

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 a follow up survey on 04/16/19 through 04/18/19.	D 000		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur.</p> <p>THIS IS A TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure referral and follow up for routine and acute health care needs for 4 of 5 sampled residents (#2, #3, #4 and #5) as evidenced by not reporting to the primary care provider and/or dentist for continued oral pain and limited dietary intake for more than two weeks following extraction of an infected tooth (#5); not reporting the need for a podiatry consult for a resident with a history of diabetes and toe nails approximately one half inch in length (#3); not scheduling an eye examination following a</p>	D 273		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>referral on 12/04/18 by the PCP for a resident with a history of diabetes (#2); and not scheduling an ordered swallowing evaluation for a resident with a history of dysphagia (#4).</p> <p>The findings are:</p> <p>1. Review of Resident #5's current FL-2 dated 01/07/19 revealed: - Diagnoses of Diabetes Mellitus, dementia, neuropathy, intermittent asthma, chronic gout, hypertension, and congestive heart failure. -There was an order for Acetaminophen 325mg, every 6 hours as needed for pain.</p> <p>Record review revealed an order dated 03/08/19 for Ibuprofen 600mg, 1 tablet every 6 hours as needed for pain.</p> <p>Review of a dentist visit report dated 03/28/19 revealed: -Resident #5 had an extraction of tooth #11, a single extraction without complications. - There were instructions to apply gauze to affected area until bleeding stops.</p> <p>Interview with Resident #5 on 04/16/19 at 11:05am revealed: -He had a tooth pulled less than a month ago (on the upper left side) -He had been having mouth pain since extraction. -It is very painful when he tries to chew food and he can only eat soup or soft foods. -He reported mouth pain repeatedly to the personal care aides (PCA) and the medication aide (MA). -He had not returned to the dentist to check his mouth/gums. -They had not scheduled an appointment. -He has not received any medication to relieve his</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 2</p> <p>mouth pain since the tooth was pulled.</p> <p>Review of medication administration records (MAR) for March 2019 and April 2019 revealed: -Documentation of administration of Acetaminophen on 03/04/19 (1dose), 03/5/19 (2 doses) and 03/06/19 (1 dose). -There were no documentation of administration of pain medication after 03/28/19.</p> <p>Interview with Resident #5 on 04/17/19 at 11:40am revealed: -When he attempted to chew food, his bottom teeth sinks into the upper gum (left side) causing him pain. -He only ate soft food such as grits, scrambled eggs and rice which he could mash with his tongue, but nothing solid or hard. -He had partial dentures (upper left side), but could not wear them because after the tooth was pulled, the dentures could not be secured and would fall out of his mouth. -He told the 1st shift MA and the PCA who assisted him with care about the pain about a day or two after the tooth was extracted. -He asked to go back to the dentist, but nothing had been done. -He had not returned to the dentist since the tooth was extracted on 03/28/19. -He placed a folded piece of bathroom tissue on his left upper gum to protect it from being struck by the lower teeth. -The PCAs and the MAs who provided care was aware he used bathroom tissue to protect his upper gum. They had observed the tissue folded in his mouth.</p> <p>Observation made on 04/17/19 at 11:45pm revealed Resident #5 placed a small folded piece of tissue inside of his mouth on the left upper</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 3</p> <p>gum.</p> <p>Interview with the PCA on 04/17/19 at 11:55am revealed:</p> <ul style="list-style-type: none"> -Resident #5's left upper tooth was pulled about 2 weeks ago. -The resident had not been able to wear his partial dentures since extraction -The tooth which was extracted helped secure his upper partial dentures -The partial dentures would not stay in place. -The 1st shift MA was aware of the resident's complaint of mouth pain because he always took the resident to the MA when he complained of mouth pain. -The MA did not report the resident's complaint of mouth pain to any other staff. -The resident complained of mouth pain every day since the tooth was extracted 2 weeks ago. -The resident had not returned to the dentist since his tooth was extracted. -The resident did not chew any food because he complained of pain when he tried to chew any food. The resident mashed his soft food with his tongue or ate soup only. -Before the tooth extraction, the resident ate a regular diet with his dentures in without problem. <p>Interview with the 1st shift MA on 04/17/19 at 12:05pm revealed:</p> <ul style="list-style-type: none"> -Resident #5's upper left tooth was extracted on 03/28/19 -When he returned back to the facility, thick folded gauze was packed into the site -The gauze was changed when soaked with blood. -The next day, Resident #5 complained of mouth soreness. He reported the bottom teeth were striking the top gum and causing pain. -She attempted to put the top partial dentures in 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 4</p> <p>but they only fell out.</p> <ul style="list-style-type: none"> -The resident could not wear his partial dentures because the tooth which held the dentures in place was extracted. -Last week (she did not remember the day), the PCA reported Resident #5 was complaining that his top gum was hurting and had folded tissue on his gums. -She could not remember if she gave him pain medication and she did not contact the dentist or the resident's primary care provider. -She told the facility's medical transporter and expected the transporter to make a dental appointment. -She only made medical appointments if the transporter was not available. -She did not know if the resident had a dental or medical appointment. -She did not report the resident's complaint of pain to the Administrator and did not remember if she reported his pain to the RCC. -When a resident complained of pain that was not resolved with current medications, the MAs or the RCC contact the resident's medical provider. <p>Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 12:20pm revealed:</p> <ul style="list-style-type: none"> -Resident #5 had 1 tooth pulled on 03/28/19. -Staff had not reported to her the resident's complaint of mouth/gum pain. -She was not aware the resident was still having gum pain and could not wear partial dentures. -The facility's transporter was responsible for making medical appointments for the residents, but if the transporter was not available, the MA should make the appointments. -If a resident was complaining of pain and the current pain medication orders were not effective, the MAs were responsible for following up with the PCP. