NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

April 4, 2022

Shaquitta Murray, Administrator
Vintage Inn Retirement Community, LLC, Licensee
Vintage Inn Retirement Community
P.O. Box 547
Williamston, NC 27892

email address: meredith@mytahome.com

Re: Receipt of Plan of Correction (ASPEN Event ID EVC712)
Facility: Vintage Inn Retirement Village
Licensure Number: HAL-058-010
County: Martin

Dear Ms. Murray:

Based on my telephone conversation with Meredith Seals on 04/04/22, there was an addendum to the Plan of Correction for the Statement of Deficiencies dated 06/17/21. The pages noting the addendum are provided for your records.

Please do not hesitate to contact us at 919-855-3765, if you have questions or we may be of further assistance.

Sincerely,

Theresa A. Lloyd, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure

cc: Meredith Seals, Chief Operating Officer (meredith@mytahome.com)
Veronica Taylor, Adult Services Supervisor, Martin County Department of Social Services
Linda Kirby, Team 6 Supervisor, NC Department Health Service Regulation Office, Adult Care Licensure Section
Suzy Morgan, Team 5 Supervisor, NC Department Health Service Regulation Office, Adult Care Licensure Section
Heather Bingham, Eastern Branch Manager, NC Department Health Service Regulation Office, Adult Care Licensure Section
Raleigh Facility File

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 _____	R 06/17/2021

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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 conducted a follow up survey from 06/15/21 to 06/17/21.	{D 000}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the environment on the Special Care Unit (SCU) was clean and free of obstructions and hazards as evidenced by a clogged toilet in a shared resident bathroom between (room #52 and #54) which had feces sitting inside the toilet bowl for more than two days and a second clogged toilet in an unoccupied resident room (room #62); hair care products and thermal curling appliances accessible in an unlocked beauty salon which had balls of hair, dirt and grime accumulated on the floor and several loose floor tiles; personal care products including hair spray, mouthwash and body lotion on the bedside table in resident room (room #61); a hardened amber colored substance on the hand rail under a hand sanitizer dispenser; dirt build up with a sticky substance on the floors in the hallways and common areas; and a wire clothes hanger being used by a resident to unclog the toilet. The findings are:	{D 079}		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

7/28/21

The Plan of Correction with addendum was reviewed and acknowledged on 04/04/22. Refer to the addendum on page 19 of this Statement of Deficiencies

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{D 079}	Continued From page 1 1. Observations during the initial tour of the (SCU) on 06/15/21 between 9:30am and 11:30am revealed: -The toilet in the shared bathroom between resident rooms #52 and #54 was clogged with feces and toilet paper. -The water to the toilet in the shared bathroom between rooms #52 and #54 was turned off. -The resident in room #52 was walking down the hall to use the toilet in the spa room because her toilet was not operable. -Room #54 was vacant. -Room #62 was vacant with door closed and unlocked and accessible to residents. -The toilet in room #62 was clogged with feces and toilet paper. Based on observations and interviews, the resident in room #52 was not interviewable. Interview with a personal care aide (PCA) on 06/15/21 at 3:00 pm revealed: -He was not aware of the clogged toilet with feces and toilet paper. -He was not aware that the water was turned off in the shared bathroom between rooms #52 and #54. -The maintenance manager was at the facility once or twice a week. Interview with a medication aide (MA) on 06/15/21 at 3:30 pm revealed: -PCAs had not reported any toilet issues to her. -PCAs reported to the MA, who reported to SCU Coordinator, who reported to Administrator. Interview with SCU Coordinator on 06/17/21 at 9:30 am revealed: -She had been employed at the facility for about a	{D 079}	Administrator secured all hair care products, curling appliances and other hazardous items in locked area. Toilets were repaired. Administrator conducted training with all staff on expectations of keeping the facility uncluttered, clean and orderly manner, free from all obstructions and hazards. SIC/SCUC will conduct rounds of the facility daily to assure the facility is uncluttered, clean and orderly manner, free of all obstructions and hazards (including curling appliances and care/hygiene items).	6/17/2021 6/16/2021 6/30/2021 7/15/2021 & Ongoing

