STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure section conducted an annual survey on November 19, 2019 through November 22, 2019 and November 25, 2019 through November 26, 2019 with an exit via telephone on November 26, 2019, and a complaint investigation initiated by the county on October 15, 2019.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures lower than 100°F and higher than 116°F for 4 of 15 water fixtures (sink and shower) in the residents' common bathroom and 2 sinks in 2 residents rooms on the 300-hall. The findings are: Observation on 11/19/19 at 10:32am revealed the hot water temperature of the second shower (handheld) in the common bathroom of the 300-hall was 87º F.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 113	Continued From page 1 Interview with the resident observed exiting the common bathroom on 300-hall on 11/19/19 at 10:36am revealed: -He never used the second shower with the shower curtain because it was always cold. -The hot water would warm up if it ran about 30 minutes. -Everyone on the hall knew that shower was cold, so they did not use it. -They used the rain shower with the half tile wall. -He was not sure if anyone had told any of the staff or not about that shower being cold. Observation on 11/21/19 at 8:12am revealed: -The hot water temperature at the second shower in the common bathroom of the 300-hall was 87º F. -After the hot water was allowed to run for approximately 8 minutes, the hot water temperature at the second shower in the common bathroom of the 300-hall remained at 87º F. Interview with the maintenance staff on 11/21/19 at 8:20am revealed: -He had never been told to check the hot water temperatures in the showers and had never checked them. -He had been at the facility about a year. -He had never had anyone complain about the hot water temperatures. -He had never known anyone to use second shower (handheld) in the common bathroom of the 300-hall. -It provided more privacy since it had a shower curtain. -"I have checked the sink in here and it's always been good." -He thought if the sink was good then the showers should be good too.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 113	Continued From page 2	D 113		

-He would adjust the mixing valve on the second shower and on the sink in the common bathroom of the 300-hall.

Interview with the Administrator in Charge on 11/25/19 at 4:15pm revealed:
-The maintenance staff was supposed to check them every other day.
-The maintenance staff had checked the water temperatures in the dietary department and specifically room 105.
-She had not been aware of any hot water issues.
-She knew the hot water should be maintained between "110°F and 116°F".
-She was not aware the shower in the common bathroom on 300-hall was not used due to the temperature being too cold.
-The temperature log was kept in the Administrator's office.
-She did not say if the logs were reviewed once the maintenance staff completed the checks.
Observations on 11/21/19 at 8:22am revealed:
-The hot water temperature of the sink in the common bathroom on 300-hall was 118º F.
-There was visible steam when the water was running.
-The previous observation of this fixture was done on 11/19/19 at 10:28am and was 113º F.
-Fixtures in the adjoining resident room and the residents' room across the hall were checked due to the 118º F.

Observation on 11/21/19 at 8:25am in the resident room directly across the hall from the common bathroom on the 300-hall revealed the hot water temperature of the sink was 117º F.

Observation on 11/21/19 at 8:26am in the resident room next door to the common bathroom on the 300-hall revealed the hot water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 113	Continued From page 3	D 113		

temperature of the sink was 118º F.

Based on observations, record reviews and interviews it was determined that the resident in the room next door to the common bathroom on the 300-hall was not interviewable.

Review of the facility's water temperature log on 11/21/19 revealed:
-The readings for the residents' common bathrooms and the sinks in residents' rooms ranged from 101º F to 115º F with the documented dates of 08/23/19 to 11/19/19.
-The temperatures were documented weekly.
-There were no temperature reading for any of the residents' showers.

Observation on 11/21/19 at 5:02pm of the water temperature in the common bathroom on 300-hall revealed:
-The hot water temperature of the sink was 105º F.
-The hot water of the second shower (handheld) was 104º F.

Observation on 11/21/19 at 5:04pm of water temperature of the sink in the resident room directly across the hall from the common bathroom on the 300-hall revealed the hot water temperature of the sink was 105º F.

Observation of the re-check of water temperature of the sink in the resident room next door to the common bathroom on the 300 hall on 11/21/19 at 5:05pm revealed the hot water temperature of the sink was 105º F.

Interview on 11/21/19 at 4:45pm with another resident in a room at the other end of the 300-hall revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 113	Continued From page 4 -He never knew anyone to use the second shower on the 300-hall bathroom. -He never had a problem with the water being too cold or too hot. -He used the hot water in his sink to fix instant coffee. -"It's not real hot but it's warm enough for my coffee."	D 113		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 6 residents (#1, #5) sampled related to a change in condition ranging from hallucinations to over sedation and to obtain a urine specimen for a urinalysis ordered for Resident #1 who had a history of recurrent urinary tract infections; and a physician's order for a dermatology appointment for a lesion on the breast (#5). The findings are:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 273	Continued From page 5 1. Review of Resident #1's current FL-2 dated 10/17/19 revealed diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility. Review of Resident #1's current assessment and care plan dated 08/21/19 revealed: -The resident used a wheelchair for ambulation. -The resident required supervision with ambulation. -The resident required limited assistance with eating, toileting, dressing, grooming, and transferring. -The resident required extensive assistance with bathing. -The resident had occasional incontinence with bladder. -The resident was sometimes disoriented, forgetful and needed reminders. a. Review of an accident/injury report for Resident #1 signed and dated 10/07/19 revealed: -The Resident Care Coordinator (RCC) completed the report. -The date and time of the incident was 10/06/19 at 10:15pm. -The personal care aides (PCAs) reported to the medication aide (MA) that Resident #1 was acting strange, hallucinating, and yelling. -Staff monitored the resident all shift and reported extreme lethargy in the morning. -The resident was taken to urgent care on 10/08/19 per primary care provider (PCP) verbal order to have lab work and drug screen. -The resident tested positive for benzodiazepines, but the resident was not prescribed any benzodiazepines. (Benzodiazepines are used to	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 273	Continued From page 6 treat anxiety. Ativan is a benzodiazepine.) Review of a second accident/injury report for Resident #1 revealed: -The RCC completed the report. -The date of incident was "10/06/19 / 10/07/19" and the time was documented as third shift and 6:00am count. -The resident was drowsy, lethargic, and pale. -The resident was very difficult to arouse and the resident seemed to be hallucinating. -The MAs noted during "med count" that medications were not documented correctly (did not specify which documentation) and they notified the RCC. -The RCC notified and spoke with the PCP and got an order to check labs and screen Resident #1 for drugs. -The resident was taken to an urgent care center (on 10/08/19) for a drug screen. Review of Resident #1's progress notes revealed: -There were no progress notes for 10/06/19. -On 10/07/19, the resident was acting very lethargic. The responsible party was notified and would be in on 10/16/19 to discuss hospice. -On 10/08/19, the resident was taken to urgent care for test. Review of a Health Care Personnel Registry (HCPR) 5-day investigation report dated 10/09/19 revealed: -The allegation details documented Resident #1 was not her normal self on Monday (10/07/19). -Resident #1 appeared to be sleepy, sluggish, and very pale. -The resident "couldn't even hold a spoon or fork to her mouth". -On Tuesday (10/08/19), the resident was sent out of the facility to have blood work done.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 7	D 273		

-Other residents' medications were missing but were not documented as given on the electronic medication administration record (eMAR).
-Benzodiazepines were detected in Resident #1's blood work but the resident had no orders to receive any benzodiazepine medications.
-The resident was hallucinating and very sluggish and sleepy.

Interview with a MA on 11/22/19 at 9:54am revealed:
-When she came to work one time last month (could not recall date), Resident #1 slept all day.
-She tried to talk to the resident, but the resident wanted to sleep.
-The second or third shift had reported the resident was sleeping a lot and could not hold her head up.
-The resident was usually alert.
-She did not call the resident's PCP and she did not know if staff on the previous second or third shift contacted the PCP.

Interview with a second MA on 11/22/19 at 12:54pm revealed:
-She came into work at the facility on third shift on 10/06/19.
-Two PCAs called her to Resident #1's room.
-Resident #1 was in bed screaming out very loud.
-The resident would lay back and sit back up then turn crossways in the bed.
-The resident would keep screaming and sitting up and down.
-One of the PCAs told the MA she thought the MA on the previous shift gave Resident #1 some medication.
-She checked to see if Resident #1 had any orders for a prn (as needed) medication to help with the agitation but the resident did not.
-She checked the resident's blood pressure and it

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 273	Continued From page 8	D 273		

was normal.
-The resident stopped screaming around 5:00am and started sleeping.
-The resident was "knocked out" and she thought it was because the resident was tired.
-She did not send the resident to the emergency room because she eventually calmed down.
-She called the PCP's triage line around 5:45am and got the voice mail and they did not call her back.
-She did not call them back before she left the facility around 6:00am.
-She reported the resident had been screaming to the next shift that came in at 6:00am.
-She reported the resident's behavior to the AIC the next morning (10/07/19) also.
-She documented it on an incident report.

Interview with a PCA on 11/26/19 at 12:12pm revealed:
-One night last month on the weekend (October 2019 - could not recall date), she worked on third shift.
-She and another PCA went into Resident #1's room and the resident was "discombobulated".
-The resident's hands and entire body were shaking.
-The resident was sitting on the bed rocking back and forth saying "woo, woo".
-The resident was hallucinating and thought there was a man in the room, but there was no man in the room.
-The PCAs reported it to the MA who was the supervisor on duty.
-The residents were usually sent out to the hospital when there was a change in condition.
-She did not why Resident #1 was not sent out that night because the supervisor was responsible for sending residents to the hospital.
-The resident went to sleep eventually but would

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 9 wake up every 2 hours screaming. Review of a signed statement by a second PCA dated 10/06/19 revealed: -On Sunday, 10/06/19, Resident #1 was sitting in front of her doorway reaching for something on the floor that wasn't there. -She asked the resident what she was doing but she could not get a response out of the resident. -"It's like she was completely out of it". -She took the resident into the room to change her but as she stood the resident up, the resident could not stand up and it was almost as if the resident was going to fall on the floor. -She had no choice but to change the resident's incontinence brief while the resident was in her bed. -All that night, Resident #1 fussed and the resident was not acting like herself. -Resident #1 was hallucinating and shaking. -Resident #1's words were "real slurred" and the resident was talking out of her head. Telephone interview with the AIC on 11/25/19 at 3:10pm revealed: -When she came into the facility on Monday, 10/07/19, Resident #1 was sitting in the front living room. -The resident was sitting in a chair, leaning to the side, very drowsy, and sleepy. -The resident was usually alert and responsive, but the resident was sluggish and sleepy. -This was not like the resident's "normal self" as the resident was usually alert. -One staff told the AIC that the resident had stayed up late on third shift. -A second staff said the resident had been "kind of sleepy". -A third staff said she had to feed the resident because the resident was so tired.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10	D 273		

-The resident's vital signs were taken and they were normal.
-Later that day, the resident still appeared sleepy.
-Nothing prompted her to send the resident to the hospital because the vital signs were normal and the resident could talk and respond at times but was slow.
-A fourth staff who came in on second shift on 10/07/19 reported the resident had been hallucinating on third shift on 10/06/19.
-The next morning (10/08/19), the resident was back to her "normal self".
-This made the AIC think that something else was wrong and the resident may have gotten the wrong medication.
-The RCC checked the controlled substance (CS) logs and it appeared some Ativan that belonged to other residents were documented on the CS log but not documented as administered on the eMARs.
-She spoke with the RCC and the RCC contacted the PCP on Tuesday, 10/08/19.
-The PCP said to send the resident out and to get a drug screen.
-The resident was sent out for blood work to an urgent care center on 10/08/19.

Interview with the RCC on 11/22/19 at 11:42am revealed:
-When she came to work on Monday, 10/07/19, Resident #1 was in the living room with her eyes closed, head back, and mouth open.
-Third shift staff reported to first shift staff that the resident had been more disoriented than normal, hallucinating, was pale and clammy.
-She thought third shift staff verbally reported Resident #1's symptoms had started around 10:00pm, when third shift began on 10/06/19.
-Third shift staff should have called the resident's PCP because they had a 24-hour triage line.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11 -Third shift staff did not call to report the resident's change in behavior to her knowledge. -One of the MAs told the RCC to look at the documentation on the CS logs for another resident's oral Ativan and a third resident's Ativan gel. -She and the AIC were suspicious because of the CS logs and Resident #1's change in condition that Resident #1 may have been administered Ativan that belonged to the other residents. -She notified Resident #1's PCP and got a verbal order to get a drug screen on the resident. -The resident tested positive for benzodiazepines on 10/07/19 or 10/08/19. Telephone interview with a medical assistant at Resident #1's mental health provider's (MHP) office on 11/26/19 at 11:19am revealed: -The facility usually called the MHP when there was a change in the resident's condition, but they did not notify them when the resident had a recent change in condition (referring to 10/06/19). -The facility notified them after the incident when the resident tested positive for benzodiazepines at an urgent care center (could not recall date). -The facility reported the resident was found sitting in her wheelchair "pretty sedated" and difficult to wake up. -The facility should have sent the resident to the emergency room when she experienced a change in condition on 10/06/19. -The resident was last seen by the MHP at the end of last week and there were no concerns of any lasting effects noted at that time. -The resident was currently prescribed Ativan (within the last few days) but was not prescribed Ativan or any other benzodiazepine medications at the time of the incident or when she tested positive.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12	D 273		

Telephone interview with Resident #1's PCP on 11/26/19 at 1:29pm revealed:
-Resident #1 was a "firecracker", usually alert with moments of emotional distress.
-Resident #1 was not usually sedated or lethargic.
-She was not told of Resident #1's change in condition on 10/06/19 until a few days after the occurrence.
-She was not pleased with that and expected to be notified at the time the symptoms were occurring.
-They had a triage line 24 hours a day, 7 days a week with one of the providers always on call.
-If the facility had contacted the triage line over the weekend, she would have received a message on Monday morning at 7:00am but she did not receive a message.
-The resident should have been sent to the emergency room when she experienced the change in condition on 10/06/19.
-When the RCC notified her on 10/08/19, the RCC was asking for drug testing but she told the RCC the resident needed a medical evaluation.
-She could not recall if she specified the evaluation needed to be done at a hospital or an urgent care center.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

b. Review of Resident #1's progress note dated 02/16/19 revealed the resident was diagnosed with a urinary tract infection and was prescribed an antibiotic.

Review of Resident #1's emergency room visit forms dated 03/19/19 revealed the resident was diagnosed with a urinary tract infection and cystitis and given an antibiotic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13	D 273		

Review of Resident #1's progress notes revealed:
-On 04/18/19, the resident needed to be seen by a urologist for recurrent urinary tract infections.
-On 05/09/19, the resident was seen by a urologist for recurrent urinary tract infections.
-On 10/02/19, the resident had a new order for an antibiotic to treat a urinary tract infection.
-On 10/29/19, the resident was ordered a urinalysis and culture and sensitivity for altered mental status.

Review of Resident #1's physician's order dated 10/29/19 revealed:
-There was an order for a urinalysis with culture and sensitivity due to altered mental status.
-There was a handwritten note initialed by the Resident Care Coordinator (RCC) that the form was faxed to the lab provider on 10/30/19.
-There was no fax confirmation noted or attached.

Review of Resident #1's progress notes and lab work results revealed no documentation the 10/29/19 order for a urinalysis and culture and sensitivity was done.

Review of the facility's lab collection form revealed no documentation that a urine sample was obtained from Resident #1 to perform a urinalysis with culture and sensitivity as ordered on 10/29/19.

Interviews with the RCC on 11/21/19 at 5:30pm and 11/22/19 at 12:10pm revealed:
-The facility's contracted lab provider came to the facility every other week to implement lab orders.
-She could not recall if Resident #1's urinalysis was done as ordered on 10/29/19.
-If they were not able to get a urine sample due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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D 273	Continued From page 14	D 273		

resident refusal, it would be documented in the resident's record.
-She would check with the lab provider and the resident's primary care provider (PCP).

Telephone interview with a processor for the facility's lab provider on 11/26/19 at 11:54am revealed:
-They never received the 10/29/19 order for a urinalysis and culture and sensitivity for Resident #1.
-They had not received any lab orders for Resident #1 since September 2019.
-If they had received the order, the lab would have picked up the resident's urine sample during their scheduled visits to the facility.
-The facility staff would be responsible for collecting the urine sample.

Interview with the RCC on 11/26/19 at 10:41am revealed:
-She contacted the lab provider and they never received the 10/29/19 order for Resident #1's urinalysis and culture and sensitivity.
-She faxed the order to the lab provider and noted it on the bottom of the form, but she could not find a confirmation to show the fax went through to the lab provider.
-She usually made sure to get a fax confirmation, but she did not get one for this order.
-The facility's process was that she or the medication aides (MAs) or personal care aides (PCAs) would have collected the urine sample for the test on the day the lab came if it had been done.
-There was no documentation the resident refused so the urine sample was never collected for the urinalysis.
-She notified the resident's PCP today (11/26/19) and the PCP would determine if she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 273	Continued From page 15	D 273		

reorder a urinalysis.
-The resident was not currently exhibiting any symptoms of a urinary tract infection.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

2. Review of Resident # 5's current FL2 dated 06/03/19 revealed diagnosis of chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease, diastolic congestive heart failure, hypertension, osteoarthritis of hip, hypothyroidism, dysphagia, hyperlipidemia and radiculopathy-cervical region.

Review of Resident #5's physician's orders dated 09/19/19 revealed to schedule a dermatology appointment as soon as possible for an irregularly shaped lesion near the left breast.

Review of Resident #5's progress notes revealed no documentation a dermatology appointment was scheduled.

Interview with Resident #5 on 11/20/19 at 3:25pm revealed:
-She did not have a dermatology appointment.
-She remembered the Primary Care Provider (PCP) informed her of the dermatology referral.

Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 4:10pm revealed:
-The transportation staff was responsible for scheduling appointments.
-She was responsible for giving any physician referrals to the transportation staff for the appointments to be scheduled.
-If the transportation staff could not make the appointment, then the RCC would make the

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 273	Continued From page 16	D 273		

appointment.
-The transportation staff was recently hired.
-There was a timeframe where the facility did not have a transportation staff.
-She did not know how long the facility was without transportation staff.
-She was responsible for scheduling appointments when the facility did not have transportation staff.
-She did not know about the dermatology referral.
-The appointment was not scheduled.
-She felt the referral was missed when the facility was without transportation staff.
-She did not know Resident #5 had a lesion on her breast.

Interview with the Administrator-in-Charge (AIC) on 11/21/19 at 4:20pm revealed:
-The transportation staff was responsible for scheduling appointments for the residents.
-If the transportation staff was not available, the RCC would schedule the appointment.
-There was a period of time the facility did not have transportation staff.
-She did not know Resident #5 had an order for a dermatology referral.

Interview with Resident #5's family member on 11/21/19 at 2:30pm revealed:
-The family member did not know the PCP had ordered a dermatology referral.
-The family member occasionally provided transportation to appointments.

