STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054069	A. BUILDING: _____ B. WING _____	R-C 07/18/2024

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 and Lenoir County Department of Social Services conducted a follow up survey and a complaint investigation on July 17, 2024, through July 18, 2024.	D 000		
D 229	10A NCAC 13F .0702 (g) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary; (2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination that is capable of meeting the needs of the resident; and (A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the facility administrator or their designee shall contact the local adult care home resident discharge team as defined in G.S. 131D 4.8(e) to assist with placement; and (B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible person of their right to request the Regional Long-Term Care Ombudsman to serve as a	D 229		

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D 229	Continued From page 1 member of the adult care home resident discharge team; and (3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's most current assessment and care plan; (C) a list of referrals to licensed health professionals, including mental health; (D) a copy of the resident's current physician orders; (E) a list of the resident's current medications; (F) the resident's current medications; and (G) a record of the resident's vaccinations and TB screening; (4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule: (A) the regional long-term care ombudsman; and (B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities; (5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility. This Rule is not met as evidenced by: TYPE B VIOLATION	D 229		

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D 229	Continued From page 2 Based on record reviews and interviews, the facility failed to discharge a resident after given a discharged notice dated 04/10/24 and did not notify the local County Department of Social Services (DSS) that appropriate placement had not been found for 1 of 5 sampled residents (#5) who was diagnosed with dementia and who's primary care provider (PCP) signed a new FL-2 dated 03/27/24 that required a level of change in care to a Special Care Unit (SCU). The findings are: Review of the facility's discharge policy, not dated, revealed: -The discharge of the resident would be done with prior written and oral notification to the resident, the family, responsible party, and to the County DSS allowing 30 days for discharge/transfer. -The discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility as documented by the resident's physician, physician assistant, or nurse practitioner. Review of Resident #5's current FL-2 dated 02/20/24 revealed: -Diagnoses included moderate dementia and diabetes mellitus. -The resident was ambulatory and intermittently disoriented. -The resident was continent of bladder and was incontinent of bowels. -The resident's current level of care was Assisted Living. Review of Resident #5's Resident Register revealed an admission date of 02/17/24.	D 229		

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D 229	Continued From page 3 Review of Resident #5's current care plan dated 02/24/24 revealed: -The resident was receiving mental health services. -The resident was currently receiving medications for mental health behaviors. -The resident was incontinent of bladder and bowels. -The resident required supervision with activities of daily living such as toileting, grooming and personal hygiene. Review of Resident #5's notice of transfer/discharge dated 04/10/24 revealed: -The transfer/discharge was necessary for the resident's welfare and needs could not be met in this facility. -Resident #5's representative was notified. -The facility's plan to transfer or discharge the resident was unknown and to be determined. -The PCP signed a new FL-2 dated 03/27/24 that required a level of change in care to a Special Care Unit (SCU). -The transfer/discharge notice was signed by the facility's Administrator on 04/10/24. Review of Resident #5's electronic progress notes for February 2024 revealed: -On 02/23/24 at 9:21am, she did not want staff to provide incontinence care, and she was fighting and biting. -On 02/28/24 at 10:24am, staff had a difficult time changing her without fighting and biting. -On 02/28/24 at 11:25am, she refused to let staff provide incontinent care to her. Review of Resident #5's electronic progress notes for March 2024 revealed: -On 03/03/24 at 9:11am, she refused incontinent	D 229		

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care, and she was fighting and biting.
-On 03/10/24 at 10:00am, she refused incontinent care and was fighting.
-On 03/10/24 at 10:54pm, she would not allow staff to provide incontinent care without fighting.
-On 03/12/24 at 11:55am, she would not allow staff to provide incontinent care (soil clothing from a bowel movement) because she wanted to eat lunch first.