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{D 079}	Continued From page 2 month. -Her responsibilities included making sure the SCU was clean and there were no hazards. -No toilet issues were reported to her. -One housekeeping staff was responsible for cleaning the facility. -She was not sure of the housekeeping schedule. -She had not inspected bathrooms. -Clogged toilets could breed germs. Interview with the Administrator on 06/15/21 at 3:45 pm revealed: -No staff had reported any toilet issues to her. -She expected staff to report directly to the new SCU coordinator. Interview with the Maintenance Director on 06/17/21 at 2:00 pm revealed: -He provided maintenance service at several facilities. -The Administrator contacted the corporate office on 06/15/21 regarding toilets needing repair. -He was usually at this facility once a week on Fridays. -He made a note of the toilets to be repaired by taking pictures of the room numbers beside the door. 2. Observation during initial tour of the Special Care Unit (SCU) on 06/15/21 at 9:30 am revealed: -The beauty salon was unlocked. -There were three unplugged thermal curling appliances and a handheld hair blow dryer on a table. -Hair care products were on a table (hair conditioner and coconut oil). -There were balls of hair on the floor of the beauty salon and chair. -The floor had grime and dirt with several loose	{D 079}		

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{D 079}	Continued From page 3 tiles. Interview with a medication aide (MA) on 06/15/21 at 3:30 pm revealed: -She did not know much about the beauty salon. -She was not aware of items in the beauty salon. -The beauty salon was last used before COVID-19. -She did not think it was being used currently. Interview with Administrator on 06/15/21 at 3:45 pm revealed: -The beauty salon on the SCU was not in use currently. -She did not know it was unlocked. -She was not aware of items in the room. 3. Observations during initial tour of Special Care Unit (SCU) on 06/15/21 between 9:30am and 11:30am revealed: -There were containers of mouthwash, lotions, and hairspray on the nightstand in room #61. -One resident resided in room #61 and was awake in bed. -The warning on label of mouth wash stated it was not to be ingested or swallowed but used for rinsing mouth. -The lotion contained denatured alcohol, isopropyl palmitate, cetearyl alcohol, and other non-ingestible ingredients. -The hairspray contained denatured alcohol, butylene glycol, and other non-ingestible ingredients. Interview with a medication aide (MA) on 06/15/21 at 3:30 pm revealed: -Personal care items should not be left in residents' rooms on the SCU. -Sometimes family members brought personal care items in the facility to residents.	{D 079}		

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{D 079}	Continued From page 4 -Residents personal care items were supposed to be kept in the medication room when not being used. -There was no system in place to monitor where residents' personal care items were stored and residents' rooms. Interview with the Administrator on 06/15/21 at 3:45 pm revealed: -She was not aware of personal care items in room #61. -Personal care items should not be left in residents' rooms for safety concerns. Interview with the SCU Coordinator on 06/17/21 at 10:50 am revealed: -She was not aware of personal care items in room #61. -She did not know where resident personal care items were kept -Personal care items should not be left in room for safety concerns. 4. Observations on the Special Care Unit (SCU) on 06/15/21 at 8:59am revealed the floors in the hallways, common area and 13 resident rooms (#38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49 and #50) made a sticky sound with walking and had an accumulation of dirt and grime. Observation on the SCU on 06/16/21 at 8:11am revealed handrails were sticky which consisted of a brown substance. Interview with a personal care aide (PCA) on 06/15/21 at 10:04am revealed: -There was one housekeeper for the whole facility. -The housekeeper mostly cleaned the assisted	{D 079}		

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{D 079}	Continued From page 5 living (AL) side. -PCAs and medication aides (MAs) on the SCU helped with cleaning resident rooms, floors, and bathrooms on the SCU. -There was no cleaning assignment or schedule for PCAs and MAs on the SCU. Interview with a second PCA on 06/15/21 at 11:53am revealed: -Housekeeping staff were responsible for cleaning the floors in the hallways, dining room and common areas on the SCU. -There was one housekeeper for the facility, and she worked her way back to the SCU from the AL side when she could. Interview with a housekeeper on 06/15/21 at 11:41am revealed: -She was a PCA but was working as the housekeeper on the AL side on 06/15/21. -There was just one housekeeper for the facility. -There was no schedule for PCAs working as housekeepers. -Some PCAs and other staff volunteered to help with housekeeping duties. Interview with a second housekeeper on 06/15/21 at 2:24pm revealed: -She worked as a housekeeper every day; she did not know if her hours were full time or part time. -She sometimes worked on Saturdays and Sundays. -She was responsible for cleaning resident rooms, bathrooms, common areas and all floors daily. -She was currently the only housekeeper and did the best she could to clean all areas each day. -She did not remember how long she had been the only housekeeper for the facility.	{D 079}		