Interview with transportation staff on 11/21/19 at 4:55pm revealed:
-The transportation staff did not remember scheduling or taking Resident #5 to a dermatology appointment.
-The transportation staff did not know there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 273	Continued From page 17 an order or referral to the dermatologist. Attempted interview with Resident #5's PCP on 11/21/19 at 3:30pm and 11//22/19 at 10:30am was unsuccessful. _____ The facility failed to seek medical attention and notify Resident #1's PCP when the resident had a change of condition on 10/06/19 with symptoms including hallucinations and screaming loudly to being so lethargic and sedated, the resident had to be fed by staff; failed to obtain a urine specimen for a urinalysis ordered on 10/29/19 for Resident #1 who was exhibiting symptoms of altered mental status and had a history of recurrent urinary tract infections; and failed to schedule Resident #5 a dermatology appointment to have a lesion on her left breast evaluated. The facility's 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 11/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 10, 2020.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 283	Continued From page 18	D 283		

This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to assure foods were free from contamination related to cups stored inside of bulk food containers with food, open food packages that were not labeled or dated, foods not labeled or marked with an expiration date, and leftover food not labeled or dated.

The findings are:

Observation of the reach-in refrigerator in the kitchen on 11/20/19 at 9:08am revealed:
-There were two squirt bottles, that were not dated or labeled; each containing approximately 2 tablespoons of a white thick substance.
-There was a one-gallon plastic bag with a mixture of lettuce, carrots, and cabbage that was not labeled or dated with an open date.

Observation of a policy and procedure posted in the kitchen on 11/21/19 at 11:47am revealed "all left over food must be clearly labeled and dated before storing in the refrigerator, discard after three days".

Interview with a cook on 11/20/19 at 9:16am revealed:
-She knew all items in the refrigerator were supposed to be labeled and dated.
-Whoever opened an item was responsible for labeling and dating the item.
-She thought the lettuce mixture was left-over from salads "night before last."
-The two-squirt bottles should have been washed and not stored in the refrigerator.
-She was not aware the items discussed were not labeled or dated with an open date.

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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D 283	Continued From page 19 -She had not been told to go through the refrigerator and make sure all the items were labeled and dated. -She did not know who was responsible for making sure all items were labeled and dated. Observation of the dry storage room in the kitchen on 11/20/19 at 9:19am revealed: -There was a large clear plastic container of bulk flour on a shelf; the flour was removed from the manufactures original package and stored in the plastic container; there was no date or label on the bulk flour container. -There was a disposable foam cup setting in the flour inside the plastic container. -There was a large clear plastic container of bulk sugar on a shelf; the sugar was removed from the manufacture's original package and stored in the plastic container. -There was a disposable plastic cup setting in the sugar inside the plastic container. -There was a large clear plastic container of bulk dried rice on a shelf; the rice was removed from the manufactures original package and stored in the plastic container; there was no date or label on the bulk dried rice container. Interview with the cook on 11/20/19 at 9:20am revealed: -She knew to use a piece of equipment with a handle, like a large spoon or a scoop when she removed flour and sugar from the bulk containers -She knew the cups should not have been used to "scoop" flour and sugar from the bulk containers. -She did not know she could not to leave anything used to remove flour or sugar inside the bulk containers. -She did not know who left the cups inside the sugar and flour containers.	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 283	Continued From page 20 -She knew the flour and the dried rice needed to be dated and labeled when removed from the manufactures original package. -She thought the flour and the rice were placed into the plastic containers for storage about a week ago. -She did not know why there were no dates and labels on the plastic containers. Interview with the Kitchen Manager (KM) on 11/22/19 at 8:52am revealed: -She knew not to leave scoops inside of the bulk containers of flour and sugar containers. -The kitchen staff was supposed to use a large spoon to get food like sugar and flour from the bulk food containers; cups should never be used to scoop food from the bulk food containers. -All opened food and left overs should be dated and labeled; left overs should be thrown out after three days. -She tried to look for dates on food everyday, but it was hard to keep up with. -She tried to teach the kitchen staff to date and label food; all of the kitchen staff knew to date and label food after opening and storing leftovers. Interview with the Administrator on 11/22/19 at 9:53am revealed: -She trained the KM herself; she trained the KM to date and label everything in the kitchen. -She expected the kitchen staff to date and label every item after it was opened and to date and label leftovers before they were placed into the refrigerator. -She "checked" on the kitchen storerooms and the refrigerator three times a week by walking around in the kitchen. -She would point out food items without dates but	D 283		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 283	Continued From page 21 the kitchen staff were "pretty good" about keeping up with dates and labels. -She checked for dates on food and expired food items when she checked on the kitchen; the kitchen staff knew to throw food items like leftovers out after three days.	D 283		
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) Hot foods shall be served hot and cold foods shall be served cold. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure hot foods were maintained hot until served to the residents. The findings are: Review of a policy and procedure posted in the kitchen on 11/21/19 at 11:47am revealed "Hot food must be served at a temperature of 135 degrees or higher". Observation of the lunch meal on 11/21/19 at 12:30pm revealed: -The menu for lunch consisted of a pork chop in sauce, bread dressing, cauliflower, dinner roll and apple slices. -The hot food was served from a hot food table; the pork chops, bread dressing, cauliflower and sliced apples were each in pans in the hot food table. -There were two plates setting on the edge of the	D 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 288	Continued From page 22	D 288		

hot food table; one plate held ground pork chops and the second plate help chopped pork chops.
-The temperatures of the food on the hot line were taken by the cook; the whole pork chops were 140°F, the ground pork chop was 110°F, the chopped pork chop was 110°F, the bread dressing was 110°F, and the cauliflower was 110°F.
-The plates used to serve food on were not heated and there was not a system to keep plates warm once there was food on them.
-Twelve plates of food were prepared one at a time and placed on an open cart; once the cart had twelve plates on it the cart was pushed into the adjoining dining room and the plates were served to the residents seated in the dining room.
-The cook began to place food onto new plates and place them on the open cart; it took about 15 minutes for the twelves plates to be prepared and served to the residents.

Observation of the thermometer used by the kitchen on 11/21/19 at 1:00pm revealed the thermometer was calibrated using an ice slurry solution and was accurate at 32°F.

Interview with a resident on 11/19/19 at 9:58am revealed:
-Hot food was served cold and cold food was served at room temperature.
-Plates were plated too early and the plates were on the tables before the residents were "even in the dining room."

Interview with a second resident on 11/19/19 at 10:14am revealed:
-Hot food and cold food were not always the temperature they were supposed to be.
-She would like her hot food to be served hot; the cold food did not matter as much.

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 288	Continued From page 23 Observation of the breakfast meal service on 11/20/19 at 8:25am revealed a resident loudly complained her food was always cold and asked if her breakfast tray could be checked for the temperature at the time it was served. Interview with the resident on 11/21/19 at 10:39am revealed: -The food was always cold, "the grits would not even melt butter." -All three meals were served cold every day. -Cold food was always served at room temperature. Interview with a personal care aide (PCA) on 11/22/19 at 8:44am revealed: -Some residents complained their food was not hot. -Residents' plates were served, even when the residents were not in the dining room. Interview with a second PCA on 11/22/19 at 9:14am revealed: -She had only heard one resident complain of meals not being hot. -The resident who complained was one of the first residents served, so her plated food should have been hot unless it was not hot enough when it was cooked. -She did not put a plate at the table unless the resident was at the table and ready to eat. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:16am revealed: -The only residents who complained their food was not hot were the ones who did not go to meals on time; there were residents who would go smoke before eating, or would get up during the meal and go to the bathroom.	D 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 288	Continued From page 24 -Typically the plates were held in the kitchen until the resident went to the meal. -She had seen staff put plates down on the table when the resident was not there and had told the staff not to put the plate down until the resident was ready to eat. Confidential telephone interview with a family member revealed: -The family member had observed residents complaining of cold food. -The family member had observed a resident asking for their plate to be heated. -The family member observed the food being returned to the resident with steam visible across the room; the family member told the resident to not eat the food because it was too hot. Interview with the cook on 11/22/19 at 8:52am revealed: -She knew to cook pork chops to 170°F when she cooked them; she had had not taken a temperature on the pork chops but had cut them open and looked to see if they were done. -She usually looked at the food to see if it was done and not pink in the middle; she did not always take a temperature of the food. -She knew the temperature of the food should be 140°F when she served it to the residents, but she never took a temperature of the food once she had cooked it. -She always placed 12 plates of food on a cart at a time and one of the facility staff would push the cart into the dining room; that was the way the plates had always been served to the residents. -She thought all of the residents had to be served at the same time and if a resident was not at a table the staff would put that plate at the empty seat. -She did not know how to calibrate a	D 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 288	Continued From page 25 thermometer. Interview with the Administrator on 11/21/19 at 12:00pm revealed: -There was only one resident who complained about food temperatures being cold; staff would reheat the food in the microwave when the resident complained. -She did not think there was a problem with the temperatures of the food served; she was not aware of any other residents complaining of cold food. -The cook should take temperatures of the food before serving; she did not know if the cook took temperatures of all the food. -The cook used to document the temperatures of the food at every meal; she did not know when the practice stopped. -She thought the food was cold because the cook would make more than one plate of food at a time. A second interview with the Administrator on 11/22/19 at 9:53am revealed: -She had trained the cook on the proper temperatures for cooking food and for before serving food. -She had not trained the cook to use a cart to push the plated food into the dining room; she trained the dietary staff to plate the food one plate at a time and then serve the residents by carrying two plates at a time into the dining room. -She did not know when the cart started being used to serve the plated food; the staff thought the residents all had to be served their food at the same time. -She checked the meals in the dining rooms at least once a week; she would talk to the residents when she went into the dining rooms.	D 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 297	Continued From page 26	D 297		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, record reviews and interviews it was determined the facility failed to serve adequately nutritional meals by not serving the proper portion sizes of food. The finding are: Observation during the breakfast meal on 11/20/19 at 8:19am revealed: -Resident had only one sausage link on his plate when served. -Two residents requested a second serving of sausage and eggs. -Dietary staff informed residents there was no more sausage. -Dietary staff gave the two residents a second serving of scrambled eggs each. Review of the menu in the kitchen for 11/22/19 revealed: -Pork chops, cauliflower, and bread dressing were on the lunch menu. -The serving sizes were listed on the menu as one pork chop, half of a cup of cauliflower, and half of a cup of bread dressing. Observation of the lunch meal on 11/22/19 from 12:30pm to 1:00pm revealed:	D 297		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 297	Continued From page 27 -There were pork chops, cauliflower, bread dressing, dinner roll and sliced apples. -The Kitchen Manager (KM) was serving the meal. -The KM was using a two-ounce serving scoop to serve the cauliflower and the bread dressing; there was an engraving on the scoop that indicated it was a quarter of a cup. -The portions of food the KM was scooping did not fill the bowl of the scoop. -There was not enough cauliflower to finish serving the last four plates; the two-ounce portions were cut in half for the last four plates. Interview with six residents on 11/19/19 between 10:00am and 10:18am revealed: -The food was good but they did not get enough food to eat. -The residents could sometimes get seconds if the residents asked for it. -Sometimes second servings were not available. -The residents did not get enough food to eat at breakfast. -The residents did not think there was enough food to go around for everyone. -One resident thought they were served "childlike portions" of food. -Most of the residents appeared to need more food. -One resident would eat larger portions if it was offered. -One resident was never served enough food to eat; she asked for more food, "sometimes you got more food and sometimes you did not." Interview with two residents on 11/20/19 at 8:20am and 8:44am revealed: -He would like to get more food. -"I only got one sausage link this morning". -It was "hit and miss" when asking for a second	D 297		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 297	Continued From page 28	D 297		

serving.
-Most of the time there were no seconds available at lunch or dinner.
-The residents in the other dining room always got more food than the residents in the small dining room because they got served first.
-He did not get enough food to eat.
-No one had offered him seconds; he had not thought to ask for more food.

Interview with a resident on 11/21/19 at 8:45am revealed:
-The food was good.
-"Today was really good, I even got seconds."
-We do not get seconds too often.
-If we do get seconds, it is usually at breakfast, not lunch or dinner.

Interview with a second resident on 11/21/19 at 10:39am revealed:
-The residents were not served enough food to eat.
-If she was served something she did not like, she gave it to other residents because not everyone knew to ask for second helpings.

Interview with a third resident on 11/21/19 at 4:45pm revealed:
-"They give us more water than food."
-They do not give us enough to eat.
-We only get seconds "once in a while"; there is not enough food for everyone to get seconds.

Interview with a personal care aide (PCA) on 11/22/19 at 8:44am revealed:
-It was very common to hear residents complain they did not get enough food to eat.
-The residents wanted more food to eat because the portion sizes were small.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 297	Continued From page 29 Interview with a second PCA on 11/22/19 at 9:14am revealed: -The cook usually cooked enough for second portions, and if not they told the residents there was not enough food for seconds. -She thought the portion sizes were large enough, "some residents just like to eat more." Interview with a medication aide (MA) on 11/22/19 at 9:32am revealed: -If residents wanted extra portions they could ask. -The male residents always got more on their plates. -The cook was "now cooking just enough"; she did not know why the cook was not cooking extra servings. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:16am revealed: -She was only aware of one resident who complained they did not get enough to eat. -If there was enough for seconds it was always provided. Interview with the Kitchen Manager (KM) on 11/22/19 at 8:52am revealed: -She knew the portions were listed on the menu for the lunch items; she did not look at the menu because she already knew the portion size for vegetables and starches was half a cup. -She indicated she used the two-ounce serving utensil to serve meals to residents. -She did not know how to identify the portion size of the utensil she was using to serve the food; it "looked like a half of a cup". -She thought a half of a cup was equal to three ounces. -She did not know the scoop she used to serve the residents' food was not the correct portion size and was only two-ounces.	D 297		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 297	Continued From page 30 -She did not give the residents full scoops of food; she gave the residents "enough food because they do not eat it anyway". -She gave the residents seconds after everyone was fed. -Sometimes she would not give seconds to the residents because too many would want seconds and if she did not have enough for everyone to get seconds the residents would get mad. Interview with the Administrator on 11/22/19 at 9:53am revealed: -She had trained the KM on how to read the daily menu for portion sizes of items. -She thought the portions of food were too much; the "plates were full". -She had purchased scoops for the kitchen staff to use; including plenty of scoops for half cup portions. -She knew the portion sizes were engraved on the scoops; she had showen the KM how to find the portion size on the serving utensils. -Residents should be able to get seconds as long as there were seconds available; everyone had to be fed first before seconds could be given to anyone. -Residents knew they could ask for a sandwich if they were still hungry.	D 297		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 299	Continued From page 31	D 299		

Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.

This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to serve eight ounces of pasteurized milk at least twice a day.

The findings are:

Review of the Week at a Glance menu for 11/19/19-11/22/19 revealed milk was to be served with all meals, but no portion size was indicated.

Observation on 11/19/19 at 11:40am of the walk-in cooler revealed 3 1/2 gallons [448 ounces (oz.)] of milk for a census of 42.

Observation on 11/20/19 from 8:09am to 8:48am of the breakfast meal being served in the main dining room revealed:
-Twenty-five residents were eating breakfast.
-Residents were served orange juice and coffee.
-Milk was not served to any of the residents.
-At 8:18am and again at 8:23am a female resident asked for milk; the resident was served milk at 8:27am.
-No other resident was offered or served milk.

Observation on 11/20/19 from 12:20pm to 1:20pm of the lunch meal being served in the main dining room revealed:
-Twenty-five residents were eating lunch.
-Water and iced tea were served to the residents.
-Milk was not served or offered to any of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 299	Continued From page 32	D 299		

Observation on 11/21/19 from 8:10am to 8:41am of the breakfast meal for a resident fed in his room revealed he was not offered or served milk to drink; he was served coffee and orange juice with his tray.

Review of receipts from a local grocery store provided by the Administrator in Charge revealed:
-Ten gallons of whole milk were purchased on Thursday, 10/03/19; ten gallons equaled 160 8-ounce cups of milk.
-Eight gallons of 2% milk were purchased on Thursday, 10/17/19; eight gallons equaled 128 8-ounce cups of milk.
-Four gallons of 2% milk were purchased on Thursday, 11/07/19; four gallons equaled 64 8-ounce cups of milk
-Four gallons of whole milk were purchased on Wednesday, 11/13/19; four gallons equaled 64 8-ounce cups of milk.
-Eight gallons of 2% milk were purchased on Wednesday, 11/20/19; eight gallons equaled 128 8-ounce cups of milk.

Interview with a resident on 11/19/19 at 9:58am revealed:
-She had not been offered milk to drink.
-She liked to drink milk.
-She would drink milk if it was offered.

Interview with a second resident on 11/19/19 at 10:14am revealed:
-No one offered her milk to drink.
-She asked for milk to drink every day and they always gave it to her.
-Anybody could have milk, they just had to ask.

