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	HAL011262	A. BUILDING: _____ B. WING _____	C 10/28/2025

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 an annual survey and complaint investigation on 10/21/25-10/24/25 and 10/27/25-10/28/25. The complaint investigations were initiated by the Buncombe County Department of Social Services on 09/07/25, 10/06/25, 10/10/25, and 10/13/25.	D 000		
D 056	10A NCAC 13F .0305 (f)(5) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (5) the requirements for housekeeping storage are: (A) a housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof. In multi-level facilities, each resident floor shall have a housekeeping closet; and (B) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a container of bleach was secured in a storage area in a housekeeping cart that could be locked, resulting in a resident to access bleach for personal use (Resident #10). The findings are:	D 056		

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D 056	Continued From page 1 Review of the facility's undated chemical storage policy revealed all chemicals must be stored in a safe, secure location. Review of Resident #10's current FL2 dated 09/11/25 revealed: -Diagnoses included post traumatic stress disorder, mild cognitive impairment and major depressive disorder. -He was documented as intermittently disoriented. Review of Resident #10's Resident Register revealed he was admitted to the facility on 09/09/25. Observation of Resident #10 in the hallway outside of resident room #30 on 10/23/25 at 2:30pm revealed: -Resident #10 exited the room carrying a drinking glass. -Resident #10 walked to a housekeeping cart parked in the hallway outside his room. -Resident #10 proceeded to remove a large bottle of bleach from the bottom shelf of the housekeeping cart. -Resident #10 opened the container of bleach and poured a small amount of the bleach into the drinking glass and carried it back into his room. -Resident #10 placed the drinking glass with bleach on a table located in the middle of the room and left the room. -The housekeeping staff observed Resident #10 approach the housekeeping cart, remove the container of bleach, and pour the bleach into a drinking glass and walk away with it. -The housekeeping staff did not intervene to stop Resident #10 from taking the bleach back to his room.	D 056		

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D 056	Continued From page 2 Interview with Resident #10 on 10/23/25 at 2:32pm revealed: -He wanted the bleach to add additional designs to the jeans he was wearing. -He needed the bleach to lighten the fabric to create new designs on the jeans. -He was just on his way out to smoke a cigarette outside and left the glass of bleach on the table in his room. Observation in the hallway outside of resident room #30 on 10/23/25 at 2:33pm revealed: -Survey staff removed the drinking glass with bleach in it from the table in room #30 and handed the glass to the housekeeping staff. -The housekeeping staff proceeded to take a large bleach container from the bottom of the housekeeping cart, unscrewed the cap, and poured the bleach from Resident #10's drinking glass into the large container of bleach. Attempted interview with the housekeeping staff assigned to the cart from which the bleach was taken on 10/23/25 at 2:34pm was unsuccessful due to a language barrier. Interview with the Resident Care Coordinator (RCC) on 10/23/25 at 2:37pm revealed: -The housekeeping staff should not have allowed Resident #10 access to the bleach. -The bleach should have been locked up on the housekeeping cart so residents could not access it. -Neither Resident #10 or his roommate would drink the bleach. Interview with the Administrator on 10/23/25 at 2:39pm revealed he did not know Resident #10 had taken bleach from a bottle on the	D 056		

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D 056	Continued From page 3 housekeeping cart. Observation of the housekeeping cart on 10/23/25 at 2:52pm revealed there was no lockable area on the housekeeping cart. Interview with the Administrator on 10/24/25 at 12:15pm revealed: -The incident on 10/23/25 was the first time Resident #10 had taken a chemical from the housekeeping cart. -The housekeeping cart was not lockable. -The housekeeping cart was used all over the facility. -There were some residents in the facility with dementia as a diagnosis. -There had never been an incident before of a resident removing a chemical from the unlocked housekeeping cart. _____ The facility failed to ensure a container of bleach was secured in a locked storage space in a housekeeping cart, resulting in a resident to access the bleach for personal use. This failure was detrimental to the health, safety, and welfare of Resident #10 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/27/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 12, 2025.	D 056		
D 108	10A NCAC 13F .0311 (b)(2) Other Requirements 10A NCAC 13F .0311 Other Requirements	D 108		

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D 108	Continued From page 4 (b) The following shall apply to heaters and cooking appliances: (2) unvented fuel burning room heaters and portable electric heaters are prohibited; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to prohibit the use of a portable electric heater used in a staff office. The findings are: Observation of a staff office in the facility on 10/27/25 at 9:30am revealed there was a portable electric heater plugged into the wall and blowing hot air. Interview with the Resident Care Coordinator (RCC) on 10/28/25 at 10:11am revealed: -She brought the portable electric heater to the facility on 10/24/25 because she was cold in her office. -She did not know the heater was not allowed in the facility. Interview with the Maintenance Director on 10/28/25 at 9:17am revealed: -Portable electric heaters were not allowed in the facility. -He knew there was a portable electric heater in the RCC's office, but it was rarely used by the RCC. -The RCC only turned the heater on using the low setting. Interview with the Assistant Administrator on 10/28/25 at 9:58am revealed: -Portable electric heaters were not allowed in the facility.	D 108		

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D 108	Continued From page 5 -He just found out there was a portable electric heater in the RCC's office last week. -He meant to have a conversation with the RCC and tell her the heater was not allowed in the facility but had not had a chance yet. Interview with the Administrator on 10/28/25 at 10:05am revealed: -He did not know there was a portable electric heater in the RCC's office. -All staff were informed that those type of heaters were not allowed in the facility.	D 108		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a	D 194		

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census of 81 to 90 residents.
(G) 40 hours of aide duty for facilities with a census of 91 to 100 residents.
(H) 44 hours of aide duty for facilities with a census of 101 to 110 residents.
(I) 48 hours of aide duty for facilities with a census of 111 to 120 residents.
(J) 52 hours of aide duty for facilities with a census of 121 to 130 residents.
(K) 56 hours of aide duty for facilities with a census of 131 to 140 residents.
(L) 60 hours of aide duty for facilities with a census of 141 to 150 residents.
(M) 64 hours of aide duty for facilities with a census of 151 to 160 residents.
(N) 68 hours of aide duty for facilities with a census of 161 to 170 residents.
(O) 72 hours of aide duty for facilities with a census of 171 to 180 residents.
(P) 76 hours of aide duty for facilities with a census of 181 to 190 residents.
(Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents.
(R) 84 hours of aide duty for facilities with a census of 201 to 210 residents.
(S) 88 hours of aide duty for facilities with a census of 211 to 220 residents.
(T) 92 hours of aide duty for facilities with a census of 221 to 230 residents.
(U) 96 hours of aide duty for facilities with a census of 231 to 240 residents.
(2) On third shift, the total aide duty hours shall be at least:
(A) 8 hours of aide duty for facilities with a census of 21 to 30 residents.
(B) 16 hours of aide duty for facilities with a census of 31 to 60 residents.
(C) 24 hours of aide duty for facilities with a census of 61 to 90 residents.

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D 194	Continued From page 7 (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a census of 151 to 180 residents. (G) 56 hours of aide duty for facilities with a census of 181 to 210 residents. (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents. (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the required aide duty hours were met to meet the needs of residents residing in the facility for 24 of 45 sampled shifts from 09/01/25 through 09/15/25. The findings are: Review of the facility's current license issued by the Division of Health Service Regulation effective January 1, 2025, revealed the facility was licensed for a capacity of 67 beds for an Adult	D 194		

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Care Home.

Observation during the initial tour on 10/21/25 at 9:00am revealed the facility was not sprinkled for fire suppression.

Review of the Facility Request for Information obtained upon entry on 10/21/25 revealed:
-Sixteen residents received 80 hours of personal care services.
-One resident received 110 hours of personal care services.
-Four residents received 130 hours of personal care services.

Review of the facility's census for 09/01/25 to 09/15/25 revealed there were 48 residents which required 24 aide duty hours on first and second shift and 16 aide duty hours on third shift.

Interview with one resident on 10/21/25 at 10:06am revealed:
-The facility did not have enough staff.
-There were a "whole bunch" of medication aides (MAs) who quit or were fired.

Telephone interview with a former resident on 10/21/25 at 2:19pm revealed:
-The facility had two employees who worked the 7:00pm-7:00am shift.
-There were times when there was only one of those staff in the building on night shift.

Interview with a third resident on 10/28/25 at 10:20am revealed:
-The facility had a shortage of nursing staff.
-Some nights a MA worked alone, but usually there were two MAs.
-The Resident Care Coordinator (RCC) usually worked during the day but stayed overnight

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sometimes because staff were scheduled but did not always show up.

Interview with a fourth resident on 10/13/25 revealed there was never enough staff working and she often could not find anyone.

Interview with an MA on 10/24/25 at 1:25pm revealed she usually worked first shift and was frequently the only MA available when she worked.

Interview with the RCC on 10/23/25 at 4:34pm revealed:
-The facility had been overall short staffed recently.
-Due to the staff shortages she helped fill in shifts, cook meals and complete housekeeping duties.

Review of the employee time punch detail report dated 09/01/25 revealed there were a total of 18.25 aide duty hours provided on second shift with a shortage of 5.75 aide duty hours.

Review of the employee time punch detail report dated 09/02/25 revealed there were a total of 16.25 aide duty hours provided on second shift with a shortage of 7.75 aide duty hours and a total of 13.25 aide duty hours provided on third shift with a shortage of 2.75 aide duty hours.

Review of the employee time punch detail report dated 09/03/25 revealed there were a total of 15 aide duty hours provided on second shift with a shortage of 9 aide duty hours.

Review of the employee time punch detail report dated 09/05/25 revealed there were a total of 16 aide duty hours provided on first shift with a

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shortage of 8 aide duty hours and a total of 14.25 aide duty hours on second shift with a shortage of 9.75 aide duty hours.

Review of the employee time punch detail report dated 09/06/25 revealed there were a total 16 aide duty hours provided on first shift with a shortage of 8 aide duty hours and a total of 16 aide duty hours on second shift with a shortage of 8 aide duty hours.

Review of the employee time punch detail report dated 09/07/25 revealed there were a total 16 aide duty hours provided on first shift with a shortage of 8 aide duty hours and a total of 17.75 aide duty hours on second shift with a shortage of 6.25 aide duty hours.

