

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL054069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/17/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROSE VISTA ASSISTED LIVING

**2130 ROSE VISTA ROAD
KINSTON, NC 28504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/16/22 - 03/17/22.	D 000		May 5, 2022 and on going
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: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 3 of 5 residents sampled (#3, #4, #5) related to not failure to refer two residents who had long thick toenails for podiatry (#4, #5) and not notifying the provider of a resident who had episodes of low oxygen levels or seizures (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 02/24/22 revealed diagnoses included acute respiratory failure, community acquired pneumonia, obstructive sleep apnea, diabetes mellitus, and history of breast cancer. Review of Resident #3's current assessment and care plan dated 03/09/22 revealed: -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required the use of oxygen. -The resident required supervision with eating. -The resident required limited assistance with toileting, ambulation, dressing, grooming, and transferring. -The required total assistance with bathing.	D 273	It is the policy of Rose Vista Assisted Living to assure the routine and acute health care needs of residents. Following the conclusion of the survey, a new process was implemented to track and follow-up with referrals. The spreadsheet is maintained by the Resident Care Coordinator (RCC). An RCC training was conducted on 5/4/2022, by a pharmacist from the long-term care pharmacy, including but not limited to Health Care Referral and Follow up and Medication Administration. A podiatrist was at Rose Vista on May 2nd and 3rd, 2022, to attend to the needs of the residents of Rose Vista. The RCC will document any change of condition and notify the Primary Care Provider when the change occurs. The RCC or designee will follow up weekly to ensure continued compliance.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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FRUV11

If continuation sheet 1 of 58

Reviewed and Acknowledged
wfu
5/26/22

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D 273	Continued From page 1 Review of Resident #3's handwritten progress note dated 10/12/21 at 1:25pm revealed: -The progress note was documented by the facility's contracted Licensed Health Professional Support (LHPS) registered nurse (RN). -Resident #3's roommate hollered out for help. -Resident #3 was in the room, slumped forward in her wheelchair with oxygen tubing and nasal cannula on the bed. -The resident's eyes were closed and she did not respond verbally. -The resident quickly began to hyperventilate so the resident's oxygen was applied and the resident was instructed to breathe in through her nose. -The resident as able to follow instructions and her oxygen level was checked and was 98%. -The resident's pulse was 127 and she began breathing through her mouth again and her oxygen level dropped to 92%. -The resident was reminded to breathe through her nose. -The resident's oxygen level fluctuated between 94 - 96% and her pulse ranged from 104 - 116. -The resident began to respond verbally. -The resident had just returned from a smoking break and had gone to the bathroom without wearing her oxygen. -The resident was reminded to wear her oxygen when walking to the bathroom. -The Resident Care Coordinator (RCC) was made aware of the episode. -There was no documentation the resident's primary care provider (PCP) was notified of the episode. Review of Resident #3's handwritten progress note dated 11/09/21 revealed: -The progress note was documented by the facility's contracted LHPS RN.	D 273		

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D 273	Continued From page 2 -Resident #3's roommate reported Resident #3 was having "another episode". -Resident #3 was in the bed on her right side with her head propped on a pillow, her hand shaking, her eyes closed, and not responding to verbal stimuli. -The resident's respiratory effort was normal and her oxygen was on via nasal canula with an oxygen level of 95%. -The resident was able to hold her arm up to have her pulse checked but her eyes were still closed and she did not respond verbally. -The resident's pulse fluctuated from 107 - 111. -After 5 minutes, the resident responded verbally, opened her eyes and was able to sit up in bed. -The MA and RCC were made aware and staff would continue monitoring the resident. -There was no documentation the PCP was notified of the episode. Review of Resident #3's handwritten progress note dated 12/14/21 at 9:44am revealed: -The progress note was documented by the facility's contracted LHPS RN. -The LHPS RN was called to Resident #3's room for report of the resident having "another episode". -Resident #3 was in the bed lying on her right side with her head propped on a pillow, her eyes were closed, her right hand was shaking more than the left hand, and she not responding to verbal stimuli initially. -The resident had returned from a smoking break shortly before the episode. -The resident's oxygen was on via nasal canula and her oxygen level was 92% and her pulse was 105 - 116. -The resident was repeatedly encouraged to breathe through her nose. -The resident's oxygen level increased to 96 -	D 273		

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D 273	Continued From page 3 98% and her pulse was 102 - 105. -The resident's right hand tremor decreased significantly and after almost 5 minutes, the resident opened her eyes and began responding verbally. -The resident was left resting in bed. -There was no documentation the PCP was notified of the episode. Review of Resident #3's hospital emergency department (ED) after visit summary dated 12/30/21 revealed the reason for visit was seizure (prior history of) and the resident was diagnosed with convulsions. Review of Resident #3's handwritten progress note dated 01/07/22 (no time) revealed: -The progress note was documented by a medication aide (MA). -The resident had a "seizure" that lasted about 7 minutes. -The resident's vital signs and oxygen levels were checked: blood pressure was 135/75, pulse was 101, respirations were 14, and oxygen saturation level was 98%. -There was no documentation the PCP was notified of the "seizure". Review of Resident #3's PCP visit notes dated 01/10/22 revealed: -The resident reported she had a seizure last week that "just lasted for a few minutes". -The PCP noted Keppra and Depakote (anti-seizure medications) levels would be obtained to assess if the resident was in therapeutic range. Review of Resident #3's handwritten progress note dated 01/20/22 (no time) revealed: -The progress note was documented by the	D 273			

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D 273	Continued From page 4 facility's contracted LHPs RN. -The RN was called to the hallway where Resident #3 was slumped forward in a chair. -The resident was non-verbal but breathing and able to follow instructions to lift her feet while being pushed in the wheelchair to her room. -The resident's oxygen saturation level was 82 - 83% and oxygen was placed on the resident at 2.5 liters per minute (LPM). -The resident's pulse was 102 - 111 and the resident had increased tremors to her right arm. -After 2 minutes, the resident began holding her head up, opened her eyes, and responded verbally. -The resident as able to identify staff by name and she was assisted to bed and encouraged to breathe through her nose. -The resident's oxygen was increased to 3 LPM and then to 3.5 LPM and her oxygen saturation levels were 85 - 86 %, then 90%, then back down to 85 - 86%. -The resident's tremors persisted and Lorazepam was administered by the supervisor per order. -The RCC was aware and the resident was to be seen today (01/20/22) by the PCP at the facility. Review of Resident #3's PCP visit notes dated 01/20/22 revealed: -The resident was seen for an acute visit requested by staff. -Staff reported the resident had 2 seizures this week, duration unknown. -The resident had shortness of breath and low oxygen saturation levels. -Staff reported the episodes in which her oxygen saturation dropped was when the resident was not wearing oxygen and when outside to smoke and returned from smoking. -The resident was advised not to smoke and to continue current medication regimen.	D 273			

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D 273	Continued From page 5 -The PCP would obtain a Keppra level. -The resident's Depakote level this month was therapeutic. -This was the second time staff reported to the PCP that the resident had a seizure this month, with 2 this week. -The PCP would refer the resident to neurology for the frequent seizures to get their input. Review of Resident #3's hospital ED after visit summary dated 02/01/22 revealed the reason for visit was seizure (prior history of) and the resident was diagnosed with convulsions. Review of Resident #3's electronic MA charting notes revealed: -On 02/14/22 at 3:01pm, the resident had a seizure at 2:45pm and it lasted for 2 minutes. -On 02/14/22 at 10:30pm, the resident had a seizure at 9:40pm and it lasted for 4 minutes. -There was no documentation the resident's PCP was notified of either seizure on 02/14/22 Interview with Resident #3 on 03/17/22 at 3:39pm revealed: -She did not wear her oxygen when she went outside to smoke. -She sometimes had "spells" when she felt like she was hyperventilating, and she also had "fainting spells" when she was a child. -About 3 months ago, she went to the hospital and the hospital staff said she had a seizure. -She did not know what caused the episodes and she had no warning signs prior to an episode occurring. Interview with the facility's contracted LHPS RN on 03/17/22 at 2:30pm revealed: -Resident #3's "episodes" did not appear to be seizures to her. -She thought the resident may have diagnosed at	D 273		

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D 273	Continued From page 6 some point with seizures at a hospital in the past (not sure when) so the facility staff referred to the resident's episodes as seizures. -She thought the resident's episodes were related to and caused by her oxygen levels dropping too low. -The resident's episodes usually occurred about 30 minutes after the resident went outside to smoke without her oxygen and then came back inside. -During the observed episodes, the resident's eyes were closed and the resident would not respond verbally but she could follow commands. -The resident's tremors would get worse and her heart rate would increase. -The resident's PCP was aware the resident's oxygen saturation levels dropped in the 80s when the resident chose not to wear her oxygen. -She did not think Emergency Medical Services (EMS) needed to be contacted when the resident had the episodes based on her assessments of the resident's during the episodes. -She did not usually contact the PCP when the resident had episodes but she always let the RCC know about the episodes. Interview with the RCC on 03/17/22 at 3:49pm revealed: -When Resident #3 had "episodes", the resident would say she was hot, her hands would shake more than usual, and she would slump over. -The resident's episodes usually occurred after the resident came inside from her smoking breaks and not wearing her oxygen. -The resident's PCP said it was up to the resident if she wanted to go to the hospital ED when she had an episode because the resident had the issue for a long time. -If the resident was unconscious or not responding, they would send her to the ED.	D 273		

