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| | HAL054069 | A. BUILDING _____ B. WING _____ | 04/04/2024 |

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| 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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and Lenoir County Department of Social Services conducted an annual survey and a complaint investigation on 04/03/24 - 04/04/24. The Lenoir County Department of Social Services initiated the complaint investigation on 03/04/24. | D 000 | | |
| D 079 | 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br>(a) Adult care homes shall<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to provide a safe and clean environment free of hazards related to bed bugs in the facility.<br><br>The findings are:<br><br>Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 60 beds for a special care unit (SCU).<br><br>Review of the facility's census reports provided on 04/03/24 revealed the facility's in-house census was 56 residents.<br><br>Review of the facility's bed bug policy revealed:<br>-Every item shall be pulled from the room that will | D 079 | It is the policy of Rose Vista Assisted Living to ensure that the facility is maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards.<br><br>The exterminator inserviced staff on April 29, 2024 on topics including but not limited to identify bed bugs and treatments for them.<br><br>Staff was inserviced shift to shift by the Administrator on topics including but not limited to identifying bed bugs and the facility policy on reporting bed bugs and how they are treated.<br><br>The exterminator was actively treating the facility on April 3, 2024 when the survey team arrived at the facility. The common areas of the facility along with a batch of resident rooms were treated on March 27, 2024 and follow up testing and treatments were conducted on the week of April 8, 2024. Other areas were treated on April 4th and May 2nd. Follow up on the May 2, 2024 treatments will happen two week from that date. All resident rooms and common areas have been treated. Bed bug indicators have been placed in rooms that have been treated and cleared to allow for staff to quickly and easily determine if bed bugs are active in a particular room. | |



Reviewed and Acknowledged 05/10/24-MB

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| D 079 | Continued From page 1<br>fit in a clothes dryer, including but not limited to bedding, clothing, stuff animals, linen, shoes, pillows, and furniture coverings.<br>-All items shall be placed in a hot dryer for at least 45 minutes.<br>-The resident (s) will be relocated to another area of the facility temporarily while the room is being treated.<br>-The room will be super cleaned, including the walls, windows, closets, and other areas, using a strong disinfectant solution<br>-The entire room should be empty at this point, and everything should be sanitized.<br>-The room will be chemically treated by the exterminator or heat treated by the facility.<br>-Once the treatments are finished the clothes and furniture can be brought back into the room and set back up for the resident.<br>-The room shall be checked in two weeks for follow-up.<br>-Attempt to find the source of the bed bugs (ex. new resident, employee or visitor, or other sources) and monitor the potential culprit of the onset to prevent further infestations.<br>-If it is suspected that a new resident might be bringing in the bed bugs, the above steps will be taken with their possessions immediately upon admission.<br><br>Review on the contracted exterminator terms and agreement dated 11/02/23 revealed:<br>-Standard pest control services would be monthly for targeted pests such as roaches, rats, mice, ants, silver fish, spiders, earwigs, sow bugs, pill bugs, crickets, centipedes, millipedes, and ground beetles.<br>-Treatment will occur in the main structure and 3 feet from the foundation of the building.<br>-Bedbug treatment will be available on a per-room basis. | D 079 | The exterminator will continue to service the facility weekly and will treat any problem areas identified at that time.<br><br>Residents leaving the facility to go to the hospital or therapeutic leave will be taken immediately to the shower when returning to the facility and any clothes that were brought or worn back to the facility will be immediately taken to the laundry and washed and dried.<br><br>Indoor visitation has been halted through May 31, 2024 or until the exterminator is able to determine that there are no bed bugs at the facility.<br><br>The Administrator, Maintenance Director or designee will monitor weekly for continued compliance. | May 19, 2024 and on going |

