Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R **03/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	**2060 WEST FIFTH STREET** **GREENVILLE, NC 27835**

(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 and follow-up survey from March 14, 2018-March 16, 2018.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the floors, walls, and ceilings were clean and in good repair for 4 resident rooms, 6 shared bathrooms, and the community bathroom on the Men's Hall. The findings are: Observation on 3/14/18 at 11:35 a.m. of resident room #137 revealed: -There were yellow and brown stains on the linoleum tile flooring in the room. -There was a build-up of dust and dirt on the floor at the base of the floor molding around the room; there were several small dead roaches on the floor at the molding around the room. -There were black smudges on the wall, 1 and ½ feet above the floor molding. -There were black dots and smudges on the lower 1 and ½ feet of the room side of the door. -There were 5 horizontal scrape marks on the	D 074		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 074	Continued From page 1	D 074		

lower 2 feet of the hallway side of the door.

Observation on 3/14/18 at 11:38 a.m. of resident room #135 revealed:
-There were yellow and dark brown stains on the linoleum tile flooring in the room.
-There was a build-up of dust and dirt on the floor at the base of the floor molding around the room.
-There were black smudges, on the wall, 1 foot above the floor molding.
-There were 2 lines of ½ inch brown dots on the floor at the side wall molding.
-There were several small dead roaches on the floor at the molding around the room; there were dust particles, food crumbs, and 5 small dead roaches, on the floor, between the bed and nightstand, at the head of the resident's bed.
-There were light brown stains and a build-up of dust on the vents of the air conditioner cover.

Interview on 3/14/18 at 11:40 a.m. with a resident in room #135 revealed:
-Housekeeping staff swept and mopped the floor every day.
-The yellow and brown stains on the floor had been there for a while (did not remember how long); pest control came weekly to spray for roaches.

Observation on 3/14/18 at 12:05 p.m. of resident room #133 revealed:
-There were yellow and brown stains on the linoleum tile flooring in the room.
-There was a build-up of dust and dirt on the floor at the base of the floor molding around the room.
-There was missing paint on the lower 1 foot on each side of the door frame.
-There was a build-up of brown dirt on the floor at the base of door frame.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 074	Continued From page 2	D 074		

Interview on 3/14/18 at 12:07 p.m. with a resident in room #133 revealed:
-Housekeeping came in to sweep a couple of days per week, the days varied.
-The floor had the yellow and brown stains for a long time (did not remember how long).

Observation on 3/14/18 at 12:57 p.m. of resident room #125 revealed:
-There were yellow and dark brown stains on the linoleum tile flooring in the room.
-There was a build-up of dust and dirt on the floor at the base of the floor molding around the room.
-The baseboard was coated with specks of dark brown dust.
-The 6 foot metal floor vent had drops of wall paint along the top edge and had brown horizontal scrape marks over the front cover.

Interview on 3/14/18 at 12:18 p.m. with the Men's Hall Housekeeping Staff (Housekeeper) revealed:
-Staff was to sweep and mop the resident rooms every day.
-The Men's Hall required more work, the floors needed checking to see who urinated on the floor.
-Maintenance staff came in to do a thorough cleaning of the floors and walls; the Housekeeper did not know their schedule.
-Maintenance staff cleaned 1 day last week (did not remember the day) they cleaned a couple of rooms.
-The Maintenance staff used a baseboard cleaner.

Observation on 3/14/18 at 11:30 a.m. of the bathroom between resident rooms #135/137 revealed:
-There were pale yellow, white, and brown stains on the linoleum tile flooring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 074	Continued From page 3 -There were black stains in the grout between the linoleum tiles. -There was a solid coating of yellow brown stains on the flooring around the base of the toilet. -There were dark brown stains in the grout at the base of the toilet. -There were white and brown stains on the wall baseboard. -There were brown stains on the linoleum tile flooring at the bathroom doorway. Observation on 3/16/18 at 8:48 a.m. of the bathroom between resident rooms #134/136 revealed: -There were pale yellow and brown stains on the linoleum tile flooring. -There were black stains in the grout between the tiles. -There was a solid coating of yellow brown stains on the flooring around the base of the toilet. -There were dark brown stains in the grout at the base of the toilet. -The ceiling vent was coated in light brown dust. -There were dust particles around the edges of the ceiling vent. -There was a build-up of dust and dirt on the floor at the base of the floor molding around the room. -There was missing paint on the lower 1 foot on each side of the door frame. -There was a build-up of brown dirt on the floor at the base of door frame. Observation on 3/16/18 at 8:50 a.m. of the bathroom between resident rooms #130/132 revealed: -There were pale yellow and brown stains on the linoleum tile flooring. -There were black stains in the grout between the tiles. -There were dark yellow and brown stains on the	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 074	Continued From page 4	D 074		

flooring surrounding the base of the toilet.
-There was missing paint on the lower 1 foot on each side of the door frame.
-There was a build-up of brown dirt on the floor at the base of the door frame.
-There was a coating of yellow dust on the ceiling air vent.
-There were ¼ inch light tan colored dust balls hanging from the ceiling around the air vent.
-There were missing pieces of textured ceiling on two sides of the ceiling air vent.

Observation on 3/16/18 at 8:53 a.m. of the bathroom between resident rooms #122/124 revealed:
-There were pale yellow and brown stains on the linoleum tile flooring.
-There were black stains in the grout between the tiles.
-There were dark brown stains on the tile flooring at the base of the toilet.
-There was missing paint on the lower 1 foot on each side of the door frame.
-There was a build-up of brown dirt on the floor at the base of door frame.