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D 273	Continued From page 7 -If an episode lasted more than a minute, the resident should be sent to the ED. -She was not aware Resident #3 had episodes documented by staff that lasted longer than a minute. -The PCP was not notified at the time of each episode because she usually made the PCP aware during the PCP's weekly visits to the facility. -The resident had an upcoming appointment with a neurologist in May 2022 related to the episodes / seizures. Interview with the Administrator-in-Charge (AIC) on 03/17/22 at 4:35pm revealed: -She did not want to call Resident #3's "episodes" seizures because she was not a health care professional. -Resident #3's episodes usually occurred after the resident came in from smoking and she had not been wearing her oxygen. -The resident would start shaking more than usual and get hot. -The facility's LHPS RN had been at the facility at times when the resident had an episode and the RN would assess and monitor the resident during the episode. -The resident had also been to the hospital at times for her episodes. -The RCC or the MAs should notify the PCP when the resident had an episode. Telephone interview with Resident #3's PCP on 03/17/22 at 4:11pm revealed: -She was not sure if Resident #3 was having seizures so she had referred the resident to neurology but there was long waiting time to be seen by neurology. -The resident did not wear her oxygen all the time and smoked and her oxygen levels would get low.	D 273		

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D 273	Continued From page 8 -The facility staff usually notified her during weekly visits of Resident #3 having "episodes". -The facility staff should notify her at the time an "episode" occurred with the resident in case it warranted an intervention such as needing to go to the hospital ED for evaluation. 2. Review of Resident #4's current FL-2 dated 07/01/21 revealed: -Diagnoses included deep vein thrombosis (DVT) and dementia. -The resident was intermittently disoriented and required staff assistance for bathing and dressing. Review of Resident #4's current care plan dated 06/22/21 revealed: -The resident required staff supervision with ambulation, grooming, and dressing. -The resident required limited staff assistance with bathing. Observation of Resident #4's right foot on 03/17/22 at 10:50am revealed: -The first toenail was dark grey, thick and had a buildup of growth between the nail and the nailbed which elevated it from the nailbed. -The second and fourth toenail were thick, cracked and dark tan to light brown with buildup under the nails. -The second and fourth toenails extended past the toes and curved down over the tips of the toes. -The fourth toenail was jagged. Observation of Resident #4's left foot on 03/17/22 at 10:55am revealed: -The first toenail grew past the tip of the toe, was thick, elevated in a V shaped, and jagged. -The second and third toenails were thick,	D 273			

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D 273	Continued From page 9 extended past the toes and curved to the bottom of the bottom of the toes. -The fourth toenail was elevated from the nailbed and jagged. Review of Resident #4's physician's order dated 02/07/22 revealed an order to cut and file the resident's toenails. Review of Resident #4's handwritten progress notes from 05/13/21 to 03/16/22 revealed: -On 05/13/21, the Licensed Health Professional Support (LHPS) nurse provided toenail care. -The resident's feet were soaked, nails clipped and filed. -The resident's toenails were thick and discolored. -There was no documentation the resident's toenails had been cut or filed after 05/13/21. -There was no documentation the resident's primary care provider (PCP) had been notified of long, thick, jagged, dark toenails. -There was no documentation the resident had seen a podiatrist. Interview with the Resident Care Coordinator (RCC) on 03/17/22 at 12:30pm revealed: -She saw Resident #4's feet every day. -Resident #4's feet were dry and cracked since he was admitted to the facility. -Resident #4's nails were cared for by the LHPS nurse. -She was not notified by the LHPS nurse Resident #4's nails were long, jagged, and thick. -She was not notified by the LHPS nurse she could not cut or file Resident #4's toenails. -She expected the LHPS nurse to leave a note for Resident #4's PCP regarding the condition of Resident #4's toenails and if she could not cut or file them.	D 273		

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D 273	Continued From page 10 -She expected the LHPS nurse to notify her the condition of Resident #4's toenails if she could not cut or file them. -Had she been told, she would have scheduled Resident #4 an appointment with an outside podiatrist. Interview with the Administrator in Charge (AIC) on 03/17/22 at 12:40pm revealed: -She was not told by the LHPS nurse that Resident #4's toenails were thick, jagged, overgrown, or discolored. -Had she known, Resident #4 would have been referred to an outside podiatrist instead of waiting for the facility podiatrist to visit. Interview with the LHPS nurse on 03/17/22 at 2:20pm revealed: -She told the RCC Resident #4 needed an appointment with podiatry the last time she cut the resident's toenails. -She did not remember when she last cut Resident #4's toenails or when she told the RCC Resident #4 needed a podiatry referral. -She did not remember telling the RCC Resident #4 needed a podiatry referral in the last few months. -Resident #4 needed a podiatry referral because she did not have the equipment needed to provide safe and appropriate toenail care to the resident. -Resident #4 had a callus to his right foot. -Resident #4's toenails were thick and long but not curved past his toes. -Resident #4's left first toenail was dark grey to black in color and thick. Telephone interview with Resident #4's PCP on 03/17/22 at 4:20pm revealed: -She wrote an order for the LHPS nurse to clip	D 273			

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D 273	Continued From page 11 the resident's toenails and file in 02/07/22 because the resident needed nailcare. -Had she known the resident's nails could not be cut and/or filed she would have made a referral to an outside podiatrist. Refer to interview with a personal care aide (PCA) on 03/17/22 at 11:02am. Refer to interview with the Resident Care Coordinator (RCC) on 03/17/22 at 12:30pm. Refer to interview with the Administrator in Charge (AIC) on 03/17/22 at 12:40pm. Refer to interview with the LHPS nurse on 03/17/22 at 2:20pm. Refer to telephone interview with facility's contracted PCP on 03/17/22 at 4:20pm. 3. Review of Resident #5's current FL-2 dated 12/06/21 revealed: -Diagnoses included hypertension (HTN), chronic diastolic heart failure, bipolar disorder, encephalopathy, and dementia. -The resident was intermittently disoriented. Review of Resident #5's care plan dated 12/31/20 revealed the resident required extensive assistance with bathing, dressing, and grooming. Observation of Resident #5's feet on 03/17/22 at 11:02am revealed: -The left first toenail was black and grew up and curved down and over to the right inside of the toe from the middle of the nail bed to the base. -The left first half of the first nail bed was creamy to yellow in color and flaking. -The left second toenail was black, jagged, and	D 273			

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D 273	Continued From page 12 thick. -The left third toenail was black and extended to the tip of his toe. -The right great toenail was grey to dark tan in color, thick, and stopped at the middle of the nail bed and was ingrown on both sides of the nail. -The corners of the right great nail bed cuticles had a build up of white flaking skin. -The right second and third toenails were thick, flaking, dark brown to grey, jagged, and extended past the tips of the toes. -The right fourth toenail was thick and extended past the tip of the toe. Interview with the Resident Care Coordinator (RCC) on 03/16/22 at 4:45pm revealed Resident #5's family made medical appointments and transportation arrangements for the resident. Interview with the Administrator in Charge (AIC) on 03/17/22 at 12:40pm revealed: -She was not told by the LHPS nurse Resident #5's toenails were thick, jagged, overgrown, or discolored. -Had she known; Resident #5 would have been referred to an outside podiatrist instead of waiting for the facility podiatrist to visit. Interview with the LHPS nurse on 03/17/22 at 2:20pm revealed: -She last performed toenail care to Resident #5 in February 2022. -Resident #5's toenails were thick and black. -She did not tell the RCC or AIC that Resident #5's toenails were thick and black because she thought the resident saw podiatry every 2 to 3 months. Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/17/22 at 4:20pm	D 273		

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D 273	Continued From page 13 revealed: -She was not notified by the facility that Resident #5's toenails were jagged, thick, and black. -She did not know of Resident #5 having circulatory diagnoses. -Had she known the resident's toenails were thick, black, and jagged she would have referred to an outside podiatrist. Refer to interview with a personal care aide (PCA) on 03/17/22 at 11:02am. Refer to interview with the Resident Care Coordinator (RCC) on 03/17/22 at 12:30pm. Refer to Interview with the Administrator in Charge (AIC) on 03/17/22 at 12:40pm. Refer to Interview with the LHPS nurse on 03/17/22 at 2:20pm. Refer to telephone interview with facility's contracted PCP on 03/17/22 at 4:20pm. Interview with a personal care aide (PCA) on 03/17/22 at 11:02am revealed: -She washed resident's feet during baths or showers. -She did not document the condition of resident toenails on the shower sheets. -She did not report the condition of resident's nails because the LHPS nurse provided nail care to the residents. Interview with the Resident Care Coordinator (RCC) on 03/17/22 at 12:30pm revealed: -Podiatry's last facility visit was 07/14/21. -Podiatry was to make facility visits every 6 months but did not because the company they contract through did not have a podiatrist	D 273		

