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 _____	12/05/2024

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 and the New Hanover County Department of Social Services conducted an annual survey and complaint investigation on December 3-5, 2024. The complaint investigations were initiated by the New Hanover County Department of Social Services on October 25, 2024 and November 25, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the facility was free of hazards by not properly storing oxygen cylinders in a storage rack. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 64 residents with an Assisted Living (AL) capacity of 36 and a Special Care Unit (SCU) capacity of 28 residents. Review of the facility's resident roster on 12/03/24 revealed the facility's census was 49 with AL census was 30 and the SCU census was 19.	D 079		

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D 079	Continued From page 1 Observation of the 200 hall on 12/03/24 at 8:55am revealed there were five oxygen cylinders unsecured and not in a storage rack outside of room 204, four full and one empty in the hallway. Observation of room 204 on 12/03/24 at 8:55am revealed there were two oxygen cylinders unsecured and not in a storage rack next to the wall. Interview with a resident in room 204 at 8:55am revealed she did not know anything about how the oxygen cylinders were stored. Observation of room 217 on 12/03/24 at 9:20am revealed there was one oxygen cylinder unsecured and not in a storage rack next to the wall. Interview with resident in room 217 at 9:20am revealed she did not know how the oxygen cylinders were stored and she moved them around when needed. Observation of the recreation room on 12/03/24 at 9:30am revealed there were two oxygen cylinders unsecured and not in a storage rack. Observation of room 205 on 12/05/24 at 10:10am revealed there were four oxygen cylinders unsecured and not in a storage rack and one oxygen cylinder sitting on the resident's rollator. Interview with a medication aide (MA) on 12/04/24 at 8:10am revealed: -The oxygen cylinders were supposed to be stored in a storage rack. -She spoke with the Executive Director (ED) on 12/03/24 to see if she would call Hospice to pick up the oxygen canisters sitting in the hall.	D 079		

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D 079	Continued From page 2 -All staff should make sure the oxygen cylinders were stored in a storage rack. -She was not sure why the oxygen cylinders were not stored in storage racks. Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 8:15am revealed: -The oxygen cylinders were supposed to be stored in a storage rack. -She was not sure why the oxygen cylinders were not stored in storage racks. -The MAs were responsible for ensuring that the oxygen cylinders were stored in a storage rack. -The oxygen cylinders were only stored in the resident's rooms who were on oxygen. -There was no other place that the oxygen cylinders were stored. -She was responsible to ensure that the staff stored the oxygen cylinders correctly. -It was a safety concern when the oxygen cylinders were not stored in storage racks. Interview with the ED on 12/04/24 at 8:20am revealed: -All oxygen cylinders were to be stored in a storage rack. -She was not sure why they the oxygen cylinders were not stored in a storage rack. -All staff should make sure the oxygen cylinders were stored in a storage rack. -The oxygen companies provided the oxygen storage racks. -Oxygen cylinders that were not stored in a rack were a concern for residents' safety.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical,	D 105		

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D 105	Continued From page 3 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: Based on observations and interviews, the facility failed to ensure plumbing equipment was maintained in a safe and operating condition for one walk-in bathtub observed. The findings are: Observation of the bathtub in the shared bathroom on the assisted living (AL) side of the facility on 12/05/24 at 8:27am revealed: -The walk-in bathtub door was not able to close properly. -There was no latch on the inside of the tub to hold it closed. -There was an exposed rusty nail on the inside of the bathtub. Interview with a resident on 12/03/24 at 9:40am revealed: -She did not have a shower in her bedroom. -The bathtub door in the facility did not work properly. -In order to use the bathtub you had to hold the door closed while bathing. -She was not physically capable of holding the bathtub door closed. -She preferred to take baths instead of taking showers. -The bathtub had been broken since she had been living in the facility about 8 months. Interview with a second resident on 12/03/24 at 3:00pm revealed:	D 105		

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D 105	Continued From page 4	D 105		

-She did not have a shower in her bedroom.
-She was not able to use the bathtub in the facility because the door latch was broken.
-In order to use the bathtub you had to hold the door closed while bathing.
-She was not physically capable of holding the bathtub door closed.
-She would use the bathtub occasionally if it worked properly.
-The bathtub had not been available for use since she had been living in the facility over a year.

Interview with a third resident on 12/05/24 at 9:40am revealed:
-She had a shower in her bedroom.
-She would use the bathtub in the facility if it worked properly.
-She did not use the bathtub because the door did not close properly.
-She did not know how the bathtub door had been broken.

Interview with a personal care aide (PCA) on 12/05/24 at 9:00am revealed:
-She had been working at the facility about six months.
-The residents had never used the bathtub since she worked in the facility.
-She used the shower when she assisted residents with personal care.

Interview with a second PCA on 12/05/24 at 9:15am revealed:
-She had not witnessed any of the residents use the bathtub.
-There was no latch on the bathtub door.
-She did not know how long the bathtub had been broken.

Interview with the Maintenance Director on

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D 105	Continued From page 5 12/05/24 at 9:25am revealed: -Residents did not use the bathtub. -The bathtub latch to keep the door closed had broken off. -He was having difficulty finding a replacement latch for the bathtub. -The latch on the bathtub first broke about a year ago. -He had fixed the latch multiple times but it continued to break. -The exposed screw was from the latch that had broken off of the bathtub. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 9:35am revealed: -The latch that kept the bathtub door closed had been fixed several times. -She was not sure when the latch on the bathtub was initially broken. -She believed the residents were leaning up against the latch and holding onto it to stand up. -The exposed rusty screw was a hazard because a resident could injure themselves on it if they used the tub. Interview with the Executive Director (ED) on 12/05/24 at 9:30am revealed: -She was not aware that the latch on the bathtub was broken. -She was concerned that a resident could cut themselves on the exposed rusty screw in the bathtub. -The Maintenance Director was responsible for ensuring the bathtub was in good working order.	D 105		