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	HAL011262	A. BUILDING: _____ B. WING _____	R 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 01/21/26 - 01/22/26.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on interview and record reviews, the facility failed to ensure residents were treated with dignity and respect related to not having a signaling device to call for staff assistance, for 7 out of 10 sampled residents, including a resident who fell in his room and another resident across the hall had to call out to staff for help (#1), and a resident who had the flu and could not holler out for help when assistance was needed (#5), and other residents who had to yell and seek out staff for themselves when assistance was needed (#2, #3, #6, #7 and #8). The findings are: Review of the facility's undated policy on Resident Rights revealed: -Every Resident shall receive care and services with are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.	D 338		

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D 338	Continued From page 1 -To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. Review of the facility's undated Policy's and Procedures revealed: -It is the policy of the Assisted Living Facility to ensure that all residents call bell requests are responded to promptly, safely, and respectfully. -The facility recognizes call bell response as a critical component of resident safety, dignity, and quality of care. -All staff are responsible for responding to call bells in accordance with this policy. 1. Review of Resident #1's current FL2 dated 08/28/25 revealed: -Diagnoses included diabetes, osteoporosis, major depressive disorder, and hypertension. -Resident #1 was ambulatory and continent of bowel and bladder. Review of Resident #1's Resident Register revealed an admission date of 10/22/24. Review of Resident #1's undated Care Plan revealed he required supervision with transfers, ambulation, and toileting and required limited assistance with bathing. Review of Resident #1's Incident and Accident Report dated 01/20/26 revealed: -On 01/20/26, Resident #1 had an unwitnessed fall in his room at 4:30pm. -Resident #1 stated he fell trying to come out of room. -Resident #1 was checked for injury and there was no apparent injury found. -The Resident Care Coordinator (RCC) was notified at 4:40pm.	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 2 Interview with Resident #1 on 01/21/26 at 9:59am revealed: -He had to "holler" for staff when he needed help. -He fell yesterday on 01/20/26, and staff could not hear him "hollering" for help, and another resident across the hallway had to get the staff's attention so he could get help. -Sometimes staff could not hear him when he "hollered" for help. -He felt "bad" having to "holler" for help with no other way to alert staff he needed help. Interview with a medication aide (MA) on 01/22/26 at 2:38pm revealed: -Resident #1 had fallen on 01/20/26 and she responded to his fall after another resident got her attention. -She was on another hallway in another resident room and could not hear Resident #1 hollering for help. -When she came out of the room she was in and had walked toward the nursing station, she could hear another resident stating Resident #1 had fallen and needed help. -When she got closer to his door, she could hear him hollering out for help. -He was sitting on the floor, behind the door, when she came into his room. -Resident #1 was unable to tell her what happened, but he told her he did not get hurt. -He did not appear to be hurt and did not require a hospital visit. -She filled out an accident report. Interview with the Resident Care Coordinator (RCC) on 01/22/26 at 8:49am revealed no one had told her about Resident #1 falling and she was not aware of the incident happening.	D 338		

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Interview with the Administrator on 01/21/26 at 3:38pm revealed he was not aware of Resident #1 falling.

Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am.

Refer to interview with the MA on 01/22/26 at 2:38pm.

Refer to the interview with the RCC on 01/22/26 at 8:49am.

Refer to the interview with the Administrator on 01/21/26 at 3:38pm.

2. Review of Resident #5's current FL2 dated 12/01/25 revealed:
-Diagnoses included traumatic brain injury with mood disorder, gastro esophageal reflux disease, sleep apnea, asthma, allergies, arthritis, hypertension, and legally blind.
-Resident #5 was ambulatory and continent of bowel and bladder.

Review of Resident #5's Resident Register revealed an admission date of 12/10/25.

Review of Resident #5's Care Plan dated 12/15/25 revealed she required supervision with transfers, ambulation, and toileting.

Interview with Resident #5 during the initial tour on 01/21/26 at 9:27am and 01/22/26 at 10:40am revealed:
-She moved into the facility on 12/10/25 and was never offered a signaling device to call for staff's help.
-If she needed staff she had to walk around the facility and find them.