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D 273	Continued From page 14 available. -Podiatry was scheduled to make a visit on 03/07/22 but cancelled because the facility did not have referral orders Interview with the Administrator in Charge (AIC) on 03/17/22 at 12:40pm revealed: -She expected the PCAs to tell the RCC or Administrator when resident nails were long, thick, or jagged during personal care. -She didn't think the PCAs knew to report the condition of resident's toenails because the LHPS nurse performed resident nail care. Interview with the LHPS nurse on 03/17/22 at 2:20pm revealed she tried to fill in with resident nail care until podiatry made the facility visits every 2 to 3 months. Telephone interview with facility's contracted PCP on 03/17/22 at 4:20pm revealed: -Long, jagged toenails could cause skin injury from scraping the skin. -Skin integrity issues could cause infection, wounds, and the potential for hospitalizations for antibiotics and possibly amputations. -She expected the LHPS nurse to tell the RCC and/or AIC when discovered resident nails were thick, jagged, and/or overgrown. -She expected the LHPS nurse to tell the RCC and/or AIC when she did not have the appropriate equipment to care for resident toenails.	D 273			
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	D 310			

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D 310	Continued From page 15 supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets including thickened liquids as ordered by the resident's physician for 1 of 5 sampled (#2) residents who was served thin liquids and fruit chunks. The findings are: Review of Resident #2's current FL-2 dated 11/17/21 revealed: -Diagnoses included diabetes motilities, acute encephalopathy, hypokalemia, and anemia. -The resident was intermittently disoriented and ordered a no added salt diet. Review of Resident #2's care plan dated 09/20/21 revealed the resident required limited assistance with eating. Review of Resident #2's physician order request form dated 01/03/22 revealed: -The resident was on a puree diet. -The resident was having trouble swallowing her food. Review of Resident #2's physician order dated 01/03/22 revealed there was an order for a bedside swallow evaluation for dysphagia. Review of Resident #2's Speech Therapy (ST)	D 310	It is the policy of Rose Vista Assisted Living to assure that all therapeutic diets, including nutritional supplements and thickened liquid, shall be served as ordered by the resident's physician. Training was provided shift to shift, during the survey to dietary and care staff to ensure that they are able to provide therapeutic diets and who is to receive them. Diet list was updated and supplied to all staff involved in meal and snack service on March 17, 2022. A dietary in-service is scheduled on May 17, 2022, on topics including but not limited to therapeutic diets and thickened liquids. The Administrator in Charge will follow up weekly to ensure continued compliance.	May 5, 2022 and on going

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D 310	Continued From page 16 progress note dated 01/28/22 revealed: -During a meal monitoring and swallowing treatment observation, ST observed the resident having a runny nose, coughing, and strangling when drinking water which were signs and symptoms of aspiration. Review of Resident #2's diet order dated 02/01/22 revealed: -There was an order for no concentrated sweets, mechanical soft foods, and thickened liquids. -There was an order for the resident to be served off the diet for special occasions. Review of Resident #2's Speech Language Pathology note dated 02/21/22 revealed: -Diagnoses included moderate to severe oral stage dysphagia, moderate to severe pharyngeal stage dysphagia. -The dysphagia severity index was 5 moderately severe dysphagia. -A dysphagia severity index of 5 indicated the resident aspirated 5% to 10% on one or more consistencies, with potential for aspiration on all consistencies. Potential for aspiration minimized by specific swallow instructions, cough reflex absent or nonprotective. -Recommendations were for a puree diet with nectar-thick liquids. -The note was signed by Resident #2's Primary Care Provider (PCP) and dated on 02/28/22. Observation of the kitchen on 03/17/22 at 7:46am revealed the diet order posted for Resident #2 was for a no concentrated sweet diet dated 07/27/19. a. Observation of the lunch meal service on 03/17/22 from 11:45am to 12:05pm revealed: -At 11:45am, the dietary aide poured tea with ice	D 310			

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D 310	Continued From page 17 in a glass and placed at Resident #2's place setting. -At 11:50am, the dietary aide poured water with ice in a glass and placed at Resident #2's place setting at table #12. -At 12:02pm, Resident #2 was escorted to the dining room via wheelchair by the personal care aide (PCA). -The PCA gave Resident #2 the glass of water to drink. -Resident #2 drank a few swallows of the water. -Resident #2 did not cough when swallowing. -The water and tea were not thickened. Review of Resident #2's facility progress note dated 01/28/22 revealed the resident's Speech Therapy (ST) provider documented the recommendation of notenectar thickened liquids and the recommendation was shared with staff. Observation of the walk-in refrigerator on 03/17/22 at 12:15pm revealed there was pre-thickened nectar thick lemon-flavored water and nectar thick tea available. Interview with the dietary aide on 03/17/22 at 12:05pm revealed: -Resident #2 had an order for nectar thickened liquids. -He forgot and served Resident #2 tea and water for lunch without thickener. -He also served Resident #2 orange juice and water for breakfast without thickener. -He was responsible for getting the prethickened liquids from the walk in refrigerator and serving to Resident #2. Interview with the dietary manager (DM) on 03/17/22 at 12:09pm revealed: -Resident #2 had a physician's order for nectar	D 310			

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D 310	Continued From page 18 thickened liquids. -She did not know Resident #2 was served water and tea that was not thickened at today's lunch service by the dietary aide. -She expected Resident #2 to have been served nectar thickened liquids per the physician's order. Interview with the Administrator in Charge (AIC) on 03/17/22 at 12:20pm revealed: -Resident #2 was the only resident ordered thickened liquids. -She expected the dietary aide to have served Resident #2 thickened liquids per the physician's order. A second interview with the DM on 03/17/22 at 2:15pm revealed normally there was a sheet posted in the kitchen that listed names of resident's ordered nectar thickened liquids. Telephone interview with Resident #2's PCP on 03/17/22 at 4:20pm revealed: -Resident #2 was ordered nectar thickened liquids because of dysphagia. -Serving Resident #2 thin liquids placed the resident at risk for aspiration pneumonia which could lead to sepsis, hospitalization, intravenous antibiotics, and death. Refer to interview with the Administrator in Charge (AIC) on 03/17/22 at 12:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/17/22 at 12:25pm. Refer to a second interview with the dietary manager (DM) on 03/17/22 at 3:00pm. Refer to interview with the personal care aide (PCA) on 03/17/22 at 3:05pm.	D 310			

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D 310	Continued From page 19 Refer to interview with the cook on 03/17/22 at 3:50pm. b. Observation of the dining room on 03/17/22 at 2:55pm revealed: -Resident #2 was sitting at the dining room table with a personal care aide (PCA). -In front of Resident #2 was a plate of orange wedges and whole grapes. -The Dietary Manager (DM) was standing to the left front of the dining room. -Resident #2 could be seen from the position the DM was standing. Interview with the DM on 03/17/22 at 3:00pm revealed: -Normally there was a sheet posted in the kitchen that listed names of resident's who were ordered a puree diet. -She placed grapes and orange wedges in the dining room for residents to be served by staff during a St. Patrick's Day party. -She did not think of telling the PCA Resident #2 should not be served the orange wedges and grapes. -She did not realize the PCA served the orange wedges and grapes to Resident #2 until prompted by surveyor. Interview with the PCA on 03/17/22 at 3:05pm revealed: -She served Resident #2 orange wedges and grapes during today's St. Patrick's Day party. -She did not know Resident #2 could not have orange wedges and grapes Telephone interview with Resident #2's Primary Care Provider (PCP) on 03/17/22 at 4:20pm revealed:	D 310		

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D 310	Continued From page 20 -Resident #2 was ordered a pureed diet for dysphagia. -Serving Resident #2 orange wedges and grapes placed the resident at risk for aspiration pneumonia which could lead to sepsis, hospitalization, intravenous antibiotics, and death. Refer to interview with the Administrator in Charge (AIC) on 03/17/22 at 12:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/17/22 at 12:25pm. Refer to a second interview with the dietary manager (DM) on 03/17/22 at 3:00pm. Refer to interview with the personal care aide (PCA) on 03/17/22 at 3:05pm. Refer to interview with the cook on 03/17/22 at 3:50pm. Refer to telephone interview with Resident #2's Primary Care Provider (PCP) on 03/17/22 at 4:20pm. Interview with the Administrator in Charge (AIC) on 03/17/22 at 12:20pm revealed: -The dietary staff had a printed diet order sheet which included Resident #2's diet order. -Also, the RCC created and updated a list of resident diet orders each time a diet order changed. -She gave the list to the dietary manager (DM) and the DM posted the list by the hot bar in the kitchen for staff to see. -The last list she gave the DM was about three weeks ago. -In addition, she expected the DM to give verbal updates regarding ordered resident diets to the	D 310		

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D 310	Continued From page 21 dietary staff as the diet orders changed. -She expected the personal care aids (PCAs) to know Resident #2's diet order and to report to the dietary staff if the resident was served the wrong diet. -She expected the medication aides (MAs) to know Resident #2's diet order and report to the dietary staff immediately if the resident was served the wrong diet. -She and the Resident Care Coordinator (RCC) normally did dining room walk-throughs which would catch any errors with diet orders. -She and the RCC were unable to do dining room walk-throughs today due to the survey. -She expected the dietary staff to review Resident #2's posted diet list in the kitchen to ensure they knew the correct diet to serve the resident. Interview with the RCC on 03/17/22 at 12:25pm revealed: -She created a list of each resident's diet order and gave to the Administrator each time a diet order was updated. -The Administrator gave the updated list to the dietary staff. -She last updated the list of diet orders about three weeks ago. Second interview with the DM on 03/17/22 at 3:00pm revealed: -The sheet which contained Resident #2's diet order was taken down about 4 days ago by the RCC so she could update the diet list. -Dietary staff also knew the resident's ordered diet per a verbal report from the RCC when the resident's diet was changed and updated. -She expected dietary staff to review the posted list of resident diet orders every day before starting their shift. -Staff could not review the list if it wasn't posted.	D 310		

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D 310	Continued From page 22 Interview with the PCA on 03/17/22 at 3:05pm revealed she did not know what Resident #2's ordered diet was. Interview with the cook on 03/17/22 at 3:50pm revealed: -He tried to check behind the dietary aide to be certain residents were served the correct ordered diet. -He did not have a chance to check behind the dietary aide today, 03/17/22, for breakfast or lunch. -The last time he checked behind the dietary aide was 03/16/22. -Everyone was served the correct ordered diet on 03/16/22. Telephone interview with Resident #2's Primary Care Provider (PCP) on 03/17/22 at 4:20pm revealed she expected the facility to follow Resident #2's diet orders.	D 310			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION	D 358	It is the policy of Rose Vista Assisted living to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner which are maintained in the resident's record, the rules of 10A NCAC 13F and the facility policies. An RCC training was conducted on 5/4/2022, by a pharmacist from the long-term care pharmacy, including but not limited to Health Care Referral and Follow up and Medication Administration.		