Interview on 3/16/18 at 8: 54 a.m. with a resident in room #124 revealed:
-Staff cleaned the bathroom about once a month.
-The floor stains looked the same after the cleaning.
-The resident had not talked to anyone about the floor stains.

Observation on 3/14/18 at 12:57 p.m. of the bathroom between resident rooms #123/125 revealed:
-There were pale yellow and brown stains on the linoleum tile flooring.
-There were black stains in the grout between the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 074	Continued From page 5	D 074		

tiles.

Observation on 3/16/18 at 12:57 p.m. of the bathroom between resident rooms #120/118 revealed:
-There were pale yellow and brown stains on the linoleum tile flooring.
-There were black stains in the grout between the tiles.
-The flooring was sticky when walked on.
-There was a build-up of brown dirt on the floor at the base of the door frame.
-The ceiling vent was coated in light brown dust.

Second interview on 3/16/18 at 7:52 a.m. with the Men's Hall Housekeeper revealed:
-There were stains on the floor of the residents' bathrooms that would not come out; "they (tile flooring) needed to be ripped up and replaced".
-She had gotten on her hands and knees to scrub the floors.
-The men urinated on the bathroom floors and the stains were hard to get rid of.

Observation on 3/14/18 at 12:40 p.m. of the Men's Hall community bathroom revealed:
-The tile flooring and baseboards were covered with black stains.
-There were gray and dark brown stains on the grout between the tiles.
-There was dust on the top edge and slats of the wall air vent.
-The tile shower back corners had a coating of an unknown white substance and there was a black substance along the top edge of the tile baseboard.
-The black floor mat had splotches of a yellow and white substance on the center section of the mat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 074	Continued From page 6 Interview on 3/16/18 at 12:00 p.m. with the Administrator, Housekeeping Supervisor (HS), and the Resident Care Coordinator (RCC) revealed: -The Administrator, HS, and the RCC made rounds of resident areas on random days of each week checking on the housekeepers' cleaning work. -Staff were to sweep, mop, and clean resident rooms and bathrooms daily and as needed. -The bathroom floors needed to be replaced. -There were maintenance and housekeeping issues on the Men's Hall that would be addressed.	D 074		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 4 of 7 sampled residents (#2, #4, #5, and #6) were tested upon admission for Tuberculosis (TB) disease with a two-step TB skin test in accordance with the control measures	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234	Continued From page 7	D 234		

adopted by the Commission for Health Services.

The findings are:

1. Review of Resident #6's current FL-2 dated 05/08/17 revealed diagnoses included schizophrenia, arthritis, and seizure disorder.

Review of Resident #6's Resident Register revealed an admission date of 04/29/15.

Review of Resident #6's physician visit notes, current and previous FL-2s, and labs revealed there was no documentation of TB skin testing.

Interview with the Administrator on 03/15/18 at 9:00am revealed the facility staff was in the process of looking through Resident #6's purged records for documentation of TB tests.

Interview with the Resident Care Coordinator (RCC) on 03/15/18 at 10:15am revealed:
-Documentation of TB skin tests were usually filed in each residents' record behind the FL-2.
-She thought Resident #6 had a TB skin test sometime in 2016.
-She thought maybe documentation of Resident #6's TB testing had been "purged" from her record with older orders.
-She would continue to look for documentation of TB skin tests for Resident #6.
-Resident #6 was scheduled to get a TB skin test "tomorrow" (03/16/18).

Interview with the Administrator on 03/16/18 at 8:00am revealed:
-Staff had looked through all of Resident #6's records and did not find documentation of TB testing.
-Resident #6 was scheduled to go for a TB test

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ____ B. WING ____	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234	Continued From page 8	D 234		

that day (03/16/18).

Interview with Resident #6 on 03/16/18 at 9:35am revealed:
-She "imagined" she had "probably" had a TB test before but she was "unsure."
-She did not know when, if she had.
-She was getting ready to go "today" (03/16/18) for a TB test.

Refer to the interview with the RCC on 03/15/2018 at 12:25pm.

Refer to the interview with the RCC on 03/16/2018 at 10:35am.

Refer to the interviews with the Administrator on 03/15/2018 at 9:00am, 12:45pm, and 2:48pm.

2. Review of Resident #4's current FL-2 dated 12/12/17 revealed diagnoses included hypertension, chronic kidney disease, depression, hypothyroidism, seizure disorder, gastro esophageal reflux disease (GERD), and diverticulitis.

Review of the Resident Register revealed an admission date of 11/17/14.

Review of Resident #4's physician office visit notes revealed there was a tuberculosis (TB) skin test placed on 11/05/14 and read as negative on 11/07/14.

Review of Resident #4's record revealed there was no subsequent TB testing done.

Interview with Resident #4 on 03/16/18 at 12:46pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234		D 234		

Continued From page 9

-She had a TB test done about six months prior to moving to the facility at her old primary care provider's office.
-She had a second test done about a year after moving to the facility.
-She remembered both tests were negative for TB.

Based on interviews and record reviews, no additional documentation for TB testing was provided prior to the end of the survey.

Refer to the interview with the RCC on 03/15/2018 at 12:25pm.

Refer to the interview with the RCC on 03/16/2018 at 10:35am.