Review of the employee time punch detail report dated 09/08/25 revealed there were a total of 22.5 aide duty hours provided on second shift with a shortage of 1.5 aide duty hours.

Review of the employee time punch detail report dated 09/09/25 revealed there were a total 23.25 aide duty hours provided on second shift with a shortage of 0.75 aide duty hours.

Review of the employee time punch detail report dated 09/10/25 revealed there were a total 20.5 aide duty hours provided on second shift with a shortage of 3.5 aide duty hours.

Review of the employee time punch detail report dated 09/11/25 revealed there were a total of 23.75 aide duty hours provided on first shift with a shortage of 0.25 aide duty hours and a total of 22 aide duty hours on second shift with a shortage of 2 aide duty hours.

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D 194	Continued From page 11 Review of the employee time punch detail report dated 09/12/25 revealed there were a total of 17 aide duty hours provided on first shift with a shortage of 7 aide duty hours, a total of 9.75 aide duty hours on second shift with a shortage of 14.25 aide duty hours and a total of 9 aide duty hours on third shift with a shortage of 7 aide duty hours . Review of the employee time punch detail report dated 09/13/25 revealed there were a total of 16 aide duty hours provided on first shift with a shortage of 8 aide duty hours and a total of 21.75 aide duty hours on second shift with a shortage of 2.25 aide duty hours. Review of the employee time punch detail report dated 09/14/25 revealed there were a total 16 aide duty hours provided on first shift with a shortage of 8 aide duty hours and a total of 15.5 aide duty hours on second shift with a shortage of 8.5 aide duty hours. Review of the employee time punch detail report dated 09/15/25 revealed there were a total 17.25 aide duty hours provided on first shift with a shortage of 6.75 aide duty hours and a total of 16.5 aide duty hours on second shift with a shortage of 7.5 aide duty hours. Interview with the Administrator on 10/27/25 at 4:06pm revealed: -If staffing was short, he and the Assistant Administrator filled in. -Because he and the Assistant Administrator did not punch a time clock there was no way he could prove there was enough staff in the building. -He always worked on Mondays and Fridays and usually stayed late to cover shifts. -He would never leave the building with only one	D 194		

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D 194	Continued From page 12 staff working. -The Assistant Administrator frequently worked in the kitchen, so the personal care aids and the MAs were available to do their jobs. -It was hard to hire reliable employees and get them to show up for work. -The Assistant Administrator and the RCC were responsible for scheduling employees.	D 194		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (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: Based on interviews and record reviews the facility failed to contact the primary care provider (PCP) for 1 of 5 sampled residents (#2) related to elevated blood sugar levels. The findings are: Review of Resident #3's undated FL2 revealed: -Diagnoses included type 2 diabetes. -An order for finger stick blood sugars (FSBS) three times daily before meals and to notify the PCP if the FSBS was <70 or >350. Review of Resident #2's Resident Register revealed she was admitted to the facility on 09/09/25, Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times	D 273		

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daily and call the PCP if FSBS was <70 or >350.
-There was documentation Resident #2's FSBS on 09/14/25 at 4:00pm was 366 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 09/22/25 at 12:00pm was 360 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 09/26/25 at 4:00pm was 399 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 09/27/25 at 4:00pm was 361 and there was no documentation the PCP was notified.

Review of Resident #2's October 2025 eMAR revealed:
-There was an entry to check FSBS three times daily and call the PCP if FSBS was >350.
-There was documentation Resident #2's FSBS on 10/08/25 at 4:00pm was 355 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 10/10/25 at 4:00pm was 421 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 10/13/25 at 12:00pm was 414 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 10/14/25 at 12:00pm was 359 and there was no documentation the PCP was notified.
-There was documentation Resident #2's FSBS on 10/15/25 at 8:00am was 439 and there was no documentation the PCP was notified.

Interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and 10/23/25 at 4:34pm revealed:
-When Resident #2's FSBS was greater than 350 the medication aides (MAs) needed to notify the PCP and document the call in the eMAR system.

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D 273	Continued From page 14 -If a note was not documented in the eMAR, the MAs did not notify the PCP. -She did not know why the MAs were not notifying the PCP. -She contacted the PCP "a couple times" but she did not document it in the eMAR. -She did not know why she did not document a call in the eMAR system or contact the PCP after she documented a FSBS of 366 on 09/14/25 and a FSBS of 414 on 10/13/25. -It "gets crazy" when she administered medications because "everyone's yelling at me at one time, and you get distracted". -She was responsible for conducting chart audits but had not had time to do them in more than a month because she was busy cooking meals and helping with housekeeping. Interview with an MA on 10/23/25 at 4:20pm revealed: -She did not call the PCP when Resident #2's FSBS were 399 on 09/26/25, 361 on 09/27/25, 421 on 10/10/25 or 439 on 10/15/25. -She forgot to call the PCP because residents were standing around the medication cart, and she was trying to tend to all the residents at one time. Interview with Resident #2's PCP on 10/23/25 at 9:50am revealed: -The RCC and MAs were able to contact her via email or through the PCP's corporate server. -She was never notified Resident #2 had some FSBS that were >350. Interview with the Administrator on 10/24/25 at 1:30pm revealed: -He expected the RCC and MAs to contact the PCP if there was an order to notify them if Resident #2's FSBS was >350.	D 273		

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D 273	Continued From page 15 -All the MAs were trained properly to read orders. -If the MAs cannot do their job properly, they should not be an MA. -The RCC depended on the pharmacy to do chart audits, but she should also be checking behind the MAs though because that was part of the RCC's job.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the dining room on 10/22/25 at 11:30am revealed: -The tables were set for lunch. -Table service included a spoon and fork but did not include a knife.	D 286		

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D 286	Continued From page 16 Interview with the Kitchen Supervisor on 10/22/25 at 11:31am revealed: -Knives were never put on the table along with the fork and spoon because there were residents with Alzheimer's disease that lived at the facility. -Residents with Alzheimer's disease sometimes got mean and having a knife on the table would not be safe. -She started working at the facility about 4 months ago and she never put a knife on the table for meals. -If a resident wanted something cut, they needed to ask staff. -There were enough knives available if one needed to be available for each resident at meals. Observation in the kitchen on 10/22/25 at 11:35am revealed a drawer in the kitchen contained enough knives for each resident to have one at meals. Interview with one resident on 10/23/25 at 9:40am revealed: -He did not receive a knife in his place setting at meals. -He would like a fork, knife, and spoon to eat his meals. Interview with a second resident during the intial tour on 10/21/25 at 9:15am revealed: -He resided at the facility for about 2 months and was never provided a knife to use during meals. -He had asked staff for a knife to cut up his meat and was told residents were not allowed to have knives. -He had to use the side of his spoon to cut up his meats. -He was not given a spoon this morning with	D 286		

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breakfast because the staff in the dining room told him they ran out of clean spoons.

Interview with a third resident on 10/23/25 at 9:42am revealed:
-He was only provided a spoon and fork with his meals.
-He asked the staff for a knife to cut up his meat and was told he could not have a knife.
-Staff would cut up his food if he asked but he did not like to bother them to cut up his food because they had to help so many other residents.
-He would like a knife to use during meals because he had a hard time cutting up meat with a spoon.

Interview with a fourth resident on 10/23/25 at 10:06am revealed:
-He was not provided a knife during the meal service and had to use a fork to cut up his food.
-He would like a knife to use to cut up his food.

Interview with the Assistant Administrator on 10/22/25 at 11:40am revealed:
-Knives were not put on the table because he and the Administrator did not want to be held responsible for a resident hurting another resident with a knife.
-If a resident requested a knife to cut the food they would not be denied one.
-He never received a complaint from a resident about not having a knife available.

Interview with the Administrator on 10/22/25 at 11:37am revealed:
-Knives were put out upon request.
-They had always done it that way and it always worked.
-He would instruct staff to start including a knife when the table was set.

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D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide 14 hours of planned group activities per week for active involvement of residents. The findings are: Observation of the October 2025 activities calendar on 10/21/25 at 9:15am revealed: -There was a calendar posted on the wall across from the nurse's station next to the common living room. -On 10/21/25, the activities listed were daily chronicles at 8:00am, exercise at 9:30am, and bible study at 2:00pm with no end times. -On 10/22/25, the activities listed were daily chronicles at 8:00am, exercise at 9:30am, and table pong at 2:00pm with no end times. -On 10/23/25, the activities listed were daily chronicles at 8:00am, exercise at 9:30am, and darts at 2:00pm. Observation of the common living room area on	D 315		

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D 315	Continued From page 19 10/21/25 from 9:30am through 10:59am revealed there was no staff providing an activity of exercise with the residents. Interview with one resident on 10/21/25 at 9:14am revealed: -Staff provided activities to the residents when they had time. -She used to participate when chair exercises were offered. -She could not remember the last time chair exercises were offered. Interview with a second resident on 10/21/25 at 9:29am revealed: -The facility did not provide much in the way of activities. -He spent his time laying around and doing nothing. Interview with a third resident on 10/21/25 at 9:47am revealed: -The Activity Director resigned a few months ago so there was noone to do activities. -There was nothing for her to do so she sat in her room. Interview with a fourth resident on 10/22/25 at 3:06pm revealed the facility did not offer activities. Interview with a fifth resident on 10/23/25 at 9:40am revealed: -The facility did not offer activities. -He spent some time going to meals and the rest of his time was spent sleeping. -That was all there was to do. Interview with a medication aide (MA) on 10/21/25 at 10:59am revealed: -The Resident Care Coordinator (RCC) was	D 315		

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responsible for doing activities with the residents.
-The RCC was not working today so the activities were not being provided to the residents.

Interview with a resident on 10/23/25 at 9:42am revealed:
-The facility did not offer any activities over the past couple of months.
-He would not participate in the activities offered previously because they were juvenile and included things "like coloring".

Interview with a second resident on 10/23/25 at 10:06am revealed:
-The facility had not offered activities in 3 or 4 months.
-He was "bored" and stayed in his room and watched television or slept.
-He would like some fun activities offered.