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D 358	Continued From page 23 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 3 of 5 residents sampled (#3, #4, #5) including errors with medications for anxiety (#3), asthma (#4), depression, infection, hypertension, and a vitamin supplement prescribed for deficiency and memory (#5). The findings are: Review of the facility's undated Medication Policy and Procedure Manual revealed: -Administration of medications are in accordance with orders by a licensed prescribing practitioner and the facility's policies and procedures. -At no time should any resident be without medication that has been prescribed by their physician and recorded on the medication administration record (MAR) for administration. 1. Review of Resident #5's current FL-2 dated 12/06/21 revealed: -Diagnoses included hypertension (HTN), chronic diastolic heart failure, a virus transmitted by blood and bodily fluids, anemia of chronic disease, bipolar disorder, encephalopathy, and dementia. -The resident was intermittently disoriented. a. Review of Resident #5's physician's order dated 08/16/21 revealed: -There was an order for Zoloft 100mg one tablet daily (Zoloft is used to treat depression and social anxiety disorder. Do not stop taking without consulting with the prescribing provider as some conditions may become worse when the medication is suddenly stopped. The dose may be gradually decreased to prevent symptoms such as mood swings, tiredness, headache,	D 358	The RN Consultant from the long-term care pharmacy conducted a training for Medication Technicians on April 14, 2022 on topics including by not limited to Residents' Rights, Medication Administration & Documentation, and Medication Errors & Exceptions. All residents are now getting medications from the same long-term care pharmacy and a procedure is in place to ensure that medication is in the facility. On April 6, 2022, the owners of Rose Vista Assisted Living, met with the long-term care pharmacy in regards to, topics including but not limited to ensuring that all medications are in the facility on a daily basis. The RCC or Designee will audit medication carts twice a week to ensure that all medications are present. The Administrator in Charge will audit monthly to ensure continued compliance.	May 1, 2022 and on going

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D 358	Continued From page 24 sleep changes and brief feelings like electrical shock). -The order was signed by Resident #5's Veterans Administration (VA) primary care provider (PCP). Review of Resident #5's current FL-2 dated 12/06/21 revealed: -There was an order for Zoloft 100mg one tablet daily. -The FL-2 was signed by Resident #5's facility PCP. Review of Resident #5's subsequent physician's order dated 02/21/22 revealed: -There was an order for Zoloft 100mg one tablet daily. -The order was signed by Resident #5's facility PCP. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Zoloft 100mg take one tablet daily to be administered at 8:00am. -Zoloft was not documented as administered from 11/19/21 to 11/21/21 and 11/23/21 to 11/30/21 because the facility was waiting on the medication from the pharmacy. -Zoloft was not documented as administered on 11/22/21 and there was no reason why. -Resident #5 was not documented administered Zoloft for 12 of 30 days during November 2021. Review of Resident #5's December 2021 eMAR revealed: -There was an electronic entry for Zoloft 100mg take one tablet daily to be administered at 8:00am. -Zoloft was not documented as administered from	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL054069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/17/2022
NAME OF PROVIDER OR SUPPLIER ROSE VISTA ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 ROSE VISTA ROAD KINSTON, NC 28504			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 25 12/01/21 to 12/27/21 and 12/29/21 to 12/30/21 because the facility was waiting on the medication from the pharmacy. -Zoloft was not documented as administered on 12/28/21 and 12/31/21 and there was no reason why. -Zoloft was not documented as administered for 31 of 31 days during December 2021. Review of Resident #5's January 2022 eMAR revealed: -There was an electronic entry for Zoloft 100mg take one tablet daily to be administered at 8:00am. -Zoloft was not documented as administered from 01/02/22 to 01/06/22, 01/08/22 to 01/14/22, and 01/16/22 to 01/31/22 because the facility was waiting on the medication from the pharmacy. -Zoloft was not documented as administered on 01/01/22 and 01/07/22 and there was no reason why. -Zoloft was not documented as administered for 30 of 31 days during January 2022. Review of Resident #5's February 2022 eMAR revealed: -There was an electronic entry for Zoloft 100mg take one tablet daily to be administered at 8:00am. -Zoloft was not documented as administered on 02/01/22 and from 02/03/22 to 02/05/22, 02/08/22 to 02/21/22, and 02/23/22 to 02/28/22 because the facility was waiting on the medication from the pharmacy. -Zoloft was not documented as administered on 02/07/22 and there was no reason why. -Zoloft was not documented as administered for 25 of 28 days during February 2022. Review of Resident #5's March 2022 eMAR from	D 358			

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D 358	Continued From page 26 03/01/22 to 03/16/22 revealed: -There was an electronic entry for Zoloft 100mg take one tablet daily to be administered at 8:00am. -Zoloft was not documented as administered from 03/01/22 to 03/05/22, 03/08/22 to 03/10/22, and 03/12/22 to 03/16/22 because the facility was waiting on the medication from the pharmacy. -Zoloft was not documented as administered for 13 of 16 days during March 2022. Observation of Resident #5's medications on hand on 03/16/22 at 2:27pm revealed Zoloft was not available on the medication cart for administration to the resident. Interview with the medication aide (MA) on 03/16/22 at 2:30pm revealed: -Zoloft was not available for administration to the resident. -On 03/15/22, the medication aide/supervisor (MA/S) called the VA to request a refill of Resident #5's Zoloft. -Resident #5 normally would watch television and talk with other residents. -At times, Resident #5 was not talkative and stayed in his room. Interview with the Resident Care Coordinator (RCC) on 03/16/22 at 2:45pm revealed Resident #5 had no status changes related to mood or behavior. Interview with the Administrator in Charge (AIC) on 03/16/22 at 3:05pm revealed: -She did not know Resident #5 was not administered Zoloft from 11/19/21 to 12/31/21. -She did not know Resident #5 had missed multiple doses of Zoloft from December 2021 to March 2022.	D 358		

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D 358	Continued From page 27 -Resident #5 had not had any status changes related to mood or behavior. Interview with the M/S on 03/16/22 at 3:55pm revealed: -The facility ran out of Resident #5's Zolofit two months ago. -Two months ago, she reordered Resident #5's Zolofit through the eMAR system which would go to the facility's contracted pharmacy. -The contracted pharmacy would contact the VA to reorder Resident #5's Zolofit. -At that time, she called the facility's contracted pharmacy to check the status of Resident #5's Zolofit. -She was told by the RCC to call the VA to reorder Resident #5's Zolofit. -She did not remember when. -She called the VA pharmacy and was told Resident #5 needed a new prescription for Zolofit. -She called Resident #5's VA PCP and left messages with someone several times over the last two months regarding refills for Resident #5's Zolofit. -She did not remember the dates. -She did not remember who she spoke to or the what the PCP's name was. -Resident #5's VA PCP never returned her call. -She documented on Resident #5's eMAR the facility was waiting on the pharmacy to send Resident #5's Zolofit. -She did not document when she called the VA pharmacy for a reorder of Resident #5's Zolofit. -Resident #5 had not had any status changes related to mood or behavior. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/16/22 at 4:30pm revealed: -On 02/20/22, someone from the facility	D 358		

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D 358	Continued From page 28 requested refills for Resident #5's Zoloft. -Before Resident #5's Zoloft could be refilled on 02/21/22, the RCC told the pharmacy that the facility had received Resident #5's Zoloft and not to refill the medications. -Resident #5's Zoloft was not filled by the facility's contracted pharmacy at that time. A second interview with the RCC on 03/16/22 at 4:45pm revealed she did not recall the conversation with the facility's contracted pharmacy on 02/21/22 to stop the refill of Resident #5's Zoloft. A second interview with the AIC on 03/16/22 at 4:50pm revealed the blank documentation blocks in the eMAR indicated a medication was not administered. Review of Resident #5's mental health progress note dated 12/13/21 revealed: -The resident was seen for dementia with behaviors, anxiety, and depression. -The resident was on Zoloft. -The resident's mood and anxiety was stable on current medications. -Staff reported no change in the resident's mood or behavior. -The current treatment plan was to be continued. -Medications were reviewed for a possible gradual dose reduction of psychotropics. -Any reduction in regimen was likely to risk decompensation and was not recommended. -There was no clinical indication in gradually reducing the resident's psychotropic medications. Review of Resident #5's mental health progress note dated 03/14/22 revealed: -The resident was seen for dementia with behaviors, anxiety, and depression.	D 358		