Refer to the interviews with the Administrator on 03/15/2018 at 9:00am, 12:45pm, and 2:48pm.

3. Review of Resident #2's current FL-2 dated 11/08/2017 revealed diagnoses included end stage renal disease on dialysis, chronic obstructive pulmonary disease, "AVN" with chronic pain, traumatic brain injury with memory loss/dementia, anxiety, hypertension, hepatitis C, and depression.

Review of Resident #2's Resident Register revealed an admission date of 10/18/2013.

Review of Resident #2's documentation of tuberculosis (TB) skin testing revealed:
-There was documentation for a TB skin test reading on 02/13/2011 of 0mm (millimeter).
-There was no documentation of the date the TB skin test was administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234	Continued From page 10	D 234		

-There was no documentation for any additional TB skin tests for Resident #2.

Interview with the Administrator on 03/14/2018 at 4:30pm revealed:
-Documentation for resident TB skin testing results would be in the resident record.
-She would look through documents at the facility to try and find documentation for TB skin testing for Resident #2.

Interview with the Administrator on 03/15/2018 at 9:02am revealed:
-She had not located any TB skin test results for Resident #2.
-She was still working on trying to locate results of TB skin testing for Resident #2.

Interview with the RCC on 03/15/2018 at 12:25pm revealed:
-She had no knowledge of Resident #2 not having documentation of a 2-step TB skin tests result.
-Resident #2 was admitted to the facility prior to her being in the RCC position.
-The Administrator found documentation made by the previous Administrator that Resident #2 had a chest xray to test for TB.
-She had contacted Resident #2's primary care provider (PCP) on 03/14/2018 after she realized she could not find documentation in the resident's record for 2-step TB skin testing.
-The PCP gave a verbal order on 03/14/2018 for Resident #2 to have a chest xray to screen for TB which was completed today (03/15/2018).
-She did not know if Resident #2 had a history of TB.
-She contacted two medical facilities today to inquire about previous TB skin testing for Resident #2 and was waiting on return calls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234	Continued From page 11	D 234		

Continued From page 11

Interview with Resident #2 on 03/16/2018 at 2:25pm revealed:
-He did not remember if TB skin tests were administered when he was admitted.
-He remembered having a TB skin test administered "a couple weeks ago, they put a needle in my arm, looked for it to rise but it didn't rise."
-He had a chest x-ray completed on yesterday (03/15/2018).

Refer to the interview with the RCC on 03/15/2018 at 12:25pm.

Refer to the interview with the RCC on 03/16/2018 at 10:35am.

Refer to the interviews with the Administrator on 03/15/2018 at 9:00am, 12:45pm, and 2:48pm.

4. Review of Resident #5's current FL-2 dated 08/29/2017 revealed a diagnosis of dementia without behavioral disturbances.

Review of Resident #5's Resident Register revealed an admission date of 08/22/2016.

Review of Resident #5's documentation of tuberculosis (TB) skin testing revealed:
-There was documentation for a TB skin test administered on 08/19/2016 with a reading on 08/22/2016 of 0mm (millimeter).
-There was no documentation for any additional TB skin tests for Resident #5.

Interview with the Administrator on 03/14/2018 at 4:30pm revealed:
-Documentation for resident TB skin testing results would be in the resident record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234	Continued From page 12 -She would look through documents at the facility to try and find documentation for TB skin testing for Resident #5. Interview with the Administrator on 03/15/2018 at 9:02am revealed: -She had not located any TB skin test results for Resident #5. -She was still working on trying to locate results of TB skin testing for Resident #5. Interview with the RCC on 03/15/2018 at 12:25pm revealed: -She had no knowledge of Resident #5 not having documentation of 2-step TB skin tests result. -Resident #5 was admitted to the facility prior to her being in the RCC position. -She did not know if Resident #5 had a history of TB. Interview with the Administrator on 03/15/2018 at 1:05pm revealed: -She could not find any additional documentation for TB skin testing for Resident #5. -The hospice nurse would be in the facility tonight to administer a TB skin test to Resident #5. -She would need to go through all resident records to determine who needed TB skin testing. Following record review and observation of Resident #5 on 05/04/2017 and 05/05/2017, the resident was determined not to be interviewable. Refer to the interview with the RCC on 03/15/2018 at 12:25pm. Refer to the interview with the RCC on 03/16/2018 at 10:35am.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234		D 234		

Continued From page 13

Refer to the interviews with the Administrator on 03/15/2018 at 9:00am, 12:45pm, and 2:48pm.

____

Interview with the RCC on 03/15/2018 at 12:25pm revealed:
-The normal process for resident admission to the facility was to for the resident to have a negative TB skin test reading before admission.
-If the TB skin test was completed prior to admission, the test must be no older than 6 months.
-Within the first month of admission to the facility, the resident would have a second TB skin test administered if the resident had been admitted with only one TB skin test reading.
-She was responsible to ensure residents were sent out to have the second step TB skin test administered.
-It was probably about 6 months after she became the RCC that she learned residents were supposed to have results for a 2-step TB skin test kept in their records.
-She had not gone back through resident records to make sure all residents had documentation for 2-step TB skin testing.
-TB skin testing results were kept in front of the resident record behind the FL-2 and care plans.
-She really did not have a system in place for monitoring records to ensure TB skin testing results were in the records.
-She probably went through resident records quarterly to thin the records.