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| D 079 | Continued From page 2<br><br>Review of Appointment Record Invoices from the facility's contracted pest control company revealed:<br>-There was an invoice dated 03/04/24 from 1:53pm- 5:42pm with a technician note that rooms 103, 114, 116 was treated and needed follow-up.<br>-Rooms 106, 113 and 115 had bed bugs in the beds and walls.<br>-Rooms 107, 109, 110 and 113 had bed bugs in the beds.<br>-Room 108 had bed bugs in bed, walls and dresser.<br>-Room 105 had bed bugs in the bed and wall outlets.<br>-Room 104 had bed bugs in the box spring and wall outlets.<br>-Room 102 had light bed bug light activity.<br>-Room 101 had bed bugs in the beds and upper molding.<br>-Rooms 210 and 212 had bed bugs in the bed and sheets.<br>-Rooms 200, 211 and 215 had light bed bug activity in beds.<br>-There were 2 invoices dated 03/11/24 for rooms 203 and 209 with technician notes that the rooms with treated for control and elimination of bedbug infestation using liquid and aerosol insecticide.<br>-There was an invoice dated 03/27/24 from 1:57pm-3:59pm with a technician note that the front day room, activity room and dining room were treated for the control of bedbugs with liquid and aerosol insecticide.<br>-Bed bugs were located in furniture in all 3 areas.<br>-There was a second invoice dated 03/27/24 from 10:38am-11:10am for room 207 service with a technician note that a follow-up treatment was conducted with liquid, aerosol and vacuum was completed for light activity. | D 079 | | |

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| D 079 | Continued From page 3<br>-There was a third invoice dated 03/27/24 from 9:30am-10:56am for common areas with a technician note that treatment was completed in the rear day room and smoking area for the control of bed bugs using vacuum, liquid and aerosol insecticide.<br>-There was a fourth invoice dated 03/27/24 from 11:02am- 11:27am for room 102 with a technician note that follow-up treatment was completed using vacuum, liquid and aerosol insecticide for light activity.<br>-There was a fifth invoice dated 03/27/24 from 11:31-12:27 for room 202 with technician note that bedbug activity was primarily in a wedge pillow and light activity in both beds was treated using vacuum, liquid and aerosol insecticide.<br><br>Observation of the closet in room 102 on 04/03/24 at 9:29am revealed there was a dead bedbug on the floor inside of the closet.<br><br>Interview with resident from room 102 on 04/03/24 at 9:29am revealed:<br>-She had informed staff of the dead bedbug inside of her closet a few days ago.<br>-Staff had not swept and mopped inside of her closet.<br><br>Interview with a second resident from room 103 on 04/03/24 at 9:34am revealed:<br>-She had last seen bedbugs in her room a month ago.<br>-She did report seeing the bedbugs to staff.<br>-She was informed by the Resident Care Coordinator (RCC), her room would be treated for bedbugs but was not informed when the service would be scheduled.<br><br>Observation of a third resident's arm on 04/03/24 at 9:56am revealed there were several small | D 079 | | |

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| D 079 | Continued From page 4<br>reddish weeps on the resident's right arm.<br><br>Interview with a third resident from room 112 on 04/03/24 at 9:56am revealed:<br>-He had been bitten by bedbugs over the past few weeks.<br>-He had reported being bitten to the staff.<br>-He had slept in the hallway in his wheelchair on 04/03/24 to avoid being bitten at night.<br><br>Interview with a fourth resident on 04/03/24 at 10:03am revealed:<br>-Bed bugs fell from the ceiling approximately 2 weeks prior but had improved since the facility was treated.<br>-He continued to have bites on his arms and lower back from the previous week that were healing.<br>-His room was treated but thought he and other residents were bringing bedbugs back into the bedrooms after they were treated from the common areas.<br><br>Observation of the fourth resident's arms and lower back on 04/03/24 at 10:03am revealed:<br>-There were several small red sores on his lower arms; some were scabbed and some were open with smears of blood on the surrounding skin.<br>-There were red spots that were scabbed over on his arms.<br>-There were a few raised bumps on his lower back.<br><br>Interview with a housekeeper on 04/03/24 at 10:03am revealed:<br>-The facility had an issue with bedbugs about two months ago.<br>-She had not observed any bedbugs in residents' rooms since February 2024.<br>-Residents had not reported to her about having | D 079 | | |