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D 358	Continued From page 29 -The resident was on Zoloft. -The resident's mood and anxiety was stable on current medications. -Staff reported no change in the resident's mood or behavior. -The current treatment plan was to be continued. -Medications were reviewed for a possible gradual dose reduction of psychotropics. -Any reduction in regimen was likely to risk decompensation and was not recommended. -There was no clinical indication in gradually reducing the resident's psychotropic medications. Telephone interview with Resident #5's mental health provider on 03/17/22 at 9:40am revealed: -Zoloft was prescribed to Resident #5 to treat depression and anxiety. -Resident #5 was diagnosed with Parkinson's disease which could cause increased depression. -Sometimes Zoloft would gradually be discontinued over one to two weeks, however, it was not uncommon to discontinue Zoloft without tapering. -Abruptly discontinuing Zoloft could cause withdrawal symptoms or symptoms of depression such as withdrawn or tearfulness. -He examined Resident #5 last week and there were no mental health concerns. -Resident #5 did not experience adverse effects of the facility not administering Zoloft to the resident. -He discontinued Resident #5's Zoloft on 03/16/22. Attempted telephone interview with Resident #5's VA pharmacy on 03/16/22 at 4:00pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #5 was not	D 358			

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D 358	Continued From page 30 Interviewable. b. Review of Resident #5's current FL-2 dated 12/06/21 revealed there was an order for Thiamine 100mg one tablet daily (used to treat Vitamin B1 deficiency). Review of Resident #5's subsequent physician's order dated 02/21/22 revealed there was an order for Thiamine 100mg one tablet daily. Review of Resident #5's January 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Thiamine 100mg take one tablet daily to be administered at 8:00am. -Thiamine was not documented as administered from 01/02/22 to 01/06/22, 01/08/22 to 01/14/22, and 01/16/22 to 01/31/22 because the facility was waiting on the medication from the pharmacy. -Thiamine was not documented as administered on 01/01/22 and 01/07/22. There was no reason why. -Thiamine was not documented as administered for 30 of 31 days during January 2022. Review of Resident #5's February 2022 eMAR revealed: -There was an electronic entry for Thiamine 100mg take one tablet daily to be administered at 8:00am. -Thiamine was not documented as administered on 02/01/22 and from 02/03/22 to 02/05/22, 02/08/22 to 02/21/22, and 02/23/22 to 02/26/22 because the facility was waiting on the medication from the pharmacy. -Thiamine was not documented as administered on 02/07/22 and there was no reason why. -Thiamine was not documented as administered	D 358			

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D 358	Continued From page 31 for 24 of 28 days during February 2022. Review of Resident #5's March 2022 eMAR from 03/01/22 to 03/16/22 revealed: -There was an electronic entry for Thiamine 100mg take one tablet daily to be administered at 8:00am. -Thiamine was not documented as administered from 03/01/22 to 03/02/22, 03/04/22 to 03/05/22, 03/08/22 to 03/10/22, and 03/12/22 to 03/16/22 because the facility was waiting on the medication from the pharmacy. -Thiamine was not documented as administered for 12 of 16 days during March 2022. Observation of Resident #5's medications on hand on 03/16/22 at 2:27pm revealed Thiamine was not available on the medication cart for administration to the resident. Interview with the medication aide (MA) on 03/16/22 at 2:30pm revealed the medication aide/supervisor (MA/S) called the Veteran's Administration (VA) on 03/15/22 to request a refill for Resident #5's Thiamine. Interview with the MA/S on 03/16/22 at 3:55pm revealed: -Two months ago, she reordered Resident #5's Thiamine through the eMAR system which would go to the facility's contracted pharmacy. -The contracted pharmacy would contact the VA to reorder Resident #5's Thiamine. -At that time, she called the facility's contracted pharmacy to check the status of Resident #5's Thiamine. -She was told by the Resident Care Coordinator (RCC) to call the VA to reorder Resident #5's Thiamine. -She called the VA pharmacy and was told	D 358		

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D 358	Continued From page 32 Resident #5 needed a new prescription for Thiamine. -She called Resident #5's VA primary care provider (PCP) and left messages with someone several times over the last two months regarding refills for Resident #5's Thiamine. -She did not remember the exact dates. -She did not remember who she spoke to or what the PCP's name was. -Resident #5's VA PCP never returned her call. -She documented on Resident #5's eMAR the facility was waiting on the pharmacy to send Resident #5's Thiamine. -She did not document when she called the VA pharmacy for a reorder of Resident #5's Thiamine. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/16/22 at 4:30pm revealed: -On 02/20/22, someone from the facility requested refills on Resident #5's Thiamine. -Before Resident #5's Thiamine could be refilled on 02/21/22, the Resident Care Coordinator (RCC) told the pharmacy that the facility had received Resident #5's Thiamine and not to refill the medications. -Resident #5's Thiamine were not filled by the facility's contracted pharmacy at that time. A second interview with the RCC on 03/16/22 at 4:45pm revealed she did not recall the conversation with the facility's contracted pharmacy on 02/21/22 to stop the refill of Resident #5's Thiamine. Telephone interview with the facility's contracted PCP on 03/17/22 at 10:00am revealed: -Resident #5 was prescribed Thiamine to treat a Vitamin B1 deficiency.	D 358		

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D 358	Continued From page 33 -Resident #5's Vitamin B1 level was satisfactory on 02/14/22. -Not administering Thiamine to Resident #5 could cause a future deficiency. -Resident #5 also had a diagnosis of dementia and Thiamine was also used to treat dementia. -Not administering Thiamine to Resident #5 could cause the resident to have a worsening memory. Attempted telephone interview with Resident #5's VA pharmacy on 03/16/22 at 4:00pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. c. Review of Resident #5's physician's order dated 02/21/22 revealed there was an order for Coreg 12.5mg take one-half tablet twice daily (used to treat hypertension and heart failure). Review of Resident #5's March 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Coreg 12.5mg take one-half a tablet twice daily to be administered at 8:00am and 8:00pm. -Coreg was not documented as administered at 8:00am and 8:00pm from 03/08/22 to 03/09/22, and from 03/12/22 to 03/14/22 because the facility was waiting on the pharmacy to send the medication. -Coreg was not documented as administered at 8:00pm on 03/04/22, 03/06/22, 03/07/22, and 03/11/22 because the facility was waiting on the pharmacy to send the medication. -Coreg was not documented as administered for 19 of 31 doses from 03/01/22 to 03/16/22.	D 358		

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D 358	Continued From page 34 Observation of Resident #5's medications on hand on 03/16/22 at 2:27pm revealed Coreg was not available on the medication cart for administration to the resident. Interview with the medication aide (MA) on 03/16/22 at 2:30pm revealed the medication aide/supervisor (MA/S) called the Veteran's Administration (VA) on 03/15/22 to request a refill for Resident #5's Coreg. Interview with the MA/S on 03/16/22 at 3:55pm revealed Resident #5 had no cardiac complaints. Telephone interview with the facility's contracted primary care provider (PCP) on 03/17/22 at 10:00am revealed: -Coreg was prescribed to Resident #5 to treat HTN. -Not administering Coreg to Resident #5 as prescribed could cause the resident to have hypertensive episodes, headache, and vision changes. -Because Resident #5 had a diagnosis of dementia, the resident may not have known to report hypertensive symptoms to the facility. -She did not have a recent blood pressure for Resident #5 since he had not been administered the Coreg as ordered. -She expected the facility to have notified her when the resident had missed two or three days of missed doses of Coreg. -Had she known; she would have tried to get the resident's Coreg filled by a local pharmacy or tried to obtain the medications through a medication assistance program. Interview with the Administrator in Charge (AIC) on 03/17/21 at 5:15pm revealed Resident #5's current blood pressure was 135/85 on 03/17/22.	D 358			

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D 358	Continued From page 35 Attempted telephone interview with Resident #5's VA pharmacy on 03/16/22 at 4:00pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. d. Review of Resident #5's current FL-2 dated 12/06/21 revealed there was an order for Nystatin 1000,000 units per gram (g) apply to skin folds twice daily (used to treat fungal infections). Review of Resident #5's physician's order dated 02/21/22 revealed there was an order for Nystatin 1000,000 units/g powder apply topically to rash in skin folds twice a day. Review of Resident #5's March 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Nystatin 100,000 units/g powder to apply topically to a rash in the skin folds twice daily to be administered at 8:00am and 8:00pm. -Nystatin was not documented as administered at 8:00am and 8:00pm on 03/09/22 and 03/14/22 because the facility was waiting on the pharmacy to send the medication. -Nystatin was not documented as administered at 8:00am on 03/03/22, 03/08/22, 03/10/22, and from 03/12/22 to 03/13/22 and 03/15/22 to 03/16/22 because the facility was waiting on the pharmacy to send the medication. -Nystatin was not documented as administered for 11 of 31 doses from 03/01/22 to 03/16/22. Observation of Resident #5's medications on hand on 03/16/22 at 2:27pm revealed Nystatin	D 358			

