears and some soreness, at 7:00am to 3:00pm and the resident stated he was okay but had a little soreness, at 3:00pm to 11:00pm. -There was an entry on 09/26/23 7:00am to 3:00pm that while doing skin assessment, noticed the resident's right hand was swollen, the resident voiced no pain or discomfort. Review of Resident #1's radiology report of the right hand dated 09/27/23 revealed: -Age indeterminate, obliquely oriented, nondisplaced fracture of the fifth proximal phalanx. -Age indeterminate, nondisplaced fracture at the base of the fourth proximal phalanx, no other acute fracture or dislocation. Interview with the Resident Care Coordinator (RCC) on 09/29/23 at 12:26 revealed: -Residents were sent to the ED after a fall if they hit their head, were bleeding or complained of pain. - The MAs evaluated residents after a fall and if they complained of pain but did not want to be sent out then they would call the PCP. -If a resident complained of soreness or pain, they would be sent to ED based on the severity of pain. -She expected the MAs to question the residents regarding pain and soreness after a fall. -If a resident experienced pain, they should be sent to ED, or the PCP should be contacted. -Resident #1's record was placed in the Hot Box charting for increased monitoring after his fall on 09/23/23. -Hot Box charting meant she contacted the MA each shift for an update on the residents in the Hot Box.	D 273		

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 _____	R-C 09/29/2023

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 273	Continued From page 13	D 273		

-The night shift MA reported to her that Resident #1 had swelling in his right hand on Tuesday 9/26/23.
-She performed a skin assessment and found Resident #1's right hand was swollen.
-She contacted the PCP by phone on Tuesday afternoon 9/26/23 and was told he would see Resident #1 on Wednesday 9/27/23.

Interview with the Administrator on 09/29/23 at 8:07am revealed:
-Resident #1's right hand radiology report came back last evening and showed a fracture of indeterminate age.
-He sent Resident #1's right hand radiology report to Resident #1's PCP last evening.
-He was informed Resident #1's PCP was not available due the having the flu.
-There was no on-call provider covering for Resident #1's PCP.
-He called 911 and for Emergency Medical Technicians (EMTs) to take Resident #1 to the ED for further x-rays or treatment of the right hand.
-When the EMTs arrived, he said they evaluated Resident #1's right hand and did not feel that he needed to go to the ED.
-He said he wanted Resident #1 to go to the ED to be evaluated and to possibly have further x-rays of the right hand.
-Resident #1 agreed to go to the ED for evaluation.

Review of the ED After Visit Summary dated 09/28/23 revealed:
-The reason for the visit was a hand injury.
-The diagnosis for the visit was a sprain of the interphalangeal joint of the right ring finger.
-Imaging tests that included x-ray right hand PA/LAT and Oblique were ordered.
-Resident was to see an orthopedic specialist in 3