Interview with the RCC on 10/24/25 at 8:44am revealed:
-She was responsible for doing activities with residents since 05/29/25 when the former Activity Director left.
-She had not done any activities with the residents since 08/01/25 because the facility was short staffed, and she filled in as a medication aide (MA) on day shift and night shift and as a cook sometimes.

Interview with the Administrator on 10/24/25 at 12:15pm revealed:
-The facility provided a minimum of 14 hours per week of activities for the residents.
-The RCC had been filling in doing activities with residents for the past 6 months.
-Physical therapy and occupational therapy helped some of the residents with exercising and he thought that counted towards the exercise

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D 315	Continued From page 21 listed at 9:30am on the activities calendar. -He and the Administrator Assistant both "chipped in" to provide activities to the residents.	D 315		
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: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to ensure residents rights were maintained related to a perpetually locked door that disallowed residents to freely exit and enter their assigned hall, staff who did not treat residents with dignity and respect, not providing salt and pepper at meals, and a resident who fell and lay in the floor for 30 minutes because the facility did not have hand signaling devices for residents to alert staff they needed assistance (#12). The findings are: 1. Interview with a medication aide (MA) on 10/21/25 at 9:04am revealed: -Keypad codes were required to unlock doors that connected hallways to allow movement within the facility. -There was a locked door located at the entrance of Hall A which required a keypad code to enter and exit. -There was a locked door located on the back hall of Hall A which required a keypad code to	D 338		

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enter and exit Hall B.
-There was a locked door located at the entrance to Hall B from the foyer of the facility which required a keypad code to enter and exit Hall B.
-There were 12 residents who resided on Hall B.

Observation of the keypad for the locked doors leading to the nurse's station from the Hall B hallway on 10/21/25 at 10:20am revealed:
-There was a keypad on the wall near the double doors locked leading to the main common living room.
-The keypad code that was provided to the state surveyor by staff was typed in four times and the doors would not unlock.
-A resident walked up and reported the buttons "get stuck" and it took her a few times to get the doors to unlock.
-The resident was able to unlock the double doors for the surveyor.

Observation at the keypad location leaving Hall A entering Hall B on 10/21/25 at 11:10am revealed:
-There was a set of control doors between Hall A and Hall B.
-The control doors were closed and locked.
-A keypad code was required to be entered to unlock the doors to allow passage into the Hall B.

Observation of the keypad on 10/21/25 at 10:18am revealed:
-The keypad would not open the locked door when the correct code was entered.
-A resident demonstrated to the state surveyor how to operate the keypad.

Observation of the keypad for the locked doors on Hall B on 10/21/25 at 4:46pm revealed:
-The keypad code was typed in several times by the state surveyor, and the doors would not

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unlock.
-Another locked door leading to the main offices had to be used by the state surveyor to access a different area of the building.

Observation of the keypad for the locked doors leading to the nurse's station from Hall B on 10/22/25 at 11:56am revealed:
-The code was typed into the keypad several times by the state surveyor and the doors did not unlock.
-A resident walked up and typed in the code three times and the doors unlocked.

Interview with a resident on 10/22/25 at 11:56am revealed:
-The buttons on the keypad stick sometimes and would not unlock the doors.
-He usually had to try several times to get the doors to unlock.
-He had to help other residents because they were unable to unlock the doors to get to the main area of the facility or the dining room.
-He did not have a code for the keypad at the other end of the hallway for the door leading to the main offices.

Observation on Hall B near the keypad on 10/23/25 at 8:55am revealed:
-A resident unsuccessfully attempted to operate the keypad four times.
-The resident said, "I can't operate that button".
-Another resident came and taught him how to operate the keypad when it was "sticking".

Interview with a second resident who resided on Hall B on 10/21/25 at 9:16am revealed:
-He did not require any staff assistance.
-He had to enter a code into a keypad to leave Hall B when he wanted to go to the other part of

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the facility.

Interview with a third resident who resided on Hall B on 10/21/25 at 9:47am revealed:
-She had to enter a code into a keypad to leave Hall B.
-The keypad was hard to operate and sometimes the keypad did not work at all.
-When the keypad "stuck" she had to knock on the door and wait for someone to hear because there was not a signaling device to alert staff.
-Sometimes her roommate was available to help her when she could not operate the keypad and get the locked door to open.

Interview with a fourth resident who resided in a room near the physical therapy office on 10/23/25 at 9:42am revealed:
-He was the only resident who lived on the hallway because the other rooms were for staff, laundry, and physical therapy.
-He had to use a keypad code on the door that led to the dining room.
-Sometimes he could not remember the code for the keypad to get to the dining room, and he would have to wait for staff to pass by and let him in.

Interview with a fifth resident who resided on Hall B on 10/23/25 at 9:40am revealed:
-He did not require a lot of staff assistance.
-He did not have a way to notify staff from his room if he needed their assistance.
-He had to walk to the nurse's station located on the Hall A and talk with staff if he needed something.
-There was a keypad requiring a code to unlock the doors located between Hall B and Hall A.
-He had lived at the facility for two months and the keypad access between Hall B and Hall A had

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not worked correctly for him the entire time he had lived there.
-He had the keypad code to the door but was unable to get the code to unlock the door.
-Other residents who lived on Hall B would help him to open the door.
-He would go back to his room if he could not find anyone to help him open the door.
-He saw staff on Hall B at 6:30am when they administered medications.
-Staff would come over to remind them of meals and let them out to go to the dining room located on Hall A.
-He should not be "locked up."
-The facility was not a "prison."
-He wanted to be able to "walk outside freely."
-He had not "broken any rules or laws."

Interview with a sixth resident who resided on Hall B on 10/23/25 at 10:00am revealed:
-He used a wheelchair.
-He was able to transfer himself independently to his wheelchair.
-He did not have a way to notify staff from his room if he needed their assistance.
-He used to have a handbell.
-He did not know where it was now.
-When he had a handbell, he had staff leave it on the floor, because if he fell that would be where he would need it.
-If he needed assistance, he would wheel himself down to the nurse's station on Hall A.
-He did not have any problems reaching the keypad from a seated position in his wheelchair.
-He was able to deactivate the door lock between Hall B and Hall A and get his wheelchair through the door.
-He saw staff on the Hall B at "different times."
-There had been staff on the Hall B to administer medications "this morning."

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D 338	Continued From page 26 -He did not know when staff would return to Hall B again. -The staff had "more important things to do besides coming over here." Interview with a seventh resident who resided on Hall B on 10/23/25 at 10:21am revealed: -She did not have a way to notify staff from her room if she needed their assistance. -If she needed assistance, she would go to the nurse's station located on the Hall A or "wait until they came through" to administer medications. -She saw staff on Hall B "some" but "not much." -Hall B was a "quiet area." Interview with an eighth resident on 10/23/25 at 10:29am revealed: -The buttons on the keypad to unlock the door on Hall B would sometimes stick and even the Maintenance Director had trouble opening the door on 10/22/25. -The door was difficult to unlock and some of the residents could not unlock it to go to the common living room or dining room. -Her room was close to the locked doors, and she often heard other residents yelling for help and saying they could not get out several times a day every day. -Staff did not usually stay on Hall B and were only there to pass medications. -She had to come out of her room several times a day to open the door for other residents. Interview with a ninth resident who resided on Hall B on 10/23/25 at 10:45am revealed: -He had "bad spatial awareness" because of cataracts that affected his vision. -He used a wheelchair due to vision loss. -He was able to transfer himself independently to his wheelchair.	D 338		

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-He did not have a way to notify staff from his room if he needed their assistance.
-If he needed staff assistance, he had to go down to the nurse's station on Hall A.
-He was able to reach the keypad from a seated position in his wheelchair.
-He was able to enter the passcode on the keypad successfully to unlock the doors to enter Hall A, however he was unable to get his wheelchair through the doors before it locked again.
-He would "bang" on the door with his foot and someone from the Hall A would open it for him.
-He did not have the keypad code for the locked door exiting Hall B into the lobby.
-Staff came to Hall B to administer medications at least three times a shift.
-He did not know how often staff rounded on Hall B at night because he went to bed.

Interview with a tenth resident on 10/23/25 at 3:25pm revealed:
-She knew the code to unlock the doors on the hallway but could not get the doors to unlock.
-She had to get another resident to open the door for her when she wanted to go to the living room, dining room, or to find staff to ask for medication.
-If another resident was not available to let her out to the main area, she did not have a way to call staff for help and had to just wait for staff to come by.
-She was "pretty much on my own" living on Hall B.
-She was scared that if there was a fire all the residents living on the hallway including herself would "burn up" because they would not be able to get the doors unlocked because the keypad did not work most of the time.

Interview with the Maintenance Director on

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D 338	Continued From page 28 10/24/25 at 8:36am revealed: -The doors between Hall B and Hall A were not fire doors. -The locked doors with keypads would automatically unlock when a fire alarm was activated. -He was aware the keypad at the Hall B exit door into Hall A would not work at times. -They recently had a local alarm company replace a broken keypad at the dining room entrance into the Hall A. -The alarm company did not have another keypad available to replace the keypad on the Hall B. -A replacement keypad for Hall B was ordered and he was waiting to install it pending a conversation with the Fire Marshal who was due to come for inspection. -He was not sure the Hall B door leading to Hall A needed to be closed and locked or not. Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 11:27am revealed: -She was aware the keypad on Hall B "sticks" and some of the residents were unable to unlock the door. -All residents on Hall B knew the keypad code to exit Hall B to Hall A. -If the residents could not get the keypad to work to open the door, they knocked on the door and someone from Hall A would open the door for them. -Staff walked the Hall B every hour on the 7:00pm-7:00am shift. -On the 7:00pm-7:00am shift, the staff would keep one of the doors between Hall B and Hall A "propped open" so they could see and hear the residents on Hall B. -On the 7:00am-7:00pm shift, the staff would go to Hall B to check on residents every two hours. -During the day, most of the residents from the	D 338		

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Hall B stayed in the TV room or out smoking.
-There were only four residents that routinely stayed on Hall B during the day.
-The facility did not have call lights in resident rooms.
-All residents had handbells at one time.
-She did not know what happened to the handbells.
-None of the residents were given the keypad code to unlock the door between Hall B and foyer exit or the door outside the dining room to the foyer hall.
-The doors were kept locked for the protection of the residents.
-If the residents wanted to go out, the staff would open the doors for them.
-The residents could then sign out and leave.