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 5</p> <p>-Resident #5 had not been back to the dentist since his tooth was extracted on 03/28/19.</p> <p>Interview with the facility's transporter on 04/17/19 at 12:40pm revealed: -The 1st shift MA did not did not inform her that Resident #5 needed a follow-up dental appointment. -She would contact his dentist today (04/17/19) and make an appointment.</p> <p>Interview with the Administrator on 04/17/19 at 4:15pm revealed: -She was aware Resident #5 had a tooth extraction on 03/28/19 and had partial dentures prior to the extraction. -She was not aware the resident had been complaining of upper gum pain since the extraction and was not aware he was unable to chew his food due to pain. -When a resident complained of pain, the MA should administer pain medication if the resident had a current order. -If the resident did not have ordered pain medication or if the pain medication was not effective, the MA should contact the resident's medical provider and schedule a follow-up appointment. -The MA or the RCC should have contacted the resident's dentist to report his mouth pain and problem. -Today (04/17/19) a dental appointment for Resident #5 had been scheduled for 04/19/19.</p> <p>Interview with Resident #5's guardian on 04/18/19 at 9:27am revealed: -She was not aware the resident was having mouth/gum pain after a tooth extraction. -The facility did not report the resident was scheduled for a tooth extraction and she was not</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 6</p> <p>aware the resident had a tooth extraction on 03/28/19.</p> <p>-The facility did not report the resident could not wear his partial dentures.</p> <p>-She expected the facility to inform the resident's PCP or dentist of his gum/mouth pain because the resident should not have to endure continued pain after a tooth extraction.</p> <p>Observation made on 04/18/19 at 11:10am revealed:</p> <p>-Resident #5 was in the dining room eating lunch.</p> <p>-The Resident was served beef roast with gravy, rice, carrots, corn bread, and peaches (in syrup).</p> <p>-The resident swallowed about 3 bites of rice and a bite of carrots after sucking/mashing the rice with his tongue and about 3-4 bites of peaches mashed with his tongue.</p> <p>Resident #5's dentist was not available for interview.</p> <p>Resident #5's PCP was not available for interview.</p> <p>2. Review of Resident #3's FL-2 dated 05/29/18 revealed:</p> <p>-Diagnoses included delusional disorder, personality disorder, dyspepsia, hypertension essential, chronic obstructive pulmonary disease, cervical disc disease, Crohn's disease and Type 2 diabetes mellitus.</p> <p>Review of Resident #3's care plan dated 07/11/18 revealed the resident needed supervision with bathing, dressing, grooming and personal hygiene.</p> <p>Interview with Resident #3 on 04/16/19 at 1:06 pm revealed:</p> <p>-Her toe nails needed to be cut.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 7</p> <p>-The facility had someone cut the men's toe nails. -"Some of us women cannot reach our feet."</p> <p>Observation on 04/17/19 at 1:06 pm of Resident #3's feet revealed dry, cracked skin, ingrown toenails, calluses, redness, half inch long, thick and jagged toe nails on both feet.</p> <p>Interview with a Medication Aide (MA) on 04/17/19 at 3:04pm revealed: -The personal care aides (PCA) at the facility clip toe nails for non-diabetic residents. -Resident #3 had not asked for her toe nails to be clipped.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 3:18pm revealed: -The PCAs' cut residents' toe nails if they are not diabetic. -Residents need to notify staff if they want their nails clipped. -Diabetic residents are automatically put on a list to see the podiatrist. -Resident #3 had not seen a podiatrist. -No one made her aware Resident #3 needed her toe nails clipped.</p> <p>Interview with Resident #3 on 04/17/19 at 4:02pm revealed: - She told the administrator last week she needed her toe nails clipped. -The staff here have not seen my toe nails. -Her toe nails were done in February 2019, by a family member.</p> <p>Interview with a PCA on 04/17/19 at 4:58pm revealed: -Resident #3 does not allow staff to assist her with personal care. -She had not seen Resident #3's toe nails.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 8</p> <p>Interview with another PCA on 04/18/19 at 10:33am revealed: -She examined residents for bruises and other concerns. -She lets the MA know if a resident needed appointments like podiatry visits. -Resident #3 had never asked about toe nail care. -She had not seen Resident #3's toe nails. - Resident #3 does not allow staff to assist her with personal care.</p> <p>Interview with the Administrator on 04/18/19 at 2:47pm revealed: -A nurse who previously worked with the facility's primary care physician (PCP) would put their assigned residents on a list if residents needed a podiatry visit. -Residents who needed toe nail care were either sent out to see podiatrist or seen by facility's PCP if they were diabetic, depending on their PCP assignment. -The RCC handled appointments for podiatry. -Resident #3 requested last week to have her toe nails clipped. -She informed the housekeeping staff member, who normally assisted with nail care of residents, Resident #3 wanted her toe nails clipped. -The staff member forgot.</p> <p>3. Review of Resident #2's current FL-2 dated 02/13/19 revealed under admitting diagnoses there was a notation "see attached list," but there was no attachment.