Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE INN RETIREMENT COMMUNITY	826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892

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D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted a follow-up survey and a complaint investigation on November 28-29, 2018. The compliant investigation was initiated by the Martin County Department of Social Services on October 3, 2018.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect or exploitation. THIS IS A TYPE A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to protect 1 of 1 residents (Resident #1) from falling off her bed sustaining injury, subsequently sent to the hospital, diagnosed with a fracture of the left shoulder, humerus and femur, and a right wrist sprain.	D 338		

POC reviewed and accepted,
Kim Olson, RN, 01-11-19

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D 338	Continued From page 1 The findings are: Review of Resident #1's FL-2 dated 11/28/17 revealed: -Diagnoses included hypertension, osteoarthritis, chronic obstructive pulmonary disease, acute deep vein thrombosis right lower extremities, history of anxiety, hyperlipidemia, history of falls, and allergic rhinitis. -She was oriented. -She was semi-ambulatory with wheel chair. -She was incontinent of bladder and bowel. -She needed assistance with bathing and dressing. Review of Resident #1's current FL-2 date 11/28/18 revealed: -Diagnoses included acute deep vein thrombosis right lower extremities, allergic rhinitis, anxiety, chronic obstructive pulmonary, hypertension, history of falls, hyperlipidemia, and osteoarthritis. -She was oriented. -She was non-ambulatory. -She was incontinent of bladder and bowel. -She required total care. Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/20/15. Review of Resident #1's Care Plan dated 11/28/17 revealed. -She was "oriented to person, place and time." -She needed limited assistance with eating. -She was totally dependent in toileting. -She needed extensive assistance with ambulation. -She needed extensive assistance with bathing, dressing, grooming and personal hygiene. -She required the use of a wheel chair/Hoyer lift	D 338		

Dianne Day 1/10/19 Administrator

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D 338	Continued From page 2 for ambulation/ocomotion. Review of Resident #1's Licensed Health Professional Support (LHPS) task sheet dated 09/26/18 revealed she required assistance with ambulation using a wheelchair/Hoyer lift and transfers. Review of Resident #1's Report of Health Services of Resident dated 02/20/18 revealed the facility requested a physician order for half hospital bed rails for turning and positioning. Review of Physician's Consultation Report on 02/20/18 revealed there was an order for Resident #1 to have bedrails up for turning and positioning. Review of Resident #1's Incident report dated 10/09/18 at 10:00am revealed: -Resident #1 fell in her room from her bed. -She had injuries to left shoulder. -Her Power of Attorney (POA) was notified on 10/09/18 at 10:09am. -Emergency Medical Services (EMS) was called. -There was no time or date entry for EMS notification. Review of the Emergency Room report for Resident #1 report dated 10/09/18 revealed: -The resident arrived at on 10/09/18 at 10:13am. -There was displaced fracture of the upper end of left humerus (arm). -There was unspecified fracture of lower end of left femur (leg). -There was specified sprain of right wrist. -The admitting diagnosis was a fall from a bed. Interview with Resident #1 on 10/09/18 at 3:00pm revealed:	D 338		

Dame Dens Administrator 1/1/19

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D 338	Continued From page 3 -There were two staff changing her sheets when the incident happened. -The staff rolled her onto her right side near the edge of the bed facing the window and she stabilized herself by grabbing the mattress edge behind her back with her left hand. -There were no bed rails in place. -She had a history of stroke which caused right-sided weakness. -One of the two staff had changed her bed numerous times in the past without incident. -When the two staff pulled the egg crate that was bunched up at the foot of her bed, she lost her grip of the mattress which she was holding onto while positioned on her right side causing her to fall on the floor. -She was upset because a staff said "I let go but I did not." -Her fall resulted in a broken shoulder, knee and sprained hand. -A family member who was also a resident at the facility was in the room sitting in the chair looking out the window when she fell from the bed. -The staff called for help and the Resident Care Coordinator (RCC) came into the room and was told not to move her until the Emergency Medical Technician arrived. Interview with a resident on 11/29/18 at 2:40pm revealed: -She was sitting in the chair when Resident #1 fell from her bed on 10/09/18 -She was in the room when she fell off the bed. -Staff rolled Resident #1 on her side then both of the staff went to the foot of the bed. -She did not see her fall because she looked away. -When she looked up, Resident #1 was on the floor. -Staff did not want Resident #1 moved until the	D 338		