Interview with the Administrator on 10/23/25 at 11:50am revealed:
-The facility did not have a call bell system.
-He kept a supply of handbells in his office.
-All residents on the Hall B had received handbells in the past.
-The residents on Hall B no longer had handbells.
-He did not know what happened to the handbells.
-There were no "bedridden" residents currently on Hall B.
-Staff performed rounds on Hall B to check on residents.
-There was no way for residents on Hall B to let staff know if they needed assistance unless staff were "walking by."
-All residents on Hall B had been given the keypad code to the door leading into Hall A.
-All residents who resided on Hall B had the ability to use the keypad code to unlock the door.
-None of the residents on Hall B were given the code to open the keypad lock to exit into the

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foyer.
-He was not aware some of the residents were unable to make the keypad code unlock the door to enter Hall A.
-It was a "simple fix" to get the keypad fixed through a local alarm company they had utilized in the past.
-He and the Assistant Administrator asked the residents daily how they could help them and "nobody says anything."
-He did not know that some residents were not able to unlock the doors to go to the common living area or dining room.
-He knew one resident forgot the code to the door and was late to the meal service.

2. Review of Resident #12's current FL2 dated 01/13/25 revealed:
-Diagnoses included suicidal ideation, post traumatic stress disorder, bipolar disorder, and insomnia.
-Recommended level of care was domiciliary.

Review of Resident #12's Resident Register revealed an admission date of 01/03/23.

Review of Resident #12's Care Plan dated 01/13/25 revealed:
-Ambulation was documented as ambulatory with a rollator to maneuver throughout the facility with supervision.
-There was documentation Resident #12 was independent with dressing, bathing, toileting, hygiene and transfers.

Interview with Resident #12 on 10/23/25 at 9:42am revealed:
-He was the only resident residing on the hallway and he liked being by himself.
-He fell about one or two months ago in his room

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and was unable to get up from the floor.
-He did not have a way to call for staff to come and help him, so he had to "just holler" until staff came which took about 30 minutes.
-He would like a way to call staff for assistance when he needed help.
-He worried about "dying in my room" if something happened to him before staff were able to "get to me".
-When he needed assistance or wanted something he sometimes did not get it because some staff did not speak English and he just had to wait until he saw a staff member that did speak English.

Review of the Incident and Accident (I&A) Report book for Resident #12 revealed:
-There was an I&A report dated 01/10/25 for a non-fall episode.
-There were no other I&A reports for Resident #12 from 01/01/25-10/27/25.

Review of Resident #12's chart notes from 12/11/24-09/11/25 revealed there was no documentation of any falls for Resident #12.

Review of a physician's order dated 05/05/25 revealed there was an order for a mobile hip x-ray to be completed for a diagnosis of a fall.

Review of Resident #12's record revealed there was x-ray of the right hip completed on 05/05/25 with no significant findings.

Second interview with Resident #12 on 10/27/25 at 11:55am revealed:
-He could not remember which staff member assisted him from the floor when he fell a couple of months ago.
-He did not have to go to the hospital, but he did

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have an x-ray done of his hip.
-Staff check on him more often now since the fall.

Interview with the Resident Care Coordinator (RCC) on 10/27/25 at 9:30am revealed:
-Resident #12 fell a lot and did not report the falls to staff.
-She did not know if Resident #12 had fallen the past 3 months.
-Staff had not reported any falls for Resident #12.
-She did not document in the chart notes anymore because "I got into trouble last time" for her documentation after a state survey was completed.
-She and other staff communicated with a PCA and housekeeper using a translator application on her phone because they did not speak English.
-Residents told her when they needed something since the residents were unable to communicate with the PCA and/or housekeeper.

Interview with the Administrator on 10/24/25 at 12:15pm revealed:
-He was not aware of any falls for Resident #12 where Resident #12 was not able to call staff for assistance or had to yell and wait 30 minutes for staff to respond.
-The facility did not have a call bell system.
-Resident #12 did not have a hand bell and he could give one to Resident #12, but it would not do any good because staff would not be able to hear it.
-Staff completed rounds on all the residents (how often rounds were completed was not specified).

Attempted interview with the personal care aide (PCA) on 10/21/25 at 10:35am was unsuccessful due to a language barrier.

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D 338	Continued From page 33 Attempted interview with the housekeeper on 10/22/25 at 12:01pm was unsuccessful due to a language barrier. 3. Review of Staff B's personnel record revealed Staff B was hired on 09/03/24 as a medication aide (MA). Interview with a resident during the initial tour on 10/21/25 at 9:15am revealed: -He was not treated with dignity and respect by Staff B. -Staff B acted like a "prison guard" and bossed him around and told him what to do. -Staff B was hateful towards him and other residents. Interview with a second resident during the initial tour on 10/21/25 at 9:37am revealed: -Staff B was mean to him and not pleasant to be around. -Staff B talked to everyone in the "wrong way" and sometimes cursed at him and other residents. -Staff B bossed him and other residents around and told them what to do. Interview with a third resident on 10/21/25 at 9:47am revealed: Staff B was "cursed by other residents and takes it out on us". -Staff B yelled at her one time and told her "You'll get your meds when I get to it". Interview with a fourth resident during the initial tour on 10/21/25 at 10:12am revealed: -Not all residents were treated with respect by staff. -Staff B sometimes had a "bad day" and was not pleasant to be around.	D 338		

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D 338	Continued From page 34 -Sometimes he heard Staff B yell at other residents. Interview with a fifth resident during the initial tour on 10/21/25 at 10:50am revealed: -He was still hungry after the breakfast meal this morning but did not ask for more food because staff always told him no. -Staff were rude when they served him his food. -Some staff "scream" and "holler" at him and other residents if they asked for anything after the food was served. Interview with a sixth resident during the initial tour on 10/21/25 at 10:56am revealed: -Staff B yelled and screamed at him all the time. -He reported Staff B to the Resident Care Coordinator (RCC) but nothing was done about it because Staff B and the RCC were family members. Telephone interview with a former resident on 10/21/25 at 2:19pm revealed: -Staff used curse words in their conversations with each other and in their responses to the residents. -She felt "disrespected" by the staff. -She heard Staff B tell a resident they did not have any [expletive] jelly. -Staff B told residents they needed to be in their rooms by eight o'clock. -Staff B told a resident with dementia "get in your room you [expletive]." -"No one should hear that." Interview with a seventh resident on 10/22/25 at 10:43am revealed: -Staff B was vindictive and took two pairs of his pants and a walking stick from his room and would not return them.	D 338		

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D 338	Continued From page 35 -Once in the dining room, another resident was giving him collard greens from his plate and Staff B grabbed his plate and dumped his food in the trash. -Staff B was belligerent mainly towards male residents. Interview with an eighth resident on 10/22/25 at 2:50pm revealed: -He saw Staff B push a resident in a wheelchair into the wall last week and heard Staff B tell the resident it was not time to go into the dining room to eat. -He asked a personal care aide (PCA) for a towel, washcloth, and bed linens about a week ago and Staff B saw him carrying the linens and thought he had gone into the staff area to get them. -Staff B took the linens from him and yelled at him that he was not allowed to get linens himself. -He informed Staff B that the PCA gave him the linens. -Staff B refused to give him the linens back and when he asked Staff B how he was supposed to take a shower without a towel or washcloth, Staff B told him it was not her problem. -He was "scared" of Staff B and thought Staff B was going to "snap" at any moment. Interviews with a ninth resident on 10/21/25 at 9:34am and 10/23/25 at 2:08pm revealed: -Staff B spoke harshly to her about a week ago when she was told her male friend could not come into her room. -When she started to cry, Staff B threw up her hands and said, "I just don't want to hear it". -When Staff B started working at the facility a few months ago she told the residents she did not like them because they made complaints causing people to be fired and she would not tolerate anything.	D 338		

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-Staff B was so strict and it was sad, but she and the residents had to "comply".

Observation on Hall B on 10/23/25 at 8:50am revealed:
-There was a resident who was unable to open the open the door using the keypad code and he asked another resident to open the door for him.
-Staff B was standing on the other end of the hallway and yelled out to the two residents "stop mashing those buttons. You are going to mess it up".

Interview with a tenth resident on 10/23/25 at 9:40am revealed:
-Staff raised their voices and used "vulgar" language like cursing.
-Staff raised their voices at residents when they asked for more food at meals.

Interview with an eleventh resident on 10/23/25 at 10:06am revealed:
-Staff B was mean to him.
-Staff B bossed him around and cursed at him so he tried to stay away from her and kept to himself in his room.
-She last cursed at him about 2 or 3 weeks ago.
-He was trying to get his guardian to find him another facility to move to because Staff B was so mean to him.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 8:44am revealed:
-Some residents complained to her about being treated rudely by a former staff member.
-Some of the residents told her that staff at night would tell them to go to bed, but the residents knew they could stay up as long as they wanted.
-She heard residents cursing staff before but did not know of any staff members cursing or yelling

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at residents.
-There was a MA who was a family member that was deaf in one ear and sometimes talked loudly because she could not hear well.
-She reported the issues to the Administrator Assistant, and they both went around and asked all the residents about being treated with respect by staff.
-There were 2 residents who said either she, a former employee, or a Staff B were loud and yelled at them and the 2 residents cursed the staff and called the staff [expletive].

Interview with the Administrator on 10/24/25 at 12:15pm revealed:
-He was not aware of any complaints of staff not treating residents with dignity or respect.
-He was not aware of any staff cursing at residents.
-The local county Department of Social Services (DSS) told him residents complained about Staff B and another MA a few months ago.
-One of the MAs told the residents to go to bed at 8:00pm, "but he's no longer here".
-There were complaint boxes at the facility for the residents use.
-He communicated with the residents daily and asked the residents if they had any concerns and nothing was reported to him.
-He heard Staff B talk "short" with the residents and "I addressed her".

4. Interview with a resident during the initial tour on 10/21/25 at 9:15am revealed:
-He did not like the taste of the food provided by the facility.
-There was no salt or pepper available to use to season his food.
-He did not have a sodium restricted diet and wanted salt and pepper.