Interview with the RCC on 03/16/2018 at 10:35am revealed:
-The Administrator had informed her that if resident TB skin testing had been completed prior to admission to the facility, the TB skin testing was not to be any more than 30 days old instead of 60 days old.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234		D 234		

Continued From page 14

-TB skin testing results used to be purged from the record but that procedure had stopped after she went to a training in 2016.

Interviews with the Administrator on 03/15/2018 at 9:00am, 12:45pm, and 2:48pm revealed:
-All residents were supposed to have a two-step TB skin test.
-Before a resident was admitted to the facility, the facility got a copy of TB skin test results.
-If the TB skin test results were "old", the facility would have a new TB skin test administered and read before the resident was admitted.
-The RCC was responsible for ensuring the TB skin testing was completed for residents.
-She was not sure what was in place to get second step TB skin testing completed.
-She was not sure how the RCC kept up with resident TB skin testing.
-She had only been the Administrator for about 15 months.
-She and the RCC worked together in admitting residents to the facility.
-She was in the process of creating a checklist to assure TB tests were completed and verified upon admission.

____

The facility failed to assure 4 of 7 residents sampled were tested for TB with a two-step TB test upon admission to the facility; and failed to have a system in place to ensure the residents completed a two-step TB skin test, resulting in the residents being at risk for contracting and/or the transmission of TB. The facility's failure was detrimental to the health, welfare, and safety of all of the residents which constitutes a Type B Violation.

____

Review of the Plan of Protection submitted by the facility dated 03/15/18 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 234	Continued From page 15 -Record reviews would be completed by the Administrator and RCC; the reviews would start "immediately" and be completed within 72 hours . -TB testing would be completed on all residents in which documentation cannot be produced for completion of a two-step TB skin test. -All initial TB tests should be completed by 03/23/18 with the second step completed within 21 days of initial test. -All new admissions will have the 1st step TB test completed prior to admission and the 2nd step completed within 14-21 days of admission. -A pre-admission checklist will be put in place immediately to ensure TB screenings are in compliance with the rule. -The RCC and Administrator will complete checklist to ensure continued compliance. -A TB sub-folder will be placed in each resident record with a notation stating "Do Not Purge" on the label; all documentation related to TB test/screening will be filed behind this sub-folder. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2018.	D 234		
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, record reviews, and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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		D 273		

Continued From page 16

interviews, the facility failed to notify the medical provider for 2 of 7 sampled residents (#1, #4) for non-compliance with the use of a CPAP machine, complaints of sleep disturbances, and shortness of breath (#1); and refusal of emergent medical evaluation and treatment for high blood pressure (#4).

The findings are:

1. Observation on 03/14/18 at 12:22pm revealed:
-Resident #1 was lying on her bed in her room.
-There was a CPAP (continuous positive air pressure) machine at her bedside. (CPAP is used to treat sleep apnea).

Interview with Resident #1 on 03/14/18 at 12:22pm revealed:
-She had had the CPAP for "a long time."
-She was supposed to wear the CPAP every night to help with her breathing and sleeping.
-She had been "playing hooky" [not wearing] the CPAP for a "right good while." (She did not know how long she had not been wearing the CPAP).
-[Physician's name] did not know she was not wearing the CPAP.
-A named staff and some of the other "nurses" knew she was not wearing her CPAP.
-"I feel like I should get back on it so I can sleep better and breathe better."

Review of Resident #1's current FL-2 on 03/15/18 at 10:17am revealed:
-There were no diagnoses documented.
-The resident's orientation level was not documented.
-There were no orders for CPAP.
-The FL-2 was not signed by a medical provider.

Observation on 03/15/18 at 10:55am revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 17	D 273		

RCC provided a copy of Resident #1's current FL-2 that had been signed and was dated 02/27/18.

Review of Resident #1's previous FL-2 dated 01/06/17 revealed:
-Diagnoses included mild mental retardation, diabetes, hypothyroidism, hypertension, sleep apnea, and obesity hypoventilation syndrome. (Sleep apnea is a sleep disorder in which breathing stops during sleep. Obesity hypoventilation syndrome is a breathing disorder which can cause an excess amount of carbon dioxide in the blood and too little oxygen in the blood).
-There were no orders for CPAP.

Review of Resident #1's physician orders and physician visit notes revealed there were no orders for CPAP in the record.

Interview with the Resident Care Coordinator on 03/15/18 at 10:25am revealed she would look for Resident #1's CPAP orders.

Review of Resident #1's current Assessment and Care Plan dated 02/01/18 revealed:
-Resident #1 was oriented and had adequate memory.
-The resident required extensive assistance with toileting, bathing, dressing, grooming, and personnel hygiene, and was independent with transfers and ambulation.
-The respiration assessment was documented as normal.
-There was no mention of the CPAP machine on the Assessment and Care Plan.

Review of Resident #1's most current Licensed Health Professional Support (LHPS) Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 18	D 273		

form dated 12/18/17 revealed:
-There was documentation Resident #1 used a CPAP device every night and was compliant with use.
-The CPAP equipment was in working order.
-The resident denied shortness of breath.
-The recommendations included continue plan of care and notify PCP as needed.

Telephone interview with the former LHPS Registered Nurse (RN) on 03/16/18 at 1:00pm revealed:
-She was the facility's former LHPS RN.
-She was familiar with Resident #1.
-When she completed the last LHPS Assessment for Resident #1 (on 12/18/17), the resident told her she was compliant with the CPAP and could use it independently.
-She (the RN) had checked to assure the equipment was all there and was in working order.
-Resident #1 was supposed to wear the CPAP every night, but would go through "periods of non-compliance."
-She could not recall any complaints of shortness of breath from Resident #1.
-She could not recall if the physician was notified of the non-compliance.
-When there was non-compliance, she let the RCC know so she (the RCC) could follow up as needed.