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 _____	R-C 09/29/2023

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 273	Continued From page 14 days. The 09/28/23 ED records and 09/28/23 right hand x-ray report were requested but not received at the time of exit from the facility. Second interview with the Administrator on 09/29/23 at 11;30am revealed: -Resident #1's chart was placed in Hot Box charting for increased monitoring after his fall on 09/23/23. -Resident #1 did not complain of specific pain only generalized soreness and that would not warrant being sent to the ED or a call to the PCP -Resident #1 was able to open and close his right hand on 09/23/23 and on 09/28/23. -Resident #1 had a skin assessment on Tuesday 09/26/23 by the RCC and was noted to have swelling in the right hand. -Resident #1's chart was placed in the box for the PCP to see the following day. -Resident #1 was seen by the PCP on 09/27/23, who ordered an x-ray of the right hand, and this was done on Wednesday evening. -Resident #1's right hand x-ray revealed a fracture of indeterminate age and was sent back to the ED on Thursday 09/28/23 because the PCP was unavailable. Attempted phone interview with the PCP on 09/29/23 at 10:49am was unsuccessful.	D 273		
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.	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 15 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Noncompliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure residents on the assisted living side of the facility were spoken to and treated respectfully by staff and were free from the fear of retaliation when voicing any concerns; and Resident #3 was not treated with respect, dignity and consideration of his individual needs related to appropriate care and assistance with activities of daily living including bathing and toileting and when ill with vomiting and diarrhea. The findings are: 1. Interview with a resident on 09/28/23 at 9:10 am revealed: -The Memory Care Director (MCD) had yelled at her this morning and said "I would not get my cigarettes" because I slammed a door. -The resident denied slaming the door. Interview with another resident on 09/28/23 at 0910 am revealed: -The MCD had told her roommate that if she heard her slam the door again, she would not get her cigarettes from Resident Care Coordinator (RCC). -This happened before breakfast on today (09/28/23). Interview with a third resident on 09/28/23 at 10:40 revealed:	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 16 -The medication aide (MA) was mean to her roommate. -The MA would hold her medications if she had done something the MA had not liked. -Holding medications meant that you were the last resident to receive your evening medications. Interview with a fourth resident on 09/28/23 at 10:40 am revealed: -She was on MA's "bad list" which means she was moved to last when received evening medications. -The MA was yelling at the residents standing in the hall, the MA would not stop yelling and everyone was upset. She tried to get her to stop yelling. -Medications were administered late when residents were last to receive them. -The MA made you wait for medications; she disappeared and returned before providing evening medications. -Receiving medications late made her stay up longer than she wanted at night. -Residents were afraid to say anything because they were afraid of what the staff would do to them. Interview with a sixth resident on 09/28/23 at 10:40 am revealed: -She did not know of anything that she had done to the staff. -There were two MAs that were mean to her because she was quiet and did not talk to them. -Both MAs had yelled at her and would not give her medications until late. -She would get anxious and "worked up" when her medications were held until last. -She could not go to sleep after getting "worked up."	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 17 Interview with MCD on 09/28/23 at 12:17 pm revealed: -She denied treating the residents disrespectfully, or acting mean or nasty. -She had not interacted with any residents in assisted living side. -She would not address anything on the assisted living side that was not a medical emergency. -She did not say she would withhold cigarettes from a resident. Interview with the Administrator on 09/28/23 at 2:25 pm revealed: -He had not received any complaints from residents or staff related to the MCD. -He had never witnessed this type of behavior from the MCD. -He had never witnessed raised voices toward residents. Interview with a MA on 09/29/23 at 4:35 pm revealed: -She had not yelled at any residents. -She did not hold medications from residents. 2. Review of Resident #3's current FL-2 dated 06/16/23 revealed: -Diagnoses included diabetes mellitus, dyslipidemia, hypertension, Parkinson's disease, history of four cerebral vascular accidents, and vascular dementia. -Resident #3 was intermittently disoriented, ambulatory and had bowel incontinence. -He required assistance with bathing and dressing. Review of Resident #3's current Care Plan dated 08/04/22 revealed: -He was oriented, ambulatory with a cane and had occasional bowel incontinence.	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 18 -He required supervision with eating and bathing. -He was independent with toileting, transfers, ambulation, dressing and grooming. Interview with the Resident Care Director (RCD) on 09/27/23 at 3:50pm revealed: -She was responsible for updating resident FL-2s and care plans annually, with significant changes and after hospitalization. -She faxed an updated FL-2 and care plan to Resident #3's primary care provider (PCP) to review and sign on 07/27/23. -She did not receive the signed FL-2 and care plan back for Resident #3. -She could not find the fax confirmation. -She forgot to follow up with Resident #3's PCP to get the signed updated FL-2 and care plan. Review of Resident #3's Task Documentation Worksheets dated for the weeks of 08/04/23, 08/11/23, 08/18/23, and 08/25/23 revealed: -There was documentation that the resident bathed on second shift every Monday, Wednesday, and Friday. -There was documentation that the resident had a sponge bath on second shift every Tuesday, Thursday, and Saturday. -There was documentation that the resident was assisted with dressing, ambulation and after toileting hygiene daily on first and second shifts. Review of Resident #3's Task Documentation Worksheet dated for the week of 09/01/23 revealed: -There was documentation that the resident bathed on second shift on Friday 09/01/23, Monday 09/04/23 and Wednesday 09/06/23. -There was documentation that the resident had a sponge bath on second shift on Saturday 09/02/23 and Tuesday 09/05/23.	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 19	D 338		

