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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from December 5-8, 2022.	D 000		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that a call bell was in place for 2 of 2 sampled residents (Resident #2 and 3), who were non-ambulatory and required assistance with incontinent care. The findings are: Observation of the 300 Hall on 12/07/22 from 8:43 am to 8:47am revealed: -There were 11 resident rooms that did not have a call bell or other signaling device in the rooms or the bathrooms. -The spa bathroom located on the hallway had no call bell or other signaling device for the spa tub, the shower area, the toilet area, or the vanity area. Interview with a resident residing on the 300 Hall on 12/07/22 at 8:48am revealed:	D 119		

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D 119	Continued From page 1 -He did not have a hand bell to carry, and no one asked if he wanted one. -A couple of weeks ago he needed assistance in the bathroom. -There was no call bell in the bathroom, so he called the facility phone from his personal phone to get assistance instead of yelling. Observation of the 200 Hall on 12/07/22 from 9:16am to 9:45am revealed: -There were 5 resident rooms that did not have a call bell or other signaling device in the rooms or the bathrooms. -The shower bathroom located on the hallway had no call bell or other signaling device for the shower area, the toilet area, or the vanity area. Interview with a resident residing on the 200 Hall on 12/07/22 at 9:20am revealed: -He was not given a call bell to use in case he needed help. -He had not had an injury but did not feel comfortable knowing he would have to yell to get assistance. Observation of the 100 Hall on 12/07/22 from 9:45am to 10:16am revealed: -There were 8 resident rooms that did not have a call bell or other signaling device in the rooms or the bathrooms. -The shower bathroom located on the hallway had no call bell or other signaling device for the shower area, the toilet area, or the double vanity area. Interview with a resident residing on the 100 Hall on 12/07/22 at 10:08am revealed: -She did not have a call bell. -She was never asked if she wanted a call bell. -She would feel safer having a call bell in case of	D 119		

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D 119	Continued From page 2	D 119		

an emergency or needed staff assistance.
-She did not like to have to yell for staff assistance.

Observation of the housekeeper's closet on 12/07/22 at 8:53am revealed there were two handbells available to provide to residents who required assistance from staff with care.

Interview with a resident on 12/05/22 at 1:20pm revealed:
-Staff helped him with showers because he became short of breath.
-He used a urinal instead of going to the restroom because he became short of breath.
-He did not have a call bell or hand bell.
-If he needed assistance he had to get up and find someone.

Interview with another resident on 12/05/22 at 1:40pm revealed:
-He was independent and did not need any help with activities of daily living (ADLs).
-The facility he resided at previously had call bells, but he did not have a call bell at this facility.
-Some residents had hand bells.
-When other residents needed assistance and needed to get staff's attention, they yelled out.

Interview with a third resident on 12/05/22 at 2:12pm revealed:
-He yelled out during the night if he needed assistance from staff.
-He did not have a hand bell in his room.

Interview with a fourth resident on 12/05/22 at 1:46pm revealed:
-He used a wheelchair to move about the facility.
-He did not have a hand bell and if he needed assistance, he had to get up to tell staff.

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D 119	Continued From page 3 Interview with a medication aide (MA) on 12/07/22 at 9:03am revealed: -Some resident had hand bells. -Two residents had roommates who would come and tell staff when assistance was needed. -She thought one resident who used a wheelchair had a hand bell to use. -The resident who could not see had a call bell in his room. -She did not know the last time she saw residents with hand bells. -There was one resident who would come and notify staff if a resident who resided on the hall at the rear of the building needed assistance. -There were some residents who she did not think would use a hand bell if they had one due to a mental health illness. Interview with the Maintenance Director on 12/07/22 at 8:54am revealed: -He inspected the majority of the resident rooms, but he had not seen any hand bells in the rooms. -He did not know what residents did to gain staff assistance if needed. Interview with the Activity Director/MA on 12/07/22 at 9:38am revealed no resident had hand bells except for one female resident because all the residents were capable of doing things independently. Telephone interview with a PCA on 12/08/22 at 9:03am revealed: -She thought residents who required assistance had call bells or a hand bell. -There were 5 resident who she thought had hand bells. -She did not know the last time she saw hand bells in the rooms of the 5 residents.	D 119		

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-The other residents without a hand bell were assisted when rounds were made every 2 hours.
-There was one resident who needed assistance and he used his cellphone to call for assistance.
-When residents saw her on the hallway, they called out her name if they needed help.

Interview with the RCC on 12/07/22 at 9:46am revealed:
-The facility had hand bells and three residents had hand bells.
-If residents who did not have hand bells needed assistance, they yelled out.
-She did not know any reason other residents who needed assistance did not have a hand bell.
-She was responsible for ensuring residents who required assistance with transfers, toileting, and incontinence care had a hand bell.

1. Review of Resident #2's current FL-2 dated 06/07/22 revealed:
-Diagnoses included polyneuropathy, peripheral vascular disease, vascular dementia, chronic pain syndrome and chronic kidney disease.
-Resident #2 needed assistance with bathing and dressing.

Review of Resident #2's care plan dated 04/21/22 revealed:
-Resident #2 required extensive assistance with toileting, ambulation/locomotion, bathing, and dressing.
-Resident #2 required limited assistance with eating and transferring.
-Resident #2 used an electric wheelchair for movement about the facility.
-Resident #2 had limited range of motion and limited strength in his left hand.

Observation of Resident #2's room on 12/05/22 at

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D 119	Continued From page 5 1:39pm revealed: -There was no call bell system in the resident's room. -There was no bedside bell or hand bell in the resident's room. -There was an electric wheelchair. Interview with a PCA on 12/07/22 at 8:34am revealed: -He thought Resident #2 had a hand bell his room. -He had not seen any other hand bells since beginning his employment at the facility 3 weeks ago. -Resident #2 required assistance with transferring from bed to his wheelchair and he was incontinent. Attempted interview with Resident #2 on 12/05/22 at 9:41am was unsuccessful. Refer to the interview with the Administrator on 12/07/22 at 12:17pm. Refer to the telephone interview with the Director of Operations on 12/07/22 at 4:42pm. 2. Review of Resident #3's current FL-2 dated 11/02/22 revealed: -Diagnoses included hemiplegia and hemiparesis following cerebral infraction affection right dominant side. -Resident #3 needed assistance with dressing. -Resident #3 had an above the knee amputation of his right leg. Review of Resident #3's incident report dated 11/02/22 revealed: -Resident #3 was found on the floor in his room and it was an unwitnessed event.	D 119		

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D 119	Continued From page 6 -A medication aide (MA) documented Resident #3 was transferring from his wheelchair to the bedside toilet in his room. -Resident #3 was transported to the emergency room (ER). -The Administrator signed the incident report but did not document any corrective action for Resident #3. Review of Resident #3's progress note dated 11/02/22 revealed: -The note was written by the Resident Care Coordinator (RCC). -Resident #3 was sent to the ER due to a fall. -Resident #3 returned from the ER with no new orders and no injuries reported. -Resident #3 would have continued monitoring. Interview with Resident #3 on 12/06/22 at 2:59pm revealed: -He had lived at the facility for one month and a half. -He used a wheelchair to move about the facility. -He fell in November 2022 when he was trying to transfer from his bed to chair. -He did not lock his wheelchair before trying to transfer to it. -He fell during dayshift and had to yell out to gain assistance from staff. -When staff heard him yelling, they came running. -He did not have a call bell or hand bell. -No one gave him one after he fell. -He had not seen a hand bell since his admission and he was in a room alone without a roommate. -During the night to get the attention of staff, he would have to scream out for help if he needed it. Refer to the interview with the Administrator on 12/07/22 at 12:17pm.	D 119		

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D 119	Continued From page 7 Refer to the telephone interview with the Director of Operations on 12/07/22 at 4:42pm. _____ Interview with the Administrator on 12/07/22 at 12:17pm revealed: -She knew the facility did not have a call bell system. -She was told by the Director of Operations the facility was grandfathered and did not require an electric call bell system. -She had mentioned to the Director of Operations about obtaining more hand bells. -She wanted to obtain more hand bells for residents who were a falls risk and required assistance -She thought some residents had hand bells, but she had not checked to see that the hand bells were in place. -She was responsible for ensuring residents who required assistance had hand bells available to use. Telephone interview with the Director of Operations on 12/07/22 at 4:42pm revealed: -He was responsible for the daily operations of the facility. -He knew the facility did not have an electrical call system, but there were hand bells available for residents. -Residents who required assistance should have a hand bell. -He expected the RCC and Administrator to determine which residents required a hand bell and provide it to those residents. -He expected the Administrator to notify him if supplies were needed such as hand bells. -He ordered supplies with permission from the owner of the facility.	D 119		

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D 119	Continued From page 8 The facility failed to ensure residents who required assistance with personal care had a hand bell to use for calling staff for assistance resulting in residents yelling out for staff when they needed assistance. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	D 119		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to verify there were n substantiated findings on the Health Care Personnel Registry (HCPR) for 1 of 3 sampled staff (Staff A) prior to working in the facility. The findings are: Review of Staff A's, housekeeper, personnel record revealed:	D 137		

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D 137	Continued From page 9 -Staff A was hired on 10/11/22. -There was no documentation a HCPR check was completed upon hire. -There was documentation a HCPR check was completed on 12/07/22 with no substantiated findings. Interview with the Administrator on 12/07/22 at 12:13pm revealed: -She was responsible for making sure all personnel records were complete. -She audited the staff records when she first returned to the facility on 07/18/22. -She recalled checking the HCPR for Staff A, but she was not able to print the results because she had no paper and loss the internet signal. -She forgot to print Staff A's HCPR check once she had access to the internet again and restocked the printer paper.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's, housekeeper, personnel	D 139		

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record revealed:
- Staff A was hired on 10/11/22.
-There was documentation that a criminal background check consent was obtained on 12/01/21.
-There was no documentation that a criminal background check was completed upon or before hire.

Interview with Staff A on 12/07/22 at 8:38am revealed:
-He completed his paperwork with the Administrator.
-He remembered signing a consent form for a criminal background check, but he did not know if the Administrator completed a criminal background check for him.

Interview with the Administrator on 12/07/22 at 12:13pm revealed:
-She had obtained Staff A's criminal background check, but she did not print it.
-If she could print it from the online site, the date of the background check could be seen.
-She was not able to print Staff A's criminal background check because she could not access the account.
-The online site told her that the facility could no longer use the single facility email address to send all the criminal background check reports.

Refer to the interview with the Administrator on 12/07/22 at 12:13pm.

2. Review of Staff B's personal care aide (PCA) personnel record revealed:
-Staff B was previously hired on 09/18/19 and there was a resignation dated 07/11/20.
-A new date of hire was not documented.
-There was a criminal background check

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completed on 09/18/19.
-There was no documentation that a criminal background check was completed for the most recent hire date.

Telephone interview with Staff B on 12/08/22 at 8:47am revealed:
-She worked at the facility as a PCA, but she was in training to become a medication aide (MA).
-She worked at the facility in 2019 but left for 2 months and returned.
-She resigned but she could not remember the date.
-She came back to work at the facility in October 2022.
-She remembered signing a consent form for a criminal background check.
-She did not know if a criminal background check was completed for 2022.

Interview with the Administrator on 12/07/22 at 12:13pm revealed:
-She thought Staff B had a completed criminal background check in her personnel folder.
-She could not locate a criminal background check in Staff B's personnel folder after she searched.
-She remembered completing Staff B's criminal background check online but the service she used would not allow her to enter the account on 12/07/22.

Refer to the interview with the Administrator on 12/07/22 at 12:13pm.

_____

Interview with the Administrator on 12/07/22 at 12:13pm revealed:
-She was responsible for completing criminal background checks on new hires.
-She was responsible for making sure paperwork

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D 139	Continued From page 12 was completed, but she had not reviewed personnel records to ensure the required documents and criminal background checks were obtained.	D 139		
D 156	10A NCAC 13F .0503 Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) regulations pertaining to medication administration in adult care facilities; and (10) the facility's medication administration policy and procedures (b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department. (c) Verification of an individual's completion of the written examination and results can be	D 156		

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D 156	Continued From page 13 obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result. (d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter. (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following: (1) name of the staff and adult care home; (2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature; (3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and (4) staff and instructor signatures and date after completion of tasks. Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not	D 156		

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D 156	Continued From page 14 transferable from one facility to another. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff C), who administered medications, completed the 5-hour training, the medication clinical skills checklist before passing medications; and then 10-hour training and exam within 60 days. The findings are: Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 11/15/21. -There was documentation Staff C completed the 15-hour medication aide training on 09/07/22. -There was documentation Staff C had completed the medication clinical skills checklist on 09/15/22. -There was no documentation of an employee verification of prior employment as a MA. Review of residents' October 2022, November 2022, and December 2022 electronic medication administration records (eMAR) revealed: -There was documentation Staff C administered medications on 16 days from 10/01/22-10/31/22. -There was documentation Staff C administered medications on 19 days from 11/01/22-11/30/22. -There was documentation Staff C administered	D 156		

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D 156	Continued From page 15 medication on 5 days from 12/01/22-12/06/22. Observation of Staff C on 12/05/22 at 2:30pm revealed Staff C was counting narcotics with the first shift MA. Observation of Staff C on 12/05/22 at 4:30pm revealed he was using the laptop on the medication cart and had the keys to the medication cart. Interview with Staff C on 12/08/22 at 1:48pm revealed: -He had worked at the facility since 11/15/21 as a personal care aide. -He thought he began training as a MA in October 2022. -He attempted to take the MA examination twice. -Once he did not have a webcam and the second time he did not have internet so he lost connection to the server. -When he lost the connection, the test stopped. -He was scheduled to take the MA test again on 12/15/22. -He had administered medications to residents since October 2022. Interview with the facility's nurse on 12/06/22 at 4:10pm revealed: -She completed Staff C's MA training course in September 2022 over two days. -She told Staff C that he had 90 days to take the MA examination. -Staff C had attempted to take the MA examination previously but once he did not have a private space and the test was stopped. -She did not know the dates Staff C had attempted to take the exam. -She thought MA trainees had 90 days to take the MA exam because she read it somewhere and	D 156		

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she was told when she called credentialing.
-She was responsible for ensuring training documents were placed in personnel folders.

Interview with the Administrator on 12/07/22 at 12:13pm revealed:
-The facility nurse was responsible for making sure all MA training was complete.
-She had not audited the staff records since July 2022.
-She knew Staff C had 60 days from the date he was hired as a MA and completed the MA training to take the MA examination.
-She did not know the facility nurse thought it was 90 days.
-She did not know Staff C's 60th day from the date he completed the medication clinical skills checklist and the 15-hour medication aide training had passed.
-She usually kept track of the date so that she could ensure staff did not administer medications beyond the 60-day time period after training was completed.
-She thought Staff C had attempted to take the MA examination, but he did not have privacy and other people were in the room with him.
-She thought Staff C had rescheduled the test and found a private space to take the test.
-She expected all MA training to be completed and verified before the MA administered medication.
-She was responsible for ensuring the MA training was completed and the MA examination was taken within 60 days from hire.