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-She did not think about asking staff for a signaling device or how she would get help from staff until she became sick with the flu.
-She had no way to call staff for help when she could not get up on her own over the past weekend because of the flu.
-She was "totally out of it" for a couple of days and could not talk so she could not yell for staff.
-Staff did not come into her room to check on her when she was sick and would just look in the doorway as they walked by.
-She would have liked staff to check on her while she was sick because she was hoarse and could barely whisper.
-She was unable to call staff to ask them to heat up some soup for her and so she just had to "live" on jello.

Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am.

Refer to interview with the MA on 01/22/26 at 2:38pm.

Refer to the interview with the RCC on 01/22/26 at 8:49am.

Refer to the interview with the Administrator on 01/21/26 at 3:38pm.

3. Review of Resident #2's current FL2 dated 08/21/25 revealed:
-Diagnoses included hypotension, diabetes, unspecified cognitive impairment, anxiety, and depression.
-Resident #2 was ambulatory and continent of bowel and bladder.

Review of Resident #2's Resident Register revealed an admission date of 08/15/25.

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D 338	Continued From page 5 Review of Resident #2's Care Plan dated 08/16/25 revealed: -He required supervision with eating, toileting, ambulation, dressing, grooming, and transfers. -He required limited assistance with bathing. Interview with Resident #2 on 01/21/26 at 9:49am and 01/22/26 at 9:20am revealed: -He did not have a call light or call bell in his room or his bathroom. -He had no way to alert staff from his room or bathroom if he needed assistance. -If he could not walk out of his room and find staff to help him, he would not get assistance. -If he was unable to get out of bed, he would just have to "holler for help" until someone came. -Staff checked on him in his room about once an hour. Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am. Refer to interview with the MA on 01/22/26 at 2:38pm. Refer to the interview with the RCC on 01/22/26 at 8:49am. Refer to the interview with the Administrator on 01/21/26 at 3:38pm. 4. Review of Resident #3's current FL2 dated 12/29/25 revealed: -Diagnoses included hypertension, history of myocardial infarction, and lower back pain. -Resident #3 was ambulatory and continent of bowel and bladder. Review of Resident #3's Resident Register	D 338		

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revealed an admission date of 02/24/25.

Review of Resident #3's Care Plan dated 01/02/26 revealed:
-He required supervision with eating, toileting, ambulation, dressing, grooming, and transfers.
-He required limited assistance with bathing.

Interview with Resident #3 on 01/21/26 at 9:57am and 01/22/26 at 9:15am revealed:
-He did not have a call light or a call bell in case of an emergency.
-He needed a call light in his room.
-He was asked by staff on 01/21/26 if he wanted a call bell in his room.
-He had never been asked prior to 01/21/26 if he wanted a call bell or any type of alert system for his room.
-If he had a call bell, he was concerned how long he would have to continuously ring it until someone came to assist him.

Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am.

Refer to interview with the MA on 01/22/26 at 2:38pm.

Refer to the interview with the RCC on 01/22/26 at 8:49am.

Refer to the interview with the Administrator on 01/21/26 at 3:38pm.

5. Review of Resident #6's FL2 dated 12/22/25 revealed:
-Diagnoses included hearing difficulty bilateral, hypertension, insomnia, memory change, and anxiety.
-Resident #6 was ambulatory and incontinent of

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bladder and continent of bowel.

Review of Resident #6's Resident Register revealed an admission date of 12/22/25.

Review of Resident #6's Care Plan dated 12/22/25 revealed she required limited assistance with transfers and ambulation and required extensive assistance with toileting.

Interview with Resident #6 on 01/21/26 at 9:23am and on 01/22/26 at 8:18am revealed:
-She had to "holler" out for staff when she needed help.
-She was unaware of any other way to call for help other than "hollering."
-She was never offered a hand signaling device.
-She would have taken a signaling device if she had been offered one.
-She felt hopeless and anxious having to "holler" out for help because she had been worried they may not hear her and respond to her.

Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am.

Refer to interview with the MA on 01/22/26 at 2:38pm.

Refer to the interview with the RCC on 01/22/26 at 8:49am.

Refer to the interview with the Administrator on 01/21/26 at 3:38pm.