-There was documentation that the resident was assisted with dressing, ambulation and after toileting hygiene on first and second shifts on Tuesday 09/05/23 and Wednesday 09/06/23.

Review of Resident #3's Nurse's Notes dated 10/11/22 through 09/06/23 revealed:
-On 09/06/23 at 8:50pm, the resident was found in bed throwing up all over himself and the floor.
-He was not acting as usual and would not stand on his feet.
-Emergency medical services (EMS) was called and the resident's family was notified.
-The previous entry was dated 10/11/22.

Review of Resident #3's incident/accident report dated 09/06/23 revealed:
-At 8:50pm, the resident was vomiting on himself and the floor.
-He could not stand on his feet.
-The resident's heart rate was 83, blood pressure was 146/81 and temperature was 97.8 degrees Fahrenheit (F).
-EMS was called and a family member was notified.

Review of Resident #3's emergency medical services (EMS) report dated 09/06/23 revealed:
-EMS was called at 8:50pm for Resident #3 having nausea and vomiting.
-EMS arrived at 9:00pm and found the resident seated upright on the floor leaning against his bed.
-The resident was covered in vomit and there was vomit all over his bed and on the floor underneath him.
-Resident #3 was able to ambulate to the stretcher with assistance and vomited bile while moving to the stretcher.
-Staff was not present with the resident and were

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 _____	R-C 09/29/2023

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 338	Continued From page 20	D 338		

unable to give a report to paramedics.
-The resident's heart rate was 122, blood pressure was 142/78 and temperature was 97.8 degrees F.

Review of Resident #3's hospital record dated from 09/06/23 to 09/15/23 revealed:
-Resident #3 presented to the emergency room (ER) due to an unwitnessed fall, nausea, and vomiting.
-He was ill appearing; diaphoretic and his blood pressure was 91/51 and his temperature was 100.3 degrees F.
-He had a rash about his groin and adjacent thigh areas.
-He was admitted to the hospital on 09/06/23 and treated with intravenous antibiotics and intravenous fluids.
-He was discharged on 09/15/23 to a skilled nursing facility (SNF).
-Discharge diagnoses included acute metabolic encephalopathy (brain dysfunction due to problems with metabolism), groin cellulitis (a potentially serious bacterial infection) from incontinence and fevers.

Telephone interview with Resident #3 on 09/29/23 at 9:51am revealed:
-He did not remember how he got sick or when it started.
-He remembered not being able to remember his family member's phone number.
-He called the number several times every day but could not remember the number that day (09/06/23).
-He remembered eating breakfast that day (09/06/23).
-Staff did not help him with showers, toileting, dressing and grooming.
-He had Parkinson's, and his legs shook.

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 _____	R-C 09/29/2023

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 338	Continued From page 21	D 338		

-He walked with either a rollator or a cane depending how much his legs were shaking.
-He was on his own taking care of himself because staff did not help him or offer to help him.
-One MA always made him wait until last for his 8:00pm medications.