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| D 079 | Continued From page 5<br>bedbugs in their rooms within the past two months.<br>-She was not trained on room preparation for bedbug prevention.<br><br>Interview with a personal care aide (PCA) on 04/04/24 at 4:21pm revealed:<br>-She began working with the facility in June 2023 and bed bugs were there when she came.<br>-She found the bed bugs in the light fixtures and in outlets.<br>-She reported the bed bugs to the Administrator, and she was told that someone came out to spray.<br>-She did not see anyone spray until October 2023.<br>-She did not notice a difference once sprayed.<br>-Residents complained to her that they did not want to sleep in their beds.<br>-On 04/02/24, she saw four bed bugs crawling on a resident and she took a disposable wipe, killed them, and discarded in the trash.<br>-On 04/02/24 one resident slept in his wheelchair while another resident slept on the sofa in the front room due to the bed bugs in their room.<br>-She did not report the bed bugs on 04/02/24 because she knew the Administrator was aware of the bed bugs.<br><br>Interview with a former medication aide (MA) on 04/04/24 at 4:18am revealed:<br>-Residents had complained about being bitten by bugs starting in February 2024.<br>-He observed bedbugs in some residents' rooms on their beds and in the crevices in the walls.<br>-He observed small black and red spots on residents' bed linen.<br>-He reported the complaints to the Administrator and was told the maintenance staff and a contracted extermination company was treating | D 079 | | |

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| D 079 | Continued From page 6<br>the facility.<br>-He tried to assist residents with minimum care when reports of bug bites were reported to him.<br>-Although he did not receive any instructions from the Administrator or RCC, he would strip the residents' beds and wash their bed linen and their clothes when he received reports of bug bites.<br><br>Interview with a MA on 04/04/24 at 4:18pm revealed:<br>-He checked the residents' rooms bedbugs once he received a complaint of being bitten by bugs.<br>-He provided as needed care to residents who complained of bug bites and would notify the Primary Care Physician (PCP) for additional treatment orders.<br>-He notified the Administrator immediately of all complaints of bedbug bites.<br>-He was instructed to strip the residents' beds and place the bed linen and all clothing in a plastic bag and place in the laundry room for either the housekeeping or laundry to wash.<br>-He would have the residents' shower.<br>-He witness treatment of the residents' rooms by the contracted exterminator.<br><br>Interview with the facility's contracted primary care physician (PCP) on 04/04/24 at 11:20am revealed:<br>-Bed bugs increased the risk of infection for the residents due to scratching.<br>-Bed bugs could also disrupt residents' sleep.<br><br>Interview with the contracted exterminator on 04/04/24 at 3:50pm revealed:<br>-He provided general pest control services on a monthly basis and bedbug services were scheduled.<br>-He completed a thorough inspection of the facility and observed bedbugs in several | D 079 | | |

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| D 079 | Continued From page 7<br>residents' rooms.<br>-He completed treatment for all rooms.<br>-Follow up services were completed bi-weekly and any new services for bedbug treatment would occur at the follow up services.<br>-Once the bedbug treatments were completed, there would be bedbug monitoring stations placed in all residents' rooms.<br>-He could not remember when the bedbug services begin.<br>-There was a specific vacuum treatment to vacuum the bedbugs and any eggs and then a liquid treatment was applied to the beds, walls, floor molding/base boards and crevices on the walls and doors.<br>-The facility had purchased plastic mattress coverings but some of the beds had metal frames and the plastic mattress coverings would be ripped and this would cause bedbugs to hide inside of the mattresses.<br>-All plastic covering were removed from the mattress and the beds were treated for bedbugs.<br><br>Interview with the Maintenance Director on 04/04/24 at 4:29pm revealed:<br>-The contracted exterminator began treating the facility for bedbugs in January 2024.<br>-He had provided heat treatment for the bedbugs but stopped the heat treatment once the contracted exterminator begin services.<br><br>Interview with the Administrator on 04/04/24 at 5:01pm revealed:<br>-The issue and concerns of bedbugs was brought to her attention in October 2023.<br>-The extermination services began on 11/02/23 with treating a couple of the rooms for bedbugs.<br>-The contracted exterminator provided general termination treatment of the facility monthly and bedbug treatment were provided upon schedule. | D 079 | | |