</p> <p>Review of Resident #2's previous FL-2 dated 02/27/18 revealed diagnoses included mild mental retardation, osteopenia, psoriasis, hypothyroidism, polyarthralgia, obesity, dysthymic</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 9</p> <p>disorder, hypertension, diabetes mellitus, anemia, depression and hyperlipidemia.</p> <p>Review of orders from Resident #2's endocrinologist dated 12/04/18 revealed a referral order to schedule an appointment with the resident's eye doctor.</p> <p>Interview with Resident #2 on 04/18/19 at 4:48pm revealed she had not seen the eye doctor for a routine diabetic screening examination for "a good while, say maybe a year."</p> <p>Interview with the transportation staff on 04/18/19 at 9:38am revealed:</p> <ul style="list-style-type: none"> -Resident #2's family member took the resident to all of her medical appointments except with her primary care provider (PCP). -She was not aware of Resident #2's appointments until the family member showed up at the facility to pick Resident #2 up. -The medication aide (MA) usually made a folder for Resident #2's family member to take to medical appointments. -The folder had information for the physician and a form for any new orders. -The folder was then returned to the MA following the appointment. -When an appointment needed to be scheduled, the MA gave the order to the transportation staff. -She had never seen the referral order from Resident #2's endocrinologist dated 12/04/18 to schedule an eye doctor appointment. -The form should have been given to her and she would have scheduled the appointment or checked with the family member to see if the appointment had been scheduled. -There was no system in place for follow up on referral appointments scheduled by the family member for Resident #2. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 10</p> <p>-The MAs would ask the family member when she visited the facility, if there were any appointments that day and that was it.</p> <p>Interview with a MA on 04/18/19 at 10:15am revealed:</p> <p>-Normally Resident #2's family member let staff know when the resident had an appointment, or it would be documented in the folder when the resident returned from the physician's office.</p> <p>-Most of the time, the family member would come in and tell the staff Resident #2 had an appointment and the staff would not know anything about the appointment.</p> <p>-If there was an appointment date the transportation staff would put the date on the calendar.</p> <p>-If there was an order for a referral, either the MA or the transportation staff would contact the family member to make sure the appointment was made.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/18/19 at 9:31am revealed:</p> <p>-She had spoken with Resident #2's family member on 04/17/19 about the eye doctor appointment because the family member scheduled all of the resident's appointments.</p> <p>-The family member said she would find an eye doctor and schedule an appointment because the original eye doctor was no longer in business.</p> <p>Telephone interview with a medical office assistant from Resident #2's PCP's office on 04/18/19 at 2:19pm revealed the last eye doctor appointment scanned into Resident #2's record was on 02/03/17.</p> <p>Interview with the Administrator on 04/18/19 at 2:48pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 11</p> <p>-She was not exactly sure what the protocol was for scheduling referral appointments.</p> <p>-The RCC had spoken to Resident #2's family member on 04/17/19 about the eye doctor appointment.</p> <p>-The family member scheduled Resident #2's appointments and called the facility and told staff when to have the resident ready for an appointment.</p> <p>Attempted interview with Resident #2's family member on 04/18/19 at 10:04am was unsuccessful.</p> <p>Attempted interview with Resident #2's PCP on 04/17/19 at 4:28pm was unsuccessful.</p> <p>Attempted interview with Resident #2's endocrinologist on 04/17/19 at 4:33pm and 04/18/19 at 9:04am were unsuccessful.</p> <p>4. Review of Resident #4's current FL-2 dated 02/13/19 revealed diagnoses included schizophrenia, hypertension, chronic obstructive pulmonary disease, dysphagia, sciatica, severe protein calorie malnutrition and tobacco use disorder.</p> <p>Review of a Physician Office Visit form for Resident #4 dated 02/20/19 revealed there was an order to refer Resident #4 for a repeat swallowing study.</p> <p>Review of a Physician Office Visit form for Resident #4 dated 04/01/19 revealed there was no documentation of follow up on the swallowing study.</p> <p>Interview with Resident #4 on 04/18/19 at 4:53pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 12</p> <ul style="list-style-type: none"> -He did not have a problem with swallowing; he did okay. -Somebody had watched him drink something a couple months ago, he could not really remember when. -There should have been paperwork on it. -He was on a pureed diet, but he did not need it or like it. <p>Interview with the transportation staff on 04/18/19 at 2:14pm revealed:</p> <ul style="list-style-type: none"> -She could not remember ever having received the paperwork for Resident #4's swallowing study referral. -Usually Resident #4's primary care provider (PCP) made their own referrals. <p>Interview with the Resident Care Coordinator (RCC) on 04/18/19 at 2:14pm revealed:</p> <ul style="list-style-type: none"> -She had asked Resident #4's PCP to order the swallowing study because the resident was on a pureed diet and he did not like pureed food. -Resident #4 was on a pureed diet from when he was on Hospice; Resident #4 came off of Hospice in January 2019. -She did not know if the swallowing study had been done; there were no orders for a diet change for the resident. -Usually Resident #4's PCP made the referrals herself. -When the PCP made the referral, the PCP would document the referral was made. -There was no documentation in Resident #4's record that the PCP made a referral for the resident to have a follow up swallowing study. -When the PCP wanted the facility to make the referral appointment, the PCP usually filled out a specific order form. -The order form had the PCP's office heading at the top of the page with "Physician Order," the 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 13</p> <p>order and the PCP's signature.