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D 338	Continued From page 38 -He asked staff for salt and pepper and was told he could not have any. Observation of the lunch meal service on 10/22/25 at 12:05pm revealed: -The meal consisted of barbeque sandwiches, French fries, slaw and pudding -Tables did not have salt or pepper available for resident use. -Staff asked residents if they needed condiments such as sweeteners, coffee creamer or ketchup but did not offer salt or pepper. -One resident brought his own condiments to the dining room, including cayenne pepper and pink Himalaya salt. Interview with a second resident on 10/22/25 at 2:50pm revealed: -He was not on a sodium restricted diet and would like to season his food with salt and pepper because it was bland. -He asked for salt and pepper several times in the dining room and was told he could not have any. -He did not understand why he was not allowed to have salt and pepper. Interview with a third resident on 10/23/25 at 9:40am revealed he would like to have salt and pepper available on the table during meals. Interview with a fourth resident on 10/23/25 at 9:42am revealed the facility did not have salt and pepper available in the dining room. Interview with a fifth resident on 10/23/25 at 10:06am revealed: -The facility did not have salt and pepper available. -He did not have any dietary restrictions including	D 338		

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sodium.
-He wanted salt and pepper available to season his food.

Interview with a sixth resident on 10/23/25 at 10:21am revealed the staff did not put salt and pepper on the table at meals.

Interview with a seventh resident on 10/23/25 at 10:29am revealed:
-The facility used to have salt and pepper available a long time ago but did not offer it anymore.
-Some of the residents bought their own salt and pepper and took them to the dining room with them.
-She asked staff why salt and pepper were no longer supplied, and she was told that too many residents started having heart attacks, so they were no longer allowed to supply salt and pepper.
-She was not on diet that restricted salt intake and would like salt and pepper available.

Telephone interview with a family member on 10/23/25 at 1:45pm revealed:
-The resident called her about a month ago and asked her to bring him some salt because the facility did not have any.
-The resident was not on a sodium restricted diet.
-She did not know why the facility did not provide salt for her family member.
-She had not been to the facility to ask management about the salt and pepper since her family member asked her to bring some.

Interview with an eighth resident on 10/24/25 at 8:48am revealed:
-Salt and pepper were not available in the dining room and he never heard staff offer any.
-He kept his own preferred condiments in a

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pouch on the back of his wheelchair so he could make the food more palatable, and he shared them with his tablemates.
-He thought salt and pepper were not offered at meals because some residents were on a low salt diet.

Observation of the lunch meal service on 10/24/25 at 12:10pm revealed:
-The meal consisted of fried fish, hush puppies, slaw, tartar sauce and pudding with vanilla wafers.
-Tables did not have any salt or pepper available for resident use.
-Staff asked residents if they needed condiments such as sweeteners, coffee creamer or more tartar sauce but did not offer salt or pepper.

Observation of the pantry on 10/24/25 at 8:47am revealed there were two large boxes of individual salt and pepper packets on a shelf.

Interview with the Maintenance Director on 10/23/25 at 2:39pm revealed:
-He was filling in as the cook for the supper meal.
-Salt and pepper were not put on the tables because some residents would "overuse it".
-Salt and pepper were available upon request during the meal service.
-If packets of salt and pepper were placed on the tables the residents would "take it back to their room and hoard it".
-Some residents brought their own condiments to the dining room.

Interview with the Resident Care Coordinator on 10/24/25 at 8:44am and 8:51am revealed:
-Residents had to ask for all condiments at meals, including salt and pepper.
-Staff did not put out anything on the tables

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because residents stole condiments including salt and pepper.
-There were not any residents on a sodium restricted diet.
-Some of the residents bought their own salt and pepper and took it to the dining room with them.

Interview with the Administrator on 10/24/25 at 12:15pm revealed:
-The facility had salt and pepper packets available.
-There were no sodium restricted diets at the facility.
-Residents had to ask for salt and pepper and it would be provided.
-There was a former cook who refused to give the residents salt and/or pepper, but they were terminated about 6 months ago.
-He did not allow salt and pepper to be left out in the dining room for residents' use because the residents would take the packets to their rooms, hoard them, and then there would be a problem with ants or roaches in the residents' rooms.

_____

The facility failed to ensure residents' rights were maintained when residents were not allowed to move freely between Hall B and Hall A due to a known keypad malfunction causing the B Hall doors to fail to unlock which made one resident feel locked up and a second resident feel unsafe and scared they would die if a fire occurred. Another resident fell in their room and waited 30 minutes for staff assistance because the resident was not provided a way to call for staff assistance which made the resident worry about dying in his room. Some of the staff were not able to speak English requiring the residents to wait for assistance until English speaking staff were available to help. Staff B failed to treat residents with dignity and respect by telling residents what

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D 338	Continued From page 42 to do, cursing, and yelling. These failures resulted in substantial risk for serious physical harm and verbal abuse and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/23/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 27, 2025.	D 338		
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 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: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered to 1 of 7 sampled residents (#2), related to three antibiotics to treat infections and insulin to control blood sugar levels. The findings are: Review of Resident #2's undated FL2 revealed diagnoses include type 2 diabetes.	D 358		

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D 358	Continued From page 43 Review of Resident #2's Resident Register revealed she was admitted to the facility on 09/09/25, Review of the facility's undated medication administration policy revealed: -Preparation of medications for administration must be given full and undivided attention. -In preparing to administer a medication, the label shall be checked three times. -All administered medications shall be noted on the resident's medication administration record (MAR) by recording the name of the drug given, dosage, hour of administration and initials of person administering the dose. -Any dose not given should be circled at the appropriate time slot on the front of the MAR with the reason for omission recorded on the reverse side of the MAR. -Reordering schedules should be anticipated for the proper amount of medication to be on hand for each resident. 1. Review of Resident #2's FL2 revealed there was an order for lispro 100units/ml, 7 units three times daily before meals. Review of Resident #2 September 2025 eMAR revealed: -There was an entry for lispro 100units/ml, 7 units three times daily before meals. -There was documentation Resident #2 was administered 4 units before breakfast on 09/12/25. -There was documentation Resident #2 was administered 8 units before dinner on 09/14/25. -There was documentation Resident #2 was administered 6 units before lunch on 09/15/25. -There was documentation Resident #2 was	D 358		

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D 358	Continued From page 44 administered 3 units before lunch on 09/17/25. -There was documentation Resident #2 was administered 2 units before lunch and 2 units before dinner on 09/20/25. -There was documentation Resident #2 was administered 11 units before breakfast on 09/21/25. -There was documentation Resident #2 was administered 6 units before breakfast and 9 units before dinner on 09/22/25. -There was documentation Resident #2 was administered 8 units before breakfast and 6 units before dinner on 09/23/25. -There was documentation Resident #2 was administered 4 units before dinner on 09/25/25. -There was documentation Resident #2 was administered 8 units before lunch and 8 units before dinner on 09/26/25. -There was documentation Resident #2 was administered 4 units before lunch and 8 units before dinner on 09/27/25. -There was documentation Resident #2 was administered 4 units before lunch on 09/28/25. -There was documentation Resident #2 was administered 0 units before dinner on 09/28/25. -There was documentation Resident #2 was administered 6 units before lunch and 0 units before dinner on 09/29/25. -There was documentation Resident #2 was administered 0 units before breakfast on 09/30/25. Review of Resident #2 October 2025 eMAR revealed: -There was an entry for lispro 100units/ml, 7 units three times daily before meals. -There was documentation Resident #2 was administered 6 units before breakfast, 9 units before lunch and 10 units before dinner on 10/02/25.	D 358		

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D 358	Continued From page 45 -There was documentation Resident #2 was administered 0 units before lunch and 0 units before dinner on 10/03/25. -There was documentation Resident #2 was administered 0 units before breakfast and 0 units before dinner on 10/04/25. -There was documentation Resident #2 was administered 0 units before breakfast, 0 units before lunch and 6 units before dinner on 10/05/25. -There was documentation Resident #2 was administered 11 units before breakfast, 15 units before lunch and 0 units before dinner on 10/06/25. -There was documentation Resident #2 was administered 0 units before breakfast on 10/07/25. -There was documentation Resident #2 was administered 13 units before lunch and 13 units before dinner on 10/08/25. -There was documentation Resident #2 was administered 6 units before breakfast, 6 units before lunch and 6 units before dinner on 10/09/25. -There was documentation Resident #2 was administered 6 units before lunch and 8 units before dinner on 10/10/25. -There was documentation Resident #2 was administered 0 units before breakfast, 4 units before lunch and 2 units before dinner on 10/11/25. -There was documentation Resident #2 was administered 2 units before breakfast on 10/12/25. -There was documentation Resident #2 was administered 10 units before lunch and 8 units before dinner on 10/13/25. -There was documentation Resident #2 was administered 0 units before dinner on 10/14/25. -There was documentation Resident #2 was	D 358		

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administered 8 units before lunch on 10/15/25.
-There was documentation Resident #2 was administered 4 units before breakfast on 10/21/25.

Interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and on 10/23/25 at 4:34pm revealed:
-Insulin documentation was difficult to document because the eMAR did not differentiate between the sliding scale lispro and the scheduled dose of lispro.
-She thought the medication aides (MAs) documented the combined dose rather than individual doses.
-Only the pharmacy had rights to make changes to entries in the eMAR system.
-She should have contacted the pharmacy to have them clarify the lispro on the eMAR.
-She never knew any MA to administer too much insulin.
-She was responsible for conducting chart audits but had not had time to do them in more than a month because she was busy cooking meals and helping with housekeeping.
-It "gets crazy" when she administered medications because residents were "everyone's yelling at me at one time, and you get distracted".

Interview with a MA on 10/23/25 at 4:20pm revealed:
-When she was administering medications there were residents standing around and she tried to tend to all of them at the same time and it got confusing.
-Administering insulin was confusing and "I won't lie; I've probably made mistakes".

Telephone interview with a second MA on 10/24/25 at 1:25pm revealed she made mistakes

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when administering medications because she was the only MA and was distracted because residents kept talking to her.