_____

The facility failed to ensure one staff, who worked as a MA and administered medications to residents completed the medication aide examination within 60 days from hire and completed of the 15-hour medication aide training

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D 156	Continued From page 17 course and the clinical skills checklist before administering medications resulting in possible medication errors. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	D 156		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times for the third shift	D 167		

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who had completed an accredited course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months was completed for 3 of 3 sampled staff (Staff B, C and D).

The findings are:

1. Review of Staff B's, personal care aide (PCA), personnel record revealed:
-Staff B was previously hired on 09/18/19 and there was a resignation dated 07/11/20.
-A new date of hire was not documented.
-There was no documentation Staff B had completed a CPR course.

Review of the facility's work schedule from 12/04/22 through 12/06/22 revealed:
-Staff B worked 8 hours on third shift (10:00pm to 6:00am) on 12/05/22 and 12/06/22.
-There were no staff who worked with Staff B on third shift on the above dates who had current CPR certification.

Telephone interview with Staff B on 12/08/22 at 8:47am revealed:
-She had returned to work at the facility in October 2022.
-She had worked at the facility previously in 2019 and on another date that she could not remember.
-She was a MA in training and she worked second and third shift.
-She took CPR 7 years ago, but she had not taken a recent CPR course.

Interview with the Administrator on 12/07/22 at 12:13pm revealed:
-She thought Staff B had a current CPR certification.

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-She looked in Staff B's personnel records and she did not locate a CPR certification.

Refer to the interview with the facility nurse on 12/08/22 at .11:26am.

Refer to the interview with the Administrator on 12/07/22 at 12:13pm.

2. Review of Staff C's, personal care aide (PCA), personnel record revealed:
-Staff C was hired on 11/02/21.
-There was no documentation Staff C had completed a CPR course.

Review of the facility's work schedule from 12/04/22 through 12/06/22 revealed:
-Staff C worked 8 hours on third shift (10:00pm to 6:00am) on 12/06/22.
-There were no staff who worked with Staff C on third shift on the above date who had current CPR certification.

Interview with Staff C on 12/08/22 at 1:48pm revealed:
-He worked on second and third shift.
-He had never taken a CPR course.

Refer to the interview with the facility nurse on 12/08/22 at .11:26am.

Refer to the interview with the Administrator on 12/07/22 at 12:13pm.

3. Review of Staff D's, personal care aide (PCA), personnel record revealed:
-Staff D was hired on 09/19/22.
-There was no documentation Staff D had completed a current CPR course.
-There was no documentation Staff D had ever

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D 167	Continued From page 20 completed a CPR course. Review of the facility's work schedule from 12/04/22 through 12/06/22 revealed: -Staff D worked 8 hours on third shift (10:00pm to 6:00am) on 12/04/22, 12/05/22, and 12/06/22. -There were no staff who worked with Staff C on third shift on the above dates who had current CPR certification. Attempted interview with Staff D on 12/07/22 at 11:21am was unsuccessful. Refer to the interview with the facility nurse on 12/08/22 at 11:26am. Refer to the interview with the Administrator on 12/07/22 at 12:13pm. _____ Interview with the facility nurse on 12/08/22 at 11:26am revealed: -She knew Staff B, C, and D did not have CPR. -She mentioned CPR whenever there was a staff meeting, so she thought many staff knew something about CPR. Interview with the Administrator on 12/07/21 at 12:13pm revealed: -She was unable to provide documentation that any staff on third shift had current CPR certification. -The weekly staffing schedule was managed by the Supervisor who scheduled based on the number of hours not current CPR certification. -She knew there were staff who were not CPR certified, but the facility nurse planned to do other CPR classes. -She was responsible to ensure CPR was completed by staff and scheduling staff to complete CPR certification.	D 167		

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide personal care for 2 of 2 sampled residents (#1, #2) related to incontinence care. The findings are: 1. Review of Resident #1's current FL-2 dated 01/28/22 revealed: -Diagnoses included dementia, paranoid schizophrenia, hypertension, and peripheral vascular disease. -She was ambulatory. -She was constantly confused. -She was incontinent of urine. -She required assistance with bathing. Observation of Resident #1's bedroom on 12/05/22 at 1:46pm revealed -There was a strong urine odor in Resident #1's bedroom. -There was a dark, dried, stain on the floor next to Resident #1's bed. -The stain covered a 4 feet by 2 feet area next to Resident #1's bed and extended past her bed	D 269		

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toward the window another 1 to 2 feet.
-There was a dry, stained, circular area in front of the window 3 feet in diameter.
-The chair was seated next to the bed; the chair had a three-inch, cloth cushion.
-The front side and 1/3 of both sides of the chair cushion were stained; the brown stain extended from the sides of the cushion to 2 inches on top of the cushion.
-There was a dark, stain on the floor in front of the chair.

Interview with the Activities Director on 12/05/22 at 1:50pm revealed:
-She worked as a medication aide (MA) when needed and she was familiar with Resident #1.
-Resident #1 would urinate anywhere in her room.
-She did not know why she would not go to the toilet.
-She would ask housekeeping to clean the floor.
-Resident #1's soiled chair had been removed from her room and her mattress had been changed due to being soiled.

Observation in the hallway outside Resident #1's bedroom door on 12/06/22 at 8:17am revealed:
-Resident #1's bedroom door was closed.
-There was a strong urine odor coming from Resident #1's bedroom.

Observation of Resident #1's bedroom on 12/06/22 at 8:18am revealed:
-There was a strong urine odor in Resident #1's bedroom.
-Resident #1 was lying in bed with her head covered with a sheet and bedspread.
-The bedspread hung down the side of the bed and covered the mattress.
-Resident #1 pulled the covers from her head when spoken too and revealed the flat sheet on

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the mattress and her gown.
-The flat sheet was wet and stained from Resident #1's knees to her head, and her gown was wet and stained from the neckline to the hemline in the back and from her waist to the hemline in the front.

Interview with a PCA on 12/06/22 at 8:25am revealed:
-She was making rounds and came to check on Resident #1.
-This was the first time this morning, 12/06/22, she had entered Resident #1's room.
-She had to get assistance to clean Resident #1.

Observation of Resident #1's buttocks and sacral area on 12/06/22 at 9:55am revealed her skin was intact without redness noted.

Review of Resident #1's two-hour check log dated 12/05/22 for 3rd shift revealed Resident #1 was checked on every two hours and was in her bedroom.

Review of Resident #1's personal care assistance log for 12/05/22 for 3rd shift revealed Resident #1 was provided limited assistance for routine toileting three times.

Interview with Resident #1's family member on 12/07/22 at 8:25am revealed:
-Resident #1 refused to wear incontinent briefs and she would urinate on the floor, bed, and chair.
-Resident #1 could ambulate to the toilet but she would not.
-She did not know why Resident #1 would not use the toilet.
-She thought Resident #1 was urinating on the bed, chair, and floor because of her mental health

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diagnosis.
-She had visited the facility and found Resident #1 soiled, and the staff would clean her up as soon as she asked them too.

Interview with another PCA on 12/07/22 at 12:07pm revealed:
-The on-coming and the off-going PCAs were to make rounds on all the residents and ensure everyone was clean before the off-going PCA left.
-She did not make rounds the morning of 12/06/22 with the off-going PCA.
-The third shift PCA looked tired, and she told the third shift PCA to go home, she would check on the residents.
-If she had made rounds, she would have noticed the urine smell in the hallway.
-She tried to make rounds on all the residents every two hours, but sometimes she would get busy with a resident, and it may be later than two hours before she checked on a resident.

Interview with a Medication Aide (MA) on 12/07/22 at 8:58am revealed:
-She knew Resident #1 was incontinent of urine.
-Resident #1 was able to ambulate to the toilet.
-Resident #1 would not go to the toilet to urinate; she would urinate on the bed, chair, or floor in her room.
-Resident #1 refused to wear incontinent briefs for urinary incontinence.
-Resident #1 would let some staff assist her, but not all the staff.
-She would yell and curse at some staff members.
-She did not know Resident #1 was soiled the morning of 12/06/22.
-She had smelled urine in the hallway, and she had asked housekeeping to mop the hallway; she did not realize it was coming from Resident #1's

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room.
-The on-coming PCA and the off-going PCA were to make rounds prior to the off-going PCA leaving their shift.
-She knew the PCAs did not always make rounds to ensure residents were clean and dry.
-Apparently, rounds were not made this morning, 12/06/22, at shift change.
-The 1st shift PCA had been at work over 2 hours, and she should have checked on Resident #1 before now.

Telephone interview with a 3rd shift MA on 12/07/22 at 12:13pm revealed:
-The PCAs made rounds every 2 hours on third shift, starting at 10:00pm.
-They checked the residents for the final time starting at 5:30am.
-She assisted the PCAs with their rounds and assisted with incontinent care when needed.
-Resident #1 refused incontinent care three times on third shift, 12/05/22.
-Staff tried to work with Resident #1 to provide incontinent care but she would start yelling and cursing at the staff.
-Resident #1's Primary Care Providers (PCP) was aware of the yelling and cursing and was adjusting her medications.

Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:45am revealed:
-It appeared the PCAs did not make rounds the morning of 12/06/22, as they were supposed to and the first shift PCA had not checked on Resident #1 with 2 hours of coming to work.
-Resident #1 should be checked on more frequently than every 2 hours because of urinary incontinence.
-Resident #1 should be taken to the toilet more frequently because she would not go on her on.

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-She would urinate on the floor, in the bed, and while seated in the chair.
-She refused to wear incontinent briefs.
-She would yell and curse at the staff when they tried to assist her with personal care.
-Resident #1 would allow some staff to do for her and other staff members she would not.
-Resident #1's PCP was aware of the yelling and cursing and had adjusted Resident #1's medications.

Interview with the Administrator on 12/08/22 at 11:30am revealed she knew Resident #1 could be difficult, but the staff needed to provide incontinent care when she was soiled.

Attempted interview with Resident #1 on 12/06/22 at 8:18am was unsuccessful.

Attempted telephone interview with a 3rd shift PCA on 12/07/22 at 10:45am was unsuccessful.

Refer to the interview with the RCC on 12/07/22 at 9:45am.

Refer to the interview with the Administrator on 12/08/22 at 11:30am.
2. Review of Resident #2's current FL-2 dated 06/07/22 revealed:
-Diagnoses included polyneuropathy, peripheral vascular disease, vascular dementia, chronic pain syndrome and chronic kidney disease.
-Resident #2 needed assistance with bathing and dressing.

Review of Resident #2's care plan dated 04/21/22 revealed:
-Resident #2 required extensive assistance with toileting, ambulation/locomotion, bathing, and dressing.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 27 -Resident #2 required limited assistance with eating and transferring. -Resident #2 used an electric wheelchair for movement about the facility. -Resident #2 had limited range of motion and limited strength in his left hand. Observation of Resident #2's room on 12/05/22 at 1:39pm revealed: -Resident #2 laid on his back. -When standing beside resident, there was a strong odor of urine and slight odor of ammonia. -Resident #2 wore a red t-shirt and small plaid pajama bottoms. -There were two dry chux disposable pads tucked underneath Resident #2's lower back and buttocks. -There were no wet spots on the floor. -There was a urinal on his bed side table. Observation of Resident #2 on 12/05/22 at 3:45pm revealed: -He was lying on his right side and there was a strong odor of urine. -Resident #2 wore the same small plaid pajama bottoms and red t-shirt. Observation of Resident #2 on 12/05/22 at 5:15pm revealed: -Resident #2 refused dinner and he was lying on his right side wearing the same pajamas. -There was a strong odor of urine in his room. Observation of Resident #2 in his resident room on 12/06/22 at 8:45am revealed: -Resident #2 was lying on his right side wearing the same pajamas from 12/05/22. -The sheets were pulled from the bottom of the mattress. -His room smelled of urine.	D 269		

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D 269	Continued From page 28 Observation of Resident #2 on 12/06/22 at 9:13am revealed: -Two medication aides (MA) were changing the linen on his bed. -The Administrator was speaking with Resident #2 concerning bathing and allowing a MA to assist him. -Resident #2 was sitting up in his electric wheelchair wearing the same pajamas. Review of the facility's shower schedule for Resident #2 revealed Resident #2 was listed under the second shift to receive showers on Tuesday, Thursday and Saturday. Review of the facility's two-hour check log for Resident #2 revealed: -On 12/05/22, the personal care aide (PCA) documented at 1:00 pm that Resident #2 was in the living room. -On 12/05/22, the PCA documented at 3:00pm that Resident #2 was in his bedroom, and at 5:00pm that Resident #2 was in the dining room. Review of the facility's shower binder revealed: -There was an aide weekly task schedule for Resident #2. -There was documentation that Resident #2 had his linens changed, clothes changed, and hygiene provided on both 12/05/22 and 12/06/22. Interview with Resident #2's family member on 12/08/22 at 10:33am revealed: -She visited the facility almost daily. -She was told by staff that Resident #2 refused to bathe. -He slept a lot and she thought he had a problem "holding his urine" since he went to the hospital 3 to 4 months ago.	D 269		

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D 269	Continued From page 29 -She tried to encourage him to allow staff to help him with hygiene. Interview with a PCA on 12/08/2022 at 8:40am revealed: -There was a shower schedule and a laundry schedule. -He was the assigned PCA for the 300-hall. -He made beds, washed residents' clothes and bed linen. -Most residents were independent but there were specific men he assisted with showers and incontinent care. -He walked the hall his entire shift checking residents unless he was with a resident who was blind or another resident who did not like to be alone. -Resident #2 slept a lot. -He thought Resident #2 did not feel well on Monday 12/05/22 and stayed in the bed that day. -Resident #2 refused showers from him and he would go and tell the Administrator. -He thought Resident #2 would only shower for specific staff. -No documentation was in the record if a shower was refused. -Resident #2 had to be lifted out of the bed and transferred to his electric wheelchair. -When Resident #2 was not in the bed, his linens were changed. -When he bathed Resident #2 he screamed and cussed. -On 12/05/22, Resident #2 was not assigned to him on the second shift. -He thought Resident #2 let the second shift PCA change his brief, but he did not witness it. -Resident #2 allowed him to check his incontinent brief because Resident #2 did not like to be wet. -He knew Resident #2's room had a strong odor of urine and he did not know what caused the	D 269		

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odor.
-He thought Resident #2 spilled urine onto his bed when attempting to use the urinal.
-Resident #2's family member came to the facility and she would clean his room to try to get rid of the odor.
-He had not reported the strong urine odor to any medication aide (MA) or the Administrator.