</p> <ul style="list-style-type: none"> -There was not a "specific order form" for a follow up swallowing study for Resident #4. -The swallowing study referral documented on the Physician Office Visit form was considered an order. -Orders were not usually documented on Physician Office Visit forms. -She was responsible for follow up on all PCP orders. -For referral appointments, she gave a copy of the order to the transportation staff to schedule the appointment. <p>Second interview with the RCC on 04/18/19 at 2:39pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's PCP did not always complete the order form documenting the PCP's office would make the referral. -If the PCP had not completed a form documenting the PCP made the referral, she would ask the PCP about the referral and the form when the PCP was next at the facility. -She was "pretty sure" she asked the PCP about whether or not the PCP scheduled the referral for a follow up swallowing study for Resident #4. -She had originally asked the PCP for the follow up swallowing study because Resident #4 was not eating. -She did not know what happened; she could not remember. <p>Interview with the Administrator on 04/18/19 at 2:48pm revealed:</p> <ul style="list-style-type: none"> -She was not exactly sure what the protocol was for scheduling referral appointments. -The PCP would have written the order, the order would have went to the transportation staff and the transportation staff would have scheduled the appointment. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 14 -She was not sure what happened with scheduling the swallowing study for Resident #4. -Before the previous facility PCP left, the swallowing study referral should have been clarified. -That was not done and there should have been some follow up by the RCC. Attempted interview with Resident #4's Primary Care Provider on 04/18/19 at 2:31pm was unsuccessful. The facility failed to assure referral and follow up for the acute health care needs of 4 of 5 sampled residents including Resident #5 who had continued pain following a tooth extraction. The facility's failure to contact the primary care provider and or dentist resulted in neglect with Resident #5 suffering with severe oral pain for more than 2 weeks with substantial risk of further infection and malnutrition due to decreased dietary intake and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/18/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 18, 2019.	D 273		
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.	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 338	<p>Continued From page 15</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of sexual abuse, exploitation and neglect and were treated with respect and dignity.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 sampled residents (#1 and #5) were free of sexual abuse, exploitation and neglect as evidenced by allegations of multiple sexual contacts between a third shift staff and a resident accompanied by allegations of "blackmail" of the resident in regards to the incidents (#1); and neglecting to administer pain reliving medications for a resident experiencing pain for more than two weeks following a tooth extraction (#5). [Refer to Tag 0914 G.S. 131D-21 (4) Declaration of Residents' Rights (Type A1 Violation)] 2. Based on observations, interviews and record reviews, the facility failed to assure 1 of 5 sampled residents (#2) was treated with respect, consideration and dignity by staff who spoke to Resident #2 harshly and used beverages and snacks as leverage for desired behaviors.[Refer to Tag 0911 G.S. 131D-21 (1) Declaration of Residents' Rights (Type B Violation)] 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure 1 of 5 sampled residents (#2) was treated with respect, consideration and dignity by staff who spoke to Resident #2 harshly and used beverages and snacks as leverage for desired behaviors.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 02/13/19 revealed under admitting diagnoses there was a notation "see attached list," but there was no attachment.</p> <p>Review of Resident #2's previous FL-2 dated 02/27/18 revealed diagnoses included mild mental retardation, osteopenia, psoriasis, hypothyroidism, polyarthralgia, obesity, dysthymic disorder, hypertension, Diabetes Mellitus, anemia, depression and hyperlipidemia.</p> <p>Interview with Resident #2 on 04/16/19 at 12:03pm revealed: -The housekeeper said she touched her breast on 04/16/19. -She "did not touch or hit anyone." -The Administrator and the medication aide (MA) want to get rid of her now and "send me to the</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 17</p> <p>hospital".</p> <ul style="list-style-type: none"> -The MA said she (Resident #2) could not go out to lunch with her family member; the MA was "punishing me". -The MA was punishing her because the MA said she (Resident #2) was "cutting up" in the dining room this morning (04/16/19). -She wanted some coffee and the MA "talked ugly" to her saying, "You can't have it. I'll send you across the street to the mental hospital." -She was upset before going into the dining room because another MA had kept her waiting for a long time. -She had to wait to get her blood sugar checked before she could sit down in the dining room for the meal. -This had happened before with the same MA in the dining room. -She wanted some orange juice and the MA told her she could only have cranberry juice. -She tried to "straighten things out" by talking to the MA, but the MA "closed the window (to the front desk) and pulled the shade down on me." <p>Observations of Resident #2 during interview on 04/16/19 from 12:03pm until 12:20pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was upset, speaking rapidly and tearful. -Resident #2 was not aggressive and did not yell. <p>Interview with the MA on 04/16/19 at 12:20pm revealed:</p> <ul style="list-style-type: none"> -A personal care aide (PCA) had set a cup of coffee on the table in front of Resident #2 at breakfast on 04/16/19. -She asked Resident #2 why she was drinking the coffee before getting her blood sugar checked. -She told Resident #2 she was supposed to come to the medication room to get her blood sugar 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 18</p> <p>checked first and then go get her meal.