Interview with Resident #1 on 03/15/18 at 4:40pm revealed:
-She had not worn her CPAP the previous night (03/14/18).
-"I don't have a nurse to help me put it on. I don't know how."

Interview with Resident #1 on 03/16/18 at 9:40am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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		D 273		

Continued From page 19

revealed:
-She had not worn her CPAP the previous night (03/15/18).
-"Nobody asks why I am not wearing it."
-Staff did not ask if she needed help with the CPAP.
-She was not sure if a nurse ever watched her put on the CPAP.
-"I need to use it."
-"I am not sleeping good at all and I am restless all night and day."
-"I have shortness of breath when I don't get my sleep and wake up at night."
-She had told a "nurse" [named MA] "yesterday" (03/15/18).
-She had told other "nurses" (to include one other named third shift MA) before but she did not know when.
-She had had the new mask "a long time."
-She could get water out of her bathroom sink to put in the CPAP machine but she did not know how much water was supposed to be put in the machine.

Observation on 03/16/18 at 9:40am revealed:
-Resident #1 removed a CPAP mask that was still in unopened plastic packaging from a drawer of a bedside table.
-The resident pointed to a button on the CPAP machine that she identified as how the CPAP was turned on.
-The resident pointed to an area on the right side of the CPAP machine that she identified as where water went.

Interview a Medication Aide (MA) on 3/16/18 at 9:45am revealed:
-Resident #1 had never complained of any breathing issues.
-She did not recall seeing Resident #1 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ____ B. WING ____	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	**2060 WEST FIFTH STREET GREENVILLE, NC 27835**

(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 20	D 273		

shortness of breath.
-She did not know much about Resident #1's CPAP machine but third shift was expected to put the CPAP on and first shift was expected to remove it.
-She mostly worked the men's hall but had worked the women's side in the past but that was several months ago.
-She had never seen Resident #1 using her CPAP machine.
-She did not report Resident #1's noncompliance with the CPAP machine to anyone else.

Interview with a second MA on 03/16/18 at 9:50am revealed:
-She usually worked on the women's hall.
-Resident #1 was ordered a CPAP at one time but she was not sure who ordered it or if the order was current.
-Resident #1 was not compliant with wearing the CPAP; she had only seen the resident wearing the CPAP "maybe once."
-Resident #1's CPAP use was not documented anywhere.
-Resident #1 had not notified her about not using the CPAP or shortness of breath until "yesterday."
-She had not been notified of any sleep disturbances.
-She was "unsure" if the physician was aware of the non-compliance.
-She had not notified the physician.

Interview with a Personnel Care Aide (PCA) on 03/16/18 at 10:50am revealed:
-She did not know if Resident #1 wore her CPAP.
-When the staff got to work at 7:00am, Resident #1 was usually already out of bed.
-She had never seen Resident #1 wearing the CPAP.
-She thought staff on second and/or third shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 21	D 273		

would monitor it.
-Resident #1 had not complained of any shortness of breath.
-There were "several times" she had heard Resident #1 say she was "tired" and "didn't get any sleep" but she did not know when the first time or last time this occurred; but the last time was "recently."

Telephone interview with the named MA on 03/16/18 at 1:54pm revealed:
-Resident #1 had a CPAP she was supposed to wear every night.
-The resident was non-compliant with use of the CPAP.
-She thought Resident #1 could use the CPAP without assistance; the resident had never asked her for help with the CPAP.
-She had never seen Resident #1 operate the CPAP but had seen her with the mask on "a while ago" (unsure when) when checking on the resident at night.
-There was no documentation kept for Resident #1's use of the CPAP.
-Resident #1 had not complained of shortness of breath but had complained of "waking up at night" (no dates provided).
-She did not know if the physician was aware.
-She had not notified the physician.

Telephone interview with Resident #1's family member/guardian on 03/16/18 at 1:10pm revealed:
-Resident #1 had a CPAP machine for "several years" that she was supposed to wear every night.
-Resident #1 had a sleep study test about one year ago and was told she needed to continue to wear the CPAP at night.
-Resident #1 had mild mental retardation, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 22	D 273		

"child-like" and did not have the ability to understand her need for the CPAP.
-Resident #1 told the family member she was not wearing the CPAP.
-Resident #1 would need staff assistance with the CPAP machine; she could put on the mask, but could not adjust the mask, add water, or clean the machine.
-Staff "should be" helping Resident #1 with the CPAP machine.
-Resident #1 said she slept "ok most times."
-Resident #1 would complain "once in a while" of "heavy breathing."
-Resident #1 was due for a pulmonology appointment.
-She did not know if the facility had notified the physician.
-Over one year ago, the family member had talked with the previous Administrator about making sure the facility had distilled water for the CPAP machine.
-The family member had not reported "anything" to the new (current) Administrator.

Review of Resident #1's "Nurses Notes" and communication with medical providers revealed there was no documentation of the resident not using the CPAP, complaints of sleep disturbance, or shortness of breath.