Interview with a day shift medication aide (MA) on 12/07/22 at 9:03am revealed:
-She expected the PCAs to complete their job duties for the shift.
-Resident #2 would get out of bed some days and some days he spent the entire day in the bed.
-She knew his room smelled like urine.
-When she smelled urine in Resident #2's room, she told the PCA to go and "straighten" his room.
-Resident #2 refused assistance with hygiene and staff would get the Administrator to speak with him.
-She had asked Resident #2's family member to speak with him concerning bathing.
-She thought the urine odor came from Resident #2's incontinence in the bed.
-Resident #2 wore an incontinence brief and Resident #2 allowed staff to change him.
-However, one day a week Resident #2 would stay in the bed and refused staff assistance with hygiene.
-Resident #2 fussed and told staff to leave his room when he refused, but he would take his medication.
-On days when he was out of the bed, he went to the restroom and used the urinal.
-She had not told Resident #2's Primary Care Provider (PCP) but she thought the Resident Care Coordinator (RCC) had told the PCP.

Telephone interview with an evening/night shift

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D 269	Continued From page 31 PCA on 12/08/22 at 8:47am revealed: -She checked residents every 2 hours and helped them to the restroom or provided incontinence care. -She was not always able to assist Resident #2 and she encouraged him to use the urinal. -Resident #2 was "difficult" and he was not good at responding to staff. -Resident #2 responded well to the Administrator, but he would shove other staff away from him. -However, the MAs should report Resident #2's condition at the end of the shift so that they knew whether he refused care or not. -She worked third shift on 12/05/22 and she checked Resident #2 every 2 hours. -She encouraged him to sit up in his wheelchair so that his bed could be changed, but he refused. -She thought staff had tried discussing his refusals with his family member, going in with two other staff to speak with him, and discussing with his PCP. -Resident #2 had good and bad days. -On a good day, Resident #2 came and requested his room to be cleaned. -For a 30-day month, 20 of those days were good for Resident #2. -She thought Resident #2 did not have any changes to the skin on his back and buttocks. -She knew his room smelled of urine. -She did not know of any care meetings held related to Resident #2's hygiene care. Interview with an evening/night shift PCA on 12/08/22 at 1:48pm revealed: -Resident #2 could be difficult. -He refused care and would fuss and cuss at staff. -When Resident #2 behaved like that staff just left Resident #2 alone and would not bother him. -He had smelled the urine odor in Resident #2's	D 269		

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room.
-He thought that cleaning Resident #2's urinal would help the urine odor.
-However, he thought the odor was also coming from Resident #2's mattress due to incontinence.
-Resident #2's room had smelled of urine for a long time.
-When Resident #2 was out of his bed and went out to smoke, he would change the bed linen.

Interview with the RCC on 12/07/22 at 9:46am revealed:
-Resident #2 refused care a lot.
-She had been in his room previously and it smelled of urine.
-She thought the urine odor was emitted from Resident #2.
-Housekeeping mopped his floor, but the room still smelled of urine.
-Staff did not provide incontinence care to Resident #2 on 12/05/22 for the odor of urine to be that strong.
-Sometimes Resident #2 agreed to assistance and some days he refused.
-He allowed certain staff to provide him with assistance with hygiene.
-She had spoken with Resident #2's PCP concerning his refusal for assistance with hygiene.
-She had not documented that she discussed Resident #2's refusals with his PCP.
-Resident #2's PCP had not offered any interventions or suggestions to help with Resident #2's refusals for hygiene care.
-Resident #2 cussed and fussed when he refused care.
-Resident #2 did not have any opened areas on his lower back but his lower back had some redness.
-She noted the redness on his lower back one

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D 269	Continued From page 33 week ago. Interview with the Administrator on 12/07/22 at 12:13pm revealed: -Resident #2 refused care and she was called by staff to come to speak with Resident #2. -Resident #2 needed assistance getting out of the bed, with bathing, and with incontinence care. -Staff should document Resident #2's refusal to shower and hygiene care. -She knew there was a strong smell of urine in Resident #2's room. -She expected staff to speak with Resident #2 concerning offering hygiene care and document in the resident record after three refusals. -She knew Resident #2's family member spoke with him concerning incontinence care. -There were times that Resident #2's clothes were saturated with urine. -She knew there were days Resident #2 would let staff assist him with incontinence care and some days he refused. -She knew Resident #2 cussed at staff when he refused care. -She thought Resident #2's PCP and mental health provider were aware of his refusal to have assistance with incontinence care. -She did not know of any interventions or suggestion provided from his PCP or mental health provider. Telephone interview with the Director of Operations on 12/07/22 at 4:42pm revealed: -He came to the facility once a month. -When he visited the facility, he made rounds and spoke with residents. -He had been in Resident #2's room and thought it smelled "terrible". -He knew Resident #2 refused care and staff could not force Resident #2 to do anything.	D 269		

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D 269	Continued From page 34 -He thought staff tried to encourage Resident #2 to bathe, cleaned the room, and washed the linen. Attempted telephone call to Resident 2's PCP on 12/08/22 at 1:01pm was unsuccessful. Refer to the interview with the RCC on 12/07/22 at 9:45am. Refer to the interview with the Administrator on 12/08/22 at 11:30am. _____ Interview with the RCC on 12/07/22 at 9:45am revealed: -The PCA were to make rounds on all residents every two hours or more frequently if needed. -When the shift changed the PCA coming on should make rounds with the PCA leaving to ensure all residents were clean and dry. Interview with the Administrator on 12/08/22 at 11:30am revealed: -She expected rounds to be made on residents every 2 hours, especially the residents who were incontinent. -She expected the PCAs to do rounds at each shift change.	D 269		
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	D 273		

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Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 residents sampled (#6) related to notifying the physician of weight loss and refusal of nutritional supplements.

The findings are:

Review of Resident #6's current FL-2 dated 10/27/22 revealed diagnoses included adult failure to thrive, major depression disorder, anxiety, hypertension, chronic pain syndrome.

1. Review of Resident #6's current FL-2 dated 10/27/22 revealed there was an order for weekly weights.

Review of Resident #6's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to check weight weekly between 2:00pm and 10:00pm.
-There was documentation Resident #6 weighed 108 pounds on 10/05/22 at 2:00pm.
-There was documentation Resident #6 refused to be weighed on 10/12/22.
-There was documentation Resident #6 weighed 100.2 pounds on 10/19/22 and 10/26/22 at 2:00pm.

Review of Resident #6's November 2022 eMAR revealed:
-There was an entry to check weight weekly between 2:00pm and 10:00pm.
-There was documentation Resident #6 weighed 100.2 pounds on 11/02/22.
-There was documentation Resident #6 weighed 101.2 pounds on 11/09/22 and 11/16/22.
-There was documentation Resident #6 weighed

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D 273	Continued From page 36 101.0 pounds on 11/23/22 and 11/30/22. Observation of Resident #6 being weighed on 12/06/22 at 2:47pm revealed a current weight of 99.5 pounds. Based on observation and record reviews of Resident #1's weight, she had a 7% weight loss from 10/05/22 to 10/19/22.. Review of Resident #6's progress notes from 10/01/22 to 12/06/22 revealed there was no documentation of Resident #6's Primary Care Provider (PCP) being notified of Resident #6's of weight loss. Interview with Resident #6 on 12/06/22 at 11:14am revealed: -She thought she was weighed monthly. -She thought she had lost some weight, but she did not know how much. Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am revealed: -The medications aides (MA) were responsible for obtaining Resident #6's weekly weight. -The MAs would document Resident #6's weights in the eMAR. -She would review the weights and look for weight loss or weight gain. -If she saw a weight loss or gain of 5 pounds, she would re-weigh the resident. -She re-weighed Resident #6 in October 2022 when her weight dropped. -She thought she recorded the weight she obtained in Resident #6's record. -She notified Resident #6's PCP when the PCP made his weekly visit to the facility. -She thought she documented in Resident #6's record that she had notified the PCP.	D 273		

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D 273	Continued From page 37 Interview with the Administrator on 12/08/22 at 11:30am revealed: -The facility did not have a weight loss policy. -The RCC should notify the resident's PCP for weight loss of 3 pounds in a week of 5 pounds in a month. -The RCC should document notifying the PCP in the resident's record. Attempted telephone interview with Resident #6's PCP on 12/07/22 at 11:12am was unsuccessful. 2. Review of Resident #6's current FL-2 dated 10/27/22 revealed there was an order for nutritional shakes three times daily with meals. Review of the diet order list posted in the kitchen dated 12/05/22 revealed Resident #6 was to be served a nutritional supplement three times daily with meals. Observation of the dinner service meal on 12/05/22, the breakfast and lunch service meal on 12/06/22 and the lunch service meal on 12/07/22 and 12/08/22 revealed Resident #6 was not served a nutritional supplement. Review of Resident #6's October, November, and December 2022 electronic medication administration record (eMAR) revealed: -There was no entry to administer nutritional supplements three times daily with meals. -There was no documentation that nutritional supplements were administered three times daily. Review of Resident #6's progress notes from 10/01/22 to 12/06/22 revealed there was no documentation of Resident #6's Primary Care Provider being notified of Resident # not receiving	D 273		

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her nutritional supplements.

Interview with Resident #6 on 12/06/22 at 11:14am revealed:
-She used to drink nutritional supplements.
-She stopped drinking nutritional supplements about a month ago, the first week of November.
-The facility changed the brand of nutritional supplements they were purchasing, and she did not like the new brand.
-Sometimes the staff would give her a nutritional supplement at a meal, but she rarely was offered a nutritional supplement.
-She had not spoken to her Primary Care Provider PCP about the nutritional supplements.

Interview with a medication aide (MA) on 12/07/22 at 8:38am revealed:
-Resident #6 refused to drink her nutritional supplements after the facility changed brand a month ago.
-Resident #6 stated she did not like the taste of the new brand of nutritional supplements the facility purchased.
-She did not realize Resident #6 did not have an entry on the eMAR for her nutritional supplement.
-She had not spoken to Resident #6's PCP regarding Resident #6's not receiving her nutritional supplement.
-The Resident Care Coordinator (RCC) was responsible for notifying the PCP of Resident #6 not receiving her nutritional supplements.

Interview with a dietary aide (DA) on 12/08/22 at 9:26am revealed:
-She did not serve Resident #6 her nutritional supplements this morning, 12/08/22.
-Resident #6 stopped drinking the nutritional supplements because she did not like the new brand of supplement, so she stopped serving

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them to her.
-She stopped serving nutritional supplements to Resident #6 about 2 weeks ago.
-No one instructed her to stop serving the nutritional supplements to Resident #6.
-If Resident #6 would drink the supplement, she would serve it to her.
-She had told the MA that Resident #6 was not drinking her nutritional supplements.

Interview with the RCC on 12/07/22 at 9:29am revealed:
-She was aware Resident #6 did not like the nutritional supplements.
-Resident #6 said she did not need the supplements, but she would drink them occasionally.
-The facility changed brands of nutritional supplements and Resident #6 did not like the brand of supplements served.
-She had spoken with the PCP regarding Resident #6 refusing her nutritional supplements a few weeks ago on his weekly facility visit.
-She thought she documented the notification in Resident #1's record.

Interview with the Administrator on 12/08/22 at 11:30am revealed:
-She knew Resident #6 had an order for nutritional supplement three times a day with meals.
-She did not know Resident #6 was not drinking her nutritional supplements.
-She did not know the DA had stopped serving Resident #6 the nutritional supplements because Resident #6 was not drinking the nutritional supplements.
-She expected the DA to serve nutritional supplements as ordered.
-She expected the RCC to notify Resident #6's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 40 PCP of refusal to drink the nutritional supplements. -She expected the RCC to document in Resident #6's record of notifying the PCP of Resident #6's refusal to drink the nutritional supplements. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 12/07/22 at 11:12am was unsuccessful. Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation). The facility failed to notify the PCP for a resident (#6) which had a diagnosis of failure to thrive, and order for weekly weights and nutritional supplements three times daily. The resident had a weight loss of 7.8 pounds in two weeks and was not receiving her nutritional supplements three times daily with meal. This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	D 273		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of	D 285		

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non-perishable food in the facility based on the menus, for both regular and therapeutic diets.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, record reviews, and interviews, the facility failed to ensure there was at least a three-day supply of perishable food and a 5-day supply of non-perishable food to serve 41 residents based on the menus.

The findings are:

Review of the census report dated 12/05/22 revealed the facility census was 41 residents.

Interview with a resident on 12/05/22 at 1:22pm revealed:
-The food at the facility "would do" but residents were given smaller portions and he only had a good meal at breakfast when he was served eggs, grits and sometimes cereal.
-For the lunch meal on 12/05/22, he was served spaghetti and iced tea, there were no vegetables or fruit, just spaghetti.
-He asked to have more spaghetti but was told there was none; there usually were no seconds to have.

Interview with a second resident on 12/05/22 at 1:35pm revealed:
-There was not enough food at the facility and the servings were small.
-He had French toast and a scrambled egg for breakfast; there was no milk or orange juice to drink.
-The facility would often go 2 to 3 days without having any milk to drink or put in his cereal.

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D 285	Continued From page 42 -When he asked the dietary staff for milk to drink, they would say there was no milk in the kitchen. -He had spaghetti and a piece of bread with iced tea for lunch today, 12/05/22. -There were no vegetables, fruit, or dessert to go with the meal. -The kitchen staff did not have enough food to prepare a proper meal for the residents. -The kitchen staff sometimes did not post a daily menu to read; they would just tell you what the cook was going to fix. -Sometimes he would like more to eat but was told there was no more food in the kitchen. Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/05/22 at 1:45 pm revealed: -There were 7 one-gallon zip-lock bags of chicken, 20 pounds of spareribs, 8 servings of blueberry pancakes, 8 servings of buttermilk pancakes, 24 servings of waffles, and 12 ice cream sandwiches, in the freezer. -There were 2 one-gallon zip-lock bags of chicken thawing in the sink. -There was one 64-ounce container of 10 6-ounce servings of apple juice, 65 individually wrapped slices of cheese, 2 individual servings of pre-packaged pudding, 42-ounces of 5 servings of 8-ounces of milk, in the refrigerator. -There were two 64-ounce containers of twenty-one 6-ounce servings of apple juice, two 64-ounce containers of twenty-one 6-ounce servings of grape juice, one 10 pound bag of 14 servings of baking potatoes, one 29 ounce can of 5 servings of ½ cup of pasta sauce, one 26 ounce can of cream of 6 servings of ½ cup of chicken condensed soup, four 40 ounce jars of 142 servings of 2 tablespoons of peanut butter, two jars of 84 servings of 1 tablespoon of grape jelly, 2 boxes of 16 servings of ¾ cup of rotini	D 285		

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noodles, five boxes of 15 servings of 1/3 cup macaroni and cheese, five bags of 12.5 servings of ½ cup of chicken flavored broccoli, one box of 6 servings of 1 ¼ cups of bowtie pasta, two packs of 16 servings of one tortilla shell, 3 packages of 18 servings of 5 saltine crackers, four boxes of 16 servings of ½ cup of instant pudding, 48 servings of 1 hamburger bun, two 12 ounce bags of 52 servings of ¼ cup of northern beans, two 12 ounce bags of 36 servings of ¼ cup of lima beans, six 14 ounce cans of 36 servings of ¼ cup of cranberry sauce, two 15 ounce boxes of 20 servings of yellow cake mix, four 3.4 ounce boxes of 16 servings of ½ cups of instant pudding, one bag of 61 servings of ¼ cup of grits, one box of 30 servings of ½ cup of oatmeal, 72 servings of individual pre-packaged applesauce, one box of 18 servings of ½ cup of instant potatoes, and 6 servings of 2 slices of bread, in the pantry.

Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/06/22 at 7:45 am revealed:
-There were forty servings of 1 hash brown in a pan on the kitchen counter.
-There were four 80 servings of 2 slices of bread, 40 servings of one tortilla shell, six cans of 27 servings of 1/2 cup of pineapple, and 5.5 pounds of 36 servings of ½ banana, in the pantry.
-There was one 64-ounce container of 10 6-ounce servings of orange juice, one 64-ounce container of 10 6-ounce servings of apple juice, two 64-ounce containers of 21 6-ounce servings of grape juice, 2 gallons of 32 servings of 8-ounces of milk, and 60 servings of one egg, two 24-ounce bags of 16 servings of 1 ½ cups of shredded lettuce, in the refrigerator.

Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/06/22

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D 285	Continued From page 44 at 3:45pm revealed: -There were 72 servings of individual packaged applesauce, 108 ½ cup servings of pineapple chunks, 64 servings of individual packaged fruit cups, 96 servings of individual packaged fruit medley, 144 servings of individual packaged pudding, 75 3-ounce servings of canned chicken breast, 72 servings of individual packaged peaches, 128 servings of apple juice, 24 servings of pecan pie, 54 servings of ½ cup of macaroni and cheese, 36 servings of one English muffin, 72 servings of one hotdog roll, 80 servings of 2 slices of bread, 100 servings of ½ cup green beans, 108 servings of ½ cup sweet peas, 56 servings of ½ cup of yams, 80 servings of 4-ounce canned chicken breast, 192 servings of ½ cup of instant potatoes, 98 servings of 1 ½ cups of cereal, 30 individual bags of chips, 48 individually wrapped crème cookies, in the pantry. -There were 53 6-ounce servings of orange juice, 5 trays of 7.5 dozen of eggs (450 eggs), 48 8-ounce servings of milk, 5 3-ounce servings of carrots, 126 servings of sausage patties, 43 servings of 4.5 ounces of grapes,192 servings of 4 meatballs, 22 servings of 2 cups of garden salad, and 100 servings of 2 slices of bacon, in the refrigerator. -There were 72 servings of 4 ounces of chicken tenders, 60 servings of 2 ounces of turkey lunch meat, 48 servings of porkchops, 40 servings of one beef patty. 96 servings of 1 wiener, and 100 servings of 2 slices of bacon, in the freezer. Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/08/22 at 11:15am revealed there were 8 14.5-ounce, 36 ½-cup servings of carrots. Interview with the cook on 12/05/22 at 4:00pm revealed:	D 285		

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-The facility no longer had a contracted food service to bring food supplies routinely to the facility.
-Staff had to go shopping to get the foods to prepare the residents' meals.

Interview with a cook on 12/06/22 at 1:25pm and 4:00pm revealed:
-She would prepare meals based on the food that was available in the kitchen.
-There were times she did not have food or enough food to prepare for all the residents and she and other staff would purchase food with their own money to serve the residents.
-She had not spoken to the Administrator about the lack of food in the facility, but she knew the DM had spoken to the Administrator.
-The menu was not able to be followed due to lack of funds to purchase food.

Interview with the cook on 12/08/22 at 11:16am revealed she had asked a staff member to go to the local store and purchase additional carrots for the lunch meal on 12/08/22.

Interview with the Dietary Manager (DM) on 12/06/22 at 9:30am and 1:25pm revealed:
-She did not know how many days of perishable and non-perishable food should be on hand.
-She placed a food order weekly on Monday and picked up the food order on Tuesday.
-There were some weeks, since the first week of October 2022, when there was no funding on Monday and the food order was delayed by a day or two.
-The cooks would prepare meals based on what was available in the kitchen.
-The staff would go to a local store to purchase enough food, with their money, to supplement what was available in the kitchen.

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-The menu items were not always substituted for equal nutritional value.
-Seconds were not always available to serve the residents.
-The last time she ordered food was last Tuesday, 11/29/22.
-The facility received a check yesterday from the Director of Operations.
-The food order was placed today and would be picked up this afternoon, 12/06/22.
-There were not enough funds to purchase everything on the menu for this week.
The Administrator was aware of funding issues for the food.

Interview with the DM on 12/09/22 at 9:30am revealed:
-She was not always able to order everything on the menu due to lack of funds.
-The last order for food was placed on Tuesday, 11/29/22; She would place another order on Tuesday, 12/06/22.
-The staff would purchase food with their own money that was needed to serve when food was running low.
-She was not always able to order everything on the menu due to lack of funds.
-The last order for food was placed on Tuesday, 11/29/22; She would place another order on Tuesday, 12/06/22.
-The staff would purchase food with their own money that was needed to serve when food was running low.
-The menu was not able to be followed due to lack of funds to purchase food.

Interview with the Administrator on 12/05/22 at 4:50pm revealed:
-The Administrator knew there was to be a 3-day supply of perishable food and a 5-day supply of

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non-perishable food in the facility.
-The DM would order the food needed every week, usually on Mondays based on the menu for the week.
-Once the DM entered the order into the computer, she would enter the payment information and placed the order for the food.
-The Administrator had to request funding for food every Friday from the Director of Operations.
-The funds would be loaded onto a debit card, which should be available on Mondays.
-There had been times when the funds to order food were not available until Tuesday or Wednesday.
-When the weekly food order could not be placed on Mondays because the funding had not been loaded on to the debit card, the staff would purchase food with their own money to supplement food needed to prepare meals for the residents.
-She did not know if the food substation was of the same nutritional value or not.
-She had called the Director of Operations three times today, 12/05/22, regarding the need for funds to purchase food for the facility.
-There were not enough funds to maintain 3 to 5 days of perishable and non-perishable food.

Telephone interview with the Owner of the facility on 12/08/22 at 10:45am revealed:
-He was aware of one order of food that was delayed due to an issue with the bank.
-He was made aware earlier in the week that the weekly food supply order was not placed timely for the week of 12/05/22.
-He was not aware that the kitchen staff could not prepare meals as listed on the menus due to the weekly food supply order being delayed.

Attempted telephone interview with the Director of

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D 285	Continued From page 48 Operations on 12/08/22 at 10:40am was unsuccessful. _____ Refer to Tag 291, 10A NCAC 13F .0904(c)(2) Nutrition and Food Service. Refer to Tag 292, 10A NCAC 13F .0904(c)(3) Nutrition and Food Service (Type B Violation). Refer to Tag 297, 10A NCAC 13F .0904(d)(1) Nutrition and Food Service (Type B Violation). Refer to Tag 299, 10A NCAC 13F .0904(d)(3)(A) Nutrition and Food Service. Refer to Tag 302, 10A NCAC 13F .0904(d)(3)(D) Nutrition and Food Service. Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation). _____ The facility failed to maintain a 3-day supply of perishable and a 5-day supply of non-perishable food for 41 residents to provide meals based on the weekly menus, resulting in residents not being served adequately, nutritious meals. This failure resulted in serious neglect to the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/22 for this violation. THE CORRECTION DATE FOR THIS A1 VIOLATION WILL NOT EXCEED JANUARY 8, 2023.	D 285		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service	D 287		

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D 287	Continued From page 49 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all residents were provided with napkins and beverage cups. The findings are: Review of the census report on 12/05/22 at 1:45pm revealed the facility census was 41 residents. Observation of the dinner meal on 12/05/22 at 5:15 revealed: -There were 4, 6, and 8-ounce non-disposable, plastic cups on the dining room tables. -Each resident had two of the three different sized non-disposable, plastic cups at their setting. -The residents were served milk, water or tea, but the serving size was not the same for each resident. -The dietary aide (DA) did not serve milk in the same ounce cup to each resident and water was not served in the same ounce cup to each resident. -The silverware consisted of a fork and spoon,	D 287		

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D 287	Continued From page 50 wrapped in a 12 x 12 paper hand towel. Observation of the breakfast meal on 12/06/22 at 8:00am revealed: -There were 4, 6, and 8-ounce non-disposable, plastic cups and 20 non-disposable coffee cups on the dining room tables. -Some resident had 2 of the three sizes non-disposable, plastic cups and a non-disposable coffee cup and other residents had 3 of the non-disposable, plastic cups without a non-disposable coffee cup. -The residents were served milk, water or juice, but the serving size was not the same for each resident. -The DA did not serve milk in the same ounce cup to each resident and juice was not served in the same ounce cup to each resident. -The non-disposable, coffee cups contained coffee and the non-disposable, plastic cups contained either milk, juice, water, or coffee. Observation of the dining room on 12/06/22 at 10:30am revealed: -The DA was walking from table to table with a container of silverware, a pair of scissors and a roll of paper hand towels. -The DA would roll out the paper hand towels and cut approximately a 12 x 12-inch section. -The DA would place a spoon and fork in the paper hand towel and wrap the silverware. -She would place the rolled silverware at each place setting on the dining room table. Interview with the DA on 12/06/22 at 10:33am revealed: -She cut the paper hand towels and used them as napkins for the residents. -She had been using the paper hand towels for weeks.	D 287		

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D 287	Continued From page 51 -There were no napkins in the facility for the residents to use. -She did not know the last time the facility had napkins for the residents. Observation of supplies in the kitchen on 12/06/22 at 1:30pm revealed: -There were 23 non-disposable coffee cups available for 41 -There were 32 4-ounce non-disposable, plastic cups. -There were 16 6-ounce non-disposable, plastic cups. -There were 34 8-ounce non-disposable, plastic cups. -There were no disposable cups in the facility. -There were no napkins in the facility. Interview with a resident on 12/08/22 at 10:45pm revealed: -The utensils were wrapped in hand paper towels. -It was a rough towel. -She did not know the last time they had napkins in the facility. -There were several different sizes of cups. -There were not enough coffee cups; some residents drink coffee out of disposable cups or non-disposable cups. Interview with a second resident on 12/08/22 at 10:55pm revealed: -The DA did not place napkins on the table during mealtime. -The DA wrapped the utensils in a rough, white paper for the residents to use as napkins. -He did not know the last time the facility placed napkins on the table. Interview with a third resident on 12/08/22 at 11:05pm revealed:	D 287		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 287	Continued From page 52 -He knew there were not enough coffee cups for all the residents. -He had seen some residents drink coffee out of plastic cups, but he had not. -He could not recall the last time there were napkins on the table for the residents to use. -The paper used for the napkins was rough and scratchy. Interview with a cook on 12/06/22 at 4:00pm revealed: -She did not know if there were napkins in the facility. -The DA was responsible for wrapping and placing the silverware on the tables. -She knew there were not enough coffee cups for all residents to be served coffee. -She thought coffee was served in plastic cups to some of the residents. -She knew there were several different sizes of plastic cups, but she did not know there were not enough of each size. Interview with the Dietary Manager (DM) on 12/06/22 at 10:20am revealed: -There were enough coffee cups to serve each resident coffee. -She used to have disposable cups to supplement the remainder of coffee cups that were needed. -If she did not have disposable cups to use, the staff would serve coffee in a non-disposable plastic cups. -There were currently no non-disposable cups in the facility; she could not remember the last time there were non-disposable cups in the facility. -The dietary staff were using non-disposable plastic cups to serve coffee when the coffee cups where being used. -She was not aware the DA was wrapping	D 287		

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	HAL035031	A. BUILDING: _____ B. WING _____	C 12/08/2022

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D 287	Continued From page 53 silverware in paper hand towels. -She was not aware there were no napkins in the facility. -She had not noticed the DA cutting from the roll of paper hand towels to wrap silverware and place on the dining room tables. -There was not enough funding to always purchase napkins and non-disposable cups when needed. Interview with the Administrator on 12/08/22 at 11:30am revealed: -She did not know there were no napkins in the facility. -She did not recall the DM telling her that their were no napkins in the facility. -She would have expected the DM to order more napkins when needed. -She knew funding had been an issue with purchases but she could have requested more funding. -She was made aware of needing additional coffee cups earlier this week. -She knew there were not enough 4, 6 , and 8 ounce cups for each resident. -She reached out to the Director of Operations in July 2022 regarding the need for additional plastic cups. -The Director of Operations was going to order additional plastic cups, but the facility never received any.	D 287		
D 291	10A NCAC 13F .0904(c)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day and cycle	D 291		

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D 291	Continued From page 54 for any given day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain menus in the kitchen and have them available for guidance of food service staff. The findings are: Observations during the initial kitchen tour on 12/05/22 at 12:45 revealed a one-page regular menu titled week 1 for May 2022 in a notebook on the kitchen counter. Interview with a resident on 12/05/22 at 1:35pm revealed: -The kitchen staff did not have enough food to prepare a proper meal for the residents. -The kitchen staff sometimes did not post a daily menu to read; they would just tell you what the cook was going to fix. Interviews with the cook 12/05/22 at 4:00pm and 5:20pm revealed: -They could not access the contracted menus and they were using older menus because the subscription had not been paid for the year. -She used the menu as a guide but did not always have the food on the menu, so they cooked what food was available. Interview with a cook on 12/06/22 at 4:00pm revealed there were a few weeks when there was no menu to follow. Interview with the DM on 12/05/22 at 1:20pm	D 291		

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D 291	Continued From page 55	D 291		

revealed:
-The Administrator had not been able to print the weekly and therapeutic menus since the first week of October 2022 because the subscription had not been paid.
-The last menu the Administrator printed was for the week of 09/25/22.
-The kitchen staff did not have a menu to follow for several weeks; they started following menus from months past a few weeks ago.
-The kitchen staff was currently following a menu from the first week of May 2022.
-The cook prepared the food that was available on the menu.
-There was no sweet potatoes, broccoli, or strawberry cake in the facility to be served.
-She purchased biscuits the afternoon of 12/05/22, for dinner.

Telephone interview with the Dietary Manager (DM) on 12/08/22 at 4:15pm revealed:
-The Administrator could not print menus starting the first week of October 2022 because the subscription had not been pain.
-The was several weeks in October 2022, the cook did not have a menu to follow so there was no way to know what to substitute.