6. Review of Resident #7's current FL2 dated 01/15/26 revealed:
-Diagnoses included peripheral vascular disease, vascular dementia, anxiety, depression, and iron deficiency.

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-Resident #7 was ambulatory and incontinent of bladder and continent of bowel.

Review of Resident #7's Resident Register revealed an admission date of 10/07/22.

Review of Resident #7's Care Plan dated 01/08/25 revealed she required limited assistance with transfers and required extensive assistance with ambulation and toileting.

Interview with Resident #7 on 01/21/26 at 9:49am and on 01/22/26 at 8:11am revealed:
-She called for help by "hollering out" for staff.
-She did not have a signaling device to call out for help and had never been offered one.
-She would have taken a signaling device if they had offered her one.
-"Yelling out" for help made her feel angry.

Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am.

Refer to interview with the MA on 01/22/26 at 2:38pm.

Refer to the interview with the RCC on 01/22/26 at 8:49am.

Refer to the interview with the Administrator on 01/21/26 at 3:38pm.

7. Review of Resident #8's current FL2 dated 08/11/25 revealed:
-Diagnoses included seizure disorder, traumatic brain injury, diabetes, and cognitive dysfunction.
-Resident #8 was ambulatory and continent of bowel and bladder.

Review of Resident #8's Resident Register

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revealed an admission date of 08/11/25.

Review of Resident #8's Care Plan dated 12/15/25 revealed:
-He required supervision with eating, transfers, ambulation, and toileting.
-He required extensive assistance with bathing, dressing, and grooming.

Interview with Resident #8 on 01/21/26 at 9:36am and 01/22/26 at 9:24am revealed:
-He did not have a call light or a call bell in his room.
-He had never been asked if he wanted a call bell by staff.
-If he was unable to get out of bed and ask for help, if would have to wait for staff to come to his room to check on him.
-It was upsetting to him to think he would not be able to get help until staff checked in on him.
-Staff check on him in his room every 3-4 hours.

Refer to the interview with the personal care aide (PCA) on 01/22/26 at 8:55am.

Refer to interview with the MA on 01/22/26 at 2:38pm.

Refer to the interview with the RCC on 01/22/26 at 8:49am.

Refer to the interview with the Administrator on 01/21/26 at 3:38pm.

_____

Interview with a PCA on 01/22/26 at 8:55am revealed:
-She knew some of the residents had signaling devices, but some residents did not have one.
-Some residents had buttons they wore around their necks and other residents had bells they

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could ring if needed.
-When residents hit the buttons, it sent an alert to the nursing station and alerted the staff of the room that the resident was in who needed help.
-Some bells would get misplaced by the residents.
-Sometimes residents could not be heard by staff when they "holler" for help and especially if their doors were closed.
-She tried to check on residents every 30 minutes to make sure everyone was okay.

Interview with the MA on 01/22/26 at 2:38pm revealed:
-She began working in the facility on 01/13/26.
-She witnessed staff going around to residents and asking if they needed bells to use for assistance at least 2 times since she had begun working at the facility.
-She observed staff asking residents if they wanted a signaling device on the evening of 01/21/26 and last week but could not remember the exact date.
-She observed some residents refusing bells, but she was unsure which residents refused and which residents accepted them.

Interview with the RCC on 01/22/26 at 8:49am revealed:
-Every resident was offered a signaling device.
-Anytime a new resident was admitted, they were offered a signaling device.
-If residents did not have signaling devices, it was because they refused it.
-All residents were asked last night on 01/21/26 and on admission.
-If residents decided they needed a bell and asked for one, they were given a bell.
-They had bells in stock and could get one at any time.