Telephone interview with an RN at Resident #1's PCP's office on 03/15/18 at 11:38am revealed:
-There was no documentation on file related to Resident #1's non-compliance with the use of CPAP.
-The PCP had not ordered the CPAP for Resident #1; a [named] Pulmonologist had ordered the CPAP.

Telephone interview with an RN at Resident #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 23	D 273		

Pulmonologist's office on 03/15/18 at 12:37pm revealed:
-Resident #1 was last evaluated by the Pulmonologist on 04/26/17.
-The Pulmonologist wrote an order on 04/26/17 for Resident #1 to wear the CPAP at night at bedtime; the order had not been discontinued.
-The Pulmonologist's note dated 04/26/17 contained documentation that Resident #1 was compliant with the CPAP.
-The RN did not know if Resident #1 would be able to use and clean the CPAP without assistance.
-Resident #1 was due back in the office for follow-up in April 2018.
-Resident #1 had not missed any appointments and had no upcoming appointments scheduled.
-Resident #1 had sleep apnea and hypoventilation syndrome so she needed to wear the CPAP nightly.
-If the resident did not wear the CPAP, the results could be decreased quality of life, decreased oxygen levels, and respiratory acidosis (too much carbon dioxide in the blood).
-The Pulmonologist's office had not been notified Resident #1 was not wearing the CPAP or complaints of sleep disturbance and shortness of breath; the office would expect to be notified.

Interview with the RCC on 03/16/18 at 8:40am revealed:
-Resident #1 was oriented.
-Resident #1 had a CPAP machine that she used "most nights"; some nights she would not use it.
-The resident could use the CPAP independently.
-The CPAP was put on during third shift and removed on first shift.
-The MAs documented the application and removal of the CPAP on Resident #1's Medication Administration Record (MAR).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 24	D 273		

-The third shift MA documented that the CPAP was on; the first shift MA documented removal of the CPA.

Review of Resident #1's July 2017-March 2018 MARs revealed:
-There was no entry for CPAP.
-There was no documentation of Resident #1 using or refusing the CPAP.

Observation on 03/16/18 at 8:45am revealed the RCC looked through Resident #1's July 2017-March 2018 MARs and acknowledged there was no documentation related to the CPAP on any of the MARs.

Interview with the RCC on 03/16/18 at 8:50am revealed:
-She and (a named) MA checked all the residents' MARs once a month; she did not know the CPAP was not on Resident #1's MARs.
-She did not know Resident #1 was not using the CPAP.
-She did not know Resident #1 was having complaints about sleep disturbances and breathing problems because no staff had reported it to her.
-She acknowledged the CPAP was not addressed in Resident #1's current assessment and care plan.
-She would make sure the resident was assessed for her ability to use the CPAP, address it on the care plan, and communicate her needs to staff.
-She had not notified the physician because staff had not let her know.
-She needed to notify Resident #1's physician.

Observation on 03/16/18 at 10:55am revealed the RCC came into the Administrator's office and told her she had called Resident #1's Pulmonologist's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ____ B. WING ____	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 25	D 273		

office and the resident was supposed to wear the CPAP machine every night.

Interview with the Administrator and RCC on 03/16/18 at 10:55am revealed:
-The Administrator did not know Resident #1 was not using the CPAP or having sleeping and breathing problems.
-The Administrator was "not surprised" the resident was non-compliant.
-The RCC or MAs should have notified Resident #1's physician.
-The RCC would get an appointment for Resident #1 with the Pulmonologist and have her take the CPAP machine with her to the appointment.

2. Review of Resident #4's FL-2 dated 12/12/17 revealed:
-Diagnoses included hypertension, chronic kidney disease, depression, hypothyroidism, seizure disorder, gastro esophageal reflux disease (GERD), and diverticulitis.
-Resident #4 was ambulatory.
-Resident #4 required weekly blood pressure checks.
-There were no parameters regarding the weekly blood pressure checks.

Review of Nurses' Notes for Resident #4 dated 2/8/18 at 10:10 p.m. revealed:
-Resident #4 was walking to her room and reported that she felt like fainting.
-The Medication Aide (MA) checked Resident #4's blood pressure and the result was 212/136.
-Resident #4 refused to go to the hospital and stated she knew why her blood pressure was elevated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ____ B. WING ____	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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		D 273		

Continued From page 26

-The MA contacted the Resident Care Coordinator and monitored the resident for the rest of the night.

Review of Nurses' Notes for Resident #4 dated 2/9/18 at 2:30 a.m. revealed:
-Resident #4's blood pressure was 195/95 at 6:30 p.m. but the resident refused to go to the hospital.
-Resident #4 reported to staff that she felt a little light headed.

Review of Resident #4's Physician Office Visit note dated 2/14/18 revealed:
-Resident #4's blood pressure had been elevated.
-Resident #4's exam was stable and her blood pressure was 168/90 on 2/14/18.

Interview with Resident #4 on 3/15/18 at 5:30 p.m. revealed:
-She remembered having some dizziness and problems seeing while she was out of her blood pressure medication.
-She did not recall having any falls.

Interview with Resident #4 on 3/16/18 at 10:25 a.m. revealed:
-She remembered the day her blood pressure reading was 212/136.
-She remembered she felt badly when she woke up that morning and she could not see well.
-She did not want to go to the hospital that day.
-She realized her blood pressure was higher when she worried and she had been trying to worry less.