Interview with the Administrator on 12/05/22 at 4:50pm and 12/08/22 at 11:30am revealed:
-The menu subscriptions with the contracted food company had expired.
-She called the Director of Operations and was told the subscription had been paid.
-She was still unable to print the menus.
-She called the Director of Operations three times regarding the menus since the second week in October 2022.
-She asked the DM a few weeks ago to use past menus until she could get the accurate menus

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D 291	Continued From page 56 printed. -The subscription for the menus was paid today, 12/05/22. -She printed this week's menu today, 12/05/22.	D 291		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure menus substitutions were of equal nutritional value and documented. The findings are: Review of the census report dated 12/05/22 revealed the facility census was 41 residents. Review of the menu for the dinner service meal for 12/05/22 revealed: -There was no menu dated 12/05/22 for the dinner service meal. -There was a dinner menu dated 05/02/22 consisting of herb baked chicken, baked sweet potato, steamed rice, baked roll, strawberry cake, and milk was to be offered.	D 292		

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D 292	Continued From page 57 Review of the menu for the lunch service meal dated 12/06/22 revealed tortilla soup, chicken taco salad, Mexican cornbread, and pineapple chunks, and milk was to be offered. Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/05/22 at 1:45 pm revealed: -There were 7 one-gallon zip-lock bags of chicken, 20 pounds of spareribs, 8 servings of blueberry pancakes, 8 servings of buttermilk pancakes, 24 servings of waffles, and 12 ice cream sandwiches, in the freezer. -There were 2 one-gallon zip-lock bags of chicken thawing in the sink. -There was one 64-ounce container of 10 6-ounce servings of apple juice, 65 individually wrapped slices of cheese, 2 individual servings of pre-packaged pudding, 42-ounces of 5 servings of 8-ounces of milk, in the refrigerator. -There were two 64-ounce containers of twenty-one 6-ounce servings of apple juice, two 64-ounce containers of twenty-one 6-ounce servings of grape juice, one 10 pound bag of 14 servings of baking potatoes, one 29 ounce can of 5 servings of ½ cup of pasta sauce, one 26 ounce can of cream of 6 servings of ½ cup of chicken condensed soup, four 40 ounce jars of 142 servings of 2 tablespoons of peanut butter, two jars of 84 servings of 1 tablespoon of grape jelly, 2 boxes of 16 servings of ¾ cup of rotini noodles, five boxes of 15 servings of 1/3 cup macaroni and cheese, five bags of 12.5 servings of ½ cup of chicken flavored broccoli, one box of 6 servings of 1 ¼ cups of bowtie pasta, two packs of 16 servings of one tortilla shell, 3 packages of 18 servings of 5 saltine crackers, four boxes of 16 servings of ½ cup of instant pudding, 48 servings of 1 hamburger bun, two 12 ounce bags of 52	D 292		

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D 292	Continued From page 58	D 292		

servings of ¼ cup of northern beans, two 12 ounce bags of 36 servings of ¼ cup of lima beans, six 14 ounce cans of 36 servings of ¼ cup of cranberry sauce, two 15 ounce boxes of 20 servings of yellow cake mix, four 3.4 ounce boxes of 16 servings of ½ cups of instant pudding, one bag of 61 servings of ¼ cup of grits, one box of 30 servings of ½ cup of oatmeal, 72 servings of individual pre-packaged applesauce, one box of 18 servings of ½ cup of instant potatoes, and 6 servings of 2 slices of bread, in the pantry.

Based on observation of the pantry, refrigerator, and the freezer and review of the dinner menu for 12/05/22 and the lunch menu for 12/06/22, the following items were not available to be served:
-Sweet potatoes.
-Rolls.
-Strawberry cake.
-Tortilla soup.
-Mexican cornbread
-Pineapple chunks.

Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/06/22 at 7:45 am revealed:
-There were forty servings of 1 hash brown in a pan on the kitchen counter.
-There were four 80 servings of 2 slices of bread, 40 servings of one tortilla shell, six cans of 27 servings of 1/2 cup of pineapple, and 5.5 pounds of 36 servings of ½ banana, in the pantry.
-There was one 64-ounce container of 10 6-ounce servings of orange juice, one 64-ounce container of 10 6-ounce servings of apple juice, two 64-ounce containers of 21 6-ounce servings of grape juice, 2 gallons of 32 servings of 8-ounces of milk, and 60 servings of one egg, two 24-ounce bags of 16 servings of 1 ½ cups of shredded lettuce, in the refrigerator.

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D 292	Continued From page 59 Observation of the food storage areas including the pantry, refrigerator, and freezer on 12/06/22 at 3:45pm revealed: -There were 72 servings of individual packaged applesauce, 108 ½ cup servings of pineapple chunks, 64 servings of individual packaged fruit cups, 96 servings of individual packaged fruit medley, 144 servings of individual packaged pudding, 75 3-ounce servings of canned chicken breast, 72 servings of individual packaged peaches, 128 servings of apple juice, 24 servings of pecan pie, 54 servings of ½ cup of macaroni and cheese, 36 servings of one English muffin, 72 servings of one hotdog roll, 80 servings of 2 slices of bread, 100 servings of ½ cup green beans, 108 servings of ½ cup sweet peas, 56 servings of ½ cup of yams, 80 servings of 4-ounce canned chicken breast, 192 servings of ½ cup of instant potatoes, 98 servings of 1 ½ cups of cereal, 30 individual bags of chips, 48 individually wrapped crème cookies, in the pantry. -There were 53 6-ounce servings of orange juice, 5 trays of 7.5 dozen of eggs (450 eggs), 48 8-ounce servings of milk, 5 3-ounce servings of carrots, 126 servings of sausage patties, 43 servings of 4.5 ounces of grapes,192 servings of 4 meatballs, 22 servings of 2 cups of garden salad, and 100 servings of 2 slices of bacon, in the refrigerator. -There were 72 servings of 4 ounces of chicken tenders, 60 servings of 2 ounces of turkey lunch meat, 48 servings of porkchops, 40 servings of one beef patty. 96 servings of 1 wiener, and 100 servings of 2 slices of bacon, in the freezer. Observation of the dinner service meal on 12/05/22 at 5:00pm revealed: -The residents were served two chicken legs or a chicken leg and a thigh in gravy, a ½ cup of buttered rice and	D 292		

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D 292	Continued From page 60	D 292		

a biscuit with iced tea.
-The following items were not available for the dinner meal on 12/05/22, sweet potatoes, rolls, or strawberry cake.

Observation of the lunch meal on 12/06/22 at 12:10pm revealed:
-The residents were served 2 tablespoons of shredded chicken on a tortilla soft shell, with 1 tablespoon each of lettuce and salsa and a 1/4 cup of pineapple chunks, a cup of tea and water.
-The following items were not available for the lunch meal on 12/06/22, tortilla soup, tomatoes for the taco salad, and Mexican cornbread.

The menu substation list was requested on 12/06/22 at 1:00pm but was not provided by survey exit.

Interviews with the cook 12/05/22 at 4:00pm and 5:20pm revealed:
-She was supposed to follow the prepared menu and serve residents the documented foods.
-She did not follow the menu because they did not have the foods in the kitchen to prepare the meal as written.
-They could not access the contracted menus and they were using older menus because the subscription had not been paid for the year.
-She used the menu as a guide but did not always have the food on the menus, so they cooked what food was available.

Interview with the cook on 12/06/22 at 12:30pm revealed:
-She did not complete a menu substitution list.
-There was no food in the facility to substitute for the food listed on the menu.
-She prepared the food that was in the facility based on the menu as much as possible.

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D 292	Continued From page 61 -She had never completed a menu substitution list. Telephone interview with the Dietary Manager (DM) on 12/08/22 at 4:15pm revealed: -The cook decided what to substitute when the food listed on the menu was not available. -There was not always food to substitute of equal nutritional value. -The cooks should be completing a menu substitution list when possible. -Menu substitution forms were not being completed with each food substitution. -Sometimes there was no food available to substitute for the food listed on the menu. Interview with the Administrator on 12/08/22 at 11:30am revealed: -Menu substitution lists should be completed with each food that was substituted. -The DM should decide what food would be substituted if the food on the menu was not available and complete the menu substitution list. -The food substituted should be of the same nutritional value as was listed on the menu. -The cook was not responsible for deciding what food to substitute; it was the responsibility of the DM. -She expected the DM to substitute foods correctly and to complete the menu substitution list daily when needed. _____ The facility failed to document substitutions to the menu and ensure foods served as substitutions were of equal nutritional value which was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. — _____	D 292		

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D 292	Continued From page 62 The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	D 292		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to offer servings from all food groups and the portion sizes of food and beverages which matched the menu. The findings are: Review of the census report dated 12/05/22 revealed the facility census was 41 residents. Interview with the DM on 12/05/22 at 1:20pm revealed: -The Administrator had not been able to print the weekly and therapeutic menus since the first week of October 2022 because the subscription had not been paid. -The last menu the Administrator printed was for the week of 09/25/22.	D 297		

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D 297	Continued From page 63 -The kitchen staff did not have a menu to follow for several weeks; they started following menus from months past a few weeks ago. -The kitchen staff was currently following a menu from the first week of May 2022. -The cook prepared the food that was available on the menu. Interview with a resident on 12/05/22 at 12:55pm revealed: -She had eggs, grits, and French toast this morning, 12/05/22, for breakfast. -She would have liked milk to drink but there was none in the facility. -She had not been offered milk in 3 days. Interview with a second resident on 12/05/22 at 1:22pm revealed: -The food at the facility "would do" but residents were given smaller portions and he only had a good meal at breakfast when he was served eggs, grits and sometimes cereal. -For the lunch meal on 12/05/22, he was served spaghetti and iced tea, there were no vegetables or fruit, just spaghetti. -He asked to have more spaghetti but was told there was none; there usually were no seconds to have. Interview with a third resident on 12/05/22 at 1:35pm revealed: -There was not enough food at the facility and the servings were small. -He had French toast and a scrambled egg for breakfast; there was no milk or orange juice to drink. -The facility would often go 2 to 3 days without having any milk to drink or put in his cereal. -When he asked the dietary staff for milk to drink, they would say there was no milk in the kitchen.	D 297		

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D 297	Continued From page 64 -He had spaghetti and a piece of bread with iced tea for lunch today, 12/05/22. -There were no vegetables, fruit, or dessert to go with the meal. -The kitchen staff did not have enough food to prepare a proper meal for the residents. -The kitchen staff sometimes did not post a daily menu to read; they would just tell you what the cook was going to fix. -Sometimes he would like more to eat but was told there was no more food in the kitchen. Interview with a fourth resident on 12/05/22 at 1:45pm revealed: -He was served spaghetti, a piece of bread, and a glass of iced tea to eat for his lunch on 12/05/22. -There were no vegetables, no fresh fruit, fruit juice, or dessert served with the meal. Interview with a fifth resident on 12/05/22 at 1:50pm revealed: -"He could cook a better meal than what he was served for lunch". -He was served spaghetti, a piece of bread, and a glass of tea, for lunch today, 12/05/22. -He was not offered any vegetables, fruit, dessert, or milk. -Milk would run out 2 days of every week; no one would go and buy more milk. Interview with a sixth resident on 12/05/22 at 2:15pm revealed: -She was served spaghetti and garlic bread for lunch today, 12/05/22. -She asked for seconds but there was no more to be served. -The kitchen staff did not serve meat at breakfast today, 12/05/22. -The residents had not been served milk in 2 to 3 days.	D 297		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 297	Continued From page 65	D 297		

-The kitchen staff had not served dessert in about 2 weeks; a staff member brought cake to the residents for the holiday last month.
-She could not recall the last time she was served greens.

Interviews with the cook 12/05/22 at 4:00pm and 5:20pm revealed:
-She was supposed to follow the prepared menu and serve residents the documented foods.
-She did not follow the menu because they did not have the foods in the kitchen to prepare the meal as written.
-The facility no longer had a contracted food service to bring food supplies routinely to the facility.
-Staff had to go shopping to get the foods to fix the residents' meals.
-They could not access the contracted menus and they were using older menus because the subscription had not been paid for the year.
-She used the menu as a guide but did not always have the food on the menu so they cooked what food was available.

Observation of the dinner service meal on 12/05/22 at 5:00pm revealed
the residents were served two chicken legs or a back and a chicken leg, a 1/4 cup of buttered rice and a biscuit.

Observation of breakfast service meal on 12/06/22 at 8:15am revealed
the residents were served 1/4 cup of scrambled eggs, one hash brown, 15 to 20 grapes, and one piece of toast.

Observation of the lunch meal on 12/06/22 at 12:10pm revealed the residents were served 2 tablespoons of shredded chicken on a tortilla soft

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	HAL035031	A. BUILDING: _____ B. WING _____	C 12/08/2022

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D 297	Continued From page 66 shell, with 1 tablespoon each of lettuce and salsa and a 1/4 cup of pineapple chunks, Interview with a cook on 12/06/22 at 12:30pm revealed: -She prepared a chicken taco for all the residents. -She did not have the ingredients to prepare the Mexican cornbread. -She did not serve the tortilla soup because she chose to serve the soft-shell taco. -She only had to serve the tortilla soup or the taco, not both. -She thought she could choose which one to serve, the tortilla soup or the soft-shell taco. -She did not know she was to serve the tortilla soup and the taco salad. -There were no ingredients available to prepare the tortilla soup. -She thought the chicken soft-shell taco she served was the same as the chicken taco salad. -She did not have cheese or tomato to go on the chicken soft-shell taco. -They did not always have the food to prepare as listed on the menu. Observation of the lunch menu on 12/07/22 at 12:02pm revealed the residents were served 3/4 cups of baked ziti, a 1/2 cup of lettuce salad, a slice of garlic toast and a pre-fixed cup of fruit. Interview with a cook on 12/07/22 at 12:33pm revealed: -She had to serve the Italian vegetable soup or the baked ziti; she chose to serve the baked ziti. -She thought she only had to serve either the Italian vegetable soup or the baked ziti; she did not know she was to prepare both. -She did not recall who told her she did not have to serve both food items.	D 297		

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D 297	Continued From page 67 -She did not have tomatoes for the salad. Observation of the breakfast meal on 12/08/22 at 8:10am revealed the residents were served 2 inch by 2 inch serving of the ham, egg and cheese casserole, 15 to 20 grapes and one piece of toast. Observation of the lunch service meal on 12/08/22 at 12:05pm revealed the residents were served a beef patty with gravy, 1/2 cup of carrots and one slice of toast. Interview with the cook on 12/08/22 at 1:35pm revealed: -The turkey for lunch on 12/08/22 was not taken out of the freezer the previous night. -The hamburger patties were taken out this morning and thawed in time for lunch. -She switched the lunch and dinner menu for today, 12/08/22. -She did not have green salad or baked potato to serve. -She did not know there was a 10 pound bag of baking potatoes in the pantry. -She did not know there was a bag of lettuce in the refrigerator. -She forgot to serve the pudding. Interview with a DM on 12/06/22 at 1:25pm revealed: -The soup and baked ziti were to be served at the lunch service meal. -There was no canned vegetable soup or ingredients to prepare a vegetable soup in the kitchen. -There were no tomatoes in the kitchen to be served with the salad. -The menu was not able to be followed due to lack of funds to purchase food.	D 297		