Telephone interview with a family member on 09/28/23 at 8:22am revealed:
-Resident #3 was admitted to the facility in March 2019 and was able to take care of himself.
-His mind was still sharp even though he had vascular dementia.
-Over time he needed more help because he had difficulty walking and was not able to take care of himself as well.
-He had Parkinson's and shuffled his feet when he walked.
-He used a walking cane and a rollator.
-She saw him frequently and he would dress himself in mismatched and dirty clothes.
-She would pick him up from the facility to take him to appointments or out to eat and his clothing looked as if it had not been changed in 3 days.
-He would tell her he slept in his clothes when she asked because there were times she would see him in the exact same clothes 2 or 3 days later.
-He needed help with dressing and bathing.
-His right hand was already weak from past strokes, he was losing strength in his left hand and he was left handed.
-He was incontinent of urine and stool and his incontinence was not managed by staff.
-Staff did not pay him any attention and left him to tend to his own needs.
-His room was at the very end of the hall and staff stayed at the front desk.
-When she came to the facility to visit him staff

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 _____	R-C 09/29/2023

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 338	Continued From page 22	D 338		

would holler to him to come to the front desk.
-She was embarrassed with how poorly kept he was when she would pick him up from the facility.
-She talked to the Memory Care Director (MCD) several times about Resident #3's appearance and was told he was able to dress himself.
-He called another family member on 09/06/23 because he could not remember her phone number.
-He told the other family member that he had been vomiting.
-The other family member called her out of concern for Resident #3.
-She called Resident #3 but could not get anything that made sense out of him.
-She had spoken to him around 11:00am on 09/06/23 and he was fine at that time.
-She called and spoke with a personal care aide (PCA) who did not know anything about what was going on with Resident #3 and transferred her to a medication aide (MA).
-She may have gotten upset with the MA out of concern for Resident #3.
-She asked the MA if she had been down to Resident #3's room to check on him.
-The MA said no because "you won't shut up for me to get off the phone and go check him."
-She was upset because she asked if they had checked his vital signs and they said they had not.
-It was near 9:00pm and the MA told her she had not checked on Resident #3 that evening.
-The family member did not see Resident #3 or provide his dinner on 09/06/23.
-She last saw the resident on Sunday 09/03/23.
-She spoke with the Resident Care Director (RCD) on 09/07/23 regarding Resident #3's condition on 09/06/23.
-The RCD told her she saw Resident #3, and he was vomiting profusely on 09/06/23.

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 _____	R-C 09/29/2023

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 338	Continued From page 23 -The RCD told her staff tried to call her (family member) but were unable to reach her. Telephone interview with Resident #3's Power of Attorney (POA) on 09/29/23 at 12:22pm revealed: -There were times he picked up Resident #3 from the facility and the resident's clothing was "nasty" and there was feces on his hands, legs, and shoes. -He did not say anything about it because it was embarrassing. -Family members would assist with getting Resident #3 cleaned up. -Resident #3 had difficulty using one hand which made cleaning himself difficult. -Resident #3 did not remember that day (09/06/23); he only knew he was found on the floor. -No one knew how long he was sick, if he fell first or if he was sick and then fell. -There were no injuries found from scans done in the ER on 09/06/23. -He was with Resident #3 at the ER on 09/06/23 and saw the rash on his groin area. -The rash was a deep red, purple color and the skin on his scrotum and groin was raw like a bad diaper rash. -The ER physician asked Resident #3 what he was in the ER for, Resident #3 said he fell and did not remember anything else. -He saw Resident #3 within 15 minutes of his arrival at the ER and he was a mess. -There was vomit on his shirt, in his shorts and down inside his shoes. Interview with a PCA on 09/28/23 at 3:55pm revealed: -She did not see Resident #3 that evening until he was sick. -She was passing 8:00pm snacks when she was	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 24	D 338		

told by medical transporters he was throwing up.
-She went to check on Resident #3, but he was laying in his bed on the phone, so she went to get the medication aide (MA) who was working with him that evening (09/06/23).
-She did not know if Resident #3 needed help with bathing and dressing because she had never helped him with bathing.
-It might have been that she had never worked on his shower days.
-Resident #3 had hand tremors but it was worse on 09/06/23.
-She did not think he was incontinent.
-Resident #3 walked with a walker sometimes.