Interview with the Medication Aide (MA) on 3/16/18 at 2:55 p.m. revealed:
-Resident #4 said she was not feeling well on the night of 2/8/18.
-Resident #4 was "adamant she did not want to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 27	D 273		

go to the hospital."
-She told the MA that she was upset about her upcoming surgery and that had caused her blood pressure to rise.
-Resident #4 laid down and rested.
-The MA called the RCC and was told to monitor the resident.
-The MA did not remember if the RCC asked her to call the PCP.
-She believed the reading of 195/95 was taken on 2/9/18.
-She did not call the doctor for the reading of 212/136 on 2/8/18 or the reading of 195/95 on 29/9/18.
-She was not sure why she did not call the doctor and normally did call the doctor or the RCC when residents had high readings on blood pressure.

Interview with a second MA on 3/16/18 at 9:35 a.m. revealed:
-If a resident had a high blood pressure reading, the MA should check the orders to determine what should be done.
-She usually rechecked the reading if it was high and then called the doctor.
-If a resident refused treatment, the doctor should have been notified.
-Often staff would still call 911 and have EMS evaluate the resident.

Interview with a third MA on 3/16/18 at 9:45 a.m. revealed:
-If a resident had an abnormal vital sign such as a high blood pressure, the MA would always call the PCP.
-Sometimes there were no instructions on the Medication Administration Record (MAR) and so the PCP was contacted for further instructions.
-If a resident refused treatment, the MA would document the refusal, call the family, and notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 28	D 273		

the PCP.

Interview with the Resident Care Coordinator (RCC) on 3/16/18 at 9:55 a.m. revealed:
-If a resident had a high vital reading such as a blood pressure, the MA would follow the PCP's orders on the MAR.
-If there were instructions on the MAR regarding the blood pressure reading, those orders should be followed.
-If there were no orders in place, the MA should contact the PCP.
-When a resident refused hospital treatment, the MA should document the refusal and contact the family or guardian to see if they can convince the resident to seek treatment.
-If a resident still refused treatment, the PCP should be contacted.

Interview with the Administrator on 3/16/18 at 10:02 a.m. revealed:
-If a resident's vital signs were high, there were usually parameters on the MAR related to those vital signs.
-The MA should also check the standing orders to see if there was something available to help with the issue.
-The MA should call emergency medical services (EMS) if needed, monitor the resident, and then notify the PCP.
-If a resident refused hospital treatment, the MA should contact the family/guardian and also the physician for further instructions.
-The physician should be notified for all abnormal vitals including high blood pressure readings.
-Resident #4's PCP should have been notified of the 212/136 reading on 2/8/18.

Interview with the Primary Care Provider (PCP) on 3/16/18 at 8:49 a.m. revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	**2060 WEST FIFTH STREET GREENVILLE, NC 27835**

(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 29 -Resident #4 reported to her that she had not been getting her blood pressure medications for three months. -The Medication Administration Records did not show any missed doses. -She did not discuss this concern with the RCC or other medication staff at the facility. -Resident #4's blood pressure had been elevated for about a month at the time of the visit on 2/14/18. -At the time, Resident #4 was having some issues with her mental health and some changes had been made with her psychiatric medications. -Resident #4's blood pressure had "increased with her agitation in the past and was dependent on her mental health." -However, Resident #4's blood pressure decreased at the next visit despite being "equally agitated." -She was not notified of Resident #4's blood pressure reading on 2/8/18 of 212/136 or the reading of 195/95 on 2/9/18 or that the resident refused to go to the hospital. -She did not believe she had specific instructions in place to be called regarding the resident's blood pressure. -She would have expected to be notified of the high readings and would have advised the facility to calm the resident down and recheck the reading. Interview with Resident #4's family member on 3/16/18 at 12:00 p.m. revealed: -She was unaware of an issue with Resident #4's blood pressure on 2/8/18 or 2/9/18. -Resident #4's blood pressure usually went up when she worried. -She had never known Resident #4's blood pressure to be as high as 212/136.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 30	D 273		

Observation of Resident #4's blood pressure reading on 3/16/18 at 10:25 a.m. revealed a reading of 144/80.

Review of the Medication Administration Records for February 2018 revealed Resident #4's blood pressure reading on 2/1/18 was 130/74, 162/97 on 2/8/18, 133/90 on 2/15/18, and 141/93 on 2/22/18.

Review of the Medication Administration Records for January 2018 revealed Resident #4's blood pressure reading on 1/4/18 was 152/93, 107/62 on 1/11/18, 143/81 on1/18/18, and 137/90 on 1/25/18.

Review of the Medication Administration Records for December 2017 revealed Resident #4's blood pressure reading on 12/7/17 was 152/90, 136/83 on 12/14/17, 136/77 on 12/21/17, and 142/70 on 12/28/17.

____

The facility failed to notify the medical providers of Resident #1, who had diagnoses of sleep apnea and hypoventilation syndrome, not utilizing her CPAP machine as ordered and having complaints of sleep disturbances and shortness of breath; and of Resident #4's high blood pressure readings, complaints of feeling bad and having vision changes when her blood pressure was elevated, and the resident's refusal of medical evaluation. This failure was detrimental to the health, welfare, and safety of the residents which constitutes a Type B Violation.