Review of Resident #5's electronic progress notes for April 2024 revealed:
-On 04/05/24 at 8:14am, she would not allow staff to provide incontinent care without "hollering and screaming".
-On 04/05/24 at 1:15pm, she would not allow staff to provide incontinent care without fighting.
-On 04/05/24 at 8:16pm, she would not allow staff to provide incontinent care without fighting and kicking.
-On 04/10/24 at 11:03am, she had an accident (a bowel movement) and would not allow staff to provide incontinent care without fighting.

Review of Resident #5's electronic progress notes for May 2024 revealed:
-On 05/13/24 at 2:47pm, she refused incontinent care.
-On 05/24/24 at 1:06pm, she refused incontinent care when staff tried to assist multiple times.

Review of Resident #5's electronic progress notes for June 2024 revealed:
-On 06/04/24 at 3:10pm, she changed her clothing herself after wetting them several times today and then hung the soiled clothing back in her closet and became very upset when staff tried to take them to the laundry room to be washed.
-On 06/22/24 at 12:20pm, she refused incontinent care before lunch and said that she would change

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after lunch.
-On 06/30/24 at 12:26pm, she soiled her clothing and was combative when the staff tried to assist her; the Resident Care Coordinator (RCC) was able to calm her down and changed her soiled clothing.

Review of Resident #5's electronic progress notes for July 2024 revealed on 07/13/24 at 2:36am, she refused incontinent care.

Review of Resident #5's Psychiatry Initial Consult notes dated 03/04/24 revealed:
-Resident #5 was new to the Assisted Living facility and was having difficulty adjusting to her new environment.
-She had expressed anger and frustration, particularly in response to perceived violations of her personal space and belongings.
-She encouraged the staff to be patient and understanding during the adjustment.
-A brief interview for mental status (BIMS) could not be performed to assess the severity of her dementia.
-Medication ordered was oxcarbazepine 150 mg twice daily (a medication used to treat aggressive and impulsive behaviors).

Review of Resident #5's Psychiatry Progress notes dated 03/18/24 revealed:
-Staff reported that she had severe mood swings, agitation, and aggressive behaviors, including biting and hitting.
-Medication ordered was to increase Trileptal to 300 mg twice daily (used to treat agitation and mood swings).
-Medication ordered was to increase oxcarbazepine to 300 mg twice daily.

Review of Resident #5's Psychiatry Progress

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notes dated 04/01/24 revealed:
-Staff reported that she got agitated easily and became combative and her adjustment disorder may not be well controlled.
-Medication ordered was Seroquel 50mg at bedtime (used to treat or help regulate mood, behavior, and thoughts).
-Medication ordered was Lorazepam 0.5mg twice daily as needed (used to treat anxiety).

Review of Resident #5's Psychiatry Progress notes dated 05/24/24 revealed:
-Staff reported that she was in a good mood interacting well with other residents and staff.
-Due to the stable condition, the current medication regimen would be continued.

Review of Resident #5's Psychiatry Progress notes dated 06/10/24 revealed:
-No issues reported of depression or anxiety.
-Continue the current medication regimen without any changes.

Review of Resident #5's Psychiatry Progress notes dated 07/08/24 revealed:
-No new behavioral issues reported and interacting well with others.
-Due to the stable condition, the current medication regimen would be continued.

Interview with Resident #5's family member on 07/17/24 at 2:35pm revealed:
-She was aware when staff attempted to provide showers to Resident #5 that at times she would refuse.
-A Discharge Notice was emailed to her on 04/10/24 and the resident was never discharged.
-On 07/16/24 at 1:15pm, she visited Resident #5 and noticed she was in the bed with night clothes on covered in urine and unresponsive.