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| D 079 | Continued From page 8<br>-The maintenance director had provided heat treatment of the rooms for bedbugs but later stopped at the recommendation of the contracted exterminator.<br>-Staff were to notify her of all reports of bedbug bites.<br>-All housekeeping were trained on providing proper deep cleaning and sanitizing residents' rooms that had been treated or reports of bedbugs.<br>-Housekeeping staff, when assigned, and the laundry staff were responsible for washing all residents' bed linen and clothing.<br><br>The facility failed to ensure residents were provided with a clean and safe environment protected from hazards including bedbugs in the facility that resulted in bites to at least 4 residents and increased risk for infections. The facility's failure to control pests was detrimental to the health and safety of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/24 with amendments on 04/04/24 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 19, 2024. | D 079 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record | D 273 | It is the policy of Rose Vista Assisted Living to assure the referral and follow-up to meet the routine and acute health care needs of residents.<br><br>The Administrator and Resident Care Coordinator inserviced Medication Aides shift to shift on topics including but not limited to | |

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| D 273 | Continued From page 9<br><br>reviews, the facility failed to notify the primary care provider (PCP) for 1 of 5 sampled residents (#4) of multiple refused doses of a medication used to treat mood swings, Alzheimer's disease and to aid sleep.<br><br>The findings are:<br><br>Review of the facilty's undated Medication Administration Policy revealed:<br>-The medication administration record will include the omission of medications and the reason or omission including refusal of medications.<br>-The facility will ensure the implementation o policies and procedures governing medication errors that will include documentation of resident refusal of medication and notification of the resident's physician when necessary.<br><br>Review of Resident #4's current FL-2 dated 02/08/24 revealed:<br>-Diagnoses included Alzheimer disease and stage 4 kidney disease.<br>-There was an order for Tegretol ER 100mg, three tablets to be administered every 12 hours. (Tegretol is an anticonvulsive medication used to treat bipolar disorder.)<br>-There was an order for lithium extended release (ER) 450mg to be administered each night at bedtime. (Lithium is a medication used to treat bipolar disorder.)<br>-There was an order for memantine 10mg to be administered each day. (Memantine is a medication used to slow the progression of Alzheimer disease.)<br>-There was an order for trazodone 50mg, one half tablet to be administered each night at bedtime. (Trazodone is a medication used to treat depression and promote sleep.) | D 273 | medication administration and reporting to the Primary Care Provider if the resident refuses medications.<br><br>The Resident Care Coordinator conducted a meeting with all Med Aides and Personal Care Aides on May 2, 2024 on topics including but not limited to medication administration and reporting medication refusals to the PCP.<br><br>The RN Consultant is holding an inservice for Medication Aides on May 21, 2024 on topics including but not limited to medication administration and reporting refusals to the PCP.<br><br>The Resident Care Coordinator will monitor weekly for continued compliance. | May 19, 2024 and ongoing |