Interview with a third resident on 11/19/19 at 10:21am revealed:
-She loved milk, to drink.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 299	Continued From page 33 -She only had milk in cold cereal but never to drink. -She had not asked for milk to drink. Interview with a fourth resident on 11/20/19 at 8:44am revealed: -If milk was served, he would "definitely drink it." -He loved milk to drink. -If you wanted a glass of milk to drink you had to ask for it. Interview with a fifth resident on 11/20/19 at 9:30am revealed: -He liked milk to drink. -He sometimes asked for milk to drink but did not ask for milk often because the other residents would then ask for milk and there would not be enough to go around. Interview with a personal care aide (PCA) on 11/22/19 at 8:44am revealed: -She helped serve meals to the residents in the dining room. -Residents were served juice, water, and coffee for breakfast. -Residents were served milk with cold cereal; cold cereal was not served every day. -She had residents ask for milk and it was always provided. -Residents were served water and tea for their lunch and dinner beverages. Interview with a second PCA on 11/22/19 at 9:09am revealed: -Residents were served water, juice, and coffee for their breakfast beverages. -She had never asked residents if they wanted milk to drink at meals. -She gave the residents what she had been told to give them to drink.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 299	Continued From page 34 -No one told her to give milk except on cereal days. Interview with a medication aide (MA) on 11/22/19 at 9:32am revealed: -If residents wanted milk to drink they asked for it. -Milk was not served to the residents unless they asked because it would be wasted. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:16am revealed: -She helped in the dining room with a lot of meals. -Milk was not served every single day, but if a resident asked for milk it was provided. -She did not know milk was to be offered twice a day, every day. Interview with the Kitchen Manger (KM) on 12/22/19 at 8:52am revealed: -She purchased milk once a week from the local grocery store; she purchased 10 to 12 gallons of milk a week. -At every meal the PCAs asked each resident if they wanted milk to drink. -She knew residents drank about two and a half gallons of milk a day. Interview with the Administrator on 11/22/19 on 9:53am revealed: -The KM purchased groceries once a week on Thursdays, she did not know how much milk the KM purchased a week. -Milk was served to the residents every morning at breakfast for the cold cereal and offered to residents to drink at the lunch and dinner meals. -She observed one meal a week and saw milk offered when she observed the meals.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 310	Continued From page 35	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that nutritional supplements were served as ordered to 2 of 2 residents (#1, #2) sampled. The findings are: Observation of the dry storage room in kitchen on 11/20/19 at 10:49am revealed: -There were ten 8-ounce cartons of chocolate flavored nutritional supplements in a box; the box originally contained 24 cartons. -There were two opened cases of vanilla flavored diabetic nutritional supplements; each case originally held 24 eight-ounce cartons. -The first case of diabetic nutritional supplements was dated received on 10/18/19 and had nine 8-ounce cartons of diabetic nutritional supplements remaining. -The second case of diabetic nutritional supplements was dated 11/07/19 and had seven 8-ounce cartons of diabetic nutritional supplements remaining. Observation of the reach in refrigerator located in the kitchen on 11/20/19 at 10:52am revealed there were no nutritional supplements stored in the refrigerator.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 310	Continued From page 36 Review of receipts provided by the Administrator from local vendors revealed: -On 10/10/19 two cases of diabetic nutritional supplements were voided off the receipt; no other supplement was on the receipt. -On 10/03/19 two cases of a diabetic nutritional supplements were purchased; each case contained 24 eight-ounce cartons. -On 10/17/19 two cases of a diabetic nutritional supplements were purchased; each case contained 24 eight-ounce cartons. -On 10/24/19 three cases of nutritional supplements were purchased; each case contained 24 eight-ounce cartons. -On 10/30/19 three cases of nutritional supplements were purchased; each case contained 24 eight-ounce cartons. -On 11/07/19 two cases of a diabetic nutritional supplements were purchased; each case contained 24 eight-ounce cartons. -On 11/08/19 two cases of a nutritional supplements were purchased; each case contained 24 eight-ounce cartons. -On 11/14/19 one case of nutritional supplements was purchased; the case contained 24 eight-ounce cartons. -On 11/20/19 four cases of nutritional supplements were purchased; each case contained 24 eight-ounce cartons. 1. Review of Resident #2's FL-2 dated 09/18/19 revealed diagnosis included hypertension, cerebrovascular accident with out residual, coronary artery disease after coronary artery bypass graft with stent placement, congestive heart failure, and type two diabetes. Review of a physician's order for Resident #2 dated 10/07/19 revealed a diabetic nutritional supplement was to be administered three times a	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 310	Continued From page 37	D 310		

day with meals.

Review of Resident #2's Resident Register revealed he was admitted to the facility on 09/30/19.

Observation of the facility's therapeutic diet list posted in the kitchen and dated 11/15/19 revealed no nutritional supplements were included on the diet list, including for Resident #2.

Review of Resident #2's October 2019 electronic medication administration records (eMARs) revealed:
-There was an entry for diabetic nutritional supplements on the eMAR; administer one to drink with each meal at 7:30am, 12:00pm and 5:00pm.
-There was documentation the nutritional supplement was administered three times a day from 10/08/19 to 10/31/19; 72 out of 72 opportunities.

Review of Resident #2's November 2019 eMARs revealed:
-There was an entry for diabetic nutritional supplements on the eMAR; administer one to drink with each meal at 7:30am, 12:00pm and 5:00pm.
-There was documentation the nutritional supplement was administered three times a day from 11/01/19 to 11/21/19; 62 out of 62 opportunities.

Observation of the breakfast meal on 11/20/19 at 8:22am revealed:
-Resident #2 was fed in his room by a personal care aide (PCA).
-There was no nutritional supplement on his tray, and he was not offered or served a supplement to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 310	Continued From page 38	D 310		

drink.

Observation of the lunch meal on 11/20/19 at 12:40pm revealed:
-Resident #2 was fed in his room by a medication aide (MA).
-There was no nutritional supplement on his tray, and he was not served or offered a supplement to drink.

Interview with Resident #2 on 11/20/19 at 8:41am revealed:
-He received his diabetic nutritional supplement once a day with his evening meal.
-He never refused to drink the diabetic nutritional supplement because he liked the taste of the vanilla flavor and would drink it if he got it more often.
-He did not know how often he was supposed to get a diabetic nutritional supplement.

Refer to the interview with the cook on 11/20/19 at 10:52am.

Refer to the interview with the Kitchen Manager (KM) on 11/21/19 at 11:34am.

Refer to the interview with a medication aide (MA) on 11/22/19 at 5:23pm.

Interview with the Administrator on 11/20/19 at 10:49am revealed:
-She did not know how many residents were ordered nutritional supplements, but she knew only Resident #2 was ordered the diabetic nutritional supplements.
-The cook went to the local grocery store and purchased nutritional supplements once a week.
-The cook purchased three cases of nutritional supplements each week; she did not know how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 310	Continued From page 39	D 310		

long three cases of nutritional supplements would last.
-One case of diabetic nutritional supplements was purchased each week from the pharmacy.
-She did not know how long one case of the diabetic supplements would last Resident #2; she did not know how often Resident #2 was supposed to get his diabetic nutritional supplement.

2. Review of Resident #1's current FL-2 dated 10/17/19 revealed diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder - recurrent, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility.

Review of Resident #1's physician's orders dated 10/17/19 and 10/31/19 revealed orders for Nutritional Drink Liquid 1 shake 3 times a day with meals.

Observation of the facility's therapeutic diet list posted in the kitchen and dated 11/15/19 revealed no nutritional supplements were included on the diet list, including for Resident #1.

Review of Resident #1's October 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Nutritional Drink Liquid, drink 1 shake 3 times a day with meals with scheduled administration times of 7:30am, 12:00pm, and 5:00pm.
-Nutritional Drink Liquid was documented as administered from 5:00pm on 10/17/19 through 5:00pm on 10/31/19 with one exception.
-Nutritional Drink Liquid was documented as not administered on 10/24/19 at 12:00pm due to the supplement being unavailable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 310	Continued From page 40 -The resident's weight was documented as 84.6 pounds on 10/23/19 and 85.1 pounds on 10/30/19. Review of Resident #1's November 2019 eMAR revealed: -There was an entry for Nutritional Drink Liquid, drink 1 shake 3 times a day with meals with scheduled administration times of 7:30am, 12:00pm, and 5:00pm. -Nutritional Drink Liquid was documented as administered from 7:30am on 11/01/19 through 12:00pm on 11/21/19 except for 2 refusals. -Nutritional Drink Liquid was documented as refused at 7:30am on 11/16/19 and 11/17/19. -The residents weight was documented as 86 pounds on 11/06/19. Observation of the breakfast and lunch meals on 11/20/19 revealed Resident #1 was not served or offered a nutritional supplement during either meal. Observation of the breakfast and lunch meals on 11/21/19 revealed Resident #1 was not served or offered a nutritional supplement during either meal. Observation of the breakfast meal on 11/22/19 revealed: -At 8:22am, the resident was eating breakfast and there was no nutritional supplement on the table. -At 8:36am, a personal care aide (PCA) / medication aide (MA) gave a chocolate flavored nutritional supplement to Resident #1. -The PCA/MA did not instruct the resident to drink the supplement. -The resident picked the bottle up, looked at it, and sat it back on the table.	D 310		

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
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 310	Continued From page 41	D 310		

-At 8:44am, the resident had the unopened nutritional supplement bottle lying in the seat of her wheelchair.
-At 8:46am, the resident came out of the dining room went to the medication cart with the nutritional supplement bottle in her hand.
-At 8:50am , the MA took the nutritional supplement and sat it on top of the medication cart while she administered medications to the resident.
-At 8:52am, the MA opened the nutritional supplement bottle and gave it back to the resident with no instructions.
-At 8:55am, the resident self-propelled the wheelchair to her bedroom and sat the nutritional supplement bottle on the bedside table without drinking any of it.
-At 9:00am, the resident had not drunk any of the nutritional supplement.
-At 9:40am, the resident was in the living room.
-At 9:42am, there was no nutritional supplement bottle on the resident's bedside table in her bedroom.

Interview with the housekeeper on 11/22/19 at 9:48am revealed:
-She had just cleaned Resident #1's bedroom.
-She threw away the nutritional supplement sitting on the bedside table.
-The bottle was full, and none had been drunk.
-She had not reported it to anyone.

Interview with the MA on 11/22/19 at 12:35pm revealed:
-Resident #1 had lost some weight and was supposed to get nutritional supplements 3 times a day at meals.
-The PCAs would pass out the nutritional supplements during meals so she would ask the PCAs if the residents received the supplements.

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 310	Continued From page 42 -She would document the nutritional supplements were given on the eMAR but she did not usually see or document how much the resident drank. -She was not aware Resident #1 did not drink the nutritional supplement that morning on 11/22/19 but she documented it as administered on the eMAR. Interview with a second MA on 11/22/19 at 9:54am revealed: -All staff had been passing out the nutritional supplements. -Resident #1 had lost some weight since around June 2019. -Resident #1 would not drink the nutritional supplement with her meals. -She usually encouraged the resident to take the nutritional supplement with her after the meal so the resident could drink it later. -She documented the resident drank a nutritional supplement on the eMAR at 7:30am on 11/20/19 and 11/21/19 and at 12:00pm on 11/20/19. -She was not aware Resident #1 did not receive a nutritional supplement on those 3 occasions. -She could not explain why she documented the nutritional supplements as being given on those 3 occasions. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 11:42am revealed: -She or the MAs and PCAs were responsible for passing out the nutritional supplements. -Resident #1 was supposed to receive nutritional supplements 3 times a day at each meal. -Resident #1 did not like the chocolate flavored supplements. -The MAs should make sure the resident drank the nutritional supplement before they documented it on the eMARs.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 310	Continued From page 43 Interview with the Administrator-in-Charge (AIC) on 11/25/19 at 3:10pm revealed: -The MAs were responsible for passing out the nutritional supplements either at meals or snacks according to the order. -The MAs were supposed to document the nutritional supplements on the eMARs and they should document if the resident drank the supplement. -Resident #1 had not been eating every meal and having some weight loss recently (could not give specific time) so they got an order for the resident to receive nutritional supplements. -She was not aware Resident #1 was not receiving the nutritional supplements as ordered. -The MAs should not document the resident had received the nutritional supplements if the MAs had not observed to be sure the resident received and drank the supplement. -She was concerned if Resident #1 did not receive the nutritional supplements, the resident would continue to decline and lose weight. Telephone interview with Resident #1's primary care provider (PCP) on 11/26/19 at 1:29pm revealed: -She ordered nutritional supplements for Resident #1 to help prevent weight loss. -She expected the nutritional supplements to be given to the resident as ordered. -She was concerned the resident would continue to lose weight if the resident did not receive the nutritional supplements. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to interview with the cook on 11/20/19 at 10:52am.	D 310		

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D 310	Continued From page 44 Refer to interview with the Kitchen Manager (KM) on 11/21/19 at 11:34am. Refer to interview with a medication aide (MA) on 11/22/19 at 5:23pm. _____ Interview with the cook on 11/20/19 at 10:52am revealed: -The Kitchen Manager (KM) purchased the nutritional supplements once a week; she was not sure how much was purchased. -She placed one case of supplements at a time into the reach-in refrigerator to keep them cold; the medication aides would come and take the supplements out of the refrigerator when they needed them. Interview with the Kitchen Manager (KM) on 11/21/19 at 11:34am revealed: -She purchased the food for the facility once a week; she purchased three cases of nutritional supplements a week and one case of diabetic nutritional supplement was purchased once a week from the pharmacy. -The medication aides gave the residents the supplements. Interview with a medication aide (MA) on 11/22/19 at 5:23pm revealed: -She gave the residents supplements; she thought there were about five or six residents that got nutritional supplements with their meals. -She did not know who got supplements with each meal or just one meal a day. -She documented on the electronic medication administration record (eMAR) when she gave the supplements. -She got the supplements out of the refrigerator in the kitchen.	D 310		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 310	Continued From page 45 Interview with the Administrator on 11/20/19 at 10:49am revealed: -She did not know how many residents were ordered nutritional supplements. -The cook went to the local grocery store and purchased nutritional supplements once a week. -The cook purchased three cases of nutritional supplements each week. -She did not know how long three cases of nutritional supplements would last, but if they ran out the cook would "just go get more".	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a minimum of 14 hours of planned group activities was provided	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 317	Continued From page 46	D 317		

each week for the residents.

The findings are:

Review of the November 2019 activity calendar revealed:
-There were 14 hours of activities offered each week.
-Residents were scheduled for "open floor discussion" on 11/19/19 from 10:00am-11:00am.
-Residents were scheduled for "tabletop games" on 11/19/19 from 2:00pm-4:00pm.
-Residents were scheduled for "bingo" on 11/21/19 from 10:00am-12:00pm and 2:00pm-4:00pm.

Interview with a resident on 11/19/19 at 9:58am revealed:
-There was an activity calendar posted but they never did what was on the calendar.
-The activities coordinator was always working as a personal care aide (PCA).
-They averaged 2-3 activities in a good week.
-She wished there were more activities to pass the day.

Interview with a second resident on 11/19/19 at 10:14am revealed:
-There were no activities to do every day.
-They had an activity about "once a week."
-She would do an activity every day if it was offered.
-Activities helped to keep your mind off problems.

Interview with a third resident on 11/19/19 at 10:30am revealed:
-She would like to do more activities.
-More activities would make her feel better about herself.

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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D 317	Continued From page 47 Interview with a fourth resident on 11/19/19 at 10:42am revealed: -The residents played bingo or bean auction "about" two times a week. -She would like to have more activities to do. Observation on 11/19/19 at various times between 10:00am-11:00am revealed: -Multiple residents were sitting in the front living room; there was no staff present to initiate "open floor discussion." -Multiple residents were sitting in the side living room; there was no staff present to initiate "open floor discussion." -One resident was sitting in the back-living room; there was no staff present to initiate "open floor discussion." Observation on 11/19/19 at various times between 2:00pm-4:00pm revealed: -There were no tabletop games played. -Multiple residents were sitting in the front living room. -Multiple residents were sitting in the side living room. -There were no residents in the back-living room. -There were no residents in the small dining room used for activities. Observation on 11/21/19 at various times between 10:00am-12:00pm and 2:00pm-4:00pm revealed: -There were no residents playing bingo. -Multiple residents were sitting in the front living room. -Multiple residents were sitting in the side living room. -There were no residents in the back-living room. -There were no residents in the small dining room used for activities.	D 317		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 317	Continued From page 48 Interview with the Activities Coordinator on 11/22/19 at 8:25am revealed: -She talked to residents at the resident council meeting to get ideas on what residents liked to do. -She also had residents complete a questionnaire on activities they liked to do. -If an activity was planned and she could not do it, and other staff could not do the activity, she would double up on the next activity; "I might make bingo an hour longer to make up for it." -When she was hired, the Administrator knew she was often out of the facility on Tuesday and Thursday. -The staff does activities when she was not at the facility; she had not asked anyone to do the activities, "everyone just knows." -She was not at the facility when open floor discussion was scheduled; she did not know who did the activity in her absence. -She was not at the facility when tabletop games were scheduled; she did not know who did the activity in her absence. -She was not at the facility when bingo was scheduled; she did not know who did the activity in her absence. -She was working on getting more activities scheduled; she had already coordinated church and youth groups to come into the facility to do activities. -She worked as a PCA and a medication aide (MA) on other shifts at the facility. -She only did PCA work during the day if the facility was short-handed. Interview with a PCA on 11/22/19 at 9:17am revealed: -If the Activities Coordinator was not in the facility the residents might work on puzzles.	D 317		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 317	Continued From page 49	D 317		

-No one had told her to do activities for the Activities Coordinator, but she sometimes did things with the residents.
-Some of the residents played tabletop games in the small dining room.

Interview with a MA on 11/22/19 at 9:28am revealed:
-If the Activities Coordinator was not in the facility, she would help with activities.
-No one told her to do activities; she enjoyed helping with activities, so she "just did it."
-She sat with some of the female residents on 11/19/19 and had "free talk" where they talked about Christmas and what they liked to do.

Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:26am revealed:
-No one was technically in charge of activities when the Activities Coordinator was not in the facility.
-Different staff would do things with the residents such as reminiscing.
-The Activities Coordinator tried to schedule activities around her time out of the facility.
-She did put the Activities Coordinator on the schedule as a PCA or a MA when she needed her.
-She has had to pull the Activities Coordinator in to assist when someone called out.
-She tried not to pull the Activities Coordinator away from activities but had "maybe about eight times."
-The Activities Coordinator was scheduled to work the cart as a MA once a week.

Interview with the Administrator on 11/22/19 at 12:45pm revealed:
-She expected the Activities Coordinator to provide fourteen hours per week of activities to

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 317	Continued From page 50 the residents in the facility. -If the Activities Coordinator was not in the facility, she would expect the Activities Coordinator to assign someone to do the scheduled activities. -She was not aware residents had complained about not having activities. -She was aware the Activities Coordinator worked as a MA/PCA. Telephone interview with the Administrator in Charge on 11/25/19 at 3:02pm revealed: -She expected the Activities Coordinator to provide at least fourteen hours of activities a week to the residents. -If there was a program on the calendar, she would like for it to be carried out. -Sometimes the calendar may need to be changed, and she expected a new calendar to be copied and given out. -There were days the Activities Coordinator was out of the facility; other facility staff set activities up the residents could do on their own. -She had talked to the Activities Coordinator about her expectations related to providing activities.	D 317		
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, interviews and record reviews, the facility failed to assure residents	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 51	D 338		

were free of abuse as evidenced by allegations of Staff D verbally and physically abusing Resident #1 and Staff E exploiting Resident #11 by selling a narcotic medication for anxiety to the resident.

The findings are:

1. Review of Resident #1's current FL-2 dated 10/17/19 revealed diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder - recurrent, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility.

Review of Resident #1's current assessment and care plan dated 08/21/19 revealed the resident was sometimes disoriented, forgetful and needed reminders.

Interview with a personal care aide (PCA) on 11/22/19 at 4:30pm revealed:
-Resident #1 had dementia and would sometimes be "kinda rowdy".
-One weekend last month (October 2019 - could not recall date or time), she was working on third shift when Resident #1 was screaming loud.
-Resident #1 was standing up in her room beside the bed.
-She witnessed Staff D (a medication aide) push Resident #1 with one hand on the shoulder.
-Resident #1 fell onto the bed in a sitting position.
-Staff D told Resident #1, "I've got something for you".
-Staff D pushed Resident #1 in her wheelchair to the living room.
-About 15 minutes later, she saw Staff D administer medication to the resident from a pill cup.
-About 10 minutes after the resident took the medication, the resident went to sleep in the living

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 338	Continued From page 52	D 338		

room.