</p> <p>-Resident #2 "goes off and blows up."</p> <p>-Another MA tried to talk to Resident #2, but the resident "stayed going off" and grabbed the second MA's arm.</p> <p>-Resident #2 eventually left the medication room, but stayed in the dining room "crying and fussing."</p> <p>-Resident #2 has had "outbursts, but never like this."</p> <p>-She told Resident #2 she could have half a cup of coffee because the resident was yelling and cursing.</p> <p>-She told Resident #2 if she (resident) did not calm down, she (MA) was going to call 911.</p> <p>-Between breakfast and lunch, Resident #2 was near the front door area and hit a housekeeper in the breast.</p> <p>-Resident #2 came to the front desk window and reached through to another MA.</p> <p>-Resident #2 stepped back away from the window and the MAs closed the window "because we're not going to argue with a resident."</p> <p>-She contacted Resident #2's family member and psychiatrist.</p> <p>-Resident #2 was supposed to go out with her family member for lunch, but the family member had said to let Resident #2 know that she would not be going to lunch.</p> <p>Interview with the housekeeper on 04/16/19 at 12:49pm revealed:</p> <p>-The issues with Resident #2 started on 04/16/19 on the women's hall.</p> <p>-She was coming out of a bathroom to her cleaning cart when Resident #2 pushed the cleaning cart.</p> <p>-She reported the incident to the Housekeeping Supervisor.</p> <p>-At approximately 9:30am on 04/16/19 she went</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 19</p> <p>on her break and was going out the front entrance door when Resident #2 "elbowed me in the chest real hard." -Resident #2 said, "Get out of my [explicit] way." -Her Supervisor had witnessed Resident #2 elbow her in the chest. -Resident #2 had "been on a rampage" since 6:30am on 04/16/19, slamming doors, yelling, screaming and cursing. -She had never seen Resident #2 behave that way before and did not know why the resident was behaving that way the morning of 04/16/19.</p> <p>Interview with the Housekeeping Supervisor on 04/16/19 at 3:29pm revealed: -On 04/16/19, the housekeeper reported Resident #2 had pushed the cleaning cart. -She asked Resident #2 about pushing the cleaning cart and the resident said she did not do that. -Approximately 30 minutes later she saw Resident #2 elbow the housekeeper in her chest. -She and the housekeeper went to the medication room/front desk and Resident #2 followed to talk to the MAs. -Resident #2 was slamming things on her way to the medication room saying she did not hit the housekeeper. -There were two MAs, the Administrator and the Resident Care Coordinator (RCC) in the medication room asking Resident #2 "what's wrong" and saying hitting the housekeeper was not right. -There had been a lot of incidents with Resident #2. -Resident #2 would have "spells" of being angry with everybody and crying if the resident felt like she was not getting her way. -Resident #2 was usually angry because she wanted something to drink and was on a fluid</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 20</p> <p>restriction.</p> <ul style="list-style-type: none"> -Different staff responded differently to Resident #2 when she was angry and crying. -Resident #2 could be frustrating to deal with because she was persistent when she wanted something and wanted whatever it was "right now". -Staff normally would step in and help each other in dealing with Resident #2. -She could not say that all staff knew to walk away when they were frustrated. -She would always try to redirect and distract Resident #2 with baby dolls because the resident loved baby dolls. -She had not observed staff "go word for word" or speak disrespectfully to Resident #2; that would be unacceptable. -Anything a staff might say that was not nice, the tone of voice or even adding sighs of "argh" or "ugh" was mean. -Staff had been trained on residents' rights, mental health, dementia and behaviors. -Staff were expected to report any witnessed abuse to the Administrator. <p>Interview with the Administrator on 04/16/19 at 4:50pm revealed:</p> <ul style="list-style-type: none"> -On arrival to the facility on 04/16/19, Resident #2 was in the dining room arguing with staff over orange juice. -Resident #2 was on a fluid restriction so staff could not just give her drinks. -Resident #2 did not go to the medication room before eating breakfast; Resident #2 knew this was the protocol. -Staff tried to redirect Resident #2 and the resident called the staff idiots. -The MA checked for any scheduled or as needed medications that might help and called Resident #2's psychiatrist and family member. 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 21</p> <ul style="list-style-type: none"> -She witnessed staff redirect Resident #2 and tell the resident "we can not give you anymore juice". -The second MA tried to redirect Resident #2 because the MA "usually got along well" with Resident #2, but the resident was "undirectable". -Resident #2 went down to her room, then elbowed the housekeeper in the chest. -The Housekeeping Supervisor witnessed the elbow in the chest, but did not hear what was said between the housekeeper and Resident #2. -Staff should walk away and let another staff handle the situation when the staff become frustrated/angry with a resident. -The MA may have been frustrated with Resident #2's behavior, but the MA was not in the position to walk away because she was in the middle of administering medication to another resident. -These were common behaviors for Resident #2; staff were usually able to redirect the resident by taking her outside or changing the conversation topic. <p>Attempted telephone interview with the second MA on 04/17/19 at 8:39pm was unsuccessful.</p> <p>Review of Resident #2's FL-2s dated 02/27/18 and 02/13/19 and subsequent orders revealed there was no order for a fluid restriction for Resident #2.