Interview with Resident #2's Primary care provider (PCP) on 10/23/25 at 9:50am revealed:
-Resident #2 had diabetes and was ordered insulin to control her blood sugar levels.
-Being administered too much insulin could cause low blood sugar resulting in the person becoming jittery and possibly passing out.
-Being administered too little insulin can cause high blood sugars resulting in a hyperosmotic state (dehydration and confusion due to elevated blood sugars) which would require hospitalization to treat.
-She did not know the MAs were making insulin errors.
-After reviewing the September 2025 and October 2025 eMARs, she said, "That's a lot of errors for six weeks".

Attempted telephone interview with a third MA on 10/24/25 at 11:48am was unsuccessful.

Interview with the Administrator on 10/24/25 at 1:30pm revealed:
-He expected the MAs and the RCC to administer insulin correctly because they had all been properly trained.
-If the MAs were having problems at medication administration times they should have informed him.
-The RCC should have discovered the errors when she was doing chart reviews.
-He knew the RCC depended on the contracted pharmacists to do eMAR audits, but she should still be checking behind the MAs.

2. Review of Resident #2's FL2 revealed there

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was an order for lispro (used to control blood glucose) 100units/ml, inject units per sliding scale (SSI): FSBS 151-200 add 2 units; FSBS 201-250 add 4 units; FSBS 251-300 add 6 units; FSBS 301-350 add 8 units; call doctor if FSBS >350.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for lispro 100units/ml, inject units per sliding scale (SSI): FSBS 151-200 add 2 units; : FSBS 201-250 add 4 units; FSBS 251-300 add 6 units; FSBS 301-350 add 8 units; call doctor if FSBS >350.
-There was documentation Resident #2's FSBS before lunch on 09/09/25 was 312 and she was administered 7 units SSI not 8 units.
-There was no documentation Resident #2's FSBS was taken before dinner on 09/10/25 and therefore no SSI was documented as administered.
-There was documentation Resident #2's FSBS before dinner on 09/14/25 was 366 and she was administered 7 units SSI when the PCP should have been notified for guidance.
-There was documentation Resident #2's FSBS before dinner on 09/17/25 was 286 and she was administered 2 units SSI not 6 units.
-There was documentation Resident #2's FSBS before lunch on 09/20/25 was 123 and she was administered 2 units SSI when she should not have received any.
-There was documentation Resident #2's FSBS before dinner on 09/20/25 was 122 and she was administered 2 units SSI when she should not have received any.
-There was documentation Resident #2's FSBS before breakfast on 09/21/25 was 263 and she was administered 11 units SSI not 6 units.
-There was documentation Resident #2's FSBS

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before lunch on 09/22/25 was 360 and she was administered 9 units SSI when the PCP should have been notified for guidance.
-There was documentation Resident #2's FSBS before dinner on 09/22/25 was 300 and she was administered 9 units SSI not 6 units.
-There was documentation Resident #2's FSBS before breakfast on 09/24/25 was 288 and she was administered 7 units SSI not 6 units.
-There was documentation Resident #2's FSBS before dinner on 09/26/25 was 399 and she was administered 8 units SSI when the PCP should have been notified for guidance.
-There was documentation Resident #2's FSBS before dinner on 09/27/25 was 361 and she was administered 8 units SSI when the PCP should have been notified for guidance.
-There was no documentation Resident #2's FSBS was taken before dinner on 09/28/25 and therefore no SSI was documented as administered.
-There was documentation Resident #2's FSBS before breakfast on 09/30/25 was 263 and she was administered 0 units SSI not 6 units.

Review of Resident #2's October 2025 eMAR revealed:
-There was documentation Resident #2's FSBS before breakfast on 10/01/25 was 132 and she was administered 3 units SSI not 0 units.
-There was documentation Resident #2's FSBS before lunch on 10/02/25 was 251 and she was administered 9 units SSI not 6 units.
-There was documentation Resident #2's FSBS before dinner on 10/02/25 was 316 and she was administered 10 units SSI not 8 units.
-There was documentation Resident #2's FSBS before breakfast on 10/04/25 was 306 and she was administered 0 units SSI not 8 units.
-There was no documentation Resident #2's

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D 358	Continued From page 50 FSBS before breakfast on 10/05/25 was obtained and therefore no insulin was administered. -There was documentation Resident #2's FSBS before dinner on 10/05/25 was 218 and she was administered 6 units SSI not 4 units. -There was documentation Resident #2's FSBS before breakfast on 10/06/25 was 250 and she was administered 11 units SSI not 4 units. -There was no documentation Resident #2's FSBS before dinner on 10/06/25 was obtained and therefore no insulin was administered. -There was documentation Resident #2's FSBS before breakfast on 10/07/25 was 232 and she was administered 2 units SSI not 4 units. -There was documentation Resident #2's FSBS before dinner on 10/08/25 was 355 and she was administered 13 units SSI rather than calling the PCP for guidance. -There was documentation Resident #2's FSBS before dinner on 10/09/25 was 133 and she was administered 6 units SSI not 0 units. -There was documentation Resident #2's FSBS before lunch on 10/10/25 was 118 and she was administered 6 units SSI not 0 units. -There was no documentation Resident #2's FSBS before breakfast on 10/11/25 was obtained and therefore no insulin was administered. -There was documentation Resident #2's FSBS before lunch on 10/12/25 was 414 and she was administered 10 units SSI rather than calling the PCP for guidance. -There was documentation Resident #2's FSBS before lunch on 10/14/25 was 359 and she was administered 8 units SSI rather than calling the PCP for guidance. -There was no documentation Resident #2's FSBS before dinner on 10/14/25 was obtained and therefore no insulin was administered. -There was documentation Resident #2's FSBS before breakfast on 10/15/25 was 439 and she	D 358		

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was administered 6 units SSI rather than calling the PCP for guidance.
-There was documentation Resident #2's FSBS before breakfast on 10/22/25 was 167 and she was administered 7 units SSI not 2 units.

Interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and on 10/23/25 at 4:34pm revealed:
-Insulin documentation was difficult to document because the eMAR did not differentiate between the sliding scale lispro and the scheduled dose of lispro.
-She thought the medication aides (MAs) documented the combined dose rather than individual doses.
-Only the pharmacy had rights to make changes to entries in the eMAR system.
-She should have contacted the pharmacy to have them clarify the lispro on the eMAR.
-She never knew any MA to administer too much insulin.
-She was responsible for conducting chart audits but had not had time to do them in more than a month because she was busy cooking meals and helping with housekeeping.
-It "gets crazy" when she administered medications because residents were "everyone's yelling at me at one time, and you get distracted".

Interview with a MA on 10/23/25 at 4:20pm revealed:
-When she was administering medications there were residents standing around and she tried to tend to all of them at the same time and it got confusing.
-Administering insulin was confusing and "I won't lie; I've probably made mistakes".

Telephone interview with another MA on 10/24/25

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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
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at 1:25pm revealed she made mistakes when administering medications because she was the only MA and was distracted because residents kept talking to her.

Interview with Resident #2's Primary care provider (PCP) on 10/23/25 at 9:50am revealed:
-Resident #2 had diabetes and was ordered insulin to control her blood sugar levels.
-Being administered too much insulin could cause low blood sugar resulting in the person becoming jittery and possibly passing out.
-Being administered too little insulin can cause high blood sugars resulting in a hyperosmotic state (dehydration and confusion due to elevated blood sugars) which would require hospitalization to treat.
-She did not know the MAs were making insulin errors.
-After reviewing the September 2025 and October 2025 eMARs, she said, "That's a lot of errors for six weeks".

Attempted telephone interview with a third MA on 10/24/25 at 11:48am was unsuccessful.

Interview with the Administrator on 10/24/25 at 1:30pm revealed:
-He expected the MAs and the RCC to administer insulin correctly because they had all been properly trained.
-He would prefer if PCPs did not order SSI because his staff were MAs not nurses.
-If the MAs were having problems at medication administration times they should have informed him.
-The RCC should have discovered the errors when she was doing chart reviews.
-He knew the RCC depended on the contracted pharmacists to do eMAR audits, but she should

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D 358	Continued From page 53 still be checking behind the MAs. 3. Review of Resident #2's hospital discharge summary dated 10/20/25 revealed: -Resident #2 was admitted to the hospital on 10/16/25 due to a urinary tract infection (UTI) and discomfort in her right axilla (armpit). -A wound culture of a boil in her axilla was positive for methicillin-resistant staphylococcus aureus (MRSA) (a contagious bacterial infection). -She was ordered antibiotics while in the hospital and was transitioned to oral and topical antibiotics upon discharge. a. Review of Resident #2's hospital discharge orders dated 10/20/25 revealed an order for cefpodoxime (an antibiotic used to treat an infection) 200mg two times a day for 3 days. Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for cefpodoxime 200 mg, two times a day for three days with a starting time of 7:00pm on 10/20/25. -There was no documentation on 10/20/25 at 7:00pm. -There was documentation on 10/21/25 at 7:00am that they were awaiting the pharmacy. -There was documentation cefpodoxime was administered on 10/21/25 at 7:00pm and 10/22/25 at 7:00am. Observation of Resident #2's medications on hand on 10/22/25 at 12:50pm revealed cefpodoxime was not available to administer. Refer to interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and 10/24/25 at 8:33am.	D 358		

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D 358	Continued From page 54 Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 2:55pm. Refer to interview with Resident #2's Primary Care Provider (PCP) on 10/23/25 at 9:50am. Refer to telephone interview with an MA on 10/24/25 at 1:25pm. Refer to interview with the Administrator on 10/24/25 at 1:30pm. b. Review of Resident #2's hospital discharge orders dated 10/20/25 revealed an order for doxycycline Mono (an antibiotic used to treat an infection) 100mg two times a day for 7 days. Review of Resident #2's October 2025 eMAR revealed: -There was an entry for doxycycline Mono 100mg two times a day for 7 days with a starting time of 7:00pm on 10/20/25. -There was no documentation on 10/20/25 at 7:00pm. -There was documentation on 10/21/25 at 7:00am that they were awaiting the pharmacy. -There was documentation doxycycline was administered on 10/21/25 at 7:00pm and 10/22/25 at 7:00am. Observation of Resident #2's medications on hand on 10/22/25 at 12:50pm revealed doxycycline 100mg was not available to administer. Refer to interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and 10/24/25 at 8:33am.	D 358		