____

Review of the Plan of Protection submitted by the facility dated 03/16/18 revealed:
-The physician would be notified of any refusals or non-compliance ("example extremely low/high vitals; low/high blood sugars; oxygen, C-PAPs")

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 31 by residents immediately by the MAs, RCC, Admininstrator or SIC "by phone/fax and the conversation/faxed paperwork will be documented immediately in the resident's record." -Any parameters precribed by physicians will be followed exactly as ordered. -If parameters are not available or are unclear, staff will call the physician for clarification. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2018.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to keep 1 microwave clean and free from contamination and to repair 1 shelf in the refrigerator and 1 shelf in the freezer. The findings are: Observation of the microwave on 3/15/18 at 9:52 a.m. revealed: -There was a brown substance on the turntable, door, and walls of the microwave. -There were areas of rust on the door of the microwave and around the edges of the microwave where the door closes.	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 282	Continued From page 32	D 282		

Interview with the Kitchen Manager and Assistant Kitchen Manager on 3/15/18 at 9:50 a.m. revealed:
-A former employee burned some food in the microwave some time last year.
-The microwave was about a year and a half old.
-The microwave needed to be replaced and administration was aware of its condition.
-Kitchen staff still used the microwave.
-There had been no mention of replacing the microwave.

Interview with the Administrator on 3/16/18 at 1:00 p.m. revealed:
-The microwave was old but she did not know it was rusted.
-She would have the microwave replaced right away.

Observation of the three door refrigerator on 3/15/18 at 9:36 a.m. revealed the top shelf of the refrigerator was broken and leaning to the right.

Observation of the three door freezer on 3/15/18 at 9:36 a.m. revealed there was a broken top shelf with cracks and areas of brown rust on the end of the shelf.

Interview with the Kitchen Manager and Assistant Kitchen Manger on 3/15/18 at 9:50 a.m. revealed:
-The refrigerator and freezer were both about two years old.
-The shelves in both the refrigerator and freezer broke from the weight of the food items.
-The shelf in the refrigerator broke yesterday 3/14/18 after the food shipment was delivered.
-The shelf in the freezer had been broken for months.
-Management was made aware about a month ago about the broken shelf in the freezer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 282	Continued From page 33	D 282		

Interview with the Administrator on 3/16/18 at 1:00 p.m. revealed:
-She was not aware of the broken shelves in the refrigerator or freezer.
-She could see the weight of the food in the refrigerator and freezer likely caused the shelves to break.
-She would have maintenance look at the shelves today to see if they could repair them.

D912 G.S. 131D-21(2) Declaration of Residents' Rights — D912

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 observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and Tuberculosis testing.

The findings are:

1. Based on observations, record reviews, and interviews, the facility failed to notify the medical provider for 2 of 7 sampled residents (#1, #4) for non-compliance with the use of a CPAP machine, complaints of sleep disturbances, and shortness of breath (#1); and refusal of emergent medical evaluation and treatment for high blood pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	**2060 WEST FIFTH STREET GREENVILLE, NC 27835**

(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 34 (#4). [Refer to Tag 273, 10A NCAC 13F.0902(b) Health Care (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to assure 4 of 7 sampled residents (#2, #4, #5, and #6) were tested upon admission for Tuberculosis (TB) disease with a two-step TB skin test in accordance with the control measures adopted by the Commission for Health Services. [Refer to Tag 234, 10A NCAC 13F.0703(a) Tuberculosis Test and Medical Examination (Type B Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by:	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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
D934	Continued From page 35	D934		

Based on record reviews and interviews, the facility failed to assure 1 of 3 Medication Aides sampled (Staff C), who had been employed at least one year, completed the state mandated infection control training annually.

The findings are:

Review of Staff C's personnel record revealed:
-Staff C's hire date was documented as 05/14/15.
-Staff C's position was documented as a Medication Aide (MA).
-There was documentation Staff C completed the state infection control training course on 08/25/16.
-There was no additional documentation of infection control training for Staff C.

Interview with Staff C on 03/16/18 at 3:00pm revealed:
-She had been employed as a MA for 2 and a half years.
-She recalled completing the state infection control training "two or three times" but did not know the dates.
-She completed the training at the facility and other facilities in which she had worked.
-She thought maybe she had completed the training sometime in 2017 but she was "unsure."
-Her certificates for training should be in her record.

Interview with the Resident Care Coordinator (RCC) on 03/16/18 at 12:45pm revealed:
-She was responsible for assuring the state infection control course was completed annually.
-She was responsible for scheduling the infection control training annually at about the same time each year.
-She would continue to look for documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: ______ B. WING ______	R 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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
D934	Continued From page 36	D934		

additional infection control training for Staff C.

Telephone interview with the former Licensed Health Professional Support Registered Nurse (LHPS RN) on 03/16/18 at 1:00pm revealed:
-She was the facility's former LHPS RN.
-She recalled providing training to Staff C "many times" but couldn't recall if Staff C had actually completed the in-service for infection control training in 2017.
-If Staff C had attended/completed the infection control training, she would have signed the sign in log sheet for the training.

Observation on 03/16/18 at 1:36pm revealed:
-The Administrator had a large black binder with documentation of staff training inside.
-The Administrator was looking for documentation of Staff C signing the log for the infection control training course in 2017.
-Staff C's signature was not on the log for the 2017 course.
-She did not find additional documentation of infection control training for Staff C.
-Staff C's signature was on the sign in sheet for completion of infection control training dated 08/25/16.

Interview with the Administrator on 03/16/18 at 1:36pm revealed:
-She was "almost positive" Staff C had not completed infection control training in 2017.
-The RCC was responsible for assuring the infection control training was scheduled annually and assuring all MAs completed the course annually.