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D 358	Continued From page 36 was not available on the medication cart for administration to the resident. Interview with the medication aide (MA) on 03/16/22 at 2:30pm revealed, the medication aide/supervisor (MA/S) called the Veteran's Administration (VA) on 03/15/22 to request a refill for Resident #5's Nystatin. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/16/22 at 4:30pm revealed: -On 02/20/22, someone from the facility requested refills on Resident #5's Nystatin. -Before Resident #5's Nystatin could be refilled on 02/21/22, the Resident Care Coordinator (RCC) told the pharmacy that the facility had received Resident #5's Nystatin and not to refill the medications. -Resident #5's Nystatin was not filled by the facility's contracted pharmacy at that time. Interview with the RCC on 03/16/22 at 4:45pm revealed: -She did not recall the conversation with the facility's contracted pharmacy on 02/21/22 to stop the refill of Resident #5's Nystatin. -She had never been told by staff Resident #5's Nystatin was lost. Telephone interview with the facility's contracted primary care provider (PCP) on 03/17/22 at 10:00am revealed: -Resident #5 was prescribed Nystatin to treat a yeast infection located to his abdominal skin folds. -Not administering Nystatin to Resident #5 as ordered could cause the rash to worsen, skin breakdown, itching, and an infection from scratching.	D 358		

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D 358	Continued From page 37 -Resident #5 was diagnosed with a virus that caused immunosuppression and the lack of Nystatin could cause the resident to require intravenous antibiotics because of an infection to the abdominal skin folds. Attempted telephone interview with Resident #5's VA pharmacy on 03/16/22 at 4:00pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Interview with the MA on 03/16/22 at 2:30pm revealed: -Resident #5's medications were provided by the VA. -On 03/15/22, the RCC told the medication aide/supervisor (MA/S) to call the VA for Resident #5's medications. -The MA on duty was responsible for requesting a refill of resident medications when there were seven to ten doses remaining. -If it was before 5:00pm, the MA would call the VA for a refill. -If it was after 5:00pm, the MA would enter an electronic note, print the note, and leave it on the medication cart. -During shift change from third to first shift, the MA leaving would review the electronic charting note with the oncoming MA and the oncoming MA would call the VA for a refill. -She did not know the policy for when a resident ran out of their medications. -She did not know why some of the documentation blocks in Resident #5's eMAR were blank. -She did not know why there was sporadic documentation of Resident #5's medication was	D 358			

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NAME OF PROVIDER OR SUPPLIER ROSE VISTA ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 ROSE VISTA ROAD KINSTON, NC 28504			
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D 358	Continued From page 38 awaiting delivery from the pharmacy. -Two weeks ago, she told the MA on first shift (she could not remember who) some of Resident #5's medications were not available for administration. -She did not remember which of Resident #5's medications were not available. -She was told by another MA that the facility was waiting on VA to send Resident #5's medications. -She did not tell the Administrator or the RCC Resident #5's medications were not available for administration because she thought they knew. Interview with the RCC on 03/16/22 at 2:45pm revealed: -She was responsible for initiating the reorder of resident medications provided by the VA. -The MA would notify her when three weeks of VA medications remained. -Then, she would call the VA and make the first request for medication refills. -The MA/S would make the follow up phone calls regarding VA medication refills. -There was no time frame for following up with the VA pharmacy regarding the status of medication refills requested. -There was no time frame for following up with the VA provider regarding unreturned phone calls. -She expected the MA/S to follow up with the VA pharmacy when the MA had a chance to call. -Resident #5 would not receive his medications if not received from the VA. -She called Resident #5's VA provider and left messages with the receptionist of the need for refills. -Resident #5's VA provider had not returned her calls regarding the resident's medication refills. -She had documentation of when she contacted the VA regarding refilling Resident #5's medications but did not contain dates and times.	D 358			

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D 358	Continued From page 39 -She had no system in place for tracking the calls other than sporadic documentation on the back of a copy of Resident #5's six months physician's order sheet. Interview with the Administrator in Charge (AIC) on 03/16/22 at 3:05pm reveled: -The MA/S was to notify the RCC when two weeks of a VA resident's medications remained because it took a long time to receive medications from the VA. -The RCC was responsible for reordering VA resident's medications from the VA when there were two weeks of the medications remaining. -She did not know how long it took for a VA resident's medications to arrive from the VA when reordered. -She expected the RCC to follow up with the VA regarding the status of medications. -She did not know the timeframe she expected the RCC to follow up with the VA regarding the status of medications. -She did not know if the facility's contracted pharmacy could be used for Resident #5's back-up pharmacy. -She did not know if the facility's contracted pharmacy could fill the medications Resident #5 did not have available for administration. -In the past, the facility had used another pharmacy to refill Resident #5's medications when they were unable to obtain them from the VA. -The facility was still responsible for providing medications for Resident #5 even if he or his family member did not pay for the medication to be filled. -She knew, at times, the facility did not have some of Resident #5's medications available for administration because the facility would run out of his medications.	D 358			

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D 358	Continued From page 40 -Audits were not performed to catch when the facility ran out of resident medications. -Stand up meetings were performed twice weekly which provided an opportunity to discuss when the facility was out of medications or problems concerning refills. -The RCC told her Resident #5 was out of some of his medications but did not remember when. Telephone interview with Resident #5's family member on 03/16/22 at 4:05pm revealed: -She thought Resident #5's medications were ordered by the facility's contracted PCP. -The VA provided Resident #5's medications. -She thought the facility had run out of Resident #5's medications in the past but could not remember when. -At that time, the facility contacted a backup pharmacy to refill Resident #5's medications. -She expected the facility to be certain they did not run out of Resident #5's medications. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/16/22 at 4:30pm revealed: -The pharmacy had refilled medications for Resident #5 in the past but not on a regular basis. -Resident #5's medications were reordered through the VA. -Resident #5's family member would be responsible for the bill when the facility's contracted pharmacy provided refills for the resident. -Resident #5's family member would have to agree to the financial responsibilities of them refilling the resident's medications. 2. Review of Resident #4's current FL-2 dated 07/01/21 revealed diagnoses included asthma, dementia, and schizophrenia.	D 358		

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D 358	Continued From page 41 Review of Resident #4's physician order dated 08/10/21 revealed there was an order for Symbicort 80mcg/4.5mcg inhale two puffs twice daily (used to treat asthma by enlarging the bronchioles). Review of Resident #4's physician order dated 02/21/22 revealed there was an order for Symbicort 80mcg/4.5mcg inhale 2 puffs twice daily. Review of Resident #4's electronic medication administration record (eMAR) for January 2022 revealed: -There was an electronic entry for Symbicort 80/4.5mcg inhale 2 puffs by mouth twice daily to be administered at 8:00am and 8:00pm. -There was documentation Symbicort was not administered at 8:00am and 8:00pm from 01/20/22 to 01/22/22, 01/25/22, and 01/27/22 to 01/31/22 because the facility was waiting on the pharmacy to deliver the medication. -There was documentation Symbicort was not administered at 8:00am on 01/05/22 because the facility was waiting on the pharmacy to deliver the medication. -There was documentation Symbicort was not administered at 8:00pm on 01/19/22, 01/24/22, and 01/26/22. -Symbicort was not documented as administered at 8:00am on 01/01/22 and there was no reason why. -Symbicort was not documented as administered for 23 of 62 doses during January 2022. Review of Resident #4's February 2022 eMAR revealed: -There was an electronic entry for Symbicort 80/4.5mcg inhale 2 puffs by mouth twice daily to	D 358			

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D 358	Continued From page 42 be administered at 8:00am and 8:00pm. -Symbicort was not documented as administered at 8:00am and 8:00pm on 02/01/22, from 02/24/22 to 02/26/22, and on 02/28/22 because the facility was waiting on the pharmacy to deliver the medication. -Symbicort was not documented as administered at 8:00am on 02/02/22 and 02/27/22 because the facility was waiting on the pharmacy to deliver the medication. -Symbicort was not documented as administered on 02/27/22 at 8:00pm. -There was no reason why. -Symbicort was not documented as administered for 14 of 56 doses during February 2022. Review of Resident #4's March 2022 eMAR revealed: -There was an electronic entry for Symbicort 80/4.5mcg inhale 2 puffs by mouth twice daily to be administered at 8:00am and 8:00pm. -Symbicort was not documented as administered at 8:00am on 03/01/22 because the facility was waiting on the pharmacy to deliver the medication. -Symbicort was not documented as administered for 1 of 31 doses from 03/01/22 to 03/16/22. Observation of Resident #4's medications on hand on 03/17/22 at 3:00pm revealed there were four doses of Symbicort that remained for administration. Interview with a medication aide (MA) on 03/17/22 at 3:00pm revealed Resident #4's Symbicort had always been available for her to administer to the resident. Telephone interview with Resident #4's primary care provider (PCP) on 03/17/22 at 4:30pm	D 358			