Interview with a second PCA on 11/22/19 at 4:43pm revealed:
-She was working last month (October 2019 - did not recall date or time) on third shift.
-Resident #1 was agitated and having a verbal altercation with another resident, yelling across the hall.
-Staff D went down the hallway into Resident #1's bedroom.
-Resident #1 was sitting on the bed.
-She witnessed Staff D grab Resident #1's right arm and pinch it.
-Resident #1 told Staff D to "get off me", and asked Staff D, "why are you grabbing me?".
-Staff D yelled at Resident #1 and told the resident that she was going to give the resident some medication because Staff D was not going to deal with Resident #1 today.
-She and another PCA helped Resident #1 get dressed, transferred her to the wheelchair, and the resident followed the PCAs to the living room.
-After the resident got to the living room, the PCA witnessed Staff D at the medication cart in the hallway near the living room.
-Staff D gave Resident #1 medication from a pill cup but the PCA could not see what was in the cup.
-About 5 to 10 minutes later, Resident #1 was asleep in the living room.
-The other PCA who witnessed it, reported it to the third shift medication aide (MA).
-She did not know if it was reported to anyone else.

Review of a signed statement (not dated) by a MA revealed:
-A third shift PCA reported to the MA that the PCA witnessed Staff D standing in front of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 53	D 338		

#1, yelling and screaming and telling the resident to sit down.
-The resident was still standing up when the resident looked at the PCA "like she was saying help me".
-Staff D then lightly pushed the resident back where the resident fell backwards on the bed.
-The resident did not bump her head or fall on the floor.

Review of a signed statement (not dated) by Staff D revealed:
-When Staff D came in on the weekends, Resident #1 would be screaming and yelling and telling someone to get out of here.
-Staff D ignored it because that was Resident #1's "norm".
-Resident #1 did it every time she was in her room.
-Staff D tried to keep Resident #1 out of her room as much as possible because other residents complained about Resident #1 "going crazy".
-Staff D tried to keep Resident #1 in the main sitting room because the resident did not do all of the yelling and screaming when she was in the sitting room.
-She never put her hands on any of the residents or gave them someone else's medication.

Attempted telephone interview with Staff D on 11/22/19 at 10:46am was unsuccessful.

Interview with the Administrator on 11/22/19 at 3:30pm revealed:
-On Tuesday, 10/08/19, the Administrator-in-Charge (AIC) called the Administrator and reported Resident #1 was sleeping a lot on 10/06/19.
-She recalled staff reported witnessing Staff D punch Resident #1 during the incident on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 338	Continued From page 54	D 338		

10/06/19 but she could not recall who reported it.
-The police were contacted and they took a report.
-The AIC did an investigation and reported it to the Health Care Personnel Registry (HCPR) but she did not know when it was reported.
-She did not participate in the investigation.

Telephone interview with the AIC on 11/25/19 at 3:10pm revealed:
-Resident #1 had some dementia and sundowning in the evenings and could become easily agitated.
-The resident would scream out, go into other residents' rooms and take things, and sometimes cry.
-The resident's behavior was better in the mornings than in the evenings.
-Staff had been instructed to redirect the resident when she became agitated.
-Staff who worked with Staff D on 10/06/19 reported Staff D was verbally abusive to Resident #1 and a staff reported witnessing Staff D push Resident #1 with two fingers.
-A second staff also reported she witnessed Staff D verbally and physically abuse Resident #1.
-The physical and verbal abuse by Staff D was reported to the AIC on either 10/07/19 or 10/08/19.
-She interviewed Staff D who denied abusing Resident #1.
-She did an investigation and reported it to the Health Care Personnel Registry (HCPR).
-She thought she completed the 24-hour report and faxed it to HCPR on the same day, 10/08/19, but she was not sure.
-Staff D was terminated on 10/11/19.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 338	Continued From page 55	D 338		

interviewable.

2. Review of Resident #11's current FL2 dated 12/21/18 revealed diagnoses of seizure disorder, major depressive disorder, obesity, and hyperlipidemia.

Review of a police report dated 11/13/19 revealed:
-The local county sheriff was called to the facility to investigate a Staff (Staff E) selling narcotics to a resident.
-Staff E and resident admitted to the incident.
-Staff E was arrested for possession with intent to sell and deliver a schedule IV drug.

Interview with Resident #11 on 11/20/19 at 2:10pm revealed:
-He was on the smoking porch and saw Staff E taking medication.
-He asked Staff E what the medication was for and Staff E said anxiety.
-He told Staff E that he wanted some of the medication and Staff E said she would bring some.
-The next day Staff E gave him 5 pills and he gave her $10.
-He took 2 pills immediately and then 2 more later.
-He knew this was wrong and would not do it again.
-The medication caused him to be drowsy.

Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 11:45am revealed:
-She did not know about the incident on 11/12/19 involving Staff E and Resident #11; she was told about the incident by another staff on 11/12/19.
-The Administrator-in-Charge (AIC) was responsible for investigating the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 338	Continued From page 56 Interview with the AIC on 11/21/19 at 4:10pm revealed: -She was told about the incident by another staff on 11/12/19 who overheard the conversation between Staff E and Resident #1. -When she learned of the incident, Resident #11 was asleep and Staff E was not in the facility. -She waited until the next day to discuss the incident with Staff E and Resident #11. -On 11/13/19, she discussed the incident with Staff E, who admitted to bringing medication from home to Resident #11 because he had anxiety. -Staff E reported she brought 5 Klonopin (a narcotic used to treat anxiety) tablets to Resident #11. -Staff E could not tell her the prescribing physician for the medication, what pharmacy filled the medication or show the bottle of medication. -She interviewed Resident #11, who was observed to be in a deep sleep prior to the interview. -Resident #11 reported initially that he did not take the Klonopin, then admitted to taking 4 of the tablets. -She had Resident #11 taken to urgent care for blood work. -Resident #11 did not display any new behaviors. Attempted telephone interview with Staff E on 11/21/19 was unsuccessful. _____ The facility failed to assure two residents were free from verbal and physical abuse and exploitation resulting in Resident #1 being verbally and physically abused by Staff D by yelling, pushing, pinching, and administering an unknown medication to the resident; and Resident #11 was sold Klonopin, a narcotic used to treat anxiety, by Staff E. The failure of the	D 338		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 338	Continued From page 57 facility to protect the residents resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/25/19 and 11/26/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 26, 2019.	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 and in accordance with the facility's policies for 4 of 8 residents (#3, #5, #13, #14,) observed during the medication passes including errors with insulin (#3, #14), an inhaler (#5), and a stool softener (#13); and for 3 of 6 residents sampled (#1, #3, #5) for record review including errors with an antipsychotic (#1), a Vitamin D supplement (#3), and an antidepressant (#5).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 58 The findings are: 1. The medication error rate was 15% as evidenced by the observation of 4 errors out of 26 opportunities during the 7:00am, 8:00am, 11:30am, and 12:00pm medication passes on 11/20/19. a. Review of Resident #5's current FL-2 dated 06/03/19 revealed diagnoses included acute on chronic respiratory failure, chronic obstructive pulmonary disease, diastolic congestive heart failure, hypertension, hypothyroidism, dysphagia, gastroesophageal reflux disease, hyperlipidemia, radiculopathy of the cervical region, and osteoarthritis of the hip. Review of Resident #5's physician's order dated 07/11/19 revealed an order for Symbicort 160/4.5mcg inhaler, inhale 2 puffs twice daily, rinse mouth after each use. (Symbicort is used to treat chronic obstructive pulmonary disease. According to the manufacturer, rinsing the mouth after use will help prevent fungal infections of the mouth and throat.) Observation of the 8:00am medication pass on 11/20/19 revealed: -Resident #5 was in the dining room eating breakfast. -The medication aide (MA) put the inhaler mouthpiece in the resident's mouth and pressed the inhaler 2 quick times in a row. -The MA did not instruct the resident to inhale and the MA did not wait between puffs (According to Guidelines for the Medication Administration Clinical Skills Checklist, waiting at least 1 minute between puffs may permit additional puffs to penetrate the lungs better.)	D 358		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 59 -The resident did not inhale so the medication vapors came back out of the resident's mouth and not into the resident's lungs. -The resident did not rinse her mouth with water after the use of the Symbicort inhaler. -The MA did not offer or instruct the resident to rinse his mouth after administering the Symbicort inhaler as ordered. Review of Resident #5's November 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Symbicort 160/4.5mcg inhaler, inhale 2 puffs twice daily, rinse mouth after each use with scheduled administration times of 8:00am and 8:00pm. -Symbicort was documented as administered on 11/20/19 at 8:00am. Interview with the MA on 11/20/19 at 11:44am revealed: -She was aware she was supposed to wait between puffs when administering inhalers but Resident #5 did not want to wait sometimes. -She did not usually instruct the resident to inhale or to rinse mouth because she did not have to since the resident usually did that. -She usually administered the inhaler to the resident while the resident was in her bedroom and that may be why the resident did not rinse her mouth that morning. -The resident would complain of shortness of breath in the mornings when the resident was getting up. Interview with Resident #5 on 11/20/19 at 12:34pm revealed: -She usually received 2 puffs at a time of the Symbicort inhaler. -She did not rinse her mouth after the inhaler	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 60	D 358		

because she had never been instructed to and she did not know she was supposed to rinse it.
-Her tongue would sometimes get sore and she had a liquid medicated mouthwash that helped if her tongue got sore.
-She was not currently having issues with her tongue being sore and she was not currently short of breath.

Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 1:25pm revealed:
-The MAs had been trained on how to properly administer inhalers.
-They should wait a couple of minutes between puffs.
-They should have the resident to rinse her mouth with water after use of the inhaler because it could cause thrush if they did not rinse.
-The MA should have instructed Resident #5 to inhale and to rinse her mouth.
-Resident #5 had a medicated mouthwash she used when her tongue got sore.

Interview with the Administrator on 11/22/19 at 3:30pm revealed:
-The MAs had been trained to use proper technique when administering inhalers to residents.
-The MAs should instruct the residents to inhale and have the resident to rinse their mouth if ordered.

Telephone interview with Resident #5's primary care provider (PCP) on 11/26/19 at 1:29pm revealed:
-She expected Resident #5's Symbicort to be administered as ordered.
-It was necessary to rinse the resident' mouth with water after use of Symbicort to prevent thrush (a fungal infection of the mouth).

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 61 -She assessed the resident today (11/26/19) and the resident had some "crackles" in her lungs, and she was having some shortness of breath with exertion. -These symptoms may not have been directly related to the improper use of the Symbicort, but it could not be excluded as a potential cause. b. Review of Resident #13's current FL-2 dated 05/16/19 revealed diagnoses included major depressive disorder, mild cognitive impairment, multiple sclerosis, and memory loss. Review of Resident #13's progress note dated 11/17/19 revealed: -The resident had returned to the facility from the emergency room -The resident was diagnosed with sepsis and urinary tract infection. -The resident was to be started on Colace 200mg twice a day and Macrobid 100mg twice a day. (Colace is a stool softener. Macrobid is an antibiotic for infection.) -The discharge summary was faxed to the pharmacy. Review of Resident #13's hospital discharge instructions and medication report dated 11/17/19 revealed: -The resident was treated for a urinary tract infection and dehydration. -The resident was to start taking Colace 200mg twice a day and Macrobid 100mg twice a day with food. -The discharge instructions were signed by a Registered Nurse (RN). -The pages with the medication report which included Colace and Macrobid were electronically signed by a physician.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 62 Review of Resident #13's November 2019 electronic medication administration record (eMAR) revealed: -There was no entry for Colace. -There was an entry for Macrobid 100mg twice a day for 3 days with meal/food. -Macrobid was scheduled to be administered at 8:00am and 9:00pm. -Macrobid was documented as administered from 9:00pm on 11/18/19 through 8:00am on 11/20/19. Observation of the 8:00am medication pass on 11/20/19 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #13 at 8:35am. -No Colace was administered to the resident. Interview with the MA on 11/20/19 at 11:44am revealed: -She was not aware Resident #13 was supposed to be receiving Colace. -She had not administered any Colace because it was not on the eMAR and there was none on hand for this resident. -She was not aware of any constipation issues with Resident #13. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/19 at 11:00am revealed: -The pharmacy received Resident #13's hospital discharge instructions on 11/18/19 but they were not signed by a prescribing practitioner. -The pharmacy staff called the hospital and got a verbal order for the prescription antibiotic (Macrobid) and dispensed it. -The facility's Resident Care Coordinator (RCC) was supposed to get a signed order for the Colace from the resident's primary care provider	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 63	D 358		

(PCP).
-The pharmacy never received a signed order for the Colace so it was never dispensed.

Interview with the RCC on 11/22/19 at 11:35am revealed:
-She thought she had faxed all pages of the hospital paperwork including the signed medication report to the pharmacy.
-She spoke with the pharmacist today, 11/22/19, and she was going to fax all pages to the pharmacy today.
-The pharmacy was going to dispense the Colace and they would start administering it to the resident.

Telephone interview with Resident #13's primary care provider (PCP) on 11/26/19 at 1:29pm revealed:
-She was concerned that the facility did not start Colace for Resident #13 when it was ordered from the hospital visit.
-She was not aware of any current constipation issues with the resident.

c. Review of Resident #3's current FL-2 dated 05/17/19 revealed:
-Diagnoses included type 2 diabetes mellitus, coronary artery disease, atrial fibrillation, cardiomyopathy, Alzheimer's disease, hyperlipidemia, gastroesophageal reflux disease, and major depressive disorder.
-There was an order to check the resident's fingerstick blood sugar (FSBS) 4 times a day before meals and at bedtime.
-There was an order for Humalog Kwikpen insulin inject 10 units at midday (11:30am) and 8 units at the evening meal (5:00pm). (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends taking Humalog

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 64 15 minutes before or immediately after a meal. The Humalog Kwikpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is inserted into the skin, the dose knob should be pushed all the way in and held for 5 seconds to ensure the full amount is injected.) Interview with the medication aide (MA) on 11/20/19 at 11:20am revealed the lunch meal was usually served at 12:00pm Observation of the 11:30am medication pass on 11/20/19 revealed: -Resident #3's blood sugar was 147 at 11:25am. -The MA administered 10 units of Humalog Kwikpen insulin into Resident #3's left upper arm at 11:27am. -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle. -The MA did not hold the insulin pen in the skin after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected. Observation on 11/20/19 revealed Resident #3 was served lunch at 12:31pm, 1 hour and 4 minutes after being administered Humalog. Review of Resident #3's November 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen inject 10 units at midday and 8 units at the evening meal with scheduled administration times of 11:30am and 5:00pm. -The resident's blood sugar ranged from 91 - 232	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 65 from 11/01/19 - 11/20/19. Interview with the MA on 11/20/19 at 12:50pm revealed: -The lunch meal was usually served on time at 12:00pm. -If insulin was ordered with the lunch meal, the MAs were supposed to administer it at 12:00pm because that was when lunch was served. -The facility's contracted Registered Nurse (RN) trained her on how to use insulin pens. -She thought they were supposed to do an air shot only when the insulin pen was first opened and used the first time. -She was not aware the insulin pen should be primed with an air shot before each use. -She did not recall being trained to hold the injection in once the button was pressed. Interview with Resident #5 on 11/20/19 at 1:13pm revealed: -He usually had his blood sugar checked and received insulin before meals about the same time as today (11/20/19). -He usually received his lunch meal between 12:00pm and 12:15pm. -He did not usually feel any symptoms of low blood sugar while waiting for his meals after receiving insulin. Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 1:25pm revealed: -The facility's contracted RN had trained the MAs on how to administer insulin using insulin pens. -She was not sure if the MAs were trained to prime the insulin pens with an air shot or hold the injection in for a few seconds because the RCC was trained by a different trainer. -She was not aware the MAs needed to prime the pens or hold in the injection.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 66	D 358		

-The MAs were supposed to check with kitchen staff to make sure there were no delays in meal times.
-The MAs were supposed to administer the insulin about 15 minutes prior to meals.
-Lunch was usually served at 12:00pm and if there was going to be a delay, the MAs should give the diabetic residents a snack if they had already received their insulin.

Interview with the facility's contracted RN on 11/20/19 at 1:45pm revealed:
-She trained the MAs at the facility on the use of insulin pens and she brought insulin pens and demonstrated how to use them.
-The MAs were taught to prime the pen with a 2-unit air shot and to hold the injection in for at least 5 seconds to ensure all of the insulin was released from the pen and injected.

Interview with the Administrator on 11/22/19 at 3:30pm revealed the MAs had been trained to do air shots when using insulin pens and they should hold the injection in the skin for 10 to 15 seconds.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/22/19 at 2:54pm was unsuccessful.

d. Review of Resident #14's current FL-2 dated 01/24/19 revealed diagnoses included type 2 diabetes, chronic obstructive pulmonary disease, hypertension, asthma, hyperlipidemia, dysphasia, and transient ischemic attack.

Review of Resident #14's physician's order dated 11/22/19 revealed an order for Novolog Flexpen inject 5 units 3 times a day. ((Novolog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 67	D 358		

within 5 to 10 minutes after the injection. The Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is inserted into the skin, the dose knob should be pushed all the way in and held for at least 6 seconds to ensure the full amount is injected.)

Interview with the medication aide (MA) on 11/20/19 at 11:20am revealed the lunch meal was usually served at 12:00pm

Observation of the 11:30am medication pass on 11/20/19 revealed:
-Resident #14's blood sugar was 202 at 11:37am.
-The MA administered 5 units of Novolog Flexpen insulin into Resident #14's right upper arm at 11:38am.
-The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle.
-The MA did not hold the insulin pen in the skin after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected.

Observation on 11/20/19 revealed Resident #14 was served lunch at 12:28pm, 50 minutes after being administered Novolog.

Review of Resident #14's November 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog Flexpen inject 5 units 3 times a day, hold if blood sugar is less than 150 at evening dose, give within 15 minutes of food.
-Novolog Flexpen was scheduled to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 68	D 358		

administered at 7:15am, 11:45am, and 4:45pm.
-The resident's blood sugar ranged from 121 - 395 from 11/01/19 - 11/20/19.

Interview with the MA on 11/20/19 at 12:50pm revealed:
-The lunch meal was usually served on time at 12:00pm.
-If insulin was ordered with the lunch meal, the MAs were supposed to administer it at 12:00pm because that was when lunch was served.
-The facility's contracted Registered Nurse (RN) trained her on how to use insulin pens.
-She thought the MAs were supposed to do an air shot only when the insulin pen was first opened and used the first time.
-She was not aware the insulin pen should be primed with an air shot before each use.
-She did not recall being trained to hold the injection in once the button was pressed.

Interview with Resident #14 on 11/20/19 at 1:05pm revealed:
-She usually had her blood sugar checked and received insulin before meals.
-She usually received her meals 30 to 45 minutes after she received insulin.
-She did not usually feel any symptoms of low blood sugar while waiting for meals after receiving insulin.
-She had some low blood sugars in the past but she thought those were mostly at night.

Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 1:25pm revealed:
-The facility's contracted RN had trained the MAs on how to administer insulin using insulin pens.
-She was not sure if the MAs were trained to prime the insulin pens with an air shot or hold the injection in for a few seconds because the RCC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 69	D 358		

was trained by a different trainer.
-She was not aware the MAs needed to prime the pens or hold in the injection.
-The MAs were supposed to check with kitchen staff to make sure there were no delays in meal times.
-The MAs were supposed to administer the insulin about 15 minutes prior to meals.
-Lunch was usually served at 12:00pm and if there was going to be a delay, the MAs should give the diabetic residents a snack if they had already received their insulin.

Interview with the facility's contracted RN on 11/20/19 at 1:45pm revealed:
-She trained the MAs at the facility on the use of insulin pens and she brought insulin pens and demonstrated how to use them.
-The MAs were taught to prime the pen with a 2-unit air shot and to hold the injection in for at least 5 seconds to ensure all of the insulin was released from the pen and injected.

Interview with the Administrator on 11/22/19 at 3:30pm revealed the MAs had been trained to do air shots when using insulin pens and they should hold the injection in the skin for 10 to 15 seconds.

Telephone interview with Resident #14's primary care provider (PCP) on 11/26/19 at 1:29pm revealed:
-She expected Resident #14's insulin to be administered within 15 to 30 minutes of eating a meal.
-Resident #14 had a history of hypoglycemia.
-She was concerned if the resident received insulin more than 15 to 30 minutes prior to a meal, it could cause the resident to have hypoglycemia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 70 2. Review of Resident #1's current FL-2 dated 10/17/19 revealed: -Diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility. -The resident was intermittently disoriented. a. Review of Resident #1's progress notes revealed: -On 10/07/19, the resident was acting very lethargic. The responsible party was notified and will be in on 10/16/19 to discuss hospice. -On 10/08/19, the resident was taken to urgent care for test (did not specify what kind of test). Review of an accident/injury report for Resident #1 signed and dated 10/07/19 revealed: -The date and time of the incident was 10/06/19 at 10:15pm. -The personal care aides (PCAs) reported to the medication aide (MA) that Resident #1 was acting strange, hallucinating, and yelling. -Staff monitored the resident all shift and reported extreme lethargy in the morning. -The resident was taken to urgent care per primary care provider (PCP) verbal order to have lab work and drug screen. -The resident tested positive for benzodiazepines, but the resident was not prescribed any benzodiazepines. (Benzodiazepines are used to treat anxiety and they are narcotics. Ativan is an example a drug classified as a benzodiazepine.) Review of a second accident/injury report for Resident #1 revealed: -The date of incident was "10/06/19 / 10/07/19" and the time was documented as third shift and 6:00am count.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 71 -The resident was drowsy, lethargic, and pale. -The resident was very difficult to arouse and the resident seemed to be hallucinating. -The MAs noted medications were not documented correctly during "med count" and they notified the RCC. -The RCC notified the resident's PCP and got an order to check labs and screen the resident for drugs. -The resident was taken to an urgent care center for drug screening on 10/08/19. Review of Resident #1's lab report dated 10/08/19 revealed: -A drug panel screen was collected for testing on 10/08/19 at 11:41am. -Benzodiazepine was detected in the resident's blood specimen. -The drug screen report did not specify which specific benzodiazepine was detected. Review of Resident #1's September 2019 - November 2019 electronic medication administration records (eMARs) revealed: -There were no entries or orders for any medication classified as a benzodiazepine. -There was no documentation the resident had received any medication classified as a benzodiazepine. -There was documentation of the resident receiving her routine medications as ordered on 10/06/19. -There was no documentation of the resident receiving any prn (as needed) medications on 10/06/19. Review of an electronic prn (as needed) administration report dated 10/06/19 - 10/08/19 revealed: -No prn (as needed) medications were	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 72	D 358		

documented as administered to Resident #1 during that time period.
-There was no Ativan documented as administered to any resident during that time period.

Review of another resident's controlled substance (CS) log for Ativan 0.5mg revealed:
-The MA documented 2 Ativan 0.5mg tablets were administered on 10/06/19 but there was no time documented.
-The MA noted the amount remaining was 28 tablets.
-Prior to 10/06/19, Ativan was not documented as administered to the resident since 08/13/19 at 8:44am.

Interview with a MA on 11/22/19 at 12:54pm revealed:
-She came into work at the facility on third shift on 10/06/19.
-Two personal care aides (PCAs) called her to Resident #1's room.
-Resident #1 was in bed screaming out very loudly.
-The resident would lay back and sit back up then turn crossways in the bed.
-The resident would keep screaming and sitting up and down.
-One of the PCAs told the MA she thought the MA on the previous shift gave Resident #1 some medication.
-The MA from the previous shift had already left the facility when she came into work around 10:00pm.
-The MA from the previous shift reported before she left that Resident #1 was agitated because Resident #1 was arguing with another resident.
-She checked to see if Resident #1 had any orders for a prn (as needed) medication to help

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 73	D 358		

with the agitation but the resident did not.
-The resident stopped screaming around 5:00am and went to sleep.
-The resident was "knocked out" and she thought it was because the resident was tired.

Interview with a PCA on 11/22/19 at 4:30pm revealed:
-Resident #1 had dementia and would sometimes be "kinda rowdy".
-Once weekend last month (October 2019 - could not recall date or time), she was working on third shift when Resident #1 was screaming loud.
-The MA told Resident #1, "I've got something for you".
-The MA pushed Resident #1 in her wheelchair to the living room.
-About 15 minutes later, she saw the MA administer medication to the resident from a pill cup.
-She could not see how many pills were in the cup.
-About 10 minutes after the resident took the medication, the resident went to sleep in the living room.
-She did not report it to anyone because the MA and she assumed the MA was administering medication to calm the resident.

Interview with a second PCA on 11/22/19 at 4:43pm revealed:
-She was working last month (October 2019 - did not recall date or time) on third shift.
-Resident #1 was agitated and having a verbal altercation with another resident, yelling across the hall.
-The MA yelled at Resident #1 and told the resident that she was going to give the resident some medication because the MA was not going to deal with the resident today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 74 -She and another PCA helped Resident #1 get dressed, transferred her to the wheelchair, and the resident followed the PCAs to the living room. -After the resident got to the living room, the PCA witnessed the MA at the medication cart in the hallway near the living room. -The MA gave Resident #1 medication from a pill cup but the PCA could not see what was in the cup. -About 5 to 10 minutes later, Resident #1 was asleep in the living room. Interview with a third PCA on 11/26/19 at 12:12pm revealed: -One night last month on the weekend (October 2019 - could not recall date), she worked on third shift. -She and another PCA went into Resident #1's room and the resident was "discombobulated". -The resident's hands and entire body were shaking. -The resident was sitting on the bed rocking back and forth saying "woo, woo". -The resident was hallucinating and thought there was a man in the room, but there was no man in the room. -The PCAs reported it to the MA who was the supervisor on duty. -The resident went to sleep eventually but would wake up every 2 hours screaming. Attempted telephone interview with the MA on 11/22/19 at 10:46am was unsuccessful. Review of a signed statement by the MA (not dated) revealed: -When the MA came in on the weekends, Resident #1 would be screaming and yelling and telling someone to get out of here. -The MA ignored it because that was Resident	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 75 #1's "norm". -Resident #1 did it every time she was in her room. -The MA tried to keep Resident #1 out of her room as much as possible because other resident's complained about Resident #1 "going crazy". -The MA tried to keep Resident #1 in the main sitting room because the resident did not do all of the yelling and screaming when she was in the sitting room. -She never put her hands on any of the residents or gave them someone else's medication. Interview with the RCC on 11/22/19 at 11:42am revealed: -When she came to work on Monday, 10/07/19, Resident #1 was in the living room with her eyes closed, head back, and mouth open. -Third shift staff reported the resident had been more disoriented than normal, hallucinating, was pale and clammy. -The MA told her to look at the documentation on the CS logs for another resident's oral Ativan and a third resident's Ativan gel. -Neither of those residents had needed or had been taking their Ativan but the MA had documented administering Ativan to both residents on the CS log over the weekend but not on the eMARs. -One of the resident's was competent and denied requesting or receiving any Ativan on 10/06/19. -The MA had worked as the MA on first and second shifts on 10/06/19. -She and the AIC were suspicious because of the CS logs and Resident #1's change in condition that Resident #1 may have been administered Ativan that belonged to the other residents. -She notified Resident #1's PCP and got a verbal order to get a drug screen on the resident.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 76 -The resident tested positive for benzodiazepines on 10/07/19 or 10/08/19 (could not recall date). -The AIC talked to the MA but the MA denied administering Ativan to Resident #1. Interview with the Administrator on 11/22/19 at 3:30pm revealed: -On Tuesday, 10/08/19, the AIC called the Administrator and reported Resident #1 was sleeping a lot on 10/06/19. -Some issues with the CS logs for two other residents with orders for Ativan triggered the AIC and RCC to question whether the Ativan was administered to Resident #1 instead. -One of the residents reported she did not ask for or receive any Ativan on 10/06/19. -The other resident was confused but did not usually need Ativan gel. -The MA was questioned about the Ativan but denied giving any medication to Resident #1 on 10/06/19. Telephone interview with the AIC on 11/25/19 at 3:10pm revealed: -When she came into the facility on Monday, 10/07/19, Resident #1 was sitting in the front living room. -The resident was sitting in a chair, leaning to the side, very drowsy, and sleepy. -The resident was usually alert and responsive but the resident was sluggish and sleepy. -This was not like the resident's "normal self" as the resident was usually alert. -One staff told the AIC that the resident had stayed up late on third shift. -A second staff said the resident had been "kind of sleepy". -A third staff said she had to feed the resident because the resident was so tired. -Later that day, the resident still appeared sleepy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 77 -A fourth staff who came in on second shift on 10/07/19 reported the resident had been hallucinating on third shift on 10/06/19. -The next morning (10/08/19), the resident was back to her "normal self". -This made the AIC think that something else was wrong and the resident may have gotten the wrong medication. -The RCC checked the CS logs and it appeared some Ativan that belonged to other residents were documented on the CS log but not documented as administered on the eMARs. -She spoke with the RCC and the RCC contacted the PCP on Tuesday, 10/08/19. -The PCP said to send the resident out and to get a drug screen. -The resident was sent out to an urgent care center for blood work on 10/08/19. -They got the results back a day or two later and started an investigation. -She interviewed the MA who denied administering any medication to Resident #1. Review of a Health Care Personnel Registry (HCPR) 5-day investigation report for the MA dated 10/09/19 revealed: -The allegations included diversion of resident drugs. -The incident date was documented as 10/06/19 - 10/08/19. -The allegation details documented Resident #1 was not her normal self on Monday (10/07/19). -Resident #1 appeared to be sleepy, sluggish, and very pale. -The resident was hallucinating and very sluggish and sleepy. -The resident "couldn't even hold a spoon or fork to her mouth". -It was documented the resident was confused and had dementia.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 358	Continued From page 78 -On Tuesday (10/08/19), the resident was sent out of the facility to have blood work done. -Other residents' medications were missing but were not documented as given on the electronic medication administration record (eMARs). -Benzodiazepines were detected in the resident's blood work but the resident had no orders to receive any benzodiazepine medications. -The MA was terminated related to the allegations on 10/11/19. Telephone interview with a medical assistant at Resident #1's mental health provider's (MHP) office on 11/26/19 at 11:19am revealed: -The facility notified them after the incident when Resident #1 tested positive for benzodiazepines at an urgent care center (could not recall date). -The facility reported the resident was found sitting in her wheelchair "pretty sedated" and difficult to wake up. -The resident was last seen by the MHP at the end of last week and there were no concerns of any lasting effects noted at that time. -The resident was recently prescribed Ativan (within the last few days) but was not prescribed Ativan or any other benzodiazepine medications at the time of the incident or when she tested positive. Telephone interview with Resident #1's PCP on 11/26/19 at 1:29pm revealed: -Resident #1 was a "firecracker", usually alert with moments of emotional distress. -Resident #1 was not usually sedated or lethargic. -When the RCC notified her on 10/08/19, the RCC was asking for drug testing but she told the RCC the resident needed a medical evaluation. -The resident did not have orders to take Ativan or any other benzodiazepines at that time and should not have tested positive.	D 358		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

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D 358	Continued From page 79 -This was "unacceptable"; the resident should not have received any Ativan. -She was unsure how much Ativan the resident was administered. -She had seen the resident for multiple visits since the incident on 10/06/19 and there had been no after effects from receiving the Ativan to her knowledge. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. b. Review of Resident #1's physician's order dated 10/31/19 revealed an order to start Seroquel 50mg 1 tablet at bedtime. (Seroquel is an antipsychotic used to treat psychosis and mood disorders.) Review of Resident #1's November 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Seroquel 50mg 1 tablet at bedtime with a scheduled administration time of 8:00pm. -Seroquel was documented as administered from 11/01/19 - 11/19/19. -Seroquel was not documented as administered on 11/20/19 due to medication not on cart, awaiting delivery. -Seroquel was documented as administered on 11/21/19. Observation of Resident #1's medications on hand on 11/22/19 at 12:35pm revealed there was no Seroquel available in the facility for the resident. Interview with the medication aide (MA) on 11/22/19 at 12:35pm revealed:	D 358		

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D 358	Continued From page 80 -She did not know why Resident #1 was out of Seroquel. -She could not find any in the medication cart or the back-up supply. Interview with a second MA on 11/22/19 at 3:05pm revealed: -Resident #1 should have some Seroquel on hand at the facility. -She looked on the eMAR and Seroquel was last dispensed on 11/14/19 and it was last ordered on 11/20/19. -She did not know why it was not available on 11/20/19 but documented as administered on 11/21/19 and none on hand on 11/22/19. Interviews with the Resident Care Coordinator (RCC) on 11/22/19 at 11:42am and 3:12pm revealed: -The MAs were responsible for ordering non-cycle fill medications from the pharmacy. -The MAs were supposed to check the medication cart at the end of each shift. -When Resident #1's Seroquel was dispensed, the pharmacy only sent 15 tablets because she was a hospice resident. -She faxed the pharmacy last night (11/21/19) to send more Seroquel and she thought they would have received the Seroquel last night (11/21/19). -She was not sure why they did not receive the Seroquel so she would contact the pharmacy today (11/22/19). Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/19 at 4:17pm revealed: -The pharmacy dispensed 15 tablets of Seroquel 50mg on 11/14/19. -They could only dispense 15 tablets each time since it was a hospice resident.	D 358		

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D 358	Continued From page 81 -There were no refills on the Seroquel and they would need a new prescription to refill the medication. Telephone interview with the Administrator-in-Charge (AIC) on 11/25/19 at 3:10pm revealed: -The RCC was responsible for medications and making sure the medications were ordered and available for administration. -The MAs used stickers on the medication packs to fax refill requests to the pharmacy if it was not a monthly cycle fill medication. -If a medication was not received by the facility, the MAs should let the RCC know so she could follow-up with the pharmacy. -She was not aware Resident #1's Seroquel had not been administered due to the medication being unavailable at the facility. Interview with a medical assistant at Resident #1's mental health provider's (MHP) office on 11/26/19 at 11:19am revealed: -The facility had not made them aware Resident #1 had missed any doses of Seroquel. -The MHP expected the resident's medication to be administered as ordered and to be notified if it was not administered. -The resident was last seen by the MHP at the end of last week and there were no concerns about the resident's behavior noted at that time. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. 3. Review of Resident #3's current FL-2 dated 05/217/19 revealed diagnoses included diabetes mellitus, coronary artery disease, atrial fibrillation, cardiomyopathy, Alzheimer's Disease,	D 358		

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D 358	Continued From page 82 hyperlipidemia, gastroesophageal reflux disease, and major depressive disorder. Review of Resident #3's physician's order dated 06/24/19 revealed an order for Vitamin D 50,000 units once a week for twelve weeks. (Vitamin D is a nutritional supplement used to treat a Vitamin D deficiency.) Review of Resident #3's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D 50,000 units weekly. -Vitamin D 50,000 units was documented as administered on 06/29/19. Review of Resident #3's July 2019 eMAR revealed: -There was an entry for Vitamin D 50,000 units weekly. -Vitamin D 50,000 units was documented as administered on 07/06/19, 07/13/19, 07/20/19 and 07/27/19. Review of Resident #3's August 2019 eMAR revealed: -There was an entry for Vitamin D 50,000 units weekly. -Vitamin D 50,000 units was documented as administered on 08/03/19, 08/10/19, 08/17/19, and 08/24/19. Review of Resident #3's September 2019 eMAR revealed: -There was no entry for Vitamin D 50,000 units weekly. -Vitamin D 50,000 units was not documented as administered.	D 358		

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D 358	Continued From page 83 Observation of Resident #3's medications on hand on 11/20/19 at 1:09pm revealed there was no Vitamin D 50,000 units available to be administered. Interview with Resident #3 on 11/20/19 at 1:20pm revealed: -He took medication every day; he did not know what medications he took. -He did not know if he had a Vitamin D deficiency or not. Telephone interview with a representative from the facility's contracted pharmacy on 11/20/19 at 10:48am revealed: -There were four tablets of Vitamin D 50,000 units dispensed on 06/24/19. -There were no subsequent refills for Vitamin D 50,000 units. -Vitamin D was not a cycle filled medication and therefore would have to be requested for a refill. -Vitamin D 50,000 unit was not on the September 2019 eMAR because they had the stop date as 08/24/19. -She was not sure why the pharmacy had put the stop date as 08/24/19 on the eMAR. -Twelve weeks from the start date would have been the week of 09/09/19. Telephone interview with Resident #2's Nephrologist on 11/20/19 at 11:30am revealed: -He saw Resident #3 on 06/24/19 and Resident #3's Vitamin D level was 12. (Normal range is greater than 20). -He started Resident #3 on Vitamin D once weekly for twelve weeks to improve his Vitamin D level. -He expected Vitamin D to be administered to Resident #3 for twelve weeks as ordered. -To only administer Vitamin D to Resident #3 for	D 358		

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D 358	Continued From page 84	D 358		

four weeks would be against his orders.
-He would like Resident #3 to have a therapeutic level of Vitamin D.
-Resident #3's Vitamin D was rechecked on 11/11/19 and was 23, which was still below a therapeutic level.
-He would have expected Resident #3's Vitamin D level to have improved more if Resident #3 had been administered the medication as ordered.

Interview with a medication aide (MA) on 11/22/19 at 9:42am revealed:
-She recalled Resident #3 took Vitamin D once a week; she did not recall how long Resident #3 took Vitamin D.
-She recalled the pharmacy only sent a few tablets of Vitamin D.
-She did not think about how many tablets were dispensed since Resident #3 only took Vitamin D once a week.

Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 9:54am revealed:
-She recalled Resident #3 having an order for Vitamin D once a week for twelve weeks.
-When there was one tablet of Vitamin D left in the package to be administered, she expected the MA to re-order the medication.
-She was concerned Resident #3 did not receive the medication as ordered.
-She tried to do cart audits once a week.
-She had not completed a cart audit for Resident #3.