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D 297	Continued From page 68 Interview with a DM on 12/09/22 at 9:30am revealed: -She did not know the lunch and dinner menu for 12/08/22 had to be switched. -She had instructed the kitchen staff to take the turkey out of the freezer the evening of 12/07/22. -There was a bag of potatoes and boxes of pudding in the pantry, and lettuce in the refrigerator, that should have been prepared for lunch on 12/08/22. -She would order food for the facility once a week on Mondays and pick the food up from a local business. -She would order enough food for a week based on the menu. -There were days when cooks had to prepare food that was available in the kitchen verses what was on the menu. Interview with the Administrator on 12/05/22 at 4:50pm and 12/08/22 at 11:30am revealed: -The menu subscriptions with the contracted food company had expired. -She called the Director of Operations and was told the subscription had been paid. -She was still unable to print the menus. -She called the Director of Operations three times regarding the menus since the second week in October 2022. -She asked the DM a few weeks ago to use past menus until she could get the accurate menus printed. -The subscription for the menus was paid today, 12/05/22. -She printed this week's menu today, 12/05/22. -She would have to notify the Director of Operations on Fridays to load money on the debit care so food could be purchased on Monday for the week.	D 297		

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D 297	Continued From page 69 -The DM would order the food weekly, on Monday, based on the menu for the week. -She would enter the payment once the debit card was loaded with funds. -She was not aware the DM was unable to purchase all the food needed to serve the residents based on the menu. -She was not aware the residents were not served a nutritious meal three times a day. -She expected the DM to order enough food for the residents for a week based on the menu. -If there was not enough funding to pay for the food the DM ordered, the Administrator would request more funding. _____ The facility failed to ensure residents were served three nutritionally adequate meals a day, including foods from five food groups, including fruits, vegetables, grains, protein and dairy to meet the dietary guidelines and provide a range of vitamins and minerals the body needs to function efficiently. The facility's failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	D 297		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes:	D 299		

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D 299	Continued From page 70 (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 8 ounces of milk was served to the residents twice daily. The findings are: Review of the census report on 12/05/22 at 1:45pm revealed the facility census was 41 residents. Review of the daily menus from 12/05/22 to 12/08/22 revealed milk was to be offered at every meal. Observation of the kitchen on 12/05/22 at 12:58pm revealed: -There were 7 non-disposable, plastic 6-ounce cups sitting on a tray in the refrigerator. -Each non-disposable, plastic 6-ounce cup contained milk. -There was no other milk available in the facility. Interview with a resident on 12/05/22 at 12:55pm revealed she would like milk to drink but there was none in the facility she had not been offered milk in 3 days.	D 299		

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D 299	Continued From page 71 Interview with a second resident on 12/05/22 at 1:35pm revealed: -The facility would often go 2 to 3 days without having any milk to drink or put in his cereal. -When he asked the dietary staff for milk to drink, they would say there was no milk in the kitchen. Interview with a third resident residing on the 300-hall on 12/05/22 at 1:50pm revealed: -He was not offered milk today for breakfast or lunch. -Milk would run out 2 days of every week; no one would go and buy more milk. Interview with a fourth resident on 12/05/22 at 2:15pm revealed the resident had not been served milk in 2 to 3 days. Review of a food purchase receipt dated 12/05/22 time stamped 21:54 revealed two gallons of 2% milk were purchased which totals 32 eight-ounce servings of milk, leaving the facility short by 9 servings. Observation of the refrigerator on 12/06/22 at 10:00am revealed: -There was 1 unopened gallon of 2% milk in the refrigerator which would serve 16 residents with one 8-ounce serving. -There was a second opened gallon of 2% milk in the refrigerator, which was about ¾ empty, leaving 4 8-ounce servings of milk available for serving. Observation of the dinner service meal on 12/05/22 at 5:00pm revealed the residents were not offered or served milk. Observation of the breakfast meal service on 12/06/22 from 8:15am to 8:30am revealed	D 299		

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D 299	Continued From page 72 6-ounces of milk were served to residents who requested milk. Observation of the lunch meal on 12/06/22 from 12:10:pm to 12:40:pm revealed residents were not served or offered milk. Interview with a dietary aide (DA) on 12/06/22 at 9:09am revealed -She offered milk to the residents at breakfast and dinner and served milk to the residents that wanted milk. -She served milk in a 6-ounce non-disposable, plastic cup. -She did not realize the residents were to receive 8 ounces of milk twice daily. -She did not realize the cups she was serving the milk in were not the correct size cups. Interview with the Dietary Manager (DM) on 12/06/22 at 9:30am revealed: -The DA offered milk to all residents and served milk to the residents who wanted milk twice daily, breakfast and dinner -She did not realize the residents received the wrong serving size of milk. -The DA served milk in the non-disposable, plastic cups that were available in the facility. -She did not realize the DA should offer milk at lunch. -Milk was not offered or served during snacks. Interview with the Administrator on 12/05/22 at 4:50pm and 12/08/22 at 11:30am revealed: -She was unaware the residents were served 6-ounces of 100% juice instead of 8-ounces. -She expected the kitchen staff to provide 8-ounces of milk for each resident for each meal.	D 299		

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D 302	Continued From page 73	D 302		
D 302	10A NCAC 13F .0904(d)(3)(D) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following (D) Eggs: One whole egg or substitute (e.g., 2 egg whites or ¼ cup of pasteurized egg product) at least three times a week at breakfast. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve eggs to residents at least three times a week for breakfast. The findings are: Observation of the refrigerator in the kitchen on 12/05/22 at 12:58pm revealed there were no eggs available to serve. Review of the weekly menu posted in the kitchen revealed: -There was no current menu for the week of 12/05/22 -There was a weekly menu dated 05/01/22 available in the kitchen for the cooks to follow. -Eggs were too be served three days a week at breakfast, based on the menu. Review of the breakfast service menu for 12/06/22 revealed that each resident was to be served 1 scrambled egg. Interview with a resident on 12/05/22 at 12:55pm revealed: -The kitchen staff served scrambled eggs this morning.	D 302		

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D 302	Continued From page 74 -The serving size was not very large. -She would have like to have had more eggs this morning, but there were not available. -The have eggs a few times a week, they are not always available to serve. Interview with a second resident on 12/05/22 at 1:22pm revealed: -He was served eggs this morning. -He did not recall the last time he was served eggs. -He thinks he gets eggs for breakfast twice a week. -He could eat eggs every day for breakfast if they were served. Interview with a third resident 12/05/22 at 1:35pm revealed: -He ate eggs this morning for breakfast. -He asked for more eggs, but he did not get anymore. -He was told there were no more eggs in the kitchen. Review of a food receipt dated 12/05/22 time stamped 21:54 revealed there were two boxes of 2.5 dozen (60) eggs purchased. Observation of the refrigerator on 12/06/22 at 10:00am revealed there was one box of 2.5 dozen eggs (30) available to be served. Interview with the cook for the breakfast meal on 12/06/22 revealed: -She cooked one box of eggs (30) for breakfast this morning. -She thought 30 eggs would be enough with the other food that was being served. -She did not check the serving size on the menu. -She should have cooked 41 eggs for breakfast	D 302		

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D 302	Continued From page 75 and served each resident one egg. Interview with the Dietary Manager (DM) on 12/06/22 at 4:00pm revealed: -The cook prepared all the eggs that were in the facility for breakfast on 12/05/22. -She did not know how many eggs she cooked. -The cook told her yesterday, 12/05/22, that there were no more eggs in the kitchen. -Funding was received from the Director of Operations on 12/05/22 and she was able to purchase eggs yesterday for breakfast on 12/06/22. -She purchased two boxes of 2.5 dozen eggs per box for a total of 60 eggs. -The cook should have prepared 41 eggs so each resident could be served one egg. -She did not know why she only prepared one box (30) eggs for 41 residents. -We have eggs in the facility most of the time, but there have been a few times we did not have them to prepare and serve for breakfast. -When there are no eggs in the facility, the cook will substitute another food that is in the facility. -Sometimes there was no food available to substitute for the food listed on the menu. -We have a difficult time keeping food stocked in the kitchen due to funding. Interview with the Administrator on 12/06/22 at 4:50pm revealed: -The DM should be ordering enough eggs for the week based on the menu. -She did not know the last eggs in the kitchen were prepared at breakfast on 12/05/22, until the DM told her later the same day. -She had notified the Director of Operations on 12/05/22 that funding was needed to purchase eggs for breakfast on 12/06/22. -The funding was received on 12/05/22, and the	D 302		

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D 302	Continued From page 76 DM purchased eggs for breakfast for 12/06/22. -She did not know how many eggs the DM purchased but she should have purchased enough for the breakfast meal. -She did not know the cook did not prepare enough eggs for the breakfast meal on 12/06/22. -The cooks should be referring to the menus when preparing meals so there to be enough food for the residents. -She expected the cooks to prepare enough eggs for each resident to have a full serving.	D 302		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure nutritional supplements were served to 5 of 7 sample residents (#2, #4, #5, #6, #7) as ordered by the Primary Care Provider (PCP). The findings are: Interview with a resident on 12/05/22 at 1:22pm revealed:	D 310		

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-The kitchen staff did not have enough food to prepare a proper meal for the residents.
-The kitchen staff sometimes did not post a daily menu to read; they would just tell you what the cook was going to fix.
-Sometimes he would like more to eat but was told there was no more food in the kitchen.

Review of the diet order list dated 12/05/22 posted in the kitchen revealed there were 5 residents receiving nutritional supplements three times daily with meals and 2 residents receiving nutritional supplements twice daily with meals for a total of 25 supplements daily.

1. Review of Resident #6's current FL-2 dated 10/27/22 revealed:
-Diagnoses included adult failure to thrive, major depression disorder, anxiety, hypertension, chronic pain syndrome.
-There was an order for nutritional supplements three times a day with meals.
-There was an order for weekly weights.

Review of diet order list posted in the kitchen dated 12/05/22 revealed Resident #6 was to be served a nutritional supplement three times daily with meals.

Observation of the dinner service meal on 12/05/22, the breakfast and lunch service meal on 12/06/22 and the lunch service meal on 12/07/22 and 12/08/22 revealed Resident #6 was not served a nutritional supplement.

Review of Resident #6's October 2022 electronic medication administration record (eMAR) revealed:
-There was no entry to administer nutritional supplements three times daily with meals and no

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documentation that nutritional supplements were administered three times daily.
-There was an entry to check weight weekly between 2:00pm and 10:00pm.
-There was documentation Resident #6 weighed 108 pounds on 10/05/22 at 2:00pm.
-There was documentation Resident #6 refused to be weighed on 10/12/22.
-There was documentation Resident #6 weighed 100.2 pounds on 10/19/22 and 10/26/22 at 2:00pm.

Review of Resident #6's November 2022 eMAR revealed:
-There was no entry to administer nutritional supplements three times daily with meals and no documentation that nutritional supplements were administered three times daily.
-There was an entry to check weight weekly between 2:00pm and 10:00pm.
-There was documentation Resident #6 weighed 100.2 pounds on 11/02/22.
-There was documentation Resident #6 weighed 101.2 pounds on 11/09/22 and 11/16/22.
-There was documentation Resident #6 weighed 101.0 pounds on 11/23/22 and 11/30/22.

Review of Resident #6's December 2022 eMAR from 12/01/22 to 12/06/22 revealed:
-There was no entry to administer nutritional supplements three times daily with meals no documentation that nutritional supplements were administered three times daily.
-The as an entry to check weight weekly between 2:00pm and 10:00pm.
-There was no documentation of a weekly weight; the weekly weight was not due until 12/07/22

Observation of Resident #6 being weighed on 12/06/22 at 2:47pm revealed a current weight of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 79 99.5 pounds. Based on observation and record reviews of Resident #6's weight, she had a 7% weight loss from 10/05/22 to 10/19/22. Interview with Resident #6 on 12/06/22 at 11:14am revealed: -She used to drink nutritional supplements. -She stopped drinking nutritional supplements about a month ago. -The facility changed the brand of nutritional supplements they were purchasing, and she did not like the new brand. -Sometimes the staff would give her a nutritional supplement at a meal, but she rarely was offered a nutritional supplement. -She thought she was weighed monthly. -She knew she had lost some weight, but she did not know how much. Interview with a medication aide (MA) on 12/07/22 at 8:38am revealed: -Resident #6 refused to drink her nutritional supplements after the facility changed brands one to two months ago. -Resident #6 stated she did not like the taste of the new brand of nutritional supplements the facility purchased. Interview with the DM on 12/06/22 at 9:50am revealed: -Resident #6 had an order to receive supplements three times daily, but she refused the supplements. -Resident #6 refused the supplements for the past month because she did not like the brand that was being currently purchased. Interview with the RCC on 12/07/22 at 9:29am	D 310		

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revealed:
-She was aware Resident #6 refused her supplements.
-Resident #6 said she did not need the supplements, but she would drink them occasionally.
-The facility changed brands of nutritional supplements and Resident #6 did not like the brand of supplements served.
-She was not aware that the nutritional supplements were not entered on the eMAR.
-The MA should have recognized the supplement was not entered on the eMAR and notified the RCC or the pharmacy.

Interview with a dietary aide (DA) on 12/08/22 at 9:26am revealed:
-She did not serve Resident #6 her nutritional drink this morning.
-She used to serve Resident #6 her nutritional drink.
-Resident #6 stopped drinking the nutritional drink so she stopped serving them to her.
-She stopped serving nutritional drinks to Resident #6 about 2 weeks ago.
-No one instructed her to stop serving the nutritional supplements to Resident #6.
-If Resident #6 would drink the supplement, she would serve it to her.
-Resident #6 stated she did not like the new brand of supplement that was being served.

Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 12/07/22 at 11:12am was unsuccessful.

Refer to the interview with a medication aide (MA) on 12/07/22 at 8:38am.