Dianne Dey Administrator 1/11/19

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D 338	Continued From page 4 Emergency Medical Technician arrived. Interview with Resident #1's family member on 10/09/18 at 3:53pm revealed: -She had observed bed rails in Resident #1's room for months but they had not been installed on her bed. -She did not ask why the bedrails were not installed on Resident #1's bed to the facility's staff. -This was upsetting because her fall could have been avoided had the bed rails been in place when the staff were changing her bed. -"She was in so much pain." -Resident #1 had a history of falling which the facility was aware of as it was listed on her FL-2. Interview with Staff A (personal care aide) on 10/10/18 at 3:00pm revealed: -She had worked with Resident #1 many times by herself but on the day of the fall she had another staff assisting her. -Resident #1 would hold on to the mattress edge behind her back with her left hand after staff positioned her on her weak right side when they changed her bed sheets. -Resident #1 was turned to her right side. -Resident #1 was holding onto the mattress then suddenly fell off the bed. -She did not have any problem changing Resident #1's bed alone but on that day Staff B offered to assist her changing Resident #1's bed linens. -Other staff rarely assisted her when changing a bed, but the additional help always accepted. -There were bed rails in her room for approximately four or five months but had never been placed on the bed. -Staff A never questioned any other staff or management as to why the bed rails were not	D 338		

Joanna Day 1/11/19 Administrator

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D 338	Continued From page 5 used. -During the bed sheet change, Staff A and B were at the foot of the bed at the same time and pulled the egg crate mattress downwards to the foot of the bed because it was bundled up under the resident. -Upon pulling the egg crate, Staff A looked up and saw Resident #1 falling to the floor and could not prevent it. Interview with Staff B (personal care aide) on 10/10/18 at 3:20pm revealed: -She did not work with Resident #1 but offered assistance to Staff A to change Resident #1's bed on 10/09/18. -Both staff were at the foot of the bed pulling the egg crate down when Resident #1 fell of the bed because Resident #1 let go of her grip of the mattress that she was holding onto. -Both staff were unable to prevent her from falling because they were standing at the foot of the bed out of reach of Resident #1. -Staff B was aware of Resident #1's right-sided weakness due to a history of stroke. -Resident #1 was turned on her right side that was paralyzed. -"There was nothing I can do, it was an accident". -When Resident #1 was rolled over onto her side, there usually was staff on each side of her bed when changing the bed. -Staff initially were on both sides of Resident #1's bed when they began changing the linens, then both staff went to the foot of the bed to fix the egg crate bundled up under Resident #1 leaving both sides of the bed unattended. -When Resident #1 was rolled on one side, the use of a bed rail would have prevented a fall. Interview with a medication aide (MA) on 10/10/18 at 3:45pm revealed:	D 338		

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D 338	Continued From page 6 -Staff A and B were in the room assisting each other with Resident #1 when she fell off the bed. -She felt that Resident #1 needed bed rails during her bed changes due to right-sided weakness. -She did not know why there were no bed rails during the bed change for Resident #1 on 10/09/18. -She had seen the bed rails in Resident #1's room leaning against the wall to the left of the window. -She never questioned any other staff or management as to why the bed rails were not used. -She did not know how many staff it normally took to change Resident #1's bed. -She did not usually observe the changing of Resident #1's bed. -The two staff were not paying attention to what they were doing. -She could not understand how Resident #1 fell off the bed with two staff members. -Resident #1 was a total care resident according to her care plan and was unable to move onto her right side. -She usually observed one staff assisting Resident #1 and none of those staff had ever requested assistance. -When Resident #1 lost her grip she fell because she was not protected with bed rails or staff support when was rolled to her right side. Interview with Resident #1 on 10/24/18 at 11:05am revealed: -She was "feeling some better today." -The RCC informed her that they would be seeking nursing home placement. Interview with Interim Director on 10/09/18 at 3:35pm revealed: -Staff were changing Resident #1 sheets when	D 338		