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D 358	Continued From page 43 revealed: -She was not aware the resident had not been administered Symbicort inhaler 21 times in January 2022. -She was not aware the resident had not been administered Symbicort inhaler 12 times in February 2022. -She was not aware the resident had not been administered Symbicort inhaler 1 time in March 2022. -The facility had not notified her of waiting on the pharmacy to provide Resident #4's Symbicort inhaler during January to March 2022. -The facility was expected to ensure Resident #4's medications are available to be administered as ordered. -She expected the MAs to notify her when residents had three consecutive missed administrations of any medication Interview with the Resident Care Coordinator (RCC) on 03/17/22 at 4:35pm revealed: -Resident #4's Symbicort was automatically refilled every month during the facility's contracted pharmacy's cycle batch refill every 28 days. -The facility was out of Resident #4's Symbicort during the end of January 2022 because the resident required a preauthorization before a refill could be provided. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/17/22 at 4:45pm revealed: -On 01/05/22, a 30-day supply of Resident #4's Symbicort was dispensed to the facility. -On 01/20/22, a refill request for Resident #4's Symbicort was submitted by the facility via the quick MAR system. It was not filled. -On 02/01/22, a 30-day supply of Resident #4's	D 358		

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D 358	Continued From page 44 Symbicort was dispensed to the facility. -On 02/14/22, another refill request for Resident #4's Symbicort was submitted by the MA via the quick MAR system. -There was no reason documented for the refill request. -The 02/14/22 refill request was not filled because it was too early. -On 02/22/22, the facility's contracted pharmacy called to tell the RCC Resident #4's Symbicort could not be refilled because the refill was too early. -The RCC then told the facility's contracted pharmacy to cancel the refill request for Resident #4's Symbicort because the medication had been found. -On 03/01/22, a 30-day supply of Resident #4's Symbicort was dispensed to the facility. -Based on the dispensing history, Resident #5 should have had enough Symbicort doses to administer January 2022 through March 2022 without any missed doses. A second interview with the RCC on 03/17/22 at 4:55pm revealed: -She did not remember if Resident #4's Symbicort was lost in February 2022. -She did not remember telling the facility's contracted pharmacy that Resident #4's Symbicort had been found in February 2022. Interview with the Administrator in Charge (AIC) on 03/17/22 at 5:10pm revealed: -She did not know Resident #4's Symbicort had been unavailable for administration to the resident. -She did not know anything about Resident #4's Symbicort being lost in February 2022. Based on observations, interviews, and record	D 358			

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D 358	Continued From page 45 reviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with a second MA on 03/17/22 at 5:00pm was unsuccessful. 3. Review of Resident #3's current FL-2 dated 02/24/22 revealed diagnoses included obstructive sleep apnea, diabetes mellitus, and history of breast cancer. Review of Resident 3's physician's order dated 09/28/21 revealed an order for Lorazepam 1mg take 1 tablet every 6 hours as needed (prn) for anxiety. (Lorazepam is an anti-anxiety medication.) Review of Resident #3's primary care provider (PCP) visit notes dated 12/06/21, 01/10/22, 01/14/22, 01/20/22, 01/27/22, and 01/31/22 revealed: -The resident's diagnoses also included Parkinson's disease, hypertension, chronic obstructive pulmonary disease, shortness of breath, depressive disorder, and seizures. -The resident's medication list included Lorazepam 1mg take 1 tablet every 6 hours prn for anxiety or seizures. Review of Resident #3's physician's orders dated 02/21/22 revealed an order for Lorazepam 1mg 1 tablet every 6 hours prn for anxiety. Review of Resident #3's clarification of physician's orders dated 02/28/22 revealed an order for Lorazepam 1mg 1 tablet every 6 hours prn for anxiety with a maximum dosage of 4 tablets in 24 hours. Review of Resident #3's handwritten progress	D 358		

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D 358	Continued From page 46 note dated 01/07/22 (no time) revealed the resident had a "seizure" that lasted about 7 minutes. Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 1mg take 1 tablet every 6 hours as needed for anxiety. -Lorazepam was documented as administered prn on 31 occasions from 01/01/22 - 01/31/22. -Lorazepam was documented as administered for reasons other than anxiety on 4 of 31 occasions. -Lorazepam was documented as administered for seizure on 01/07/22 at 10:32am; for pain on 01/12/22 at 9:43pm; for seizure on 01/18/22 at 1:21pm; and for seizure activity on 01/20/22 at 11:48am. Review of Resident #3's electronic medication aide (MA) charting notes revealed: -On 02/14/22 at 3:01pm, the resident had a "seizure" at 2:45pm; it lasted for 2 minutes; gave Lorazepam. -On 02/14/22 at 10:30pm, the resident had a "seizure" at 9:40pm; it lasted 4 minutes; Lorazepam was already given. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Lorazepam 1mg take 1 tablet every 6 hours as needed for anxiety, maximum of 4 doses in 24 hours. -Lorazepam was documented as administered prn on 27 occasions from 02/01/22 - 02/28/22. -Lorazepam was documented as administered for pain instead of anxiety on 02/02/22 at 9:30pm. Interview with a medication aide (MA) on 03/17/22 at 12:10pm revealed:	D 358		

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D 358	Continued From page 47 -She could not explain why Resident #3's prn Lorazepam was documented as administered for seizures or pain. -The prn Lorazepam should be administered for anxiety. Interview with the Resident Care Coordinator (RCC) on 03/17/22 at 3:49pm revealed: -When Resident #3 had "episodes", the resident would say she was hot, her hands would shake more than usual, and she would slump over. -The resident's episodes usually occurred after the resident came inside from her smoking breaks and not wearing her oxygen. -The resident had an upcoming appointment with a neurologist in May 2022 related to the episodes / seizures. -Resident #3's prn Lorazepam should be administered for anxiety. -The resident had an order for Lorazepam to be administered prn for seizures in the past (could not recall when) but the order was changed to prn anxiety because the resident was anxious. -The MAs may have administered the prn Lorazepam for seizures because of the previous order but the MAs should read the eMAR and follow the instructions on the current order. Interview with the Administrator-in-Charge (AIC) on 03/17/22 at 4:35pm revealed: -She did not want to call Resident #3's "episodes" seizures because she was not a health care professional. -Resident #3's episodes usually occurred after the resident came in from smoking and she had not been wearing her oxygen. -The resident would start shaking more than usual and get hot. -The resident's prn Lorazepam should be administered for anxiety as ordered.	D 358		

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D 358	Continued From page 48 -The MAs should not administer Lorazepam for seizures. Interview with Resident #3 on 03/17/22 at 3:39pm revealed: -She did not wear her oxygen when she went outside to smoke. -She sometimes had "spells" when she felt like she was hyperventilating. -About 3 months ago, she went to the hospital and the hospital staff said she had a seizure. -She did not know what caused the episodes and she had no warning signs prior to an episode occurring. -She did not recall if she asked for Lorazepam or if staff administered it to her when she had an episode. -The prn Lorazepam helped with her anxiety. The facility failed to administer medications as ordered to Resident #5 due to the medications being unavailable. Resident #5 who was diagnosed with bipolar disorder, dementia, Parkinson's disease and depression was not administered an antidepressant 105 of 136 days from 11/19/21 to 03/16/21; a medication for hypertension and heart failure with a blood pressure of 135/85 was not administered for 19 of 31 doses from 03/01/22 to 03/16/22 placing the resident at risk for increased hypertension, headaches and vision changes; a medication to improve memory and treat a vitamin deficiency was not administered for 12 of 16 days during March 2022 placing the resident at risk for increased memory loss; and a medication for fungal infections was not administered for 11 of 31 doses from 03/01/22 to 03/16/22 placing the resident at risk for infection and intravenous antibiotics. Resident #3 had an order to receive Lorazepam as needed for anxiety but received it	D 358			

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D 358	Continued From page 49 on 5 occasions in January 2022 and February 2022 for either pain or seizures instead of anxiety as ordered. The failure of the facility to administer medications as ordered 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-21 on 03/16/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2022.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents taking their medications for 2 of 5 residents sampled (#1, #6). The findings are: Review of the facility's Medication Policy and Procedure Manual revealed: -The facility shall assure that only trained staff shall administer medications.	D 366	It is the policy of Rose Vista Assisted Living to assure the recording on the medication administration record shall be by the staff person who administers the medication immediately following the administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. The policy also prohibits the pre-charting of medication administration. The RN Consultant from the long-term care pharmacy conducted a training for Medication Technicians on April 14, 2022 on topics including by not limited to Residents' Rights, Medication Administration & Documentation, and Medication Errors & Exceptions. On April 6, 2022, the owners of Rose Vista Assisted Living, met with the long-term care pharmacy in regards to, topics including but not limited to Medication Administration. The RCC or Designee will observe medication passes weekly to ensure that residents are taking the medication being given to them and ensure continued compliance. The Administrator in Charge will audit monthly to ensure continued compliance.	May 5, 2022 and on going

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NAME OF PROVIDER OR SUPPLIER ROSE VISTA ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 ROSE VISTA ROAD KINSTON, NC 28504			
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D 366	Continued From page 50 -The recording of the administration on the medication administration record (MAR) shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident taking the medication. 1. Review of Resident #1's current FL-2 dated 04/27/21 revealed diagnoses included profound mental retardation, anxiety, acute cystitis with hematuria, weakness, acute left artery pulmonary embolus, and epistaxis. Review of Resident #1's Care Plan dated 07/09/21 revealed the resident was totally dependent on staff assistance for eating. Review of Resident #1's physician orders dated 02/21/22 revealed: -There was an order for Aspirin 81mg chewable tablet, take 1 tablet once a day. (Aspirin prevents unwanted blood clotting and decreases the risk of heart attacks and strokes.) -There was an order for Buspar 10mg, take 1 tablet twice a day. (Buspar is used to relieve the symptoms of anxiety.) -There was an order for Colace 100mg, take 1 tablet twice a day. (Colace is used to treat and prevent occasional constipation.) -There was an order for Eliquis 5mg, take 1 tablet every 12 hours. (Eliquis is used to prevent unwanted blood clotting and reduce risk of stroke and heart attacks.) -There was an order for Tricor 145mg, take 1 tablet once a day. (Tricor used to reduce the symptoms of cholesterol and fatty acids in the blood.) -There was an order for Folate 1mg, take 2 tablets once a day. (Folate helps in healthy red blood cell formation and healthy cell growth and	D 366			