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D 358	Continued From page 55 Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 2:55pm. Refer to interview with Resident #2's Primary Care Provider (PCP) on 10/23/25 at 9:50am. Refer to telephone interview with an MA on 10/24/25 at 1:25pm. Refer to interview with the Administrator on 10/24/25 at 1:30pm. c. Review of Resident #2's hospital discharge orders dated 10/20/25 revealed an order for Mupirocin 2% ointment (topical antibiotic used to treat MRSA) apply to both nostrils twice a day for three days. Review of Resident #2's October 2025 eMAR revealed: -There was an entry for Mupirocin 2% ointment twice daily for three days with a starting time of 7:00pm on 10/20/25. -There was no documentation on 10/20/25 at 7:00pm. -There was documentation on 10/21/25 at 7:00am that they were awaiting the pharmacy. -There was documentation Mupirocin 2% ointment was administered on 10/21/25 at 7:00pm and 10/22/25 at 7:00am. Observation of Resident #2's medications on hand on 10/22/25 at 12:50pm revealed Mupirocin 2% ointment was not available to administer. Refer to interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and 10/24/25 at 8:33am.	D 358		

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D 358	Continued From page 56 Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 2:55pm. Refer to interview with Resident #2's Primary Care Provider (PCP) on 10/23/25 at 9:50am. Refer to telephone interview with an MA on 10/24/25 at 1:25pm. Refer to interview with the Administrator on 10/24/25 at 1:30pm. _____ Interviews with the Resident Care Coordinator (RCC) on 10/22/25 at 12:50pm and 10/24/25 at 8:33am revealed: -She faxed the discharge orders to the pharmacy on 10/20/25 and did not work on 10/21/25 so she could not confirm the antibiotics were delivered. -The third shift medication aide (MA) who accepted the pharmacy delivery should have informed the first shift MA that the antibiotics were not delivered. -The first shift MA should have contacted the pharmacy to inquire about the medications and if they were not going to be available should have had them filled by the back-up pharmacy. -She did not know why the MAs would document they administered the medications if the medication was not available; it must have been an error. -She spoke with someone at the pharmacy early on 10/22/25 and it was scheduled to be delivered after midnight. -All new medication orders were flagged in the eMAR system and needed to be approved by the MA. -The MA should have noticed the flagged medications and documented it was not	D 358		

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administered if it was still not available and should have called the pharmacy to ask why the antibiotics were not delivered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 2:55pm revealed:
-The facility sent a fax to the pharmacy of Resident #2's 0/20/25 hospital discharge orders on 10/20/25.
-A pharmacy tech failed to properly process the orders for the antibiotics, so they were never filled and sent to the facility.
-She was made aware of the error earlier in the day and the antibiotics were already filled and scheduled to be delivered to the facility after midnight.
-She adjusted the eMAR so Resident #2 would receive the full course of treatment for the antibiotics.

Telephone interview with an MA on 10/24/25 at 1:25pm revealed she made mistakes when documenting medications because she was the only MA and was distracted because residents kept talking to her.

Interview with Resident #2's Primary Care Provider (PCP) on 10/23/25 at 9:50am revealed:
-Resident #2 was septic at the hospital due to the UTI but she was stabilized and discharged back to the facility with orders to continue antibiotics to finish treating the UTI and the MRSA positive boil in her axilla.
-She would have expected the antibiotics to be started within the first 24 hours she was back at the facility.
-Resident #2 could become septic again if the infections continued to be left untreated.

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D 358	Continued From page 58 Interview with the Administrator on 10/24/25 at 1:30pm revealed: -All MAs were trained and should follow proper procedure in administering medications. -He did not know the MAs were making so many errors. _____ The facility failed to administer insulin correctly to Resident #2, putting her at risk of experiencing too high or too low blood sugar levels which could cause Resident #2 to become hyperosmotic that would necessitate a hospitalization. Resident #2 was septic at the hospital due to a UTI and had a boil in her axilla that tested positive for MRSA. When Resident #2 was discharged to the facility they failed to obtain and administer three antibiotics that were ordered to continue treatment for the UTI and MRSA until 10/23/25. Failure to start the antibiotics timely put Resident #2 at risk of becoming septic again if the infections were left untreated. These failures placed residents at substantial risk of serious physical harm or death and constitute a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/23/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 27, 2025.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of	D 392		

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D 392	Continued From page 59 controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 4 sampled residents (#5 and #6) with orders for a controlled substance used to treat moderate to severe pain and a medication used to treat nerve pain. The findings are: Review of the facility's undated Controlled Drugs policy revealed: -Individual controlled drug records shall be maintained for each resident; one medication per record with the name of the resident, name of the medication, dosage administered, date of administration, and initial and ending count. -All controlled drugs shall be counted once each shift by two persons (one from the proceeding shift and one from the incoming shift). -Documentation of count shall be maintained on individual controlled drug sheets, on the active medication administration record, one medication per sheet, signed by two people. -It shall be the medication person's responsibility to complete individual controlled substance records for each medication administered. -Periodic spot counts shall be taken of these drugs by the pharmacy Consultant and/or person designated by administration. -Results of this count should be compared with	D 392		

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patient medications records and discrepancies reported to pharmacy vendor/consultant and administration.

1. Review of Resident #6's current FL2 dated 10/06/25 revealed:
-Diagnoses included multiple sclerosis, muscle weakness, other cirrhosis of liver, and type 2 diabetes mellitus without complications.
-There was an order for oxycodone-acetaminophen 10-325mg one tablet three times a day at 5:00am, 1:00pm, and 8:00pm (oxycodone-acetaminophen is a controlled substance used to treat moderate to severe pain.)
-There was an order for oxycodone-acetaminophen 10-325mg one tablet every 24 hours as needed for pain do not take within two hours of scheduled dose.

Review of Resident #6's Resident Register revealed:
-There was an admission date of 10/01/25.
-Resident #6 was admitted from another assisted living facility (ALF).

Review of Resident #6's primary care provider (PCP) prescription dated 10/06/25 revealed oxycodone-acetaminophen 10-325mg one tablet every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am with a quantity of 120.

Review of Resident #6's Medication Release forms dated 10/01/25 revealed:
-The form documented the name of medications, strength of the medications, amount released of each medication that was brought with Resident #6 from a prior ALF where Resident #6 resided.
-There was one entry for oxycodone-acetaminophen 10-325mg with a

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quantity of 14 tablets.
-There was one entry for oxycodone-acetaminophen 10-325mg with a quantity of 23 tablets with a handwritten line through the 23 tablets and 36 tablets handwritten with the initials of the Resident Care Coordinator (RCC) beside the modified entry.
-There was one entry for oxycodone-acetaminophen 10-325mg with a quantity of 90 tablets.

Telephone interview with the previous facility's contracted pharmacy on 10/27/25 at 4:15pm revealed:
-They dispensed 90 oxycodone-acetaminophen 10-325mg tablets on 09/03/25 for Resident #6.
-They dispensed 90 oxycodone-acetaminophen 10-325mg tablets on 09/30/25 for Resident #6.
-They provided paper-controlled substance (CS) logs with an affixed pharmacy label for the packs of oxycodone-acetaminophen 10-325mg tablets they dispensed for Resident #6.

Telephone interview with the facility's contracted pharmacy on 10/27/25 at 3:35pm revealed:
-They received an electronic prescription for oxycodone-acetaminophen 10-325mg one tablet every six hours scheduled at 6:00am, 12:00pm, 6:00pm, and 12:00am on 10/20/25.
-They dispensed 120 oxycodone-acetaminophen tablets on 10/20/25 for Resident #6.
-They received an order on 10/27/25 to discontinue Resident #6's oxycodone-acetaminophen 10-325mg one tablet every six hours at 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Resident #6's new order dated 10/27/25 was for oxycodone-acetaminophen 10-325mg one tablet three times a day.
-They provided paper CS logs with an affixed

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pharmacy label for the packs of oxycodone-acetaminophen 10-325mg tablets they dispensed for Resident #6.

Review of Resident #6's October 2025 electronic medication administration record (eMAR) dated 10/01/25-10/27/25 revealed:
-There was an entry for oxycodone-acetaminophen 10-325mg one tablet three times a day scheduled at 5:00am, 1:00pm, and 8:00pm from 10/01/25-10/02/25 then the administration schedule changed to 8:00am, 2:00pm, and 8:00pm from 10/03/25 to 10/06/25.
-Oxycodone-acetaminophen 10-325mg was documented as administered three times a day from 10/01/25 at 8:00pm-10/06/25 at 8:00pm.
-There was an entry for oxycodone -acetaminophen 10-325mg one tablet every six hours scheduled at 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Oxycodone-acetaminophen 10-325mg was documented as administered four times a day from 10/07/25 at 12:00am-10/27/25 at 6:00am.
-Oxycodone-acetaminophen 10-325mg was documented as not administered at 12:00am on 10/10/25 due to resident sleeping would not wake up for medication.

Observation of Resident #6's medications on hand on 10/27/25 at 3:59pm revealed:
-There was a supply of oxycodone/acetaminophen 10-325mg tablets dispensed on 09/30/25 with instructions to take one tablet at 5:00am, 1:00pm, and 8:00pm.
-There were 24 of 90 tablets remaining.
-There was a supply of oxycodone/acetaminophen 10-325mg tablets dispensed on 10/20/25 with instructions to take one tablet every six hours for pain at 6:00am, 12:00pm, 6:00pm, and 12:00am.