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| D 273 | Continued From page 10<br><br>Review of Resident #4's Resident Register revealed he was admitted the the facility on 01/30/24.<br><br>Review of Resident #4's electronic medication administration record (eMAR) for March 2024 revealed:<br>-There was an electronic entry for Tegretol ER 100 to administer three tablets every 12 hours and scheduled for 8:00am and 8:00pm.<br>-There was documentation he refused 4 of 31 doses scheduled for 8:00am and 9 of 31 doses scheduled for 8:00pm.<br>-There was an electronic entry for lithium ER 450mg to be administered each night at bedtime.<br>-There was documentation he refused 9 of 31 doses scheduled for 8:00pm.<br>-There was an electronic entry for memantine 10mg to be administered each day.<br>-There was documentation he refused 10 of 31 doses scheduled for 8:00am.<br>-There was an electronic entry for trazodone 50mg, one half tablet to be administered each night at bedtime.<br>-There was documentation he refused 9 of 31 doses scheduled for 8:00pm.<br><br>Review of Resident #4's eMAR for April 2024 revealed:<br>-There was an electronic entry for Tegretol ER 100 to administer three tablets every 12 hours and scheduled for 8:00am and 8:00pm.<br>-There was documentation he refused 2 of 3 doses scheduled for 8:00pm.<br>-There was an electronic entry for lithium ER 450mg to be administered each night at bedtime.<br>-There was documentation he refused 2 of 3 doses scheduled for 8:00pm.<br>-Thre was an electronic entry for trazodone 50mg, one half tablet to be administered each | D 273 | | |

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| D 273 | Continued From page 11<br>night at bedtime.<br>-There was documentation he refused 2 of 3 doses scheduled for 8:00pm.<br><br>Interview with Resident #4 on 04/04/24 at 9:30am revealed:<br>-He was hospitalized for 2 months at a behavioral health inpatient hospital prior to admission to the facility.<br>-His sleep was good and he slept through the night.<br>-He got along with others most of the time but he did get into a verbal altercation with another resident in the smoking area since being admitted.<br><br>Interview with a medication aide (MA) on 04/04/24 at 10:00am revealed:<br>-Resident #4 would become agitated with other residents but there had been no physical aggression.<br>-He went to his room when he got mad but he required redirection from staff during a verbal altercation approximately 1 month prior.<br>-He refused medications sometimes and she informed the Resident Care Coordinator (RCC).<br>-An exception report was done for each refusal for the RCC to follow-up.<br><br>Interview with Resident #4's primary care provider (PCP) on 04/04/24 at 11:20am revealed:<br>-Resident #4 was diagnosed with bipolar disorder which could lead to mood swings.<br>-She was aware he had refused medication on 03/23/24.<br>-Not taking his Tegretol, lithium and trazodone could impair his sleep and cause an increase in mood swings and irritability.<br>-Not taking his memantine could cause an increase in behavioral problems. | D 273 | | |

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| | HAL054069 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| D 273 | Continued From page 12<br>-She would have wanted to know he was refusing medication so she could follow-up and be sure the mental health provider was aware.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/04/24 at 3:51pm revealed:<br>-She was aware Resident #4 was refusing medications.<br>-It was her responsibility to notify the provider of medication refusals.<br>-She had not notified the PCP or the mental health provider of Resident #4's refusal of medications because they were not 3 consecutive doses.<br>-She would have notified the PCP and the mental health provider had she known he refused so many doses because he needed his medication.<br>-She was not aware of an exception report for missed doses of medication.<br><br>Interview with the Administrator on 04/04/24 at 4:50pm revealed:<br>-If medications were refused for 3 consecutive days or twice weekly then the RCC should notify the PCP or mental health provider.<br>-Weekly exception reports for missed medications were sent to the RCC for review each week.<br>-The providers should have been notified at least by 03/14/24 so the refusals could be addressed.<br>-The RCC was responsible for notifying the providers and she did not know why it was not done.<br><br>Attempted telephone interview with Resident #4's mental health provider on 04/04/24 at 10:15am and 3:30pm was unsuccessful. | D 273 | | |