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D 338	Continued From page 11 Interview with the Administrator on 01/21/26 at 3:38pm revealed: -He had gone around to every resident and asked if they wanted a signaling device. -If residents did not have a signaling device, it was because they refused to get one. -There was no documentation completed of resident refusals for signaling devices. -Residents would also lose bells they were given. -Whoever does the admission on residents offered signaling devices. -Staff also completed checks every 2 hours on residents. _____ The facility failed to provide a signaling device to 7 out of 10 residents which resulted in Resident #1 lying on the floor after a fall hollering for help. Staff were unable to hear Resident #1 since there was no signaling device and Resident #1 could not holler loud enough. A resident across the hall heard Resident #1 and had to get staff for assistance. Resident #5 had the flu and was unable to holler for help due to her voice being hoarse and staff would not come into her room and check on her and she could not get her soup heated up, which resulted in her having to "live" on jello, and residents had to yell out from their rooms to get staff assistance for themselves (#2, #3, #6, #7, and #8). This failure resulted in a substantial risk for serious injury and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/04/26 for this violation.	D 338		
D 612	10A NCAC 13F .1801(c) Infection Prevention & Control Policies & Pro	D 612		

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D 612	Continued From page 12 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection prevention and control policies and procedures, and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health department. This Rule is not met as evidenced by: Type B Violation Based on observation, interviews, and record reviews, the facility failed to implement infection prevention and control procedures to protect residents from an influenza outbreak in the facility when 2 of 2 sampled residents who tested positive for influenza (#5 and #9) and unknown number of other residents that were not tested who had signs and symptoms of influenza. The findings are: Review of the facility's undated Infection Control/Universal Precautions policy and procedures revealed generalized infection control procedures were provided but there was no	D 612		

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D 612	Continued From page 13 specific guidance for infection control or prevention during a communicable disease outbreak. Interview with the Resident Care Coordinator (RCC) upon initial entrance to the facility on 01/21/26 at 8:45am revealed: -There was currently an influenza outbreak in the facility. -The current census was 50 and 6 of those residents tested positive for influenza. -Three residents were in the hospital. -All the residents in the facility were being treated with an anti-viral medication to treat influenza. Observation upon initial entrance to the facility on 01/21/26 at 8:45am revealed: -There were no signs posted indicating there was an influenza outbreak in the facility. -The RCC was not wearing a mask. -There were 2 staff observed standing at a medication cart and they were not wearing a mask. Interview with a resident during the initial tour on 01/21/26 at 9:17am revealed: -There was an influenza outbreak in the facility. -She stayed confined to her room because of the influenza outbreak. Interview with a second resident during the initial tour on 01/21/26 at 9:36am revealed: -She felt bad and had been sick since 01/16/26. -Staff told her to stay in her room after she got sick. -A MA administered her anti-viral medication for the first time this morning. -Staff did not wear masks while working in the facility.	D 612		

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D 612	Continued From page 14 Interview with a third resident during the initial tour on 01/21/26 at 9:42am revealed: -He was sick and had been for the past 2 weeks. -There was currently an influenza outbreak at the facility. -He thought he was sick with influenza but was not tested. -He was currently being administered antibiotics. Interview with a fourth resident during the initial tour on 01/21/26 at 9:46am revealed: -He had received a pneumonia and influenza vaccine this year. -His chest was congested and he felt like he was getting sick. -He was not instructed by staff to do anything such as staying in his room or wear a mask when he went out of his room. Interview with a fifth resident during the initial tour on 01/21/26 at 9:56am revealed: -He was currently sick. -He did not feel like answering questions and needed to rest. Interview with a sixth resident during the initial tour on 01/21/26 at 9:57am revealed: -There was an influenza outbreak in the facility. -She had developed a cough recently. -The RCC did a nasal swab on her to see if she was sick but she did not know what the results were and could not remember when the nasal swab was completed. Interview with a seventh resident during the initial tour on 01/21/26 at 10:04am revealed: -He had been sick "a little bit". -The RCC tested him "a while back" but he did not know what she tested for.	D 612		