</p> <p>Interview with the RCC on 04/17/19 at 3:12pm revealed:</p> <ul style="list-style-type: none"> -The only order she could find for the fluid restriction was dated 12/04/18 which restricted orange juice and sweet tea. -Resident #2 could not have as much water and coffee as she wanted, which had "been that way for years". -Fluid restriction orders were normally faxed to the pharmacy and entered on the resident's 	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 22</p> <p>medication administration record (MAR), but Resident #2 did not have a fluid restriction order entered on her MAR.</p> <p>Review of orders from Resident #2's endocrinologist dated 12/04/18 revealed: -There was an order to stop orange juice, sweet tea, and snacks consisting of popcorn or ice cream. -There was no order for a fluid restriction.</p> <p>Interview with Resident #2 on 04/17/19 at 4:40pm revealed: -She was on a fluid restriction, but she did not know how much. -She was "a little depressed yesterday (04/16/19)." -She slept better after a sleeping pill last night (04/16/19) and was better today (04/17/19).</p> <p>Telephone interview with Resident #2's family member on 04/17/18 at 4:56pm revealed: -Resident #2 could be easy going and have some behaviors. -Resident #2 had an obsessive compulsive disorder. -If things did not go Resident #2's way or if she did not understand then she would get upset. -Resident #2 had been placed on a fluid restriction of about 64 ounces per day and low sugar diet by her endocrinologist for the last 20 years. -If the staff did not let Resident #2 have what she wanted which was usually food or drink; "with her childlike mind" she would get agitated. -Resident #2 could have sugar free snacks such as sugar fluid restrictionee ice cream, but she did not know if the facility had sugar fluid restrictionee snacks and had not asked the staff. -Resident #2's medications gave the resident a</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 23</p> <p>dry mouth so she wanted to drink all of the time. -Resident #2 would drink copious amounts of water if you let her because the resident would get compulsive about drinking. -A lot of the time, it was how things were explained to Resident #2. -She was not sure if the new staff understood Resident #2. -How things were said to Resident #2 did have an effect on how she reacted.</p> <p>Telephone interview with a medical office assistant fluid restrictionom Resident #2's PCP's office on 04/18/19 at 2:19pm revealed: -The original order for a fluid restriction for Resident #2 was dated 01/21/13 for 64 ounces per day due to chronic low sodium levels from excessive drinking. -She could not find any current order for the fluid restriction. -The fluid restriction was not a restriction, but a limit so Resident #2 would not drink excessively. -Resident #2 was able to have sugar free snacks made for diabetics.</p> <p>Interview with the Administrator on 04/18/19 at 2:48pm revealed: -She was unable to find the order for the fluid restriction for Resident #2. -She had the RCC contact the physician on 04/18/19 to get the order clarified.</p> <p>Attempted interview with Resident #2's PCP on 04/17/19 at 4:28pm was unsuccessful.</p> <p>Attempted interview with Resident #2's Psychiatrist on 04/17/19 at 4:31pm was unsuccessful.</p> <p>Attempted interview with Resident #2's</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D911	<p>Continued From page 24</p> <p>endocrinologist on 04/17/19 at 4:33pm and 04/18/19 at 9:04am were unsuccessful.</p> <p>The facility failed to assure Resident #1 was treated with respect, consideration and dignity. The failure of the facility to speak respectfully and consider the dignity of Resident #1 contributed to the resident having escalated behavior and feeling "punished" by staff which was detrimental to the welfare of Resident #1 and constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/19 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 2, 2019.</p>	D911		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 25 federal and state laws and rules and regulations related to health care referral and follow up. The findings are: Based on observations, interviews and record reviews, the facility failed to assure referral and follow up for routine and acute health care needs for 4 of 5 sampled residents (#2, #3, #4 and #5) as evidenced by not reporting to the primary care provider and/or dentist for continued oral pain and limited dietary intake for more than two weeks following extraction of an infected tooth (#5); not reporting the need for a podiatry consult for a resident with a history of diabetes and toe nails approximately one half inch in length (#3); not scheduling an eye examination following a referral on 12/04/18 by the PCP for a resident with a history of diabetes (#2); and not scheduling an ordered swallowing evaluation for a resident with a history of dysphagia (#4) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 sampled residents (#1 and #5) were free of	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 26</p> <p>sexual abuse, exploitation and neglect as evidenced by allegations of multiple sexual contacts between a third shift staff and a resident accompanied by allegations of "blackmail" of the resident in regards to the incidents (#1); and neglecting to administer pain reliving medications for a resident experiencing pain for more than two weeks following a tooth extraction (#5).</p> <p>The findings are:</p> <p>1. Review of Resident #1's FL-2 dated 10/29/18 revealed diagnoses of substance abuse, vitamin B-12 deficiency, wound of gluteal cleft, and hyperlipidemia.</p> <p>Interview with Resident #1 on 04/16/19 revealed: -He had lived at the facility since November 2018. -Recently (within the last 2 weeks) a male staff had approached him about sex. -He and the staff had sex 3 times in the resident's room, which included oral and anal sex. -The male staff continued to work at the facility, but Resident #1 refused to identify the staff. -Resident #1 did not report the sexual encounters to any other staff member or the Administrator. -Most staff was aware of Resident #1's sexual preference and often playfully teased him about it.</p> <p>Interview with the Activity Director on 4/16/19 at 3:55pm revealed: -She was not aware of a staff member having sex with Resident #1 and had never been told by staff or residents of this happening. -Resident #1 made a comment to a staff member's husband a few months ago of "sexual nature". Resident #1 offered to have sex with him.