Jane Doe 1/1/19 Administrator

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D 338	Continued From page 7 she lost her grip of the mattress falling off the bed. -She did not understand how two staff could be in the room with a resident and the resident fell off the bed. -"The staff changing her bed were not paying attention to what they were doing." -Staff did not prevent Resident #1 from falling because both staff were at the foot of the bed. Interview with the Interim Director on 10/24/18 at 11:30am revealed: -She had been employed at the facility for the past 6 months. -Staff A and B had been reported to the Health Care Personnel Registry on 10/10/18. -She did not understand how this accident could have happened. -The two staff involved were not paying attention to Resident #1 when she fell off the bed. -After Resident #1's fall, she discovered a February 2018 order for bed rails for positioning and turning that was not clarified. -She could not explain why the former RCC who was responsible for clarifying orders failed to clarify Resident #1's bed rail order. -Resident #1 returned from the hospital the same day she fell from the bed, 10/09/18, and returned to the facility. Interview with Resident #1 on 11/28/18 at 2:29pm revealed: -It had been five weeks since her leg fracture occurred. -Her left lower leg and knee continued to hurt "really badly." Interview with complainant on 11/29/18 at 3:45pm revealed: -The two staff were at the foot of the bed	D 338		

Joanne Day 1/6/19 Administrator

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D 338	Continued From page 8 changing the bed. -The two staff pulled the sheet too hard causing Resident #1 to fall off the bed. -She should not have been on her side too close to the edge of the bed. -Resident #1 could not do anything for herself and she could not hold on. Telephone interview with Resident #1's Physician Assistant (PA) on 11/29/18 at 4:00pm revealed: -Resident #1 became her patient on 09/19/18. -She was unaware of the bed rails order written in February 2018. -She was not the provider who wrote the February 2018 bed rail order. -She wrote a physician order for hospital bed rails on 10/10/18 after the fall. -She felt that bed rails would prevent future falls. The facility failed to protect 1 of 1 residents (Resident #1) from falling from her bed while staff were changing her bed. Resident #1 sustained a left arm fracture, left leg fracture, right wrist sprain and an immobilized knee. The failure of the facility resulted in serious physical harm and neglect. This constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/29/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 29, 2018.	D 338		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of	D 375		

Joanne Day 1/11/19 Administrator

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D 375	Continued From page 9 Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record, and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure compliance with the facility's policy and procedure for self-administration of medications for 2 of 3 residents sampled with orders for self administration (#3 and #7). The findings are: 1. Review of Resident #3's current FL2 dated 01/11/18 revealed: -Diagnoses included diabetes mellitus type II, atrial fibrillation, long term use of anticoagulants, pedal edema, dementia, gout, and anemia. -Resident #3 had intermittent disorientation. -There was an order for Tylenol, take 2 tablets (650 mg) by mouth twice a day as needed for pain. The resident may self-administer. -There was an order for Nitroglycerin 0.4mg, place one tablet under the tongue as needed for chest pain every 5 minutes time 3 times, call doctor if no relief. The resident may self-administer.	D 375		

Joanne Day 1/4/19 Administrator

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D 375	Continued From page 10 -There was an order for Fluocinonide cream 0.05%; apply small amount once a day as needed to legs for itch/stinging; avoid face and genitals. The resident may self-administer. -There was an order for Ketoconazole cream 2%; apply small amount twice a day as needed for facial dandruff (redness/scaling/itching). The resident may self-administer. -There was an order for Men-phor, apply as needed for sunspots on arms. The resident may self-administer. -There was an order for Sebex, lather a capful into scalp and leave on for 5 minutes before rinsing. Use once a day as needed for dandruff. The resident may self-administer. -There was an order for Neutrogena Gel, lather a capful into scalp. Leave on for 5 minutes before rinsing. Use daily as needed for dandruff. The resident may self-administer. -There was an order for Triamcinolone cream 0.01%; apply every day to legs as needed for skin rash. The resident may self-administer. Review of the Resident # 3's care plan dated 03/06/18 revealed the resident had adequate memory and was oriented. Observation of Resident #3's room on 11/29/18 at 8:45am revealed: -Resident #3 was sitting in a recliner. -There were three 4.7 ounce bottles of Aspercreme with 4% Lidocaine (numbing medication) on his recliner-side table. -There was an unopened bottle of Nitroglycerin 0.4mg tablets that Resident #3 pulled from his pocket. -There was a bottle of approximately 30 tablets of a 250 tablet bottle of extra strength acetaminophen 500mg. -There was one-half of a 225ml bottle of	D 375		