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D 612	Continued From page 15 Interview with a eighth resident during the initial tour on 01/26/25 at 10:16am revealed: -He was a little sick. -The RCC tested him and told him he had influenza. -He was currently taking an anti-viral medication. Observation of the main living room area and staff's workstation on 01/21/26 at 1:07pm revealed: -There were 2 MAs, one personal care aide (PCA), the RCC, and the Maintenance Director in the main living room area and none of the staff were wearing a mask. -There were six residents sitting in chairs in the living room next to the staff's workstation and none of the residents were wearing a mask. -There was one resident walking down the hallway wearing a mask and went out the exit door to the smoking area while another resident not wearing a mask entered into the facility from the smoking area. Observation at the main entrance/exit on 01/21/26 at 1:13pm revealed there was a person walking down the hallway towards the exit door not wearing a mask. Interview with a visitor on 01/21/26 at 1:13pm revealed: -He was at the facility visiting one of the residents and was leaving. -He was not aware there was an influenza outbreak in the facility. -He did not see any signs posted about an influenza outbreak. -He did not see any staff or residents wearing masks and staff did not ask him to put a mask on to visit. -He would have liked staff to notify him that there	D 612		

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was influenza in the building and he would have not visited the resident because he did not want to get sick.

Observation of the main living room during a tour of the facility on 01/21/26 at 3:18pm revealed there were 7 residents sitting in chairs not wearing masks and one male resident with a mask pulled down underneath his chin with the nose and mouth exposed.

Review of an email from the RCC to the Communicable Disease Registered Nurse (CDRN) on 01/21/26 dated 01/21/26 at 2:29pm revealed the message read "We have two documented flu, however we are treating the building due to the symptomatic residents".

Review of an email from the CDRN to the Administrator on 01/21/26 dated 01/21/26 at 1:27pm revealed:
-The CDRN had left a voicemail on the Administrator's telephone and wanted to follow-up.
-The CDRN asked the RCC if the list of 14 residents were all positive for influenza or if it was only the two residents where "flu" was documented under "type of test".
-The CDRN attached guidance for influenza outbreak to the email.

Review of the guidance for influenza outbreak emailed to the facility on 01/21/26 from the CDRN revealed:
-The definition of an outbreak was 2 cases within 72 hours in the facility.
-The infectious period was 72 hours prior to symptom onset and the outbreak duration was 7 days with no new cases.
-Symptoms in elderly included anorexia, mental

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status changes, peumonia, low grade or no fever, worsening of chronic respiratory conditions or congestive heart failure.
-An outbreak was supposed to be reported to the local health department and the local county CDRN within 72 hours of 2 or more confirmed cases of influenza.
-The facility was recommended to institute facility-wide masking until the outbreak was over per Centers of Disease Control (CDC) guidance.
-Droplet precautions (infection control measures used in addition to standard care, to prevent the spread of germs transmitted through large respiratory droplets from coughing, sneezing, or talking, requiring healthcare workers to wear masks and eye protection within 3-6 feet of the sick person and the sick person should wear a mask when moving) should be implemented for residents with signs and symptoms of influenza and a mask should be worn by anyone entering the resident's room.
-The facility should post signage at the main entry and other main areas around the facility.
-The facility should test anyone who has acute respiratory symptoms and isolation should occur for 7 days after illness onset or 24 hours after fever and respiratory symptoms have resolved.
-An anti-viral medication was recommended for prevention for a minimum of 2 weeks for other residents not symptomatic and continuing for 7 days after the last case was identified.

Telephone interview with the CDRN on 01/22/26 at 4:16pm revealed:
-She received an email from the RCC on 01/21/26 at 10:35am notifying her of an influenza outbreak in the facility.
-At 11:05am on 01/21/26, she received a voicemail from the Administrator notifying her of the influenza outbreak and she was not notified

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D 612	Continued From page 18 previous to 01/21/26. -At 11:08am on 01/21/26, she emailed the facility infection prevention control guidance regarding an influenza outbreak and tried to call the facility to confirm they had received it, but no one answered the phone. -The facility filled out a report and listed 14 residents total for signs and symptoms of influenza. -The documents were not filled out entirely and it was unclear if all 14 residents had tested positive for influenza. -Two of the residents' documents were partially filled out and included positive influenza confirmation with the first confirmation date of 01/13/26 and the second resident's confirmation date was on 01/15/26. -There was confirmation of 3 residents who tested positive for influenza, and the testing was completed during hospital visits. -She did not know if any of the other residents were tested for influenza at the facility. -The Administrator told her when he called her back on 01/21/26 that the facility decided to go ahead and have all the residents treated with an anti-viral medication twice daily for 5 days which was not the standard orders for influenza prevention which she emailed to the facility after being notified of the outbreak. -The facility should have notified her immediately of the outbreak when they had 2 confirmed cases of influenza within a 72-hour timeframe so that she could provide the facility with guidance for an outbreak. -The guidance she sent included reporting an outbreak to the local health department and the local county CDRN within 72 hours of 2 or more confirmed cases, recommending the facility to institute facility-wide masking until the outbreak was over per Centers of Disease Control (CDC)	D 612		