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| D 276 | Continued From page 13<br>10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 sampled residents (#2) with orders for an orthopedic shoe daily.<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 02/22/24 revealed:<br>-Diagnoses included type II diabetes, atrial fibrillation, schizoaffective disorder, bipolar disorder, hypothyroid, chronic obstructive pulmonary disease, hypokalemia, chronic respiratory failure, and hypoxia and hyper acapnia.<br>-Resident #2's ambulated with the use of a wheelchair.<br><br>Review of Resident #2's emergency room (ER) hospital discharge summary dated 03/20/24 revealed Resident #2 was diagnosed with a closed nondisplaced fracture of proximal phalanx of lesser toe of right foot, initial encounter.<br><br>Review of Resident #2's triage notes of treating physician dated 03/25/24 revealed right toe was | D 276 | It is the policy of Rose Vista Assisted Living to assure documentation of written procedures, treatments or orders from a physician or other licensed health professional and implementation of procedures, treatments and orders.<br><br>The Administrator and Resident Care Coordinator inserviced Medication Aides shift to shift on topics including but not limited to following written procedures, treatments and orders from the PCP and reporting to the Primary Care Provider if the resident refuses medications or treatments<br><br>The Resident Care Coordinator conducted a meeting with all Med Aides and Personal Care Aides on May 2, 2024 on topics including but not limited to following written procedures, treatments and orders from the PCP and reporting to the Primary Care Provider if the resident refuses medications or treatments<br><br>The RN Consultant is holding an inservice for Medication Aides on May 21, 2024 on topics including but not limited to following written procedures, treatments and orders from the PCP and reporting to the Primary Care Provider if the resident refuses medications or treatments<br><br>The Resident Care Coordinator will monitor weekly for continued compliance. | May 19, 2024 and on going |

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| D 276 | Continued From page 14<br>fractured.<br><br>Review of triage notes of treating physician dated 03/27/24 revealed Resident #2 was to continue to wear orthopedic shoe on the right foot.<br><br>Observation of Resident #2 on 04/03/24 at 9:48am revealed:<br>-Resident #2 was in her wheelchair propelling down the 100 hallway.<br>-Resident #2 was not wearing the orthopedic shoe on her right foot.<br>-Resident #2 was wearing socks.<br><br>Interview with Resident #2 on 04/03/24 at 9:49am revealed:<br>-She had fallen in her room about two weeks ago and broken her foot.<br>-She learned of the broken foot from a visit to the orthopedic physician.<br>-She was given an orthopedic shoe to wear but she could not find the shoe.<br>-Staff had not assisted her in finding the orthopedic shoe.<br><br>Observation of Resident #2 on 04/04/24 at 8:20am revealed:<br>-Resident #2 was in her wheelchair and propelled into the dining room.<br>-Resident #2 was wearing socks and not the orthopedic shoe on her right foot.<br><br>Second interview with Resident #2 on 04/04/24 at 9:59am revealed:<br>-The orthopedic shoe was broken.<br>-Staff did not help her put on the show.<br>-Resident #2's right toe sometimes was in pain and bothered her.<br><br>Observation of two personal care aides (PCA) on | D 276 | | |

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| D 276 | Continued From page 15<br>04/04/24 at 10:01am revealed:<br>-One PCA located the orthopedic shoe on Resident #2's bed.<br>-The two PCAs assisted Resident #2 in putting the shoe on her right foot.<br>-The bottom velcro strap on the shoe was not sticking properly.<br>-The PCA reposition the bottom strap and secured the top of the velcro.<br><br>Interview with a PCA on 04/04/24 at 10:04am revealed:<br>-She did know the bottom strap would not stick to the velcro.<br>-The PCAs on the night shift placed the shoe on Resident #2 right foot each morning prior to their shift ending.<br>-The medication aides (MA) were to check each morning to see if the shoe was on Resident #2's right foot.<br>-The Resident Care Coordinator (RCC) asked her to come and put the shoe on Resident #2.<br><br>Interview with a MA on 04/04/24 at 9:45am revealed:<br>-Resident #2 would not wear the orthopedic shoe all day sometimes.<br>-Resident #2 would refuse care depending on her mood.<br>-She did not know how Resident #2 injured her right toe but knew the injury occurred about 3 weeks ago.<br>-She knew Resident #2 was sent to the ER to due to her complaining of foot pain.<br>-The MAs were responsible for ensuring Resident #2 was wearing the orthopedic shoe.<br>-She had checked to see if Resident #2 was wearing the orthopedic shoe but Resident #2 told the MA she could not find the shoe.<br>-She informed Resident #2 that she would help | D 276 | | |