Refer to the interview with a cook on 12/05/22 at

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D 310	Continued From page 81 5:55pm and 12/06/22 at 4:00pm. Refer to the interview with a DA on 12/05/22 at 5:45pm and 12/07/22 at 9:22am. Refer to the interview with the Dietary Manager (DM) on 12/06/22 at 9:50am. Refer to the telephone interview with the DM on 12/08/22 at 8:48am. Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am and 12/08/22 at 8:45am.. Refer to the interview with the Administrator on 12/08/22 at 11:12 am and 11:30am. 2. Review of Resident #7's current FL-2 dated 02/03/22 revealed: -Diagnoses included dementia, schizophrenia, Alzheimer's disease, neuropathy, and hypertension. -There was an order for nutritional shakes three times a day with meals. Review of diet order list posted in the kitchen dated 12/05/22 revealed Resident #7 was to be served a nutritional supplement three times a day with meals. Observation of the dinner service meal on 12/05/22 and the breakfast service meal on 12/06/22 revealed Resident #7 was not served a nutritional supplement. Review of Resident #7's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for nutritional supplement	D 310		

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three times daily with meals to be administered at 8:00am, 12:00pm, and 5:00pm.
-There was documentation the nutritional supplement was administered three times daily from 10/01/22 to 12/05/22 and at 8:00am and 12:00pm on 12/06/22.
-There was an entry for monthly weight check to be obtained between 2:00pm and 10:00pm.
-There was entry to check weight monthly between 2:00pm and 10:00pm.
-There was documentation Resident #7 weighed 131 pounds on 10/11/22.

Review of Resident #7's November 2022 eMAR revealed:
-There was an entry for nutritional supplement three times daily with meals to be administered at 8:00am, 12:00pm, and 5:00pm.
-There was documentation the nutritional supplement was administered three times daily from 10/01/22 to 12/05/22 and at 8:00am and 12:00pm on 12/06/22.
-There was an entry to check weight monthly between 2:00pm and 10:00pm.
-There was no documentation Resident #7 weights was obtained in November 2022.

Review of Resident #7's December 2022 eMAR revealed:
-There was an entry for nutritional supplement three times daily with meals to be administered at 8:00am, 12:00pm, and 5:00pm.
-There was documentation the nutritional supplement was administered three times daily from 10/01/22 to 12/05/22 and at 8:00am and 12:00pm on 12/06/22.
-There was an entry to check weight monthly between 2:00pm and 10:00pm.
-There was no documentation Resident #7's weight had been checked in December 2022,

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D 310	Continued From page 83 Observation of Resident #7 being weighed on 12/06/22 at 2:46pm revealed a current weight of 123 pounds. Based on observation and record reviews of Resident #7's weight, he had a 6% weight loss from 10/11/22 to 12/06/22. Interview with Resident #7 on 12/06/22 at 11:02am revealed: -He was supposed to receive supplements three times daily. -He was ordered supplements because he wanted to gain weight. -He was not weighed every month. -He was weighed about 5 to 6 months ago and he weighed about 150 pounds. -He had not been served nutritional supplements three times a day with meals for 4 to 5 months. Interview with a medication aide (MA) on 12/07/22 at 8:38am revealed: -Resident #7 had an order for nutritional supplements three times daily with meals. -She thought Resident #7 received nutritional supplements three times daily with meals. -She thought Resident #7 received a nutritional supplement during the dinner service meal on 12/05/22 and the breakfast service meal on 12/06/22. -She served Resident #7 a nutritional supplement on Tuesday, 12/06/22, during the lunch service meal. -She asked the dietary aide (DA) to ensure Resident #7 received his nutritional supplement prior to documenting on Resident #7's eMAR. -She did not recall being told that Resident #7 did not receive a nutritional supplement as ordered.	D 310		

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D 310	Continued From page 84 Interview with the RCC on 12/07/22 at 9:29am revealed: -She knew Resident #7 had an order for nutritional supplements three times daily with meals. -She thought Resident #7 received nutritional supplements as ordered. -She did not know Resident #7 was not served nutritional supplements as ordered. -She did no know Resident #7 had a 6% weight loss since 10/06/22. Interview with a DA on 12/08/22 at 9:26am revealed: -She did not serve Resident #7 a nutritional supplement for the dinner meal service on 12/05/22 or the breakfast meal service on 12/06/22. -There were only 4 nutritional supplements in the kitchen; she did not have enough for residents with nutritional supplement orders, so she did not serve them. -The MA requested the 4-nutritional supplements that were in the kitchen; she served Resident #7 a nutritional supplement during the lunch service meal. Attempted telephone interview with Resident #7's Primary Care Provider (PCP) on 12/07/22 at 11:12am was unsuccessful. Refer to the interview with a medication aide (MA) on 12/07/22 at 8:38am. Refer to the interview with a cook on 12/05/22 at 5:55pm and 12/06/22 at 4:00pm. Refer to the interview with a DA on 12/05/22 at 5:45pm and 12/07/22 at 9:22am.	D 310		

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D 310	Continued From page 85 Refer to the interview with the Dietary Manager (DM) on 12/06/22 at 9:50am. Refer to the telephone interview with the DM on 12/08/22 at 8:48am. Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am and 12/08/22 at 8:45am.. Refer to the interview with the Administrator on 12/08/22 at 11:12 am and 11:30am. 3. Review of Resident #4's current FL-2 dated 02/01/22 revealed diagnoses including dementia, schizophrenia, depressive disorder, insomnia, Gastro-esophageal reflux (GERD), alcohol dependence and nicotine dependence. Review of Resident #4's primary care provider (PCP) orders dated 10/18/22 revealed an order for a regular diet and 1 container of a name brand nutritional shakes twice daily with meals. Review of Resident #4's October 2022, November 2022 and December 2022 electronic medication administration records (E-MARs) revealed an entry for Nutritional Drink Liquid drink 1 shake twice a day with meals. -The October 2022 E-MAR for Resident #4 revealed there were MA's initials documenting the administration of the shake for 8:00am and 8:00 pm, every day, for October 1-31, 2022. -The November 2022 E- MAR for Resident #4 revealed there were MA's initials documenting the administration of the shake for 8:00am and 8:00 pm, every day, for October 1-30, 2022. -The December 2022 E- MAR for Resident #4 revealed there were MA's initials documenting the administration of the shake for 8:00am and 8:00 pm, every day, for October 1-5, 2022.	D 310		

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D 310	Continued From page 86 -Observation of the evening meal on 12/05/22 revealed no name brand nutritional shake drink was placed at Resident $4's place setting or offered to Resident #4 to drink with his meal. Observation of the kitchen refrigerator on 12/05/22 at 4:45pm and and 5:45pm revealed there were 4 containers of a name brand nutritional shake on the shelf before Resident #4 started his evening meal and 4 containers on the shelf after Resident #4's meal. Observation of Resident #4 seated in the dining room on 12/05/22 at 5:00pm revealed: -Resident #4 was given a glass of iced tea to drink. -Resident #4 ate his meal and drank all his tea. -Resident #4 was not given a nutritional shake when staff brought the resident his tea to drink with his meal. -Resident #4 was not offered a nutritional shake during the meal. -Resident #4 finished his meal and left the dining room without having the ordered nutritional shake to drink. Attempted interview with Resident on 12/05/22 at 5:35pm was unsuccessful. Observation of the kitchen refrigerator on 12/05/22 at 5:37pm revealed: -The same 4 cartons of nutritional shakes were still placed on the refrigerator shelf. -The nutritional shakes had not been distributed to residents during the evening meal. Attempted interview with Resident on 12/05/22 at 5:35pm was unsuccessful.	D 310		

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Attempted telephone call to Resident 4's Primary Care Provider (PCP) on 12/08/22 at 1:01pm was unsuccessful.

Refer to the interview with a medication aide (MA) on 12/07/22 at 8:38am.

Refer to the interview with a cook on 12/05/22 at 5:55pm and 12/06/22 at 4:00pm.

Refer to the interview with a DA on 12/05/22 at 5:45pm and 12/07/22 at 9:22am.

Refer to the interview with the Dietary Manager (DM) on 12/06/22 at 9:50am.

Refer to the telephone interview with the DM on 12/08/22 at 8:48am.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am and 12/08/22 at 8:45am..

Refer to the interview with the Administrator on 12/08/22 at 11:12 am and 11:30am.

4. Review of Resident #5's current FL-2 dated 02/08/22 revealed diagnoses including dementia, hypothyroidism, iron deficiency anemia, schizoaffective disorder and COPD (chronic obstructive pulmonary disease).

Review of Resident #4's primary care provider (PCP) orders dated 11/03/22 revealed an order for a mechanical soft diet with nectar thick liquids and 3 nutritional shakes a day with meals.

Review of the current Diet Order sheet for Resident #5 dated 12/05/21 revealed an order for a mechanical soft diet with nectar thick liquids

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D 310	Continued From page 88 and 3 nutritional shakes a day with meals. Review of Resident #5's current signed Care Plan dated 04/21/22 revealed there was no documentation for nutritional shakes 3 times a day with meals. Review of Resident #5's October, November and December 2022 electronic medication administration records (MARs) revealed an entry for Nutritional Drink Liquid drink 1 shake 3 times a day with meals. Observation of the kitchen refrigerator on 12/05/22 at 4:45pm revealed there were 4 cartons of a name brand nutritional shake on the shelf. Observation of Resident #5 seated in the dining room on 12/05/22 at 5:00pm revealed: -Resident #5 was given a glass of iced tea to drink. -Resident #5 ate very slowly and consumed only half of her meal and drank all her tea. -Resident #5 was not given a nutritional shake when staff brought the resident her tea to drink with her meal. -Resident #5 was not offered a nutritional shake during the meal. -Resident #5 finished her meal and left the dining room without having the ordered nutritional shake to drink. Observation of the kitchen refrigerator on 13/05/22 at 5:35pm revealed: -The same 4 cartons of nutritional shakes were still placed on the refrigerator shelf. -The nutritional shakes had not been distributed to residents during the evening meal.	D 310		

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Attempted telephone call to Resident 5's Primary Care Provider (PCP) on 12/08/22 at 1:01pm was unsuccessful.

Refer to the interview with a medication aide (MA) on 12/07/22 at 8:38am.

Refer to the interview with a cook on 12/05/22 at 5:55pm and 12/06/22 at 4:00pm.

Refer to the interview with a DA on 12/05/22 at 5:45pm and 12/07/22 at 9:22am.

Refer to the interview with the Dietary Manager (DM) on 12/06/22 at 9:50am.

Refer to the telephone interview with the DM on 12/08/22 at 8:48am.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am and 12/08/22 at 8:45am..

Refer to the interview with the Administrator on 12/08/22 at 11:12 am and 11:30am.
5. Review of Resident #2's current FL-2 dated 06/07/22 revealed:
-Diagnoses included polyneuropathy, peripheral vascular disease, vascular dementia, chronic pain syndrome and chronic kidney disease.
-There was no order for nutritional supplements.

Review of Resident #2's Primary Care Provider (PCP) orders dated 11/03/22 revealed there was an order for national shakes three times daily with meals.

Review of Resident #2's vital sign flow sheet revealed:
-Resident #2's documented weight for October

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2022 was 123 pounds.
-Resident #2's documented weight for November 2022 was 123.5 pounds.

Observation of Resident #2 on 12/05/22 at 5:00pm revealed he was in his room in his bed and he had not received a nutritional supplement.

Observation of Resident #2 on 12/06/22 at 12:30pm revealed he was in the dining room for the lunch meal service and he did not receive a nutritional supplement.

Observation of Resident #2 on 12/06/22 at 2:49pm revealed he was weighed by the Resident Care Coordinator (RCC) in the medication room and his weight was 107 pounds.

Based on record reviews and observations of Resident #2's weight he had a 13% weight loss from November 2022 to 12/06/22.

Interview with a Dietary Aide (DA) on 12/08/22 at 9:26am revealed:
-Resident #2's supplement was placed on the dining room table this morning, 12/08/22, for breakfast.
-Resident #2 did not come to the dining room this morning for breakfast.
-The supplement was returned to the refrigerator when Resident #2 did not come to the dining room for meals.
-Resident #2's supplement was not taken to his room for him to consume.
-She would take his meal and his supplement to Resident #2's room if the MA asked her too.

Interview with a medication aide (MA) on 12/07/22 at 9:03am revealed:
-She thought Resident #2's family member had

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brought in a case of nutritional supplements for residents.
-She thought she used those nutritional supplements for the residents.
-She thought Resident #2's family member brought them in this past weekend.
-She thought the nutritional supplements were stored in the kitchen pantry or refrigerator.
-Resident #2 sometimes refused meals and she gave him a nutritional supplement when he took his medications.
-She thought she gave residents a nutritional supplement on Monday morning 12/05/22, but she might have seen them on the dining room table.

Interview with a MA on 12/08/22 at 8:45am revealed:
-Resident #2 did not eat breakfast.
-She planned to give Resident #2 his nutritional supplement when he woke up and took his morning medications.

Attempted interview with Resident #2 on 12/05/22 at 9:41am was unsuccessful.

Attempted telephone call to Resident 2's Primary Care Provider (PCP) on 12/08/22 at 1:01pm was unsuccessful.

Refer to the interview with a medication aide (MA) on 12/07/22 at 8:38am.

Refer to the interview with a cook on 12/05/22 at 5:55pm and 12/06/22 at 4:00pm.

Refer to the interview with a DA on 12/05/22 at 5:45pm and 12/07/22 at 9:22am.