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guidance, post signage at the main entry and other main areas around the facility, testing anyone who has acute respiratory symptoms, isolation for 7 days after illness onset or 24 hours after fever and respiratory symptoms have resolved, and an anti-viral medication was recommended for prevention for a minimum of 2 weeks for other residents not symptomatic and continuing for 7 days after the last case was identified.

1. Review of Resident #9's current FL2 revealed diagnoses included diabetes mellitus type 2, anxiety, and peripheral neuropathy.

Review of Resident #9's emergency room (ER) discharge orders dated 01/13/26 revealed:
-Resident #9 developed a cough with green, thick sputum, weakness, and decreased appetite approximately one week prior to the hospital visit.
-Resident #9 tested positive for influenza type B.
-A chest x-ray was completed showing Resident #9 had left lower lobe pneumonia and met sepsis criteria related to pneumonia due to influenza.
-There was no indication to prescribe an anti-viral medication since Resident #9's symptoms began greater than a week beforehand.

Review of Resident #9's hospital discharge instructions dated 01/19/26 revealed:
-Resident #9 was seen for sepsis (a life-threatening medical emergency caused by the body's dysfunctional immune response to an infection), lactic acidosis (a serious, potentially fatal metabolic condition caused by excess lactic acid buildup in the bloodstream typically due to poor oxygenation), pneumonia, and acute influenza B infection.
-Orders were given to place Resident #9 on strict fall precautions, monitor vital signs every shift for

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72 hours and as needed, notify the primary care provider (PCP) with acute changes or concerns, and follow-up with the PCP.

Interview with the Resident Care Coordinator (RCC) on 01/21/26 at 3:03pm revealed:
-Resident #9 was the first resident to test positive for influenza B when the resident was sent to the local hospital for an evaluation on 01/16/26 and was discharged back to the facility on 01/19/26.
-She missed Resident #9 tested positive for influenza B during another hospital evaluation on 01/13/26.

Refer to the interview with a medication aide (MA) on 01/21/26 at 10:10am and 2:55pm.

Refer to the interview with a second MA on 01/21/26 at 3:01pm.

Refer to the interview with the RCC on 01/21/26 at 1:07pm and 3:03pm.

Refer to the interview with the Administrator on 01/21/26 at 3:30pm.

2. Review of Resident #5's current FL2 dated 12/01/25 revealed diagnoses included traumatic brain injury with mood disorder, gastro esophageal reflux disease, sleep apnea, asthma, allergies, arthritis, hypertension, and legally blind.

Review of Resident #5's urgent care report dated 01/17/26 revealed:
-Resident #5 was seen for a cough.
-Resident #5 was tested with positive results for influenza A and prescribed an anti-viral medication.
-Orders included to monitor symptoms due to influenza that could cause a decreased immune

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D 612	Continued From page 21 system and cause other infections such as bronchitis or pneumonia and notify the primary care provider (PCP) for worsening symptoms. Interview with the Resident Care Coordinator (RCC) on 01/21/26 at 1:07pm and 3:03pm revealed Resident #5 was sent to urgent care on 01/17/26 with coughing and a fever and test positive for influenza. Refer to the interview with a medication aide (MA) on 01/21/26 at 10:10am and 2:55pm. Refer to the interview with a second MA on 01/21/26 at 3:01pm. Refer to the interview with the RCC on 01/21/26 at 1:07pm and 3:03pm. Refer to the interview with the Administrator on 01/21/26 at 3:30pm. _____ Interview with a MA on 01/21/26 at 10:10am and 2:55pm revealed: -She did not know how many residents or which residents had tested positive for influenza. -Many of the residents were sick, coughing, and/or running a fever. -All the residents were being administered an anti-viral medication for influenza. -She was not instructed by management to wear a mask or other personal protective equipment (PPE) in the facility or do anything else to prevent the spread of influenza to other residents. -She did not wear a mask because "I don't have to" and it was her "right" to not wear a mask. -She did not know if a sign was posted to alert visitors that there was an influenza outbreak in the facility. -Visitors "knew" when they came through the	D 612		

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entrance to put a mask on because the Administrator was "usually" in his office at the entrance and would tell visitors there was an influenza outbreak in the facility and to put on a mask.