Interview with the Administrator on 11/22/19 at 12:04pm revealed:
-She was concerned Resident #3's Vitamin D had not been administered as ordered.
-She expected medications to be administered as ordered.

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D 358	Continued From page 85 -If Resident #3's Vitamin D was not available she expected the MA to contact the pharmacy to reorder. Telephone interview with the Administrator-in-Charge on 11/25/19 at 3:02pm revealed: -She was not aware Resident #3 had been diagnosed with a Vitamin D deficiency. -She was not aware Resident #3 had not received Vitamin D as ordered. -The RCC was responsible for making sure orders were sent to the pharmacy and dispensed to the facility. -When the MA used the last tablet, she expected the MA to re-order the medication and let the RCC know the medication had been ordered so the RCC could make sure the medication was dispensed. -She was concerned if Resident #3's Nephrologist ordered Vitamin D for twelve weeks and it was not administered; it should have been followed-up on. -When Resident #3's Vitamin D ran out the MA and RCC should have followed up to see why it was not reordered. 4. Review of Resident #5's current FL2 dated 06/03/19 revealed diagnoses of chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease, diastolic congestive heart failure, hypertension, osteoarthritis of the hip, hypothyroidism, dysphagia, hyperlipidemia and radiculopathy-cervical region. Review of Resident #5's physician's order dated 07/24/19 revealed an order to increase Sertraline (a medication used to treat depression) from 50mg to 75mg for 7 days, then increase to	D 358		

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D 358	Continued From page 86 100mg for depression and anxiety. Review of Resident #5's July 2019 electronic Medication Administration record (eMAR) revealed: -There was an entry for Sertraline 75mg daily scheduled at 8:00am.. -Sertraline 75mg was documented as administered from 07/26/19 through 07/31/19. Review of Resident #5's August 2019 eMAR revealed: -There was an entry for Sertraline 75mg daily scheduled at 8:00am. -Sertraline 75mg was documented as administered on 08/01/19. -There was a second entry for Sertraline 50 mg daily scheduled at 8:00am. -Sertraline 50mg was documented as administered from 08/02/19 through 08/30/19. Review of Resident #5's September 2019 eMAR revealed: -There was an entry for Sertraline 50mg daily scheduled at 8:00am. -Sertraline 50mg was documented as administered from 9/01/19 through 9/30/19. Review of Resident #5's October 2019 eMAR revealed: -There was an entry for Sertraline 50mg daily scheduled at 8:00am. -Sertraline 50mg was documented as administered from 10/01/19 through 10/30/19. Review of Resident #5's physician's order dated 11/08/19 revealed an order to increase Sertraline from 50mg to 75mg for 7 days and then 100 mg daily.	D 358		

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D 358	Continued From page 87 Review of Resident #5's November 2019 eMAR revealed: -There was an entry for Sertraline 50mg daily scheduled at 8:00am.. -Sertraline 50 mg was documented as administered from 11/01/19 through 11/08/19. -Sertraline 50mg was discontinued on 11/08/19. -There was a second entry for Sertraline 50mg, take 1 and ½ tablet once daily for 7 days scheduled at 8:00am. -Sertraline 75mg was documented as administered from 11/09/19 through 11/15/19. -There was a third entry for Sertraline 100mg 1 daily (to start after 75mg) scheduled at 8:00am. -Sertraline 100mg was documented as administered 11/16/19 through 11/19/19. Observation of Resident #5's medications on hand on 11/21/19 at 3:20pm revealed: -Sertraline 100 mg was available to be administered. -There were 28 tablets of Sertraline 100 mg dispensed on 11/20/19. -There were 28 tablets remaining. Interview with a representative with the facility's contracted pharmacy on 11/20/19 at 3:10 pm revealed: -The pharmacy received the Sertraline order dated 07/24/19. -The pharmacy entered the increase from 50mg to 75 mg on 07/25/19. -The pharmacy did not enter the increase to 100mg after the 75mg was completed. -There was a 7 day supply of Sertraline 75mg dispensed on 07/25/19. -The Sertraline 100mg was not dispensed. -After the initial 7 days of 75mg the Sertraline order reverted back to 50mg. -The pharmacy was not certain what caused the	D 358		

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D 358	Continued From page 88	D 358		

error to occur.
-The Resident Care Coordinator (RCC) or medication aide (MA) faxed new or changed orders to the pharmacy.
-The pharmacy entered all orders into the eMAR system and the facility had to approve the orders.
-The pharmacy conducted eMAR audits quarterly.

Interview with the RCC on 11/21/19 at 2:00pm revealed:
-The RCC did not know about the Sertraline order dated 07/24/19.
-Per the policy, new orders were faxed to pharmacy by the RCC or MA.
-The pharmacy entered medications into the eMAR system.
-The contracted pharmacy conducted eMAR audits quarterly.
-Her goal was to complete eMAR audits between pharmacy visits.
-She usually did not complete the eMAR audits due to other duties and needs.
-She did not notice an increase in depression in Resident #5.

Interview with a MA on 11/21/19 at 3:30pm revealed:
-She did not remember the Sertraline order dated 07/24/19 or 11/08/19.
-She administered medications according to the eMAR.
-The RCC or MA was responsible for faxing orders to the pharmacy.
-The pharmacy entered orders into the eMAR system according to the physicians' orders.
-She had not observed an increase of depression in Resident #5.

Interview with the Administrator-in-Charge (AIC) on 11/21/19 at 11:40am revealed:

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D 358	Continued From page 89 -She did not know the Sertraline was not administered correctly from August 2019 through November 2019. -The RCC conducted monthly eMAR audits. -The pharmacy conducted quarterly eMAR audits. -The RCC or MA was responsible for faxing orders to the pharmacy. -She did not notice an increase in depression or anxiety in Resident #5. -Resident #5 was moody and her emotions were up and down. Interview with a representative from Resident #5's Specialist Provider on 11/21/19 at 11:27am revealed: -The resident was last seen on 11/18/19 and the resident was not acting herself. -The resident had increased agitation and depression. -On 11/18/19, the provider determined the 07/24/19 Sertraline order was not implemented and reordered the Sertraline increase. -The provider expected the Sertraline orders to be administered as ordered. -The provider expected to be contacted by the facility with concerns or issues. -Resident #5 was seen by the Specialist Provider monthly. _____ The facility failed to administer medications as ordered to residents observed during the medication passes resulting in a 15% medication error rate with 4 errors out of 26 opportunities. Two diabetic residents (#3, #14) were administered rapid-acting insulin from 50 minutes to 1 hour and 4 minutes prior to the lunch meal being served and consumed placing the residents at risk for hypoglycemia. Resident #1 tested positive for benzodiazepines but the resident had no orders to receive any medications in that class	D 358		

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D 358	Continued From page 90 of narcotic drugs, resulting in Resident #1 having hallucinations, screaming loudly, then lethargy and over sedation. The failure of the facility to administer medications as ordered resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/22/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 26, 2019.	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 readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 2 of 3 residents sampled (Residents #8 & #9) who were prescribed controlled substances. 1. Review of Resident #8's current FL2 dated 07/18/19 revealed:	D 392		

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D 392	Continued From page 91 -Diagnoses included hypothyroidism, anxiety disorder, major depressive disorder (MDD), recurrent moderate physiological condition, insomnia, chronic pain syndrome, anorexia, and chronic obstructive pulmonary disease (COPD). -There was a medication order for Lorazepam 0.5 mg (a controlled substance used to treat anxiety) one tablet once a day as needed for anxiety/agitation. Review of Resident #8's medication orders revealed: -There was a subsequent order dated 10/03/19 to administer Lorazepam 0.5 mg ½ tablet once a day as needed for anxiety/agitation. -There was an order dated 10/31/19 to discontinue Lorazepam 0.5 mg ½ tablet once a day as needed for anxiety/agitation. Review of Resident #8's September 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lorazepam 0.5 mg ½ tablet once a day as needed for anxiety/agitation. -There was an entry for Lorazepam 0.5 mg ½ tablet was not documented as administered on any date in September 2019. Review of Resident #8's October 2019 eMAR revealed: -There was an entry for Lorazepam 0.5 mg ½ tablet once a day as needed for anxiety/agitation. -Lorazepam 0.5 mg ½ tablet was not documented as administered on any date in October 2019. Review of the Controlled Substance Count Sheet (CSCS) for Resident #8's Lorazepam revealed there was an entry on 10/06/19 with no time documenting 2 tablets of Lorazepam 0.5 mg being administered by Staff D/medication aide	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D 392	Continued From page 92 (MA). Attempted interview on 11/22/19 at 10:46am with Staff D/MA was unsuccessful. Refer to interview with Resident Care Coordinator (RCC) on 11/20/19 at 12:00pm. Refer to interview with a medication aide (MA) on 11/22/19 at 12:00pm. Refer to a second interview with the RCC on 11/26/19 at 10:41am. 2. Review of Resident #9's current FL2 dated 01/10/19 revealed diagnoses included senile dementia, hypertension, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease, and osteomyelitis/cellulitis of left foot. a. Review of Resident #9's current FL2 dated 01/10/19 revealed there was a medication order for Lorazepam 0.5 mg (a controlled substance used to treat anxiety) one tablet every 12 hours as needed for anxiety/agitation. Review of Resident #9's physician's order dated 08/22/19 revealed administer Lorazepam 0.5 mg one tablet every 12 hours as needed for anxiety/agitation. Review of Resident #9's physician's order dated 11/08/19 revealed administer Lorazepam 0.5 mg one tablet every 12 hours as needed for anxiety/agitation. Review of Resident #9's September 2019 electronic Medication Administration Record (eMAR) revealed:	D 392		

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D 392	Continued From page 93 -There was an entry for Lorazepam 0.5 mg one tablet every 12 hours as needed for anxiety/agitation. -Lorazepam 0.5 mg was not documented as administered on any date in September 2019. Review of Resident #9's October 2019 eMAR revealed: -There was an entry for Lorazepam 0.5 mg one tablet every 12 hours as needed for anxiety/agitation. -Lorazepam 0.5 mg was documented as administered for 10/29/19 at 2:59pm. Review of Resident #9's November 2019 eMAR revealed: -There was an entry for Lorazepam 0.5 mg one tablet every 12 hours as needed for anxiety/agitation. -Lorazepam 0.5 mg was not documented as administered on any date in November 2019. Observation of Resident #9's Lorazepam 0.5 mg on hand on 11/22/19 at 3:00pm for administration revealed: -There were 60 0.5 mg tablets dispensed on 06/08/19. -Resident #9 had 50 0.5 mg tablets on hand. -The Controlled Substance Count Sheet (CSCS) concurred with amount noted on hand. Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable. Refer to interview with Resident Care Coordinator (RCC) on 11/20/19 at 12:00pm. Refer to interview with a medication aide (MA) on 11/22/19 at 12:00pm.	D 392		

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D 392	Continued From page 94 Refer to a second interview with the RCC on 11/26/19 at 10:41am. b. Review of Resident #9's current FL2 dated 01/10/19 revealed there was no medication order for Lorazepam gel (a controlled substance used to treat anxiety). Review of Resident #9's medication orders revealed there was a subsequent order dated 06/09/19 for Lorazepam gel apply 1 mg topically every 4 hours as needed for agitation or 30 minutes before patient care (bath or nurse visit). Review of Resident #9's September 2019 electronic Medication Administration Record (eMAR) revealed: -Lorazepam 1mg/ml gel was administered on 09/02/19 at 9:34am. -Lorazepam 1mg/ml gel was administered on 09/03/19 at 8:05am. -Lorazepam 1mg/ml gel was administered on 09/12/19 at 9:59am. -Lorazepam 1mg/ml gel was administered on 09/19/19 at 9:57pm. -Lorazepam 1mg/ml gel was administered on 09/26/19 at 9:40pm. Review of Resident #9's October 2019 eMAR revealed Lorazepam 1mg/ml gel was not documented as administered on any date in October 2019. Review of the Controlled Substance Count Sheet (CSCS) for the Lorazepam 1mg/ml gel revealed: -The handwritten documentation was on a sheet of lined notebook paper. -There was an entry on 10/06/19 with no time documenting one tube of the Lorazepam 1mg/ml	D 392		

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D 392	Continued From page 95 gel being administered by Staff D/medication aide (MA). Review of Resident #9's November 2019 eMAR revealed Lorazepam 1mg/ml gel was not documented as administered on any date in November 2019. Observation of Resident #9's Lorazepam 1mg/ml gel on hand on 11/22/19 at 3:00pm for administration revealed: -There were 30 syringes dispensed on 07/15/19. -Resident #9 had 15 - 1 ml syringes on hand. -The 15 syringes were stored in a zipper type bag and were bundled in a rubber band. -Each syringe contained a clear substance measured to the 1 ml mark. -The CSCS concurred with amount noted on hand. -There was not any tamper resistant packaging noted for the medication. Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable. Refer to interview with Resident Care Coordinator (RCC) on 11/20/19 at 12:00pm. Refer to interview with a medication aide (MA) on 11/22/19 at 12:00pm. Refer to a second interview with the RCC on 11/26/19 at 10:41am. _____ Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 12:00pm revealed: -All medications were kept in a locked drawer on the medication cart. -The controlled substance count sheets (CSCS)	D 392		

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D 392	Continued From page 96 were kept in a book on each medication cart. -The completed CSCS were not filed in any "particular order" in a notebook in the medication room. -The MAs did not use all the CSCS provided by the facility's contract pharmacy. Interview with a medication aide (MA) on 11/22/19 at 12:00pm revealed: -The MAs had to count the controlled substances (CS) at each shift change and compare with the CS log. -If they found any discrepancies, they had to report it to the RCC immediately. Interview with the RCC on 11/26/19 at 10:41am revealed: -The MA were responsible for doing CS counts and checking the CS logs for all narcotics each shift change. -The MAs were supposed to report any discrepancies to her. -The MAs were supposed to document administration of narcotics on the eMARs and the CS logs. -She usually checked the CS logs every other week and when the monthly cycle fill medications were received. -She compared the medications on hand with the CS logs.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all	D 399		

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D 399	Continued From page 97	D 399		

suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversion by Staff D (medication aide) of Ativan, an anti-anxiety medication in a class of drugs called benzodiazepines, which Resident #1 tested positive for but had no orders to receive any medications in that class of drugs.

The findings are:

Review of Resident #1's current FL-2 dated 10/17/19 revealed:
-Diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder - recurrent, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility.
-The resident was intermittently disoriented.

Review of Resident #1's medication aide progress notes revealed:
-On 10/07/19, the resident was acting very lethargic. The responsible party was notified and will be in on 10/16/19 to discuss hospice.
-On 10/08/19, the resident was taken to urgent care for test.

Review of an accident/injury report for Resident #1 signed and dated 10/07/19 revealed:
-The date and time of the incident was 10/06/19 at 10:15pm.
-The personal care aides (PCAs) reported to the

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D 399	Continued From page 98	D 399		

medication aide (MA) that Resident #1 was acting strange, hallucinating, and yelling.
-Staff monitored the resident all shift and reported extreme lethargy in the morning.
-The resident was taken to urgent care per verbal order to have lab work and drug screen.
-The resident's blood pressure was 138/76, pulse was 77, and respirations were 20.
-The resident tested positive for benzodiazepines, but the resident was not prescribed any benzodiazepines.

Review of a second accident/injury report for Resident #1 revealed:
-The date of incident was 10/06/19 / 10/07/19 and the time was documented as third shift and 6:00am count.
-The report was signed by the Resident Care Coordinator (RCC) and the Administrator-in-Charge (AIC) but not dated.
-The resident was drowsy, lethargic, and pale.
-The resident was very difficult to arouse and the resident seemed to be hallucinating.
-The MAs noted medications were not documented correctly and they notified the RCC.
-The RCC notified and spoke with the primary care provider (PCP) and got an order to check labs and screen resident for drugs.
-The resident's blood pressure was 138/94, pulse was 68, and respirations were 12.
-The resident was taken to an urgent care center.

Review of Resident #1's lab report dated 10/08/19 revealed:
-A drug panel screen was collected for testing on 10/08/19 at 11:41am.
-Benzodiazepine was detected in the resident's blood specimen.
-The drug screen report did not specify which specific benzodiazepine was detected.

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D 399	Continued From page 99 Review of Resident #1's September 2019 - November 2019 electronic medication administration records (eMARs) revealed: -There were no entries/orders for any medication classified as a benzodiazepine. -There was no documentation the resident had received any medication classified as a benzodiazepine. -There was documentation of the resident receiving her routine medications as ordered on 10/06/19. -There was no documentation of the resident receiving any prn (as needed) medications on 10/06/19. Review of an electronic prn (as needed) administration report dated 10/06/19 - 10/08/19 revealed: -No prn (as needed) medications were documented as administered to Resident #1 during that time period. -There was no Ativan documented as administered to any resident during that time period. Review of another resident's controlled substance log for Ativan 0.5mg revealed: -Staff D (medication aide) documented 2 Ativan 0.5mg tablets were administered on 10/06/19 but there was no time documented. -Staff D noted the amount remaining was 28 tablets. -Prior to 10/06/19, Ativan was not documented as administered to the resident since 08/13/19 at 8:44am. Interview with a MA on 11/22/19 at 12:54pm revealed: -She came into work at the facility on third shift on	D 399		

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D 399	Continued From page 100 10/06/19. -Two PCAs called her to Resident #1's room. -Resident #1 was in bed screaming out very loud. -The resident would lay back and sit back up then turn crossways in the bed. -The resident would keep screaming and sitting up and down. -One of the PCAs told the MA she thought the MA on the previous shift (Staff D) gave Resident #1 some medication. -Staff D had already left the facility when she came into work around 10:00pm. -Staff D reported before she left that Resident #1 was agitated because Resident #1 was arguing with another resident. -She checked to see if Resident #1 had any orders for a prn (as needed) medication to help with the agitation but the resident did not. Interview with a PCA on 11/22/19 at 4:30pm revealed: -Resident #1 had dementia and would sometimes act out. -One weekend last month (October 2019 - could not recall date or time), she was working on third shift when Resident #1 was screaming loud. -Staff D told Resident #1, "I've got something for you". -Staff D pushed Resident #1 in her wheelchair to the living room. -About 15 minutes later, she saw Staff D administer medication to the resident from a pill cup. -She could not see how many pills were in the cup. -She did not observe Staff D administer any topical medications to the resident. -About 10 minutes after the resident took the medication, the resident went to sleep in the living room.	D 399		

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D 399	Continued From page 101 Interview with a second PCA on 11/22/19 at 4:43pm revealed: -She was working last month (October 2019 - does not recall date or time) on third shift. -Resident #1 was agitated and having a verbal altercation with another resident, yelling across the hall. -Staff D yelled at Resident #1 and told Resident #1 that she was going to give Resident #1 some medication because Staff D was not going to deal with Resident #1 today. -She and another PCA helped Resident #1 get dressed, transferred her to the wheelchair, and Resident #1 followed the PCAs to the living room. -After the resident got to the living room, the PCA witnessed Staff D at the medication cart in the hallway near the living room. -Staff D gave Resident #1 medication from a pill cup but the PCA could not see what was in the cup. -About 5 to 10 minutes later, Resident #1 was asleep in the living room. Attempted telephone interview with Staff D on 11/22/19 at 10:46am was unsuccessful. Review of a signed statement by Staff D (not dated) revealed: -When Staff D came in on the weekends, Resident #1 would be screaming and yelling and telling someone to get out of here. -Staff D ignored it because that was Resident #1's "norm". -Resident #1 did it every time she was in her room. -Staff D tried to keep Resident #1 out of her room as much as possible because other resident's complained about Resident #1 "going crazy". -Staff D tried to keep Resident #1 in the main	D 399		

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D 399	Continued From page 102	D 399		

sitting room because the resident did not do all of the yelling and screaming when she was in the sitting room.
-She never put her hands on any of the residents or gave them someone else's medication.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Review of a Health Care Personnel Registry (HCPR) 5-day investigation report for Staff D dated 10/09/19 revealed:
-The allegations included diversion of resident drugs.
-The incident date was documented as 10/06/19 - 10/08/19.
-The date the facility became aware of the incident was 10/08/19 but the time was not documented.
-The allegation details documented Resident #1 was not her normal self on Monday (10/07/19).
-Resident #1 appeared to be sleepy, sluggish, and very pale.
-The resident was hallucinating and very sluggish and sleepy.
-The resident "couldn't even hold a spoon or fork to her mouth".
-On Tuesday (10/08/19), the resident was sent out of the facility to have blood work done.
-Other residents' medications were missing but were not documented as given on the medication administration record (MAR).
-Benzodiazepines were detected in the resident's blood work but the resident had no orders to receive any benzodiazepine medications.
-Staff D was terminated related to the allegations on 10/11/19.