Jeanne Day 4/11/19 Administrator

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D 375	Continued From page 11 Men-phor 0.5% lotion in the top dresser drawer. -There was one-half of an 80 gram tube of Triamcinolone cream 0.01% in the top dresser drawer. -There was one-half of a 10 ounce tube of Dermasil lotion in the top dresser drawer. A second observation of Resident #3's room on 11/29/18 at 9:30am revealed: -Resident #3 was sitting in a recliner. -There was a spray bottle filled with clear liquid on his recliner-side table. -Resident #3 had extremely dry skin on all extremities. -There were multiple red spots on both sides of each arm and leg. -Resident #3 was picking at the red spots on his left arm and right leg. -Resident #3 scratched his left arm continuously as he spoke. Interview with Resident #3 on 11/29/18 at 9:30am revealed: -He took his own Tylenol and nitroglycerin tablets if he needed them. -He would take 2 Tylenol tablets every "few hours" if needed for pain. -He had not used the nitroglycerin tablets in 5-6 months. -His family member gave him a spray bottle filled with alcohol to spray on his skin to stop his itching. -He used the bottle of spray alcohol on all areas of his body for "itch relief." -He sprayed his arms and legs with alcohol to "kill anything on him" including bed bugs which he believed caused all of the red spots all over his body. -He had multiple creams he put on his arms and legs each day. -He had been using the creams for "years."	D 375		

11/19 Administrator

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D 375	Continued From page 12 -He did not know what purpose each cream was used for, but he used Aspercreme for shoulder pain and to help the itching on his bug bites. -His skin was increasing in dryness each day. -He sprayed alcohol on his skin multiple times each day. -The facility had steamed his room for bed bugs. -All of his sores were due to bed bugs. Interview with Resident #3's family member on 11/29/18 at 9:35am revealed: -On 11/01/18 she gave the spray bottle of alcohol to Resident #3 to keep in his room to kill bed bugs she believed were living in the carpet. -She was unaware that he was using the alcohol spray for use on his body to relieve itching. -She did not tell the facility that she had given the spray bottle of alcohol to Resident #3. -He had multiple creams in his room that he could apply to his arms, legs and feet for dryness. -He had used Aspercreme with Lidocaine for years and continued to use it for his back and shoulder pain, and put it on bug bites for the itching. -Resident #3's cognition was intermittent and he often would be forgetful. Interview with the Resident Care Coordinator on 11/29/18 at 1:50pm revealed: -The facility required a written provider order for a resident to self-administer medications. -The residents are then watched by the medication aide (MA) when they self-administer. -Resident #3 received Neosporin ointment for his bites. -Resident #3's family member mentioned possibly using Aspercreme on his bites but he would have to have an order to get it at his bedside. -She was not aware that Resident #3 had self-administration of medication orders and was	D 375		

Jane Doe 1/1/19 Administrator

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 375	Continued From page 13 not aware that he had medications in his room. Interview with a medication aide (MA) on 11/29/18 at 4:20pm revealed: -She was aware Resident #3 had Tylenol, nitroglycerin and creams in his room. -Whenever Resident #3 wanted the medication, he would tell her he was taking it or using the cream. Interview with the Administrator on 11/29/18 at 2:15pm. -Resident #3's daughter brings his medications to the facility. -Resident #3's daughter told her she was bringing the spray alcohol to his room to spray on the carpet, but she was not aware that Resident #3 had the spray alcohol left in his room. -The facility required a written provider order for a resident to self-administer medications. -She had received a policy for self-administration of medications from their corporate office that day and explained that they had not been following the policy but would begin immediately. Refer to the facility self-administration of medication policy. 2. Review of Resident #7's FL2 dated 05/23/18 revealed: -Diagnoses included diabetes mellitus, gastro esophageal reflux, hypertension, history of prostate cancer, and constipation. -There was an order for nystatin cream mix with triamcinolone cream apply topically twice daily to bilateral groin rash may keep at bedside. -There was an order for Triamcinolone cream 0.1% mix with Nystatin cream and apply topically twice a day to bilateral groin rash may keep at bedside.	D 375		

Deanne Day 12/11/19 Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	C 11/29/2018