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D 392	Continued From page 63 -There were 120 of 120 tablets remaining. Review of Resident #6's CS logs for October 2025 revealed: -There were two pages of Resident #6's oxycodone-acetaminophen 10-325mg CS log provided by the facility. -Page one of Resident #6's oxycodone-acetaminophen 10-325mg CS log had entries dated 10/04/25-10/11/25 with a starting count of 38 and an ending count of 10 tablets remaining on 10/11/25. -Page two of Resident #6's oxycodone-acetaminophen 10-325mg CS log had entries dated 10/14/25-10/27/25 with a starting count of 45 and an ending count of 24 tablets remaining on 10/27/25. -There were no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/01/25 at 8:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/02/25 at 5:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/02/25 at 1:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/02/25 at 8:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/03/25 at 8:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/03/25 at 2:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/03/25 at 8:00pm. -There was an oxycodone-acetaminophen documented as administered or declined from the	D 392		

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D 392	Continued From page 64 CS log for 10/10/25 at 12:00am with documentation on the eMAR as not administered due to resident sleeping. -There were no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/11/25 at 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/12/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/12/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/12/25 12:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/12/25 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/13/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/13/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/13/25 12:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/13/25 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/14/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/14/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/14/25 12:00pm. -There was no oxycodone-acetaminophen	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 392	Continued From page 65	D 392		

documented as administered or declined from the CS log for 10/15/25 12:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/15/25 6:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/15/25 12:00pm.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/15/25 6:00pm.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/16/25 12:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/16/25 6:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/16/25 12:00pm.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/16/25 6:00pm.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/17/25 12:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/17/25 6:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/17/25 12:00pm.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/17/25 6:00pm.
-There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/18/25 12:00am.
-There was no oxycodone-acetaminophen documented as administered or declined from the

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D 392	Continued From page 66 CS log for 10/18/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/18/25 12:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/18/25 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/19/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/19/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/19/25 12:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/19/25 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/20/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/20/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/20/25 12:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/20/25 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/21/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/21/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/21/25 12:00pm.	D 392		

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D 392	Continued From page 67 -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/21/25 6:00pm. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/22/25 12:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/22/25 6:00am. -There was no oxycodone-acetaminophen documented as administered or declined from the CS log for 10/24/25 6:00pm. Interview with Resident #6 on 10/21/25 at 10:06am revealed: -Her PCP had recently changed the order for her to receive her pain medication four times a day at 6:00am, 12:00pm, 6:00pm, and 12:00am. -The staff were not administering her 6:00pm dose until 8:00pm to 9:00pm at night. Interview with Resident #6 on 10/28/25 at 8:55am revealed: -She hurt "everywhere" especially in her neck when she did not receive the oxycodone-acetaminophen 10-325mg as scheduled. -The pain affected her sleep and "sometimes" she "hurt so bad" she would not get up for breakfast. -She did not sleep through the scheduled 12:00am doses of oxycodone-acetaminophen 10-325mg she was "wide awake." -The PCP had just decreased the frequency of the oxycodone-acetaminophen 10-325mg from every six hours to every eight hours. -She took the oxycodone-acetaminophen 10-325mg every six hours when she lived at home. -She went to the nurse's station at the scheduled	D 392		

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times and ask the medication aides (MA) for the oxycodone-acetaminophen 10-325mg.

Interview with the RCC on 10/28/25 at 9:21am revealed:
-She received the medications for Resident #6 upon admission on 10/01/25.
-She had three resident admissions on 10/01/25.
-She received multiple cards of oxycodone-acetaminophen 10-325mg on 10/01/25 for Resident #6.
-She corrected an entry on the release form from 23 to 36 as that was the actual amount received.
-She had been unable to find one of Resident #6's oxycodone-acetaminophen 10-325mg CS logs.
-The medication aides (MA) were responsible for turning in completed CS logs to her to file.

Second interview with the RCC on 10/28/25 at 11:00am revealed:
-Resident #6's medications were "thrown in a box" by the previous facility staff.
-She did not count Resident #6's medications in the box.
-She "should have counted" before she signed Resident #6's medication release forms.
-The entry of 23 oxycodone-acetaminophen 10-325mg had 36 tablets on the medication card.
-There was one medication card of 45 tablets of oxycodone-acetaminophen 10-325mg.
-There was no medication card with 14 tablets of oxycodone-acetaminophen 10-325mg.
-The starting amount on hand of 38 on page one of Resident #6's CS log was a "mistake" and should have been documented as 36.
-She did not know what happened to the CS log entries for 10/01/25-10/03/25.
-She made a "mistake" on 10/07/25 when Resident #6's oxycodone-acetaminophen

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D 392	Continued From page 69 10-325mg order changed from three times a day to every six hours she did not start a new CS log. -There was no previous pharmacy labeled CS logs brought with Resident #6's oxycodone-acetaminophen 10-325mg supply on 10/01/25 or they would have continued to document on them. -They used the left-over oxycodone-acetaminophen 10-325mg tablets from the previous facility because it had been too early to fill again at their contracted facility pharmacy. -The prior facility was supposed to provide a hard script to fill Resident #6's oxycodone-acetaminophen 10-325mg tablets at their pharmacy when they brought her on 10/01/25, but they did not. Telephone interview with Resident #6's PCP on 10/28/25 at 11:14am revealed: -Resident #6 was ordered oxycodone-acetaminophen 10-325mg for chronic pain syndrome. -On 10/06/25, he had increased the frequency of the oxycodone-acetaminophen 10-325mg to every six hours. -On 10/27/25, he had decreased the frequency of the oxycodone-acetaminophen 10-325mg to every 8 hours because staff reported to him Resident #6 slept at night and they do not want to have to wake Resident #6 up to receive the 12:00am dose of the oxycodone-acetaminophen 10-325mg. Interview with the Assistant Administrator on 10/28/25 at 11:35am revealed the RCC should have counted all the medications received for Resident #6 from the previous facility before signing the medication release forms.	D 392		

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D 392	Continued From page 70 Refer to the interview with a MA on 10/28/25 at 10:48am. Refer to the interview with the Assistant Administrator on 10/28/25 at 11:36am. Refer to the interview with the Administrator on 10/28/25 at 12:05pm. 2. Review of Resident #5's current FL2 dated 08/28/25 revealed: -Diagnoses included type 2 diabetes mellitus and osteoporosis. -There was an order for pregabalin (a narcotic used to treat nerve pain) 200mg one capsule two times a day. Telephone interview with the facility's contracted pharmacy on 10/28/25 at 9:45am revealed: -There were 60 pregabalin 200mg capsules dispensed on 06/02/25. -There were 62 pregabalin 200mg capsules dispensed on 07/01/25. -There were 60 pregabalin 200mg capsules dispensed on 08/25/25. -There were 60 pregabalin 200mg capsules dispensed on 09/24/25. Review of Resident #5's September 2025 electronic medication administration record (eMAR) revealed -There was an entry for pregabalin 200mg one capsule two times a day scheduled at 7:00am and 7:00pm. -Pregabalin 200mg was documented as administered from 09/10/25-09/30/25 at 7:00am and 7:00pm. Review of Resident #5's October 2025 eMAR dated 10/01/25-10/28/25 revealed:	D 392		

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D 392	Continued From page 71 -There was an entry for pregabalin 200mg one capsule two times a day scheduled at 7:00am and 7:00pm. -Pregabalin 200mg was documented as administered from 10/01/25-10/28/25 at 7:00am. Observation of Resident #5's medications on hand on 10/28/25 at 9:18am revealed: -There was a supply of pregabalin 200mg tablets dispensed on 09/04/25 with instructions to take one capsule two times a day. -There were 5 of 60 tablets remaining. Review of Resident #5's controlled substance (CS) logs for September 2025-October 2025 revealed: -There was no pregabalin 200mg documented as administered and declined from the CS log for 09/27/25 at 7:00pm. -There were two entries for pregabalin 200mg documented as administered and declined from the CS log for 09/29/25 at 7:00pm and 8:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/01/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/02/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/02/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/03/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/03/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/04/25 at 7:00am.	D 392		

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D 392	Continued From page 72 -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/04/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/05/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/05/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/06/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/06/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/07/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/07/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/08/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/08/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/09/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/09/25 at 7:00pm. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/10/25 at 7:00am. -There was no pregabalin 200mg documented as administered or declined from the CS log for 10/10/25 at 7:00pm. -There was no pregabalin 200mg documented as	D 392		

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administered or declined from the CS log for 10/11/25 at 7:00am.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/11/25 at 7:00pm.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/12/25 at 7:00pm.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/13/25 at 7:00am.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/13/25 at 7:00pm.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/14/25 at 7:00am.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/14/25 at 7:00pm.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/16/25 at 7:00am.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/18/25 at 7:00pm.
-There was no pregabalin 200mg documented as administered or declined from the CS log for 10/19/25 at 7:00am.
-There were two entries for pregabalin 200mg documented as administered and declined from the CS log for 10/27/25 at 7:00pm.

Interview with Resident #5 on 10/28/25 at 10:45am revealed:
-The pregabalin was ordered for arthritis pain and neuropathy (when the peripheral nerves are damaged causing weakness, numbness, and pain usually in the hands and feet) in his feet.
-He thought he was supposed to receive the

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D 392	Continued From page 74 pregabalin two times a day. -The staff administered his medications and as far as he knew he received the pregabalin. Refer to the interview with a MA on 10/28/25 at 10:48am. Refer to the interview with the Assistant Administrator on 10/28/25 at 11:36am. Refer to the interview with the Administrator on 10/28/25 at 12:05pm. _____ Interview with a MA on 10/28/25 at 10:48am revealed: -She checked the eMAR entry with the label directions on the CS medication package prior to popping a dose of the CS into a medication cup for administration. -She would sign the CS log after popping the dose of CS into the medication cup for administration. -She would document the administration of the CS in the eMAR after she observed the resident to take the CS. Interview with the Assistant Administrator on 10/28/25 at 11:36am revealed: -The RCC was responsible for auditing all the resident CS logs and making sure the MAs documented on the CS logs when they administered controlled substances. -He was responsible for ensuring the RCC was auditing CS logs. -He had not performed a CS audit in the last month. -His audit included checking the physical count against the CS log. -He also checked the individual CS log entries during his audits.	D 392		

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D 392	Continued From page 75 Interview with the Administrator on 10/28/25 at 12:05pm revealed the Assistant Administrator was responsible for CS log documentation and audits of the CS logs. _____ The facility failed to maintain documentation of receipt for oxycodone-acetaminophen 10-325mg (#6), an accurate declination log for two residents (#5 and #6), and was unable to locate one controlled substance log for oxycodone-acetaminophen 10-325mg (#6). This was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/06/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 12, 2025.	D 392		