Interview with a second MA on 01/21/26 at 3:01pm revealed:
-She started working at the facility about a week ago.
-She thought the influenza outbreak started before she started working at the facility.
-She was not instructed by management to wear a mask because it was not mandatory.

Interview with the RCC on 01/21/26 at 1:07pm and 3:03pm revealed:
-She refused to take any vaccinations and took herbal medicines daily to protect herself, so she did not need to wear a mask in the facility.
-The facility's policy for a communicable disease outbreak normally required staff to wear a mask but she would not wear a mask because "it's a religious thing for me".
-Another resident was sent to urgent care on 01/14/26 and was prescribed antibiotics for pneumonia but was not tested for influenza.
-She tested all the residents for coronavirus (COVID-19) on 01/15/26 but did not test any of the residents for influenza.
-She previously encouraged the residents to stay in their rooms and socially distance and staff checked the residents' temperatures every shift.
-The residents' primary care provider (PCP) visited the facility on 01/19/26 and ordered an anti-viral medication to treat influenza.
-She did not receive any guidance regarding communicable disease (CD) outbreaks because she just emailed the local health department today (01/21/26) and sent a report of all the

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D 612	Continued From page 23 residents who tested positive for influenza. -She did not notify the CDRN previously when the influenza outbreak was identified because all the residents were being treated with an anti-viral medication and she was making a complete list of residents that she knew tested positive for influenza. Interview with the Administrator on 01/21/26 at 3:30pm revealed: -The facility emailed the CDRN this morning (01/21/26) regarding the influenza outbreak in the facility. -The facility did not report the outbreak before because him and the RCC were "working on it". -The RCC tested all the residents for COVID-19 last week, but he did not think about testing all the residents for influenza. -He did not instruct staff to do anything for infection control prevention including to wear masks to protect the residents from contamination because "I dropped the ball". _____ The facility failed to implement infection control prevention procedures when an influenza outbreak was confirmed leading to an unknown number of residents in the facility being exposed and experiencing signs and symptoms of influenza and staff were observed not wearing a mask used to prevent the spread of infection. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 22, 2026 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 8,	D 612		

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D 618	10A NCAC 13F .1802 (a) Reporting & Notification of a Suspected or C 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report an outbreak of influenza to the local health department (LHD) related to an outbreak that started on 01/15/26. The findings are: Review of the facility's undated Infection Control/Universal Precautions policy and procedures revealed generalized infection control procedures were provided but there was no specific guidance for infection control or prevention during a communicable disease outbreak or reporting an outbreak. Observation upon initial entrance to the facility on 01/21/26 at 8:45am revealed: -There were no signs posted indicating there was	D 618		

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an influenza outbreak in the facility.
-There was a bottle of hand sanitizer and a box of face mask setting on a table next to the entrance/exit door.
-The RCC was not wearing a mask.
-There were 2 staff observed standing at a medication cart and they were not wearing a mask.

Interview with the Resident Care Coordinator (RCC) upon initial entrance to the facility on 01/21/26 at 8:45am revealed:
-There was currently an influenza outbreak at the facility.
-The current census was 50 and 6 of those residents tested positive for influenza.
-Three residents were in the hospital.
-All the residents in the facility were being treated with an anti-viral medication to treat influenza.

Review of a resident's emergency room (ER) discharge orders dated 01/13/26 revealed:
-The resident was seen for a developed a cough with green, thick sputum, weakness, and decreased appetite approximately one week prior to the hospital visit.
-The resident tested positive for influenza type B.
-A chest x-ray was completed showing the resident had left lower lobe pneumonia and met sepsis criteria related to pneumonia due to influenza.
-There was no indication to prescribe an anti-viral medication since the resident's symptoms began greater than a week beforehand.