</p> <p>Interview with Resident #1 on 04/16/19 at 4:05pm revealed:</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 27</p> <ul style="list-style-type: none"> -During the sexual encounter with the male staff, his roommate was always in bed asleep. -Resident #1 did not think anyone observed the male staff enter his room. -The sex was consensual and he was not hurt by the staff. -Even though he did not tell the Administrator, he did tell a few staff which he trusted (but did not reveal staff names). <p>Interview with the Administrator on 04/16/19 at 4:58pm revealed:</p> <ul style="list-style-type: none"> -She "absolutely" was not aware a staff member was having sex with Resident #1. -A male staff had reported to her that Resident #1 had approached him and offered to have sex with him about 2 years ago and the resident had approached a staff's husband and offered to have oral sex with him a few months ago. -If Resident #1 reported his roommate was always in bed asleep, she already knew who the staff was and the staff would be terminated. -She would complete and send a 24 hour report to the North Carolina Healthcare Personnel Registry (HCPR) and start a 5 day investigation. <p>Interview with a 1st shift personal care aide (PCA) on 04/17/19 at 11:55am revealed:</p> <ul style="list-style-type: none"> -He was not aware of a male staff member and Resident #1 having sex in the facility. -Resident #1 had not talked to him about having sex with a staff. <p>Interview with Resident #1's roommate on 04/17/19 at 5:10pm revealed:</p> <ul style="list-style-type: none"> -About 2-3 weeks ago, a male staff came in his room when he and Resident #1 were in bed. -The male staff and Resident #1 had sex in Resident #1's bed. -The same staff has come in the room and had 	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 28</p> <p>sex with Resident #1 more than one time. -He was always in bed and remained quiet, but he was never asleep when the staff was having sex with Resident #1. -He knew who the male staff member was, but refused the staff's name. The staff helped the residents with their care and baths. -He had never talked to Resident #1, other staff or the Administrator about this, but did not think this was right, the staff should not have been in his room in bed with Resident #1. -The male staff had never bothered him.</p> <p>Interview with Resident #1 on 4/18/19 at 4:05pm revealed: -After having sex with the male staff, the staff threatened to "blackmail" him and asked him for money. -Resident #1 refused to state if he had given the staff money.</p> <p>Interview with a 1st shift medication aide (MA) on 04/18/189 at 11:15am revealed: -Resident #1 had not reported he was having sex with a male staff. -She was not aware of a staff having any type of sex with residents.</p> <p>Interview with a housekeeper on 04/18/19 at 2:20pm revealed: -He worked on the Men's hall from 7:00am - 3:00pm and was responsible for cleaning the resident's room. -Resident #1 had never discussed having sex with a staff member. -He was not aware of a staff member having sex with Resident #1 or any staff member.</p> <p>Interview with the Administrator on 04/18/19 at 4:30pm revealed:</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 29</p> <ul style="list-style-type: none"> -She knew who the staff was who engaged in sex with Resident #1. -The staff worked 3rd shift and was a PCA. -She suspended the staff and she was continuing her investigation. -Resident #1 informed her the sex was consensual and the door was always closed. <p>The 3rd shift staff (named male PCA) was not available for interview.</p> <p>2. Review of Resident #5's current FL-2 dated 01/07/19 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of Diabetes Mellitus, dementia, neuropathy, intermittent asthma, chronic gout, hypertension, and congestive heart failure. -There was an order for Acetaminophen 325mg, every 6 hours as needed for pain. <p>Record review revealed an order dated 03/08/19 for Ibuprofen 600mg, 1 tablet every 6 hours as needed for pain.</p> <p>Review of a dentist visit report dated 03/28/19 revealed:</p> <ul style="list-style-type: none"> -Resident #5 had an extraction of tooth # 11, a single extraction without complications. - There were instructions to apply gauze to affected area until bleeding stops. <p>Interview with Resident #5 on 04/16/19 at 11:05am revealed:</p> <ul style="list-style-type: none"> -He had a tooth pulled less than a month ago (on the upper left side) and had been having mouth pain since the extraction. -"It's very painful when I try to chew food and can only eat soup or soft foods." -He reported mouth pain repeatedly to the personal care aides (PCA) and the medication aide (MA), but had not returned to the dentist to 	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 30</p> <p>check his mouth/gums. -He has not received any medication to relieve his mouth pain since the tooth was pulled.</p> <p>Review of medication administration records (MAR) for March 2019 and April 2019 revealed: -Documentation of administration of Acetaminophen on 03/04/19 (1dose), 03/5/19 (2 doses) and 03/06/19 (1 dose). -There were no documentation of administration of pain medication after 03/28/19.</p> <p>Interview with Resident #5 on 04/17/19 at 11:40am revealed: -When he attempts to chew food, his bottom teeth sinks into the upper gum (left side) causing him pain. -He only ate soft food such as grits, scrambled eggs and rice which he could mash with his tongue, but nothing solid or hard. -He had partial dentures (upper left side), but could not wear them because after the tooth was pulled, the dentures could not be secured and would fall out of his mouth. -He told the 1st shift MA and the PCA who assisted him with care about the pain -He asked to go back to the dentist, but nothing had been done. -He had not returned to the dentist since the tooth was extracted on 03/28/19. -He placed a folded piece of bathroom tissue on his left upper gum to protect it from being struck by the lower teeth.</p> <p>Observation made on 04/17/19 at 11:45pm revealed Resident #5 placed a small folded piece of tissue inside of his mouth on the left upper gum.