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| D 276 | Continued From page 16<br>her find the shoe once she completed the medication pass.<br>-Resident #2 would need assistance in putting on the orthopedic shoe.<br>-It was not documented when the orthopedic shoe was placed on Resident #2 right foot or when she would refuse to wear the shoe.<br><br>Interview with RCC on 04/04/24 at 9:51am revealed:<br>-Resident #2 informed staff that she had kicked something in her room and hurt her foot.<br>-She was sent to the ER for treatment because Resident #2 had complained of foot pain.<br>-She learned of the toe fracture from the 03/20/24 ER discharge summary report.<br>-Resident #2 were to wear the orthopedic shoe daily.<br>-The MAs or PCAs were responsible for putting the shoe on Resident #2's right foot in the morning.<br>-She did not know why Resident #2 was not wearing the orthopedic shoe.<br><br>Interview with Resident #2's primary care provider (PCP) on 04/04/24 at 11:19am revealed:<br>-Resident #2 informed her that she had fallen out of her bed and the mattress had fallen on top of her.<br>-Resident #2 did not say how she actually hurt her foot.<br>-She had not been informed of Resident #2 refusing to wear the orthopedic shoe.<br>-Resident #2 wearing the orthopedic shoe as recommended wear help with the healing of the toe and to prevent the toe from further injury.<br><br>Interview with the Administrator on 04/04/24 at 5:01pm revealed:<br>-She was not aware Resident #2 had not been | D 276 | | |

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| D 276 | Continued From page 17<br>wearing her orthopedic shoe.<br>-The RCC was responsible for following up with the MAs to ensure Resident #2 was wearing the orthopedic shoe.<br><br>Attempted telephone interview with the treating orthopedic physician on 04/04/24 at 3:23pm was unsuccessful. | D 276 | | |
| D 306 | 10A NCAC 13F .0904(d)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(4) Water shall be served to each resident at each meal, in addition to other beverages.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure water was served during the breakfast meal.<br><br>The findings are:<br><br>Observation of breakfast meal on 04/04/24 at 8:02am revealed residents were not served water during the breakfast meal.<br><br>Interview with a resident on 04/04/24 at 8:14am revealed:<br>-Residents were not always served water at breakfast.<br>-He had to request a glass of water during breakfast. | D 306 | It is the policy of Rose Vista Assisted Living that water shall be served to each resident at each meal, in addition to other beverages.<br><br>The dietary staff was inserviced by the owner on April 4, 2024 on beverage service at meals. It was reiterated to all staff that water is to be served at all meals, in addition to the other beverages required.<br><br>The Administrator will monitor weekly to ensure continued compliance. | May 19, 2024 and ongoing |

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| D 306 | Continued From page 18<br><br>Observation of a resident requesting water on 04/04/24 at 8:20am revealed:<br>-The resident requested a glass of water from a dietary aide.<br>-The dietary aide retrieved a glass of water from the kitchen area and served the resident.<br><br>Interview with a second resident on 04/04/24 at 8:20am revealed:<br>-She always requested water to drink during the breakfast meal.<br>-Staff would not place glasses of water on the tables for residents to drink at breakfast.<br><br>Interview with the Dietary Manager on 04/04/24 at 12:05pm revealed:<br>-She thought water was served to the residents at the lunch and dinners meals only.<br>-Residents were served water upon request at the breakfast meal.<br><br>Interview with the Administrator on 04/04/24 at 12:09pm revealed:<br>-The Dietary Manager had received additional dietary training on 04/03/24 knew to serve water to the residents at the breakfast meal.<br>-Residents were to served water at all meals in order to help keep the residents hydrated. | D 306 | | |