Review of a resident's second visit hospital discharge orders dated 01/19/26 revealed:
-The resident was seen in the ER and admitted on 01/16/26 for sepsis (a life-threatening medical emergency caused by the body's dysfunctional

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immune response to an infection), lactic acidosis (a serious, potentially fatal metabolic condition caused by excess lactic acid buildup in the bloodstream typically due to poor oxygenation), pneumonia, and acute influenza B infection.
-Orders were given upon discharge on 01/19/26 to place the resident on strict fall precautions, monitor vital signs every shift for 72 hours and as needed, notify the primary care provider (PCP) with acute changes or concerns, and follow-up with the PCP.

Review of a second resident's urgent care report dated 01/14/26 revealed:
-A chest x-ray was completed with results of right lung lower lobe infiltrates (pneumonia).
-There was no documentation of an influenza test completed.
-The resident was precribed a mucus relief medication along with an antibiotic medication to treat pneumonia infection.

Review of a third resident's urgent care report dated 01/17/26 revealed:
-The resident was seen for a cough.
-The resident was tested with positive results for influenza A and prescribed an anti-viral medication.
-Orders included to monitor symptoms due to influenza that could cause a decreased immune system and cause other infections such as bronchitis or pneumonia and notify the primary care provider (PCP) for worsening symptoms.

Second interview with the RCC on 01/21/26 at 3:03pm revealed:
-She missed documentation from a local hospital discharge report confirming the first resident who tested positive for influenza was on 01/13/26.
-Another resident was seen at urgent care on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	R 01/22/2026

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 618	Continued From page 27 01/17/26 with coughing and a fever and tested positive for influenza. -Multiple residents were sick and had not been tested for influenza but were being treated with an anti-viral medication. -She did not receive any guidance regarding communicable disease (CD) outbreaks because she just emailed the local health department today (01/21/26) and sent a report of all the residents who tested positive for influenza. -She could not find the list of residents who tested positive for influenza. -She did not notify the Communicable Disease Registered Nurse (CDRN) previously when the influenza outbreak was identified because all the residents were being treated with an anti-viral medication and she was making a complete list of residents that she knew tested positive for influenza. Telephone interview with the CDRN on 01/22/26 at 4:16pm revealed: -She was not notified of an influenza outbreak at the facility until she received an email from the RCC on 01/21/26 at 10:35am. -At 11:05am on 01/21/26, she received a voicemail from the Administrator notifying her of the influenza outbreak and she was not previously notified by the Administrator. -At 11:08am on 01/21/26, she emailed the facility infection prevention control guidance regarding an influenza outbreak and tried to call the facility to confirm they had received it, but no one answered the phone. -The facility filled out a report and listed 14 residents total for signs and symptoms of influenza. -The documents were not filled out entirely and it was unclear if all 14 residents had tested positive for influenza.	D 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	R 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 618	Continued From page 28 -Two of the residents' documents were partially filled out and included positive influenza confirmation with the first confirmation date of 01/13/26 and the second resident's confirmation date was on 01/15/26. -There was confirmation of 3 residents who tested positive for influenza, and the testing was completed during ER visits. -The facility should have notified her immediately of the outbreak when they had 2 confirmed cases of influenza within a 72-hour timeframe so that she could provide the facility with guidance for an outbreak. -The guidance she sent included reporting an outbreak to the local health department and the local county CDRN within 72 hours of 2 or more confirmed cases, recommending the facility to institute facility-wide masking until the outbreak was over per Centers of Disease Control (CDC) guidance, post signage at the main entry and other main areas around the facility, testing anyone who has acute respiratory symptoms, isolation for 7 days after illness onset or 24 hours after fever and respiratory symptoms have resolved, and an anti-viral medication was recommended for prevention for a minimum of 2 weeks for other residents not symptomatic and continuing for 7 days after the last case was identified. Interview with the Administrator on 01/21/26 at 3:30pm revealed: -The facility emailed the CDRN this morning regarding the influenza outbreak. -The facility did not report the outbreak before because him and the RCC were "working on it".	D 618		