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D 229	Continued From page 7 -She spoke with the Resident Care Coordinator (RCC) and was told the staff could not get Resident #5 to take her medications or urinate in a cup. -Resident #5 was sent to the local hospital on 07/16/24, and the hospital nurse stated that she had a severe UTI. -She agreed that the facility could not take care of Resident #5 needs. -As of 07/17/24, she had not received updates regarding finding placement for Resident #5. Interview with a personal care aide (PCA) on 07/18/24 at 10:15am revealed: -Resident #5 could be very combative such as hitting, biting, pulling hair, and pinching. -She would physically check on her as needed more than the 2-hour checks like half an hour to an hour and attempted to provide incontinent care for her. -She would say that she was not wet although she would have soiled clothing. -Two PCAs would take her to get a shower, and she would fight but once in the shower room and they explained what was going on she would calm down. -Resident #5 would take off her soiled clothing and hang them back in her closet with her clean clothes. -She would notify the medication aide (MA) when Resident #5 refused care. Interview with the Resident Care Coordinator (RCC) on 07/18/24 at 11:00am revealed: -She was aware that staff had concerns about taking care of Resident #5 and that she was combative. -Resident #5 tried to go to the bathroom alone and would soil herself and at times would urinate at her bedside.	D 229		

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-She was aware that Resident #5 would take off her soiled clothing and hang them back in her closet.
-In March 2024, she made the guardian aware of her refusal for care and her removal of soiled clothing and she returned them to the closet with clean clothes.

Interview with Resident #5's primary care provider (PCP) on 07/18/24 at 4:05pm revealed:
-She was aware of Resident #5's behaviors and that she became agitated and did not want to be bothered by staff.
-She received a call on 03/16/24 and on 05/23/24 about Resident #5's behaviors and she referred the facility to her mental health provider.
-Resident #5's refusal of care and her combativeness made it hard for the staff to care for her.
-She did not recall the facility reaching out to her about a change in level of care for Resident #5.
-She was not aware that she was currently in the hospital.
-She was concerned if the resident was refusing baths or sitting in soiled adult incontinence briefs and not allowing staff to provide personal care, she could have skin breakdowns and get infections which could increase the risk to develop a UTI.

Second interview with the RCC on 07/18/24 at 4:40pm revealed:
-She was made aware of Resident #5's discharge notice dated 04/10/24.
-She made phone calls and faxed information to various facilities to find placement.
-She did not keep documentation of phone calls (logs) or faxes of the facilities she had spoken with regarding placement.
-She knew the local Department of Social

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Services (DSS) was made aware of the discharge notice, but she did not contact DSS for further assistance in finding placement.
-The process for discharge/transfer was she received the discharge papers once they had been completed by the PCP and signed by the Administrator.
-She sent the resident's FL-2 to various facilities to get Resident #5 placed.

Interview with the facility Business Office Manager on 07/18/24 at 4:30pm revealed:
-She called Resident #5's representative, emailed the local DSS, and notified the Ombudsman on 04/10/24 regarding discharge notice.
-She did not contact the PCP about discharge notification only about the resident's care and requested a higher level of care due to dementia.
-The PCP signed off on higher level of care for a memory care placement.
-She reached out to a memory care facility "last Tuesday" (07/09/24) and the RCC sent the paperwork.
-The procedure for discharge was to contact the PCP about the change in level of care, once the PCP signed off, provide the resident's guardian with a 30-day notice that provided the reason of the discharged and notify the local DSS, and Ombudsman.
-She was not aware she should contact the local DSS for further assistance when unable to find appropriate placement for a resident.

Interview with the facility Administrator on 07/18/24 at 4:37pm revealed that she was a new Administrator to the facility, and she signed off on the notice for discharge dated 04/10/24 but did not have much more than that to do with it.

Attempted telephone interview with the mental

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D 229	Continued From page 10 health provider on 07/18/24 at 4:55pm was unsuccessful. _____ The facility failed to find appropriate placement after a discharge notice was issued on 04/10/24 related to an FL-2 signed by the PCP with a change in the resident's (#5) level of care to a Special Care Unit resulting in the resident refusing incontinent care by staff which resulted in the resident being sent to the hospital on 07/16/24 and was diagnosed with a urinary tract infection. This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/18/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED September 1, 2024.	D 229		