Interview with a MA on 09/27/23 at 4:29pm revealed:
-Resident #3 took showers on second shift on Mondays, Wednesdays, and Fridays.
-He needed help with showering sometimes, but he did not always let staff help him.
-Resident #3 was a little shaky when he walked to the medication cart in the hall for his evening medications.
-He took his medications that evening (09/06/23) with no problem.
-Before he took his medications, he ate dinner that a family member brought to him in the dining room.
-He did not fall on 09/06/23.
-She became aware Resident #3 was sick after the 8:00pm medication pass on 09/06/23.
-Medical transporters were returning Resident #3's roommate and saw Resident #3 vomiting in the room.
-The transporters told her Resident #3 was vomiting on the floor.
-She gathered cleaning supplies and went to check on Resident #3 because she was working as the personal care aide (PCA) that evening.

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 _____	R-C 09/29/2023

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 338	Continued From page 25 -He was still vomiting so she went to get the other MA working that evening. -The PCA was on the phone with Resident #3's family member who was asking questions about Resident #3's roommate. -The PCA told the family member she would get a MA to talk to her. -She took over the conversation with the family member. -She told the family member that the roommate's information was confidential. -The family member asked questions about Resident #3's condition and vital signs and said staff did not know what was going on with Resident #3. -She told the family member to let her get off the phone and check him. -She and the other MA tried to get him out of the bed to clean him and he was not able to stand. -His feet kept slipping in the vomit, so she and the other MA eased him to the floor. -They tried to clean him up but he kept vomiting. -She did not check Resident #3's vital signs and she did not know if the other MA had checked his vital signs. -She did not stay with Resident #3 because she was working as the PCA for him that evening and it was the MAs responsibility to stay with a resident while awaiting EMS. Interview with a second PCA on 09/29/23 at 9:30am revealed: -Resident #3 would sometimes "get into it" with the MAs because he wanted them to stop and check his FSBS level. -He did not want to have to wait. -He was independent and did everything for himself. -When she worked, she offered him help and he would tell her he did not need any help.	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 26	D 338		

-PCAs were responsible to check residents every 2 hours and offer help.
-If Resident #3 needed help he would stand in his door and wave his hand or walk to the front desk to let staff know.

Telephone interview with a second MA on 09/29/23 at 3:45pm revealed:
-She administered Resident #3's 4:00pm medications on 09/06/23.
-Resident #3 was fine when she saw him to administer his 4:00pm medications.
-The resident ate dinner on 09/06/23, but she did not remember what he ate.
-She did not administer Resident #3's 8:00pm medications.
-The other MA administered the resident's 8:00pm medications.
-The other MA did not like to be crowded by residents at the medication cart.
-The other MA called residents to the medication cart when she was ready.
-She was administering 8:00pm medications when the medical transporters told her Resident #3 was vomiting so she asked the other MA to check the resident.
-Resident #3 was in his bed and on his phone when she went to his room.
-She and the other MA tried to get him up to clean him, but he could not stand.
-There was vomit on the floor which was slippery, so she and the other MA eased him to the floor.
-Staff were responsible for checking residents every 2 hours.
-She saw Resident #3 last at dinner around 5:30pm on 09/06/23.
-He was eating food his family member brought to him in a takeout bag.
-He had canned sausage, pretzels, and soda open on his bed when she went to his room that

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 _____	R-C 09/29/2023

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 338	Continued From page 27	D 338		

evening (09/06/23).
-She left the room to call EMS and get the paperwork ready to send with the resident.
-The other MA stayed in the room with the resident until EMS arrived.