Review of Resident #1's facility staff progress

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D 399	Continued From page 103 notes and incident/accident reports revealed no documentation the pharmacy was notified of the suspected drug diversion. Telephone interview with the AIC on 11/25/19 at 3:10pm revealed: -The RCC was responsible for reporting drug diversion to the pharmacy. -She did not know if the RCC had reported Ativan was diverted from other residents and administered to Resident #1 who did not have an order for Ativan. Interviews with the RCC on 11/26/19 at 10:41am revealed: -She notified the AIC of the incident with Resident #1 on either 10/07/19 or 10/08/19. -She was responsible for reporting any drug diversion to the pharmacy. -She did not recall notifying the pharmacy of the Ativan being diverted from other residents and administered to Resident #1. -She would have documented it if she had reported it to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/26/19 at 10:22am revealed: -The facility had not reported any drug diversion to the pharmacy. -She was not aware of any diversion with Ativan or any other controlled substances at the facility.	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 438	Continued From page 104 supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to report allegations of abuse, neglect and drug diversion to the North Carolina Health Care Personnel Registry (HCPR) within the required timeframes for 2 of 2 staff (D, E) sampled.

The findings are:

1. Review of Resident #1's current FL-2 dated 10/17/19 revealed:
-Diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder - recurrent, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility.
-The resident was intermittently disoriented and non-ambulatory.

Review of an accident/injury report for Resident #1 signed and dated 10/07/19 revealed:
-The date and time of the incident was 10/06/19 at 10:15pm.
-The personal care aides (PCAs) reported to the medication aide (MA) that Resident #1 was acting strange, hallucinating, and yelling.
-Staff monitored the resident all shift and reported extreme lethargy in the morning.
-The resident was taken to urgent care per verbal order to have lab work and drug screen.
-The resident's blood pressure was 138/76, pulse was 77, and respirations were 20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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 438	Continued From page 105 -The resident tested positive for benzodiazepines, but the resident was not prescribed any benzodiazepines. Review of a second accident/injury report for Resident #1 revealed: -The date of incident was 10/06/19 / 10/07/19 and the time was documented as third shift and 6:00am count. -The report was signed by the Resident Care Coordinator (RCC) and the Administrator-in-Charge (AIC) but not dated. -The resident was drowsy, lethargic, and pale. -The resident was very difficult to arouse and the resident seemed to be hallucinating. -The MAs noted medications were not documented correctly and they notified the RCC. -The RCC notified and spoke with the primary care provider (PCP) and got an order to check labs and screen resident for drugs. -The resident's blood pressure was 138/94, pulse was 68, and respirations were 12. -The resident was taken to an urgent care center. Review of Resident #1's lab report dated 10/08/19 revealed: -A drug panel screen was collected for testing on 10/08/19 at 11:41am. -Benzodiazepine was detected in the resident's blood specimen. -The drug screen report did not specify which specific benzodiazepine was detected. Interview with a PCA on 11/22/19 at 4:30pm revealed: -Resident #1 had dementia and would sometimes act out. -One weekend last month (October 2019 - could not recall date or time), she was working on third shift when Resident #1 was screaming loud.	D 438		

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D 438	Continued From page 106 -Resident #1 was standing up in her room beside the bed. -She witnessed Staff D (medication aide) push Resident #1 with one hand on the shoulder. -Resident #1 fell onto the bed in a sitting position. -Staff D told Resident #1, "I've got something for you". -Staff D pushed Resident #1 in her wheelchair to the living room. -About 15 minutes later, she saw Staff D administer medication to Resident #1 from a pill cup. -She could not see how many pills were in the cup. -She did not observe Staff D administer any topical medications to the resident. -About 10 minutes after the resident took the medication, the resident went to sleep in the living room. Interview with a second PCA on 11/22/19 at 4:43pm revealed: -She was working last month (October 2019 - does not recall date or time) on third shift. -Resident #1 was agitated and having a verbal altercation with another resident, yelling across the hall. -Staff D went down the hallway into Resident #1's bedroom. -Resident #1 was sitting on the bed. -She witnessed Staff D grab Resident #1's right arm and pinch it. -Resident #1 told Staff D to "get off me', and asked Staff D, "why are you grabbing me?". -Staff D yelled at Resident #1 and told Resident #1 that she was going to give Resident #1 some medication because Staff D was not going to deal with Resident #1 today. -She and another PCA helped Resident #1 get dressed, transferred her to the wheelchair, and	D 438		

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D 438	Continued From page 107 Resident #1 followed the PCAs to the living room. -After Resident #1 got to the living room, the PCA witnessed Staff D at the medication cart in the hallway near the living room. -Staff D gave Resident #1 medication from a pill cup but the PCA could not see what was in the cup. -About 5 to 10 minutes later, Resident #1 was asleep in the living room. -The PCA told Staff D she was going to put Resident #1 back in bed but Staff D told the PCA to leave Resident #1 in the living room. -The other PCA who witnessed it, reported it to the third shift MA. -She did not know if it was reported to anyone else. Interview with a MA on 11/22/19 at 12:54pm revealed: -She came into work at the facility on third shift on 10/06/19. -Two PCAs called her to Resident #1's room. -Resident #1 was in bed screaming out very loud. -The resident would lay back and sit back up then turn crossways in the bed. -The resident would keep screaming and sitting up and down. -One of the PCAs told the MA she thought the MA on the previous shift (Staff D) gave Resident #1 some medication. -Staff D had already left the facility when she came into work around 10:00pm. -Staff D reported before she left that Resident #1 was agitated because Resident #1 was arguing with another resident. -She checked to see if Resident #1 had any orders for a prn (as needed) medication to help with the agitation but the resident did not. -She checked the resident's blood pressure and it was normal.	D 438		

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D 438	Continued From page 108 -The resident stopped screaming around 5:00am and went to sleep. -The resident was "knocked out" and she thought it was because the resident was tired. -She reported Resident #1 had been screaming to the next shift that came in at 6:00am. -She reported the resident's behavior to the AIC the next morning (10/07/19) also. -She documented it on an incident report. Attempted telephone interview with Staff D on 11/22/19 at 10:46am was unsuccessful. Review of a signed statement by Staff D (not dated) revealed: -When Staff D came in on the weekends, Resident #1 would be screaming and yelling and telling someone to get out of here. -Staff D ignored it because that was Resident #1's "norm". -Resident #1 did it every time she was in her room. -Staff D tried to keep Resident #1 out of her room as much as possible because other resident's complained about Resident #1 "going crazy". -Staff D tried to keep Resident #1 in the main sitting room because the resident did not do all of the yelling and screaming when she was in the sitting room. -She never put her hands on any of the residents or gave them someone else's medication. Interview with the RCC on 11/22/19 at 11:42am revealed: -When she came to work on Monday, 10/07/19, Resident #1 was in the living room with her eyes closed, head back, and mouth open. -Third shift staff reported the resident had been more disoriented than normal, hallucinating, and was pale and clammy.	D 438		

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D 438	Continued From page 109 -She thought those symptoms were reported verbally to have started around 10:00pm, when third shift started on 10/06/19. -Third shift staff should have called the resident's PCP because they had a 24-hour triage line. -Third shift staff did not call to report the resident's change in behavior to her knowledge. -She was told by a MA look at the documentation on the controlled substance (CS) logs for another resident's oral Ativan and another resident's Ativan gel. -Neither of those two residents had needed or had been taking their Ativan but Staff D had documented administering Ativan to both residents on the CS log over the weekend but not on the eMARs. -One of the residents was competent and denied requesting or receiving any Ativan on 10/06/19. -Staff D had worked as the MA on first and second shifts on 10/06/19. -She and the AIC were suspicious because of the CS logs and Resident #1's change in condition that Resident #1 may have been administered Ativan that belonged to the other residents. -She notified Resident #1's PCP and got a verbal order to get a drug screen on the resident. -Resident #1 tested positive for benzodiazepines on 10/07/19 or 10/08/19 (could not recall date). -It was also reported by staff (could not recall who) that Staff D shoved or pushed Resident #1. -The AIC called the police and did a 24-hour report for the Heath Care Personnel Registry (HCPR). Interview with the RCC on 11/26/19 at 10:41am revealed: -She notified the AIC of the incident with Resident #1 on either 10/07/19 or 10/08/19. -The AIC did the HCPR report and would have faxed it to the HCPR so the RCC did not know	D 438		

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D 438	Continued From page 110 when the report was sent. Review of a HCPR 24-hour initial report for Staff D dated 10/11/19 revealed: -The allegations were resident abuse, resident neglect, and diversion of resident drugs. -There was reasonable suspicion of a crime and the accused individual was Staff D. -The resident involved was Resident #1 and there was no serious bodily injury. -The incident dated was documented as 10/06/19 with no time documented except the "p.m." box was checked. -The report was signed and dated on 10/11/19 by the AIC. -The fax cover sheet was dated 10/11/19. Review of a HCPR 5-day investigation report for Staff D dated 10/09/19 revealed: -The allegations were resident abuse and diversion of resident drugs. -The incident date was documented as 10/06/19 - 10/08/19. -The date the facility became aware of the incident was 10/08/19 but the time was not documented. -The allegation details documented Resident #1 was not her normal self on Monday (10/07/19). -Resident #1 appeared to be sleepy, sluggish, and very pale. -The resident "couldn't even hold a spoon or fork to her mouth". -On Tuesday (10/08/19), the resident was sent out of the facility to have blood work done. -Other residents' medications were missing but were not documented as given on the electronic medication administration records (eMARs). -Benzodiazepines were detected in the resident's blood work but Resident #1 had no orders to receive any benzodiazepine medications.	D 438		

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D 438	Continued From page 111 -In addition, staff stated to their supervisor that they also witnessed Resident #1 being pushed down by Staff D. -It was documented no physical injury/harm resulted from the incident but there was mental anguish for the resident. -The resident was hallucinating and very sluggish and sleepy. -It was documented the resident was confused and had dementia. -The investigative actions section noted there was reasonable suspicion of a crime and it was reported to the state, county, and law enforcement. -Staff D was terminated related to the allegations on 10/11/19. -The AIC signed and dated the report on 10/09/19. -The fax confirmation page for the investigation report was dated 10/11/19 at 4:12pm. Telephone interview with the AIC on 11/25/19 at 3:10pm revealed: -When she came into the facility on Monday, 10/07/19, Resident #1 was sitting in the front living room. -The resident was sitting in a chair, leaning to the side, very drowsy, and sleepy. -The resident was usually alert and responsive but the resident was sluggish and sleepy. -This was not like the resident's "normal self" as the resident was usually alert. -One staff told the AIC that the resident had stayed up late on third shift. -A second staff said the resident had been "kind of sleepy". -A third staff said she had to feed the resident because the resident was so tired. -Later that day, the resident still appeared sleepy. -A fourth staff who came in on second shift on	D 438		

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D 438	Continued From page 112 10/07/19 reported the resident had been hallucinating on third shift on 10/06/19. -The next morning (10/08/19), the resident was back to her "normal self". -This made the AIC think that something else was wrong and the resident may have gotten the wrong medication. -The RCC checked the CS logs and it appeared some Ativan that belonged to other residents were documented on the CS logs but not documented as administered on the eMARs. -She spoke with the RCC and the RCC contacted the PCP on Tuesday, 10/08/19. -The PCP said to send Resident #1 out and to get a drug screen. -The resident was sent out for blood work to an urgent care center on 10/08/19. -They got the results back a day or two later and started an investigation. -Staff who worked with Staff D on 10/06/19 reported Staff D was verbally abusive to the resident and at least 1 staff person reported witnessing Staff D push Resident #1 with two fingers. -A second staff person also reported she witnessed Staff D verbally and physically abuse Resident #1. -The physical and verbal abuse by Staff D was reported to the AIC on either 10/07/19 or 10/08/19. -She interviewed Staff D who denied abusing Resident #1 or administering any medication to Resident #1. -She thought she completed the 24-hour report to the HCPR and faxed it on the same day, 10/08/19, but she was not sure. -She could not explain why the 24-hour report was not sent to the HCPR until 10/11/19, 3 to 4 days after she was aware of the incidents with Resident #1.	D 438		

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D 438	Continued From page 113 -She thought she sent the 5-day working report to the HCPR on 10/13/19. -The HCPR called and said they did not receive the 5-day working report so she refaxed it (could not recall date). -She was responsible for completing and sending HCPR reports. Interview with the Administrator on 11/22/19 at 3:30pm revealed: -On Tuesday, 10/08/19, the AIC called the Administrator and reported Resident #1 was sleeping a lot on 10/06/19. -The AIC had the resident's vital signs checked and they were normal. -Some issues with the CS logs for two residents with orders for Ativan triggered the AIC and RCC to question whether the Ativan was administered to Resident #1 instead. -One of the residents reported she did not ask for or receive any Ativan on 10/06/19. -The other resident was confused but did not usually need Ativan gel. -Staff D was questioned about the Ativan but denied giving any medication to Resident #1 on 10/06/19. -She recalled staff reported witnessing Staff D punch Resident #1 during the incident on 10/06/19 but she could not recall who reported it. -The AIC did an investigation and reported it to the HCPR but she did not know when it was reported. -She did not participate in the investigation. -The AIC had the paperwork in a folder and she did not know where the folder was located. -She had not followed up to see when it was reported to the HCPR. Telephone interview with a representative for the HCPR on 11/22/19 at 1:06pm revealed:	D 438		

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D 438	Continued From page 114 -The 24-hour report for the incident that occurred on 10/06/19 (Staff D) was not received by the HCPR until 10/11/19. -The 5-day report was not received by the HCPR until 10/23/19. Refer to interview with the Administrator on 11/22/19 at 11:48am. 2. Review of Resident #11's current FL2 dated 12/21/18 revealed diagnosis of seizure disorder, major depressive disorder, obesity, and hyperlipidemia. Review of Resident #11's incident report dated 11/12/19 revealed the incident report was received on 11/15/19. Review of the police report dated 11/13/19 revealed: -The Franklin County Sheriffs were called to the facility to investigate an employee selling narcotics to a resident. -The staff member and resident admitted to the incident. -The staff member was arrested for possession with intent to sell and deliver a schedule IV drug. Interview with Resident #11 on 11/20/19 at 2:10pm revealed: -He was on the smoking porch and saw Staff E taking medication. -He asked staff E what the medication was for and staff E said anxiety. -He told Staff E that he wanted some of the medication and staff E said she would bring some. -The next day Staff E gave him 5 pills and he gave her $10. -He reported that he took 2 pills immediately and	D 438		

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D 438	Continued From page 115	D 438		

then 2 more later.
-He reported he knew this was wrong and would not do it again.
-He reported the medication caused him to be drowsy.

Telephone interview with a representative from the Health Care Personnel Registry (HCPR) on 11/21/19 at 9:30 am revealed the agency received the 24 hour report for the 11/12/19 incident on 11/15/19 and also received a 5 day report.

Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 11:45am revealed:
-She did not know about the incident on 11/12/19 involving Staff E and Resident #11, until after the incident.
-The Administrator in charge was responsible for investigating the incident.