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D 375	Continued From page 14 Review of Resident #7's care plan dated 02/23/18 revealed, the resident had "adequate memory" and was oriented. -There was no documentation of monthly compliance check list or questions for self-administration of medication for Resident #7. Attempted interview with Resident #7 revealed resident was not available for interview. Interview with the Administrator on 11/29/18 at 2:15pm revealed: -The facility required a written provider order for a resident to self-administer medications. -She had received a policy for self-administration of medications from their corporate office that day and explained that they had not been following the policy but would begin immediately. Interview with a medication aide (MA) on 11/29/18 at 2:47pm revealed: -She would ask the primary care provider (PCP) for an order if a resident wanted to self-administer medication. -Resident # 7 would self-administer his Triamcinolone and Nystatin cream. -Resident #7 had the creams in his room but she was not sure if they were locked up. Interview with a second MA on 11/29/18 at 3:15pm revealed: -She would contact the PCP for an order when a resident wanted to self-administer a medication. -She did not know if there was a policy or an assessment that needed to be done if a resident wanted to self-administer medication. Refer to the facility self-administration of medication policy.	D 375		

Joanne Day 1/17/19 Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	C 11/29/2018

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D 375	Continued From page 15 Review of the facility self-administration of medication policy revealed: -The purpose of the policy was to ensure the resident who self-administers their medication are safe to administer it, store it and manage it independently. -The Supervisor in charge/Designee will audit the resident compliance with self-administration of medications using the compliance audit form. The check list would be placed in the front of the medication administration record (MAR) and completed prior to the end of each month. Any non-compliant issues will be reported to the Resident Care Coordinator (RCC) immediately. -Anytime a resident is found to be non-compliant with self-administration of medication the family, physician and the resident will be consulted by the RCC/designee	D 375		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are protected from harm and neglect and in compliance with federal and state laws and rules and regulations related to resident rights. The findings are: 1. Based on observations, record reviews and	D914		

Dianne Denny Administrator 1/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	C 11/29/2018

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D914	Continued From page 16 interviews, the facility failed to protect 1 of 1 residents (Resident #1) from falling off her bed sustaining injury, subsequently sent to the hospital, diagnosed with a fracture of the left shoulder, humerus and femur, and a right wrist sprain.[Refer to Tag C0338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).]	D914		

Dawn Denny 1/1/19

Vintage Inn Retirement Community
HAL-058-010
Plan of Correction
DHSR Follow-up Survey and Complaint Investigation

10A NCAC 13F. 0909 Residents Rights/G.S. 131D21(4) Declaration of Resident's Rights
Plan of Correction

- Upon notification of allegation of resident right violation, on 10/11/18 the facility suspended the employee and reported to HCPR.
- Facility/corporate office began an internal investigation into the incident.
- Staff that violated resident's rights were terminated. 10/18/18
- Staff that violated resident's rights were reported to HCPR. 10/18/18
- Training with all staff on resident's rights, what constitutes violation of resident's rights and the responsibilities for reporting and know violation of resident's rights. 11/7/18 and ongoing

Monitoring System

- Administrator/Designee will continue to conduct random interviews with resident's and staff weekly x4 then monthly x4 and them randomly thereafter to assure there are no violations of resident's rights. 11/19/18 and ongoing
- An employee accused of violating resident's rights will be immediately suspended pending an investigation with the assistance of the Corporate Human Resources Department. Corrective Action shall occur based on the findings of the investigation which may include disciplinary action up to and including termination. 10/18/18 and ongoing
- Facility shall follow HCPR reporting guidelines and report as required by regulation to include reporting to DSS. 10/18/18 and ongoing
- Administrator/Designee will conduct monthly staff meetings on what constitutes a violation of resident's rights and responsibilities for reporting any known or hearsay violations of resident's rights. 10/18/18 and ongoing.

10A NCAC 13F .1005(a)
Plan of Correction

- Staff retrained on self-administration of medication policy. 1/11/19 and ongoing

Monitoring Systems

- RCC/Designee will audit the resident's compliance with self-administering of medications on monthly basis. At any time the resident is found to not be compliant with the self-administration of medications the family, the physician and the resident will be counseled with the Executive Director and RCC/Designee. RCC will document the results of the consultation in the resident record. 1/11/19 and ongoing

Joanne Davis Administrator 1/11/19

Olson, Kimberly A

From: Karen Shaver <Karen.Shaver@myvschome.com>
Sent: Friday, January 11, 2019 5:59 PM
To: Olson, Kimberly A
Subject: [External] Plan of Correction for Vintage Inn
Attachments: scanner@mytahome.com_20190111_183354.pdf

Kim—
Please find attached the plan of correction for the state survey/follow-up with the exit date of 11/29/28. Please feel free to contact me with any questions. You may reach me at 336-707-9420.
Sincerely
Karen Shaver
Victorian Senior Care
Compliance Director