Interview with the Administrator on 09/29/23 at 11:28am revealed:
-Staff told him that a family member brought Resident #3 dinner and he was seen eating in the dining room.
-Staff told him Resident #3 was not sick and well enough to eat dinner.
-Staff told him when they went to his room around the 8:00pm medication pass time he had canned sausage, snack cakes and soda in his room.
-Staff thought he was sick from eating junk food.
-Staff were told that Resident #3 was sick by the medical transporters who brought Resident #3's roommate back from the ER.
-There was one PCA working the evening of 09/06/23 and she was passing out the 8:00pm snacks.
-Staff were responsible for checking residents every two hours.
-The two MAs working that evening (09/06/23) were responsible for Resident #3's care.
-One MA was responsible for administering medications and the other was responsible for PCA duties.
-The MAs told him they went to clean Resident #3 immediately after being told by the medical transporters that he had vomited on himself.
-The MAs told him they were not able to clean Resident #3 because he kept vomiting.

Review of an untitled dining room tracking sheet dated 09/06/23 revealed Resident #3 was not listed on the sheet for breakfast, lunch, and dinner.

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 _____	R-C 09/29/2023

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 338	Continued From page 28 Review of an untitled dining room tracking sheet dated 09/07/23 revealed Resident #3 was listed as in the hospital for breakfast, lunch, and dinner. Interview with a kitchen staff on 09/29/23 at 12:38pm revealed: -She remembered Resident #3 not coming to lunch on 09/06/23. -Staff told her the resident had an upset stomach. -She kept a list of who was not at each meal and looking at the list, Resident #3's name was not there so he must have been at lunch. -It might have been dinner. -According to her list he was at dinner on 09/06/23, but she was certain he did not eat. -He said his stomach was upset. -She was still working in the kitchen when she saw EMS at the facility around 9:00pm. -She went down to Resident #3's room and when she saw he was not right. -He was not able to talk right and not able to stand like someone who was having a stroke. Interview with the RCD on 09/29/23 at 2:11pm revealed: -Resident #3 had frequent pauses between phrases and took a long time to express himself but he was appropriate. -He needed help with showering and his medications. -He was ambulatory without a device; he only used a cane when he left the facility. -He always got his showers. -He toileted himself. -He nor his family member would let staff know when he was going to be leaving the facility. -If staff had been made aware, they would have made sure he was cleaned up. -She saw and talked to Resident #3 on 09/06/23.	D 338		

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 _____	R-C 09/29/2023

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 338	Continued From page 29	D 338		

-She last saw him eating dinner in the dining room and he was fine.
-She did not remember what he was eating.
-No one reported any changes in Resident #3's condition on 09/06/23 to her until that night.
-She spoke with Resident #3's family member on 09/07/23 and told her the resident was sent to the ER because he was vomiting profusely that evening.
-She did not see or hear of him vomiting during the day on 09/06/23.
-She did not know anything about Resident #3 vomiting and having diarrhea until both MAs called her that night (09/06/23).
-Both MAs tried to get Resident #3 cleaned up but the vomit just kept coming.

Interview with the Administrator on 09/29/23 at 4:30pm revealed:
-There was a focus on what Resident #3 ate the evening of 09/06/23 because there was a concern that was the cause of the vomiting.
-Staff were first concerned with getting him cleaned up but were unable because they were all slipping in vomit.
-He did not know which MA stayed with Resident #3 while awaiting EMS arrival.
-One of the MAs was responsible for staying with Resident #3 until EMS arrived.
-The PCA would not have been familiar with getting the paperwork ready for EMS.
-Giving a report was not expected because all that information was in the paperwork given to EMS.
-He did not know if staff were able to get Resident #3's vital signs.
-There was no delay in the time when the medical transporter reported Resident #3 was vomiting to EMS arrival.
-He thought staff provided the appropriate care

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 _____	R-C 09/29/2023

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 338	Continued From page 30 and assistance to Resident #3. _____ The facility failed to ensure residents on the assisted living side of the facility were spoken to and treated respectfully by staff and were free from the fear of retaliation when voicing any concerns; and Resident #3 was treated with respect, dignity and consideration of his individual needs related to appropriate care and assistance with activities of daily living including bathing and toileting and when ill with vomiting and diarrhea. The facility's failure resulted in fear and lack of consideration for residents which was detrimental to the health, safety and wellbeing of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/29/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2023.	D 338		