Interview with Administrator in charge on 11/21/19 at 4:10pm revealed:
-She was told about the incident by another staff member on 11/12/19 who overheard the conversation between Staff E and Resident #11.
-When she learned of the incident on 11/12/19, the Resident #11 was asleep and Staff E was not in the building.
-She waited until the next day to discuss the incident with Staff E and Resident #11.
-On 11/13/19 she discussed the incident with Staff E, who admitted to bringing medication from home to a resident because he had anxiety.
-Staff E reported that she brought 5 klonopin tablets to Resident #11.
-Staff E could not tell her the prescribing physician, what pharmacy filled the medication or show the bottle of medication.
-She interviewed Resident #11, who was

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D 438	Continued From page 116 observed to be in a deep sleep prior to interview. -Resident #11 reported initially that he did not take the klonopin, then admitted to taking 4 of the tablets. -She had Resident #11 taken to urgent care for blood work. -Resident #11 did not display any new behaviors. -She reported the incident to HCPR on 11/12/19. -She was not able to complete it within the 24 hour time frame. Attempted interview with Staff E on 11/21/19 was unsuccessful. Interview with a representative for the HCPR on 11/25/19 at 2:57pm revealed: -The 24-hour report for the incident that occurred on 11/12/19 was received by the HCPR on 11/14/19. -The 5-day report was due on 11/21/19 but at the time of the interview, it was not received. Refer to interview with the Administrator on 11/22/19 at 11:48am. _____ Interview with the Administrator on 11/22/19 at 11:48am revealed: -The Administrator-in-Charge (AIC) was responsible for completing the 24 hour and 5-day reports to the Health Care Personnel Registry (HCPR) for any reportable offenses. -The AIC completed the reports and sent them to the HCPR. -The Administrator was unable to locate the facility's copies of the HCPR report. -She contacted the AIC, who was not in the building at that time, and was still not able to locate the reports.	D 438		

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D912	Continued From page 117	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, medication administration, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 6 residents (#1, #5) sampled related to a change in condition ranging from hallucinations to over sedation and to obtain a urine specimen for a urinalysis ordered for Resident #1 who had a history of recurrent urinary tract infections; and a physician's order for a dermatology appointment for a lesion on the breast (#5). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with	D912		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

(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
D912	Continued From page 118 the facility's policies for 4 of 8 residents (#3, #5, #13, #14,) observed during the medication passes including errors with insulin (#3, #14), an inhaler (#5), and a stool softener (#13); and for 3 of 6 residents sampled (#1, #3, #5) for record review including errors with an antipsychotic (#1), a Vitamin D supplement (#3), and an antidepressant (#5). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for other requirements, health care, residents' rights, medication administration, controlled substances, nutrition and food service, health care personnel registry, and activities, all of which are the responsibility of the Administrator. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility neglected to protect residents's rights to be free from verbal and physical abuse, exploitation, and use of chemical restraints.	D914		

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D914	Continued From page 119 The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure residents were free of abuse as evidenced by allegations of Staff D verbally and physically abusing Resident #1 and Staff E exploiting Resident #11 by selling a narcotic medication for anxiety to the resident. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 2. Based on record reviews and interviews, the facility failed to assure Resident #1 was free of chemical restraints as related to the resident testing positive for a narcotic medication she had not been ordered to receive after the resident had an episode of agitation. [Refer to Tag D915, G.S. 131D-21(5) Declaration of Residents' Rights (Type A2 Violation)].	D914		
D915	G.S. 131D-21(5) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to assure Resident #1 was free of chemical restraints as related to the resident testing positive for a narcotic medication she had not been ordered to receive after the resident had an episode of agitation.	D915		

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SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N	361 LEONARD ROAD LOUISBURG, NC 27549

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D915	Continued From page 120 The findings are: Review of Resident #1's current FL-2 dated 10/17/19 revealed: -Diagnoses included dementia, type 2 diabetes mellitus, major depressive disorder - recurrent, Vitamin D deficiency, glaucoma, allergic rhinitis, neurosyphilis, and abnormalities of gait and mobility. -The resident was intermittently disoriented and non-ambulatory. Review of Resident #1's current assessment and care plan dated 08/21/19 revealed the resident was sometimes disoriented, forgetful and needed reminders. Review of Resident #1's progress notes revealed: -On 10/07/19, the resident was acting very lethargic. -On 10/08/19, the resident was taken to urgent care for test (the kind of test was not specified). Review of an accident/injury report for Resident #1 signed and dated 10/07/19 revealed: -The date and time of the incident was 10/06/19 at 10:15pm. -The personal care aides (PCAs) reported to the medication aide (MA) that Resident #1 was acting strange, hallucinating, and yelling. -Staff monitored the resident all shift and reported extreme lethargy in the morning. -The resident was taken to urgent care per verbal order to have lab work and drug screen. -The resident tested positive for benzodiazepines, but the resident was not prescribed any benzodiazepines. Review of a second accident/injury report for Resident #1 revealed:	D915		

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D915	Continued From page 121 -The date of incident was "10/06/19 / 10/07/19" and the time was documented as third shift and 6:00am count. -The resident was drowsy, lethargic, and pale. -The resident was very difficult to arouse and the resident seemed to be hallucinating. -The medication aides (MAs) noted medications were not documented correctly and they notified the RCC. -The RCC notified and spoke with the primary care provider (PCP) and got an order to check labs and screen resident for drugs. -The resident was taken to an urgent care center. Review of Resident #1's lab report dated 10/08/19 revealed: -A drug panel screen was collected for testing on 10/08/19 at 11:41am. -Benzodiazepine was detected in the resident's blood specimen. -The drug screen report did not specify which specific benzodiazepine was detected. Review of Resident #1's September 2019 - November 2019 electronic medication administration records (eMARs) revealed: -There were no entries or orders for any medication classified as a benzodiazepine. -There was no documentation the resident had received any medication classified as a benzodiazepine. -There was documentation of the resident receiving her routine medications as ordered on 10/06/19. -There was no documentation of the resident receiving any prn (as needed) medications on 10/06/19. Interview with a MA on 11/22/19 at 12:54pm revealed:	D915		

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D915	Continued From page 122 -She came into work at the facility on third shift on 10/06/19. -Two PCAs called her to Resident #1's room. -Resident #1 was in bed screaming out very loud. -The resident would lay back and sit back up then turn crossways in the bed. -The resident would keep screaming and sitting up and down. -One of the PCAs told the MA she thought the MA on the previous shift gave Resident #1 some medication. -The MA on the previous shift had already left the facility when she came into work around 10:00pm. -The MA on the previous shift reported before she left that Resident #1 was agitated because Resident #1 was arguing with another resident. -She checked to see if Resident #1 had any orders for a prn (as needed) medication to help with the agitation but the resident did not. -She checked the resident's blood pressure and it was normal. -The resident stopped screaming around 5:00am and went to sleep. -The resident was "knocked out" and she thought it was because the resident was tired. -She reported the resident had been screaming to the next shift that came in at 6:00am. Interview with a PCA on 11/22/19 at 4:30pm revealed: -Resident #1 had dementia and would sometimes be "kinda rowdy". -One weekend last month (October 2019 - could not recall date or time), she was working on third shift when Resident #1 was screaming loud. -The MA told Resident #1, "I've got something for you". -The MA pushed Resident #1 in her wheelchair to the living room.	D915		

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D915	Continued From page 123 -About 15 minutes later, she saw the MA administer medication to the resident from a pill cup. -She could not see how many pills were in the cup. -She did not observe the MA administer any topical medications to the resident. -About 10 minutes after the resident took the medication, the resident went to sleep in the living room. Interview with a second PCA on 11/22/19 at 4:43pm revealed: -She was working last month (October 2019 - did not recall date or time) on third shift. -Resident #1 was agitated and having a verbal altercation with another resident, yelling across the hall. -The MA yelled at Resident #1 and told the resident that she was going to give the resident some medication because the MA was not going to deal with Resident #1 today. -She and another PCA helped Resident #1 get dressed, transferred her to the wheelchair, and the resident followed the PCAs to the living room. -After the resident got to the living room, the PCA witnessed the MA at the medication cart in the hallway near the living room. -The MA gave Resident #1 medication from a pill cup but the PCA could not see what was in the cup. -About 5 to 10 minutes later, Resident #1 was asleep in the living room. Attempted telephone interview with the MA on 11/22/19 at 10:46am was unsuccessful. Review of a signed statement by the MA (not dated) revealed: -When the MA came in on the weekends,	D915		

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D915	Continued From page 124 Resident #1 would be screaming and yelling and telling someone to get out of here. -The MA ignored it because that was Resident #1's "norm". -Resident #1 did it every time she was in her room. -The MA tried to keep Resident #1 out of her room as much as possible because other residents complained about Resident #1 "going crazy". -The MA tried to keep Resident #1 in the main sitting room because the resident did not do all of the yelling and screaming when she was in the sitting room. -She never put her hands on any of the residents or gave them someone else's medication. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Interview with the RCC on 11/22/19 at 11:42am revealed: -When she came to work on Monday, 10/07/19, Resident #1 was in the living room with her eyes closed, head back, and mouth open. -Third shift staff reported the resident had been more disoriented than normal, hallucinating, was pale and clammy. -A MA on duty told her to look at the documentation on the CS logs for another resident's oral Ativan and a third resident's Ativan gel. -Neither of those residents had needed or had been taking their Ativan but a MA had documented administering Ativan to both residents on the CS log over the weekend but not on the eMARs. -One of the residents was competent and denied requesting or receiving any Ativan on 10/06/19.	D915		

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D915	Continued From page 125 -The MA who documented the Ativan on the CS logs had worked as the MA on first and second shifts on 10/06/19. -She and the AIC were suspicious because of the CS logs and Resident #1's change in condition that Resident #1 may have been administered Ativan that belonged to the other residents. -She notified Resident #1's PCP and got a verbal order to get a drug screen on the resident. -The resident tested positive for benzodiazepines on 10/07/19 or 10/08/19 (could not recall date). -The AIC talked to the MA but the MA denied administering Ativan to Resident #1. Telephone interview with the AIC on 11/25/19 at 3:10pm revealed: -When she came into the facility on Monday, 10/07/19, Resident #1 was sitting in the front living room. -The resident was sitting in a chair, leaning to the side, very drowsy, and sleepy. -The resident was usually alert and responsive but the resident was sluggish and sleepy. -This was not like the resident's "normal self" as the resident was usually alert. -One staff told the AIC that the resident had stayed up late on third shift. -A second staff said the resident had been "kind of sleepy". -A third staff said she had to feed the resident because the resident was so tired. -The resident's vital signs were taken and they were normal. -Later that day, the resident still appeared sleepy. -A fourth staff who came in on second shift on 10/07/19 reported the resident had been hallucinating on third shift on 10/06/19. -The next morning (10/08/19), the resident was back to her "normal self". -This made the AIC think that something else was	D915		

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D915	Continued From page 126	D915		

wrong and the resident may have gotten the wrong medication.
-The RCC checked the controlled substance (CS) logs and it appeared some Ativan that belonged to other residents were documented on the CS log but not documented as administered on the eMARs.
-She spoke with the RCC and the RCC contacted the PCP on Tuesday, 10/08/19.
-The PCP said to send the resident out and to get a drug screen.
-The resident was sent out for blood work to an urgent care center on 10/08/19.
-They got the results back a day or two later and started an investigation.
-She interviewed the MA who denied administering any medication to Resident #1.
-The MA was terminated on 10/11/19.

Interview with the Administrator on 11/22/19 at 3:30pm revealed:
-On Tuesday, 10/08/19, the AIC called the Administrator and reported Resident #1 was sleeping a lot on 10/06/19.
-The AIC had the resident's vital signs checked and they were normal.
-Some issues with the CS logs for two residents with orders for Ativan triggered the AIC and RCC to question whether the Ativan was administered to Resident #1 instead.
-One of the residents reported she did not ask for or receive any Ativan on 10/06/19.
-The other resident was confused but did not usually need Ativan gel.
-The MA was questioned about the Ativan but denied giving any medication to Resident #1 on 10/06/19.

Review of a Health Care Personnel Registry (HCPR) 5-day investigation report for the MA

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D915	Continued From page 127 dated 10/09/19 revealed: -The allegations were resident abuse and diversion of resident drugs. -The incident date was documented as 10/06/19 - 10/08/19. -The date the facility became aware of the incident was 10/08/19 but the time was not documented. -The allegation details documented Resident #1 was not her normal self on Monday (10/07/19). -Resident #1 appeared to be sleepy, sluggish, and very pale. -The resident was hallucinating and very sluggish and sleepy. -The resident "couldn't even hold a spoon or fork to her mouth". -On Tuesday (10/08/19), the resident was sent out of the facility to have blood work done. -Other resident's medications were missing but were not documented as given on the eMAR. -Benzodiazepines were detected in the resident's blood work but the resident had no orders to receive any benzodiazepine medications. -The MA was terminated related to the allegations on 10/11/19. Telephone interview with a medical assistant at Resident #1's mental health provider's (MHP) office on 11/26/19 at 11:19am revealed: -The facility notified them after the incident when the resident tested positive for benzodiazepines at an urgent care center (could not recall date). -The facility reported the resident was found sitting in her wheelchair "pretty sedated" and difficult to wake up. -The facility probably should have sent the resident to the emergency room when she experienced a change in condition on 10/06/19. -The resident was last seen by the MHP at the end of last week and there were no concerns of	D915		

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D915	Continued From page 128 any lasting effects noted at that time. -The resident was currently prescribed Ativan (within the last few days) but was not prescribed Ativan or any other benzodiazepine medications at the time of the incident or when she tested positive. Telephone interview with Resident #1's PCP on 11/26/19 at 1:29pm revealed: -Resident #1 was a "firecracker", usually alert with moments of emotional distress. -Resident #1 was not usually sedated or lethargic. -She was not told of Resident #1's change in condition on 10/06/19 until a few days after the occurrence. -When the RCC notified her on 10/08/19, the RCC was asking for drug testing but she told the RCC the resident needed a medical evaluation. -The resident did not have orders to take Ativan or any other benzodiazepines at that time and should not have tested positive. -This was "unacceptable"; the resident should not have received any Ativan. -She was unsure how much Ativan the resident was administered. -She had seen the resident for multiple visits since the incident on 10/06/19 and there had been no after effects to receiving the Ativan to her knowledge. _____ The facility failed to assure Resident #1 was free of being chemically restrained without a physician's order. Resident #1 tested positive for benzodiazepines (i.e. Ativan) but the resident had no orders to receive any medications in that class of narcotic drugs. Resident #1 exhibited a range of symptoms around the time she tested positive including hallucinations, screaming loudly, then lethargy and over sedation. Two staff witnessed Resident #1 being administered medication by a	D915		

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D915	Continued From page 129 medication aide who verbally threatened the resident after the resident exhibited symptoms of agitation. The failure of the facility to protect the resident's right to be free of chemical restraints resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/26/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 26, 2019.	D915		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for other requirements, health care, residents' rights, medication administration, controlled substances, nutrition and food service, health care personnel registry, and activities, all of which are the responsibility of the	D980		

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D980	Continued From page 130 Administrator. The findings are: Confidential interview with a resident revealed: -The Administrator and AIC were rarely in the facility. -The staff did not do anything but sit in the breakroom on their phones when the Administrators were not in the facility. Confidential interview with a family member revealed: -The family member visited the facility at least once a week at various times. -The family member usually was at the facility for 1-2 hours during each visit and did not see an Administrator or Administrator-in-Charge (AIC). -The family member had asked to speak to someone in administration and was told the Administrator was not at the facility. -The family member was concerned about some of the things they had observed when they were in the facility including residents ringing their call bells for assistance with no response from staff, and staff not seen for long lengths of time. Confidential telephone interview with two seperate family members revealed: -The family member visited the facility weekly and had not ever seen the Administrator. -The family member visited the facility on different days and at different times. -The family member had called the facility and asked to speak to the Administrator and had not received a return call. -The family member had asked to see the Administrator or the Resident Care Coordinator (RCC) on a visit at the end of October 2019 or early part of November 2019 and was told the	D980		

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	HAL035031	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D980	Continued From page 131	D980		

Administrator nor the RCC were in the facility.
-The family member was concerned about the administration not providing supervision because they had observed residents asking for assistance with no response, and they had assisted residents with personal care because there was no staff anywhere within sight.
-The family member had on multiple times looked for staff and would always find them on the back hall, never on the front halls.
-The family member had never "laid eyes" on the Administrator.
-The family member recently was on hold for 27 minutes to talk to the Administrator and hung up because no one ever picked the call back-up.

Interview with the Administrator on 11/20/19 at 11:58am revealed:
-There was a two-week period when the Administrator-in-Charge (AIC) was not in the facility; she knew the two-week period was recent but could not give dates.
-There was a day she, the AIC and the RCC were all out of the facility at the same time.
-There was always someone in charge of the facility when the Administrator, or the AIC could not be in the facility.
-A medication aide (MA) would be designated for supervising the facility when the Administrator, the RCC or the AIC could not be in the facility.
-She lived about two and a half hours away from the facility; she could be reached by telephone and all staff had her telephone number.
-The facility was never left without someone designated as the supervisor.

Interview with the AIC on 11/20/19 at 11:58am revealed:
-She was out of the facility for a few days, but could not give dates of the absences.

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D980	Continued From page 132 - "There was no rule stating the Administrator had to be in the facility every day." -The RCC or a MA were assigned as the supervisor when she was absent. -The MA assigned to the medication cart on the staff schedule was the MA designated as the supervisor. -She lived between a half an hour to an hour away from the facility and the facility staff could reach her by telephone when she was needed. Interview with a resident on 11/19/19 at 10:18am revealed the Administrator came to the facility about twice a month. Telephone interview with the Administrator-in-Charge (AIC) on 11/25/19 at 3:10pm revealed: -She recently conducted an investigation and documented a 24-hour report and 5 day working report for the Health Care Personnel Registry (HCPR). -The investigation was related to a resident being physically abused and being intentionally administered a medication that did not belong to the resident with behavior issues causing side effects for the resident. -She had never had this situation before and she was not sure how to investigate and report it. -No one helped her do any of the "footwork", including the Administrator. -She called the Administrator and the Administrator gave her advice and the steps to take for the procedure of reporting to the HCPR. -The Administrator did not actively participate in the investigation and reporting process. A second interview with the Administrator on 11/22/19 at 3:30pm revealed: -She was coming to the facility once every 2	D980		

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D980	Continued From page 133 weeks but she had concerns about the way the facility was being managed so she started coming to the facility more often. -She started coming 3 days a week on 10/23/19. -It seemed "dysfunctional", for example, she saw residents who were supposed to be wearing compression hose but were not. -She was also concerned about cleanliness and food service. meaning she saw resident's who were supposed to be wearing . -She had told the AIC and the RCC to work on the medication cart once a week as a monitoring system but they had not done that and she did not know why. -The facility needed a check and balance system for the medications because they did not have a system. -She had not monitored medications because she was taking one area at a time. -She was currently working with food service and housekeeping. Observations of the facility by the county Adult Home Specialist (AHS) from 10/15/19 through 11/15/19 revealed: -On 10/15/19 at 2:30pm there was one medication aide (MA) and three personal care aides (PCAs) in the facility; the Administrator, the Administrator-in-Charge (AIC) and the Resident Care Coordinator (RCC) were not in the facility. -On 10/22/19 at 3:15pm there was one MA and two PCAs in the facility; the Administrator, the AIC and the RCC were not in the facility. -On 10/24/19 at 9:30am there was one MA and three PCAs in the facility; the Administrator, the the AIC and the RCC were not in the facility. -On 10/30/19 at 4:15pm there was one MA and two PCAs and the RCC in the facility; the Administrator and the AIC were not in the facility.	D980		

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D980	Continued From page 134 -On 11/06/19 at 1:30pm there was one MA and two PCAs in the facility; the Administrator, the the AIC and the RCC were not in the facility. -On 11/15/19 at 2:30pm there was one MA and two PCAs in the facility; the Administrator, the the AIC and the RCC were not in the facility. Interview with AIC on 11/21/19 at 5:10pm revealed: -She was out of the facility some. -The RCC had been out of work. -The medication aide was the supervisor when the Administrator or RCC was not in the facility. -The AIC lived 1 hour and 45 minutes from the facility. -The Administrator lived 2 hours from the facility. Confidential interview with staff revealed: -The Administrator was sometimes in on Thursdays, but not always because she lived 2 hours away. -The AIC was not in the facility recently. -The AIC did not have set hours when she was in the facility. -Occasionally the Administrator and AIC would call and say "hold down the building, we won't be in". -Sometimes staff called out or would not show up when the Administrator and AIC were not in the facility. _____ The Administrator failed to assure responsibility for the overall management, administration, supervision and operation of the facility which resulted in serious harm and neglect of residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/25/19 for	D980		

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D980	Continued From page 135 this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 26, 2019.	D980		