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D 366	Continued From page 51 function.) -There was an order for Claritin 10mg, take 1 tablet once a day. (Claritin is used to prevent and treat allergy symptoms.) Review of Resident #1's physician orders dated 03/07/22 revealed an order for Bactrim DS, take 1 tablet twice a day for 14 days. (Bactrim DS is a combination antibiotic used to treat bacterial infections.) Review of Resident #1's standing orders dated 02/21/22 revealed an order for medication given by mouth may be crushed, if not otherwise noted, and/or placed in applesauce, juice, or food if indicated. Review of Resident #1's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg chewable, take 1 tablet once a day, scheduled at 8:00am. -There was an entry for Buspar 10mg, take 1 tablet twice a day, scheduled at 8:00am. -There was an entry for Colace 100mg, take 1 tablet twice a day, scheduled at 8:00am. -There was an entry for Eliquis 5mg, take 1 tablet every 12 hours, scheduled at 8:00am. -There was an entry for Tricor 145mg, take 1 tablet once a day, scheduled at 8:00am. -There was an entry for Folic Acid 1mg, take 2 tablets once a day, scheduled at 8:00am. -There was an entry for Claritin 10mg, take 1 tablet once a day, scheduled at 8:00am. -There was an entry for Bactrim DS, take 1 tablet twice a day for 14 days, scheduled at 9:00am. Observation of the dining room during the breakfast meal from 8:06am to 08:25am on 03/17/22 revealed:	D 366			

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D 366	Continued From page 52 -The personal care aide (PCA) was holding a plate with grits. -At 8:06am, the medication aide (MA) sprinkled crushed medications on to the grits and mixed the medications in the grits. -The MA walked out of the dining room after mixing the medication in the grits. -The PCA carried the breakfast plate containing the grits with crushed medications to a table where Resident #1 was sitting in a wheelchair. -The PCA sat beside Resident #1 and began feeding the resident the grits with crushed medications. -At 8:15am, the MA approached Resident #1, spoke to the PCA, and exited the dining room. -The PCA continued to prompt Resident #1 to eat, the resident laughed and turned her head from the spoon of grits with crushed medications. -Resident #1 did not eat half of the grits which contained the resident's crushed medications. Interview with the PCA on 03/17/22 at 8:30am revealed: -When she worked, the MA mixed Resident #1's medications in her breakfast food. -The PCA administered the medications to the resident while feeding her breakfast. -The MA did not observe Resident #1 take the medications that were mixed in her food during breakfast. -She had been administering Resident #1 medications mixed in her breakfast food for about two years without the MA observing. -She had never been told the MA needed to observe Resident #1 take her medications during breakfast. -She had never been told she could not administer Resident #1's medications mixed with her breakfast. -Resident #1 did not eat all her grits this morning.	D 366		

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D 366	Continued From page 53 -There were pill fragments on her remaining grits. Interview with the MA on 03/17/22 at 8:45am revealed: -She crushed Resident #1's 03/17/22 8:00am medications to consist of Folic Acid, Fenofibrate, Eliquis, Loratadine, Docusate Sodium, Aspirin, Buspirone, and Bactrim DS and mixed them in the resident's grits for the PCA to feed to the resident during breakfast this morning, 03/17/22. -She did not observe Resident #1 take the medications because she was running behind with the medication pass. -The PCA told her Resident #1 ate all except a little amount of the grits. -She then documented on Resident #1's 03/17/22 eMAR during her 8:00am medication pass that she had administered the Folic Acid, Fenofibrate, Eliquis, Loratadine, Docusate Sodium, Aspirin, Buspirone, and Bactrim DS to the resident. Interview with the Administrator on 03/17/22 at 8:55am revealed she expected the MA who prepared the medications to observe the resident take the medications. Telephone interview with Resident #1's primary care provider (PCP) on 03/17/22 at 4:30pm revealed: -The MA should have mixed the resident's crushed medications into a small portion of grits, pudding or applesauce to ensure the full dose was administered. -The MA should have administered the medications to Resident #1. -She was concerned the resident did not receive the correct amount of each medication as ordered. Based on observations, interviews, and record	D 366			

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D 366	Continued From page 54 reviews, it was determined that Resident #1 was not interviewable. 2. Review of Resident #6's current FL-2 dated 01/10/22 revealed a diagnosis of schizoaffective disorder. Review of Resident #6's primary care provider (PCP) orders dated 02/14/22 revealed: -The resident's diagnoses included chronic obstructive pulmonary disease. -There was an order to start Breo Ellipta 100/25mcg Inhaler, use 1 puff once daily. (Breo Ellipta is a combination inhaler used to improve breathing problems caused by lung disease.) -There was an order to start Incruse Ellipta 62.5mcg inhaler, use 1 puff once daily. (Incruse Ellipta is a combination inhaler used to improve breathing problems caused by lung disease.) Observation of Resident #6's room on 03/16/22 at 10:03am revealed: -Resident #6 was lying in bed and a second resident was lying in another bed in the room. -There was no staff in the room or in view of the residents in the room. -There was an Incruse Ellipta inhaler dispensed on 02/16/22 on top of Resident #6's bedside table. -There was a Breo Ellipta inhaler dispensed on 02/16/22 on the floor near Resident #6's bedside table. Interview with Resident #6 on 03/16/22 at 10:03am revealed: -The medication aide (MA) left the inhalers in her room earlier that morning (03/16/22) for the resident to use. -The MAs did not usually leave the inhalers in the room but she was asleep earlier that morning	D 366			

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D 366	Continued From page 55 when the MA came to administer the inhalers. -She administered 1 puff of each inhaler to herself that morning after she woke up (unsure of the time.) -The MA was not in the room and did not observe her administer the inhalers to herself. -The MA had not returned to get the inhalers. Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Breo Ellipta 100/25mcg inhaler, use 1 inhalation once a day, rinse mouth after use scheduled for administration at 8:00am. -There was an entry for Incruse Ellipta 100/25mcg inhaler, use 1 inhalation once a day, rinse mouth after use scheduled for administration at 8:00am. -Breo Ellipta and Incruse Ellipta were documented as administered by the MA on 03/16/22 at 8:00am. Interview with the Administrator on 03/16/22 at 10:07am revealed: -Resident #6's inhalers should not have been left in the resident's room for the resident to administer to herself. -The MAs were responsible for administering and observing Resident #6 take her medications. -She would have the MA remove the inhalers from the resident's room. Observation on 03/16/22 at 10:09am revealed the MA removed the inhalers from Resident #6's room and put them in the medication cart. Interview with the MA on 03/17/22 at 9:02am revealed: -Most of the time, she administered and observed Resident #6 take her inhalers but sometimes she	D 366			

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D 366	Continued From page 56 left the inhalers in the resident's room for the resident to use if she was in a rush. -She was in a rush on 03/16/22 when she left Resident #6's inhalers in the resident's room for the resident to use. -She did not observe Resident #6 administer the Incruse Ellipta or the Breo Ellipta inhalers on 03/16/22 even though she documented she administered the inhalers on the eMAR. Telephone interview with Resident #6's PCP on 03/17/22 at 4:11pm revealed: -Resident #6's inhalers should be administered and observed by the MAs. -Resident #6 should be observed by the MAs to ensure the resident was using the proper technique and taking the correct dosage.	D 366		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration. The findings are: Based on observations, interviews, and record	D912	It is the policy of Rose Vista Assisted Living to ensure that every resident has the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws, rules and regulations. Following the conclusion of the survey, a new process was implemented to track and follow-up with referrals. The spreadsheet is maintained by the Resident Care Coordinator (RCC). An RCC training was conducted on 5/4/2022, by a pharmacist from the long-term care pharmacy, including but not limited to Health Care Referral and Follow up and Medication Administration. The RN Consultant from the long-term care pharmacy conducted a training for Medication Technicians on April 14, 2022 on topics including by not limited to Residents' Rights, Medication Administration & Documentation, and Medication Errors & Exceptions.	May 5, 2022 and on going

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D912	Continued From page 57 reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 3 of 5 residents sampled (#3, #4, #5) including errors with medications for anxiety (#3), asthma (#4), depression, infection, hypertension, and a vitamin supplement prescribed for deficiency and memory (#5). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912	All residents are now getting medications from the same long-term care pharmacy and a procedure is in place to ensure that medication is in the facility. On April 6, 2022, the owners of Rose Vista Assisted Living, met with the long-term care pharmacy in regards to, topics including but not limited to ensuring that all medications are in the facility on a daily basis. The RCC or Designee will audit medication carts twice a week to ensure that all medications are present. The Administrator in Charge will audit monthly to ensure continued compliance.	