</p> <p>Interview with the PCA on 04/17/19 at 11:55am</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 31</p> <p>revealed:</p> <ul style="list-style-type: none"> -Resident #5's left upper tooth was pulled about 2 weeks ago. -The resident had not been able to wear his partial dentures since extraction -The tooth was extracted helped secure his upper partial dentures -The partial dentures would not stay in place. -The 1st shift MA was aware of the resident's complaint of mouth pain because he always took the resident to the MA when he complained of mouth pain. -The resident complained of mouth pain every day since the tooth was extracted 2 weeks ago. -The MA administered the resident medications but he did not know if the resident was given pain medication. <p>The resident did not chew any food because he complained of pain when he tried to chew any food. The resident mashed his soft food with his tongue or ate soup only.</p> <p>Interview with the 1st shift MA on 04/17/19 at 12:05pm revealed:</p> <ul style="list-style-type: none"> -Resident #5's upper left tooth was extracted on 03/28/19 and when he returned back to the facility, thick folded gauzed was packed into the site and the gauze was changed when soaked with blood. -The next day, Resident #5 complained of mouth soreness. He reported the bottom teeth were striking the top gum and causing pain. -She attempted to put the top partial dentures in but they only fell out. -The resident could not wear his partial dentures (left top) because the tooth which held the dentures in place was extracted. -She thought she had administered 1 dose of pain medication (Motrin) on 03/29/19, but there were no documentation in the resident's record 	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 32</p> <p>that he was administered the medication since the tooth extraction on 03/29/19.</p> <p>-Last week (she did not remember the day), the PCA reported Resident #5 was complaining that his top gum was hurting and had folded tissue on his gums.</p> <p>-She could not remember if she gave him pain medication and she did not contact the dentist or the resident's primary care provider.</p> <p>-She told the facility's medical transporter and expected the transporter to make a dental appointment.</p> <p>-She only made medical appointments if the transporter was not available.</p> <p>-She did not know if the resident had a dental or medical appointment.</p> <p>-She did not report the resident's complaint of pain to the Administrator and did not remember if she reported his pain to the RCC.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 12:20pm revealed:</p> <p>-Resident #5 had 1 tooth pulled on 03/28/19.</p> <p>-Staff has not reported to her the resident's complaint of mouth/gum pain.</p> <p>-She was not aware the resident was still having gum pain and could not wear partial dentures.</p> <p>-The facility's transporter was responsible for making medical appointments for the residents, but if the transporter was not available, the MA should make the appointments.</p> <p>Interview with the facility's transporter on 04/17/19 at 12:40pm revealed:</p> <p>-The 1st shift MA did not did not inform her that Resident #5 needed a follow-up dental appointment.</p> <p>-She would contact his dentist today and make an appointment.</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 33</p> <p>Interview with the Administrator on 04/17/19 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -She was aware Resident #5 had a tooth extraction on 03/28/19 and had partial dentures prior to the extraction. -She was not aware the resident had been complaining of upper gum pain since the extraction and was not aware he was unable to chew his food due to pain. -When a resident complain of pain, the MA should administer pain medication if the resident had a current order. -If the resident did not have ordered pain medication or if the pain medication was not effective, the MA should contact the resident's medical provider and schedule a follow-up appointment. -The MA or the RCC should have contacted the resident's dentist to report his mouth pain and problems with his dentures. -The MA should have administered ordered pain medication. -Today a dental appointment for Resident #5 had been scheduled for 04/19/19. <p>Interview with Resident #5's guardian on 04/18/19 at 9:27am revealed:</p> <ul style="list-style-type: none"> -She was not aware the resident was having mouth/gum pain after a tooth extraction. -The facility did not report the resident was scheduled for a tooth extraction and she was not aware the resident had a tooth extraction on 03/28/19. -The facility did not report the resident could not wear his partial dentures. -She expected the facility to inform the resident's PCP or dentist of his gum/mouth pain because the resident should have to endure continued pain after a tooth extraction. 	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/18/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SOUTHERN LIVING ASSISTED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D914	<p>Continued From page 34</p> <p>Observation made on 04/18/19 at 11:10am revealed:</p> <ul style="list-style-type: none"> -Resident #5 was in the dining room eating lunch. -The Resident was served beef roast with gravy, rice, gravy, carrots, corn bread, and peaches (in syrup). -The resident swallowed about 3 bites of rice and a bite of carrots after sucking/mashing the rice with his tongue and about 3-4 bites of peaches mashed with his tongue. <p>Resident #5's dentist was not available for interview during the survey.</p> <p>Resident #5's PCP was not available for interview during the survey.</p> <hr/> <p>The facility failed to protect Resident #1 from sexual abuse and exploitation and neglected severe oral pain for Resident #5. The failure of the facility to protect Resident #1 resulted in the resident experiencing sexual abuse and exploitation with blame and the failure to provide a pain reliever for Resident #5's resulted in untreated severe oral pain for more than two weeks which demonstrates abuse, exploitation and severe neglect and constitutes a Type A1 Violation.</p> <hr/> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/19 with revision on 04/18/19 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 18, 2019.</p>	D914		