Refer to the interview with the Dietary Manager

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 92 (DM) on 12/06/22 at 9:50am. Refer to the telephone interview with the DM on 12/08/22 at 8:48am. Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am and 12/08/22 at 8:45am.. Refer to the interview with the Administrator on 12/08/22 at 11:12 am and 11:30am. _____ Review of food receipts provided by the facility revealed: -On 10/06/22, 2 cases of fifteen 11-ounce nutritional supplements per case and 3 cases of eighteen 11-ounce nutritional supplements per case were purchased for a total of 84 nutritional supplements. -On 11/11/22, 3 cases of eighteen 11-ounce nutritional supplements per case were purchased for a total of 54 nutritional supplements. -On 12/06/22, 3 cases of eighteen 11-ounce nutritional supplements per case were purchased for a total of 54 nutritional supplements. Based on food receipts from 10/06/22 to 12/06/22 the facility purchased 192 eleven-ounce nutritional supplements for residents with nutritional supplement orders. The facility would have needed 1500 cans of nutritional supplements to meet the needs of the 7 residents who were ordered nutritional supplements. Observation of the kitchen on 12/05/22 at 12:58pm to 12/06/22 at 7:51am revealed there were four 11-ounce containers of nutritional supplements in the refrigerator. Observation of the dinner service meal on	D 310		

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D 310	Continued From page 93 12/05/22 at 5:30pm and the breakfast service meal on 12/06/22 revealed nutritional supplements were not served. Observation of the lunch service meal on 12/06/22 revealed four-11 ounce containers of nutritional supplements were served to 4 of 7 residents who had nutritional supplement orders. Observation of the kitchen on 12/06/22 at 4:30pm revealed there were 3 cases of eighteen 11-ounce nutritional supplements available to be served to the residents. Observation of the kitchen on 12/08/22 at 11:38am revealed there were 12 nutritional drinks remaining in the refrigerator and 1 case of 18 nutritional supplements in the pantry. Based on observation of the kitchen from 12/06/22 at 4:30pm to 12/08/22 at 11:38am there were 54 eleven-ounce nutritional supplements available to serve for the dinner service meal on 12/06/22, the breakfast, lunch and dinner service meal on 12/07/22 and the breakfast service meal on 12/08/22. The kitchen staff should have served a total of 39 nutritional supplements during the 5 service meals, but there were only 16 nutritional supplements missing. _____ Interview with a medication aide (MA) on 12/07/22 at 8:38am revealed: -The kitchen staff placed the nutritional supplements on the table at mealtime. -She would open the supplements for some of the residents. -The kitchen staff only had four nutritional supplements for the lunch meal service on Tuesday, 12/06/22. -She requested the four nutritional supplements	D 310		

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D 310	Continued From page 94 to serve to the residents. Interviews with a cook on 12/05/22 at 5:55pm and 12/06/22 at 4:00pm revealed: -The nutritional supplements were served to the residents by the kitchen staff. -There had been times when there were no nutritional supplements available to serve. -There were not enough nutritional supplements ordered to serve the resident with supplemental orders for a week. -The nutritional shakes ran out and the facility did not have enough to give all the residents who were to receive them to have with their meals. -The Dietary Manager (DM) should have sent someone to purchase the nutritional shakes needed for the residents. -The facility received 3 cases of nutritional supplements this afternoon, 12/06/22, for a total of 54-11 ounce nutritional supplements. Interview with a dietary aide on 12/05/22 at 5:45pm and 12/07/22 at 9:22am revealed: -She did not serve nutritional supplements to any residents on Monday, 12/05/22 or for breakfast or lunch on 12/06/22. -There were only four nutritional supplements in the kitchen; it was not enough for the 7 residents with nutritional supplemental orders, so she did not serve them. -A MA requested the four nutritional supplements during the lunch service meal on 12/06/22. -She did not know who the MA served the four nutritional supplements too. -She could not recall the last time the facility had enough shakes in the facility to serve the residents who were ordered supplements. -The kitchen staff knew there were only 4 cartons of nutrition supplements in the refrigerator but no one went to the store to buy more.	D 310		

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D 310	Continued From page 95 Interview with the DM on 12/06/22 at 9:50am revealed: -Nutritional supplements were served as ordered when there were supplements available in the facility. -Nutritional supplements were ordered last night, 12/05/22, and would be picked up this afternoon, 12/06/22. -She could not recall the last time supplements were ordered for the facility. -There was not enough funding to purchase supplements to meet the needs of the resident who were ordered supplements. -There were 4 residents who received supplements 3 times daily and 2 residents who received supplement twice daily. -The resident refused the supplements for the past month because she did not like the brand that was being purchased at this time. -The dietary staff was responsible for serving the supplements at each meal as ordered. -The supplements were listed on the diet order list posted in the kitchen to the right of the service table. Telephone interview with the DM on 12/08/22 at 8:48am revealed: -The last time supplemental drinks were purchased was Tuesday, 12/06/22. -She picked up 3 cases of 18 supplemental drinks for a total of 54 cans. -She previously purchased supplemental drinks on Tuesday, 11/29/22. -She was aware she needed more supplemental drinks in the facility. -She planned to speak to the Administrator so she could request funding from the Director of Operations for additional nutritional supplements. -The cost of food had increased, and she had	D 310		

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expressed her concerns to the Administrator.
-The facility received between $1500 to $2000 a week to purchase food, supplements, housekeeping supplies and maintenance needs.

Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 9:29am and 12/08/22 at 8:45am revealed:
-Supplements (nutritional shakes) were ordered with the dietary listing of foods and supplies and kept in the refrigerator in the kitchen.
-The MAs came to the kitchen to see if the residents were given the shakes to drink at meals.
-The Dietary Manager (DM) was responsible for keeping up with the supplement stock and ordering nutritional supplements when needed.
-She did not know why more supplements were not bought for the residents.
-She did not know why the 4 nutritional shakes were not given out and why no one went out to buy more.
-She was not aware the kitchen did not have enough stock of nutritional shakes for all the residents who were to have them at meals
-Any dietary staff could have told her they needed more nutritional shakes for the evening meal.
-She made rounds in the dining room every morning for breakfast; she occasionally made rounds at lunch and dinner.
-She could not recall the last time residents were without supplements, but she was aware that they were not always served their supplements.
-The residents had not complained to her about not having supplements at mealtime.
-She was not aware supplements were not served Monday at dinner or Tuesday at breakfast.

Interview with the Administrator on 12/08/22 at 11:12 am and 11:30am revealed:

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D 310	Continued From page 97 -The DM was responsible for making the food orders and to keep up with what was needed to feed the residents. -The DM should order enough nutritional supplements for the week when the weekly order was placed. -She was not aware the kitchen did not have enough stock of nutritional shakes for all the residents who were to have them at meals. -Any dietary staff could have told her they needed more nutritional shakes for the evening meal. -There were times there was not enough money to purchase the supplements for the week. -She knew supplements were ordered on Monday, 12/05/22, but she did not know how many were ordered. -She did not know that nutritional supplements were not served to the 7 residents on 12/05/22 at dinner and on 12/06/22 at breakfast, who had nutritional supplement orders. -She expected the DM to know how many supplements were needed for the week. -She expected the DM to order enough nutritional supplements to serve the residents who had nutritional supplement orders. _____ The facility failed to ensure that residents were served nutritional supplements as ordered by their Primary Care Provider (PCP). Resident #6 had an order for nutritional supplements three times daily with meals and the kitchen staff had stopped serving the nutritional supplements because they were being refused by the resident and who had experienced a weight loss of 8 pounds from 10/05/22 to 10/19/22. Resident #7 who had an order for nutritional supplements three times daily with meals, did not receive the supplements as ordered and had experienced an 8.5 pound weight loss in 2 months. The facility's failure was detrimental to the health, safety and	D 310		

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D 310	Continued From page 98 welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	D 310		
D 424	10A NCAC 13F .1104 (f) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (f) The resident's personal needs allowance shall be credited to the resident' s account within 24 hours of the check being deposited following endorsement This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled residents (#4 and #7) that received a personal needs allowance were credited to the residents' accounts within 24 hours of the funds being deposited for five months. The findings are: Review of the facility's resident's personal funds policy revealed: -There was no date on the policy.	D 424		

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-Personal funds will be managed according to capabilities and desires of each resident.
-Personal funds given to the resident after payment of cost of care (including the pharmacy bill) will be dated and signed by resident and staff.
-Personal funds will be managed by the administrator or designated staff if no other means were provided.

Interview with a resident who received special assistance monies on 12/05/22 at 1:20pm revealed:
-He received money monthly.
-The Administrator handed out the monies to the residents.
-He received his November 2022 money last week, 11/28/22-12/02/22, but he did not know the exact date.
-He did not know why his monies were given so late for November 2022.
-He had not received his monies for December 2022.
-He thought his check was delivered to the account on the first of the month.

Interview with a second resident who received special assistance monies on 12/05/22 at 1:43pm revealed:
-He received $90 per month.
-The residents usually received their monies on the 10th or 15th of the month.
-He did not know the day his money was deposited into the account.
-In November 2022, he received his money "late.
-His money was given to him by the Administrator on 11/29/22 for November 2022.
-He had not received his money for December 2022.

Interview with a third resident on 12/05/22 at

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D 424	Continued From page 100 1:22pm revealed: -He did not know if there was a problem with the facility bank releasing his funds, but his money was very late last month, it was distributed on November 30, 2022. -He had not received his money for December 2022 or told when he would receive it. Interview with a fourth resident on 12/05/22 at 1:35pm revealed: -He noticed receipt of his funds had become later and later in the last few months. -He was supposed to receive his money during the first of the month. -He last received his funds on the 30th of November for November 2022. -He did not know when the December 2022 funds would be distributed. -The Administrator had to be notified when the funds were ready to give out to residents. -He could not buy the personal items he needed while waiting for his funds. Interview with a fifth resident on 12/05/22 at 1:45pm revealed: -He did not know how the facility processed residents' funds, but he had been receiving his funds late the last few months. -He received the November 2022 funds on the 30th of November 2022. -He had not been told when he would receive his December 2022 funds. Interview with a sixth resident on 12/05/22 at 1:50pm revealed: -Residents' funds had been coming in later and later the past few months and getting later each month went by. -Last month, residents were told by the Administrator residents' funds would be available	D 424		

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on the 10th of November 2022.
-Residents did not receive their money until the 30th of November 2022.
-Residents have not yet received the December 2022 funds (12/05/22).
-Residents were told the funds were not yet processed in the bank due to the owner being in the hospital.

1. Review of Resident #4's current FL-2 dated 02/01 22 revealed diagnoses included dementia, schizophrenia, depressive disorder, insomnia, gastro-esophageal reflux (GERD), alcohol dependence and nicotine dependence.

Review of Resident #4's Financial Agreement document that was signed and dated on 03/03/19 revealed:
-Resident #4 received $1,182.00 in special assistance funds that were deposited to the facility's corporate office monthly.
-Resident #4 received $90.00 in personal funds monthly and was used to pay the monthly pharmacy bill.
-The funds left over would go into the resident's facility account to be used for Resident #4's personal needs.

Interview with Resident #4 on 12/07/22 at 3:30pm revealed:
-Before the last three to four months, residents were given their funds around the first week of each month.
-He did not receive his funds until 11/30/22.
-The reason for the delay was the owner was in the hospital and the transfer of residents' money from the bank to the facility was not done.
- Having to wait and not know when he would be given his funds was frustrating when he needed to buy some supplies.

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D 424	Continued From page 102 Review of the Account Ledger Sheet for Resident #4 dated August 2022 through December 2022 revealed: -For August 2022, $90.00 was credited to Resident #4's account, there was a pharmacy bill of $1.90 leaving a balance of $88.10; Resident #4 requested, signed for and received $88.00 in cash on 08/12/22. -For September 2022, $90.00 was credited to Resident #4's account, there was a pharmacy bill of $1.90 leaving a balance of $88.10; Resident #4 requested, signed for and received $88.00 in cash on 09/14/22. -For October 2022, $90.00 was credited to Resident #4's account, there was a pharmacy bill of $20.69 leaving a balance of $69.31; Resident #4 requested, signed for and received $69.00 in cash on 10/14/22. -For November 2022 $90.00 was credited to Resident #4's account, there was a pharmacy bill of $31.00 leaving a balance of $59.00; Resident #4 requested, signed for and received $59.00 in cash on 11/30/22. -For December 2022 there was no documentation on the Account Ledger Sheet of monies being credited to Resident #4's account from 12/01/22 to 12/08/22 (exit of survey). -For the past 5 months, Resident #4 did not receive his funds within 24 hours of the funds being deposited. Refer to the interview with the Administrator on 12/07/22 at 11:02am. Refer to the telephone interview with the Director of Operations on 12/07/22 at 4:42pm. Refer to the telephone interview with the Owner on 12/08/22 at 10:48am.	D 424		

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D 424	Continued From page 103 2. Review of Resident #7's current FL-2 dated 02/03/22 revealed diagnoses included Alzheimer's disease, dementia with behavioral disturbances, neuropathy, and schizophrenia. Review of Resident #7's Financial Agreement document that was signed and dated on 03/21/19 revealed: -Resident #4 received $1,182.00 in special assistance funds that were deposited to the facility's corporate office monthly. -Resident #4 received $90.00 in personal funds monthly and was used to pay the monthly pharmacy bill. -The funds left over would go into the resident's facility account to be used for Resident #7's personal needs. Review of the Account Ledger Sheet for Resident #7 dated August 2022 through December 2022 revealed: -For August 2022, $90.00 was credited to Resident #7's account, there was a pharmacy bill of $13.00 leaving a balance of $77.00; Resident #7 requested, signed for and received $77.00 in cash on 08/16/22. -For September 2022, $90.00 was credited to Resident #7's account, there was a pharmacy bill of $13.00 leaving a balance of $77.00; Resident #7 requested, signed for and received $77.00 in cash on 09/14/22. -For October 2022, $90.00 was credited to Resident #7's account, there was a pharmacy bill of $19.00 leaving a balance of $71.00; Resident #7 requested, signed for and received $69.00 in cash on 10/14/22. -For November 2022 $90.00 was credited to Resident #7's account, there was a pharmacy bill of $12.00 leaving a balance of $78.00; Resident	D 424		

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D 424	Continued From page 104 #7 requested, signed for and received $78.00 in cash on 11/30/22. -For December 2022 there was no documentation on the Account Ledger Sheet of monies being credited to Resident #7's account from December 1, 2022 to December 8, 2022 (exit of survey). -For the past 5 months, Resident #7 did not receive his funds within 24 hours of the funds being deposited. Attempted interview with Resident #7 on 12/07/22 at 2:45pm was unsuccessful. Refer to the interview with the Administrator on 12/07/22 at 11:02am. Refer to the telephone interview with the Director of Operations on 12/07/22 at 4:42pm. Refer to the telephone interview with the Owner on 12/08/22 at 10:48am. _____ Interview with the Administrator on 12/07/22 at 11:02am revealed: -There was currently no business office manager in the facility to help with distributing the residents' funds. -She was not authorized to be able to see the resident funds account and had to wait and be notified when the funds were to be transferred to the facility account. -She was aware the residents' funds were not being released as soon as they were supposed to and as months went by the waits grew longer. -The funds for November 2022 were not dispensed until 11/30/22 due to a management staff's hospitalization. -She did not know when the funds would be available to the residents for December 2022 but	D 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	C 12/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 424	Continued From page 105 would like to have them available by 12/10/22. Telephone interview with the Director of Operations on 12/07/22 at 4:42pm revealed: -He had no access to the finances or accounts for facilities. -He did not know when resident funds arrived to the account. -He knew the resident funds went to the resident trust account. -He thought it was not a specific date and the facility received funds from various resources for residents. -He knew residents were supposed to receive their allowance 24 hours after the monies were credited to the account, but that would leave the Administrator distributing money on a daily basis. -He knew that the November 2022 resident allowance was delayed because the owner was not available due to medical reasons. Telephone interview with the Owner of the facility on 12/08/22 at 10:48am revealed: -The facility had operational funds and a resident trust account. -There were occasional issues regarding funds for the facility. -He relied on the Administrator to distribute the resident allowance monthly within 24 hours after the funds were credited to the account. -He notified the Administrator each month to make her aware the resident funds were in the account. -Some resident funds cleared the account at different times and some resident funds were received from various sources. -He knew residents' allowances were late for November 2022. -He had a medical issue and was not able to notify the Administrator in a timely manner for	D 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 424	Continued From page 106 November 2022. -He looked to see if the December 2022 resident funds were available but as of 12/07/22 the funds were not available. _____ The facility failed to ensure residents who received special assistance were given their funds within 24 hours of the monies being deposited into the account possibly delaying purchases desired or needed by residents. The facility's failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 22, 2023.	D 424		