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{D 079}	Continued From page 6 -Staff helped with housekeeping duties when she was not working. Second interview with the first PCA on 06/16/21 at 10:05am revealed he was working as the only housekeeper for the whole building that day. Interview with a second MA on 06/16/21 at 10:34am revealed: -She had not noticed the hardened amber substance on the handrail near the entrance door to the SCU. -Housekeeping staff was responsible for wiping down handrails and other commonly touched surfaces such as doorknobs and counter tops daily. -SCU staff helped with housekeeping duties sometimes. -She did not know when the handrail was last cleaned. Interview with the SCU Coordinator on 06/17/21 at 8:40am revealed: -There was one housekeeper for the AL side and SCU. -PCAs picked up housekeeping duties some mornings. -Floors, handrails and bathrooms should be cleaned daily. -If staff see something that needed to be cleaned, they were expected to clean it or get the housekeeper to clean it. -Dirty areas were not good for residents because it could spread bacteria and/or germs. -She had been the SCU Coordinator for approximately one month and had not yet established a routine for monitoring the environment. Interview with the Administrator on 06/16/21 at	{D 079}		

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{D 079}	Continued From page 7 10:54am revealed: -There had been one housekeeper for approximately one month. -There were two PCA that worked extra days as housekeepers. -She had put in a work order with the corporate offices to have the floors in the SCU stripped and buffed; she did not remember when she put the work order in. -She had not noticed the hardened amber colored substance on the handrail in the hallway of the SCU. -Housekeepers and staff were responsible for wiping down frequently touched surfaces such as handrails and frequently touched surfaces. -The SCU Coordinator was responsible for completing daily environmental and safety rounds on the SCU. 4. Observation of a shared resident bathroom on 06/15/21 at 9:07 revealed: -There was a shared bathroom between two resident rooms. -There was a wire clothes hanger bent into a hook hanging over the towel rack on the wall. Interview with a resident on 06/15/21 at 9:16am revealed: -He shared the bathroom with his roommate and another resident. -The clothes hanger belonged to his roommate. -He did not know what the roommate used the clothes hanger for or why it was bent the way it was. Interview with a second resident on 06/15/21 at 4:28pm revealed that he had bent the clothes hanger to use to clear a clog from the toilet. Interview with a personal care aide (PCA) on	{D 079}		

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{D 079}	Continued From page 8 06/15/21 at 4:28pm revealed: -She was not aware there was a bent wire clothes hanger in a shared resident bathroom. -One of the residents that shared the bathroom had a diagnosis of mental illness and could have used the hanger to hurt himself. -She did not remove the bent wire hanger from the bathroom when shown the clothes bent wire hanger. Interview with the Administrator on 06/15/21 at 4:40pm revealed: -She was not aware a resident had bent a wire clothes hanger to use to unclog his bathroom toilet. -The bent wire clothes hanger was a hazard to the residents. -Residents could injure themselves on the bent wire. -Staff were expected to check the residents' bathrooms each shift and remove any hazards found.	{D 079}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the personal care needs for 3 of 5 sampled residents (#1, #5	{D 269}		

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{D 269}	Continued From page 9 and #6) were provided related to incontinence care. The findings are: 1. Review of Resident #1's current FL-2 dated 02/03/21 revealed: -Diagnoses included dementia, insomnia, anxiety, and hypertension. -Resident #1 was constantly disoriented. -Resident #1 was incontinent of bladder and had a colostomy for bowel. Review of Resident #1's care plan dated 02/03/21 revealed Resident #1 required extensive assistance with toileting. Observation of Resident #1 on 06/16/21 at 6:07am revealed a personal care aide (PCA) provided incontinence care to Resident #1. Observation of Resident #1 on 06/16/21 at 6:39am revealed the PCA pushed Resident #1 in her wheelchair into the dining room for breakfast. Observations of Resident #1 on 06/16/21 between 9:12am-11:12am revealed Resident #1 was sitting in her wheelchair in the residents' lounge. Observations of Resident #1 on 06/16/21 at 11:12am revealed: -A second personal care aide (PCA) took Resident #1 to the resident's room to provide incontinence care. -Resident #1's adult incontinence brief was soaked with urine. Interview with the second PCA on 06/16/21 at 11:12am revealed:	{D 269}	Personal Care Aides were re-trained to provide personal care including toileting, bathing, etc according to the needs of the residents and frequency, identified on their care plan. Personal Care Aides/ qualified staff will provide personal care including toileting, bathing, etc according to the needs of residents and frequency, identified on their care plan. Supervisor In Charge/Special Care Unit Coordinator will monitor daily (x7 days/week) to ensure personal care tasks are being completed on including toileting, bathing, etc according to the needs of residents and frequency, identified on their care plan. Administrator/Designee will conduct stand up meeting 5 days/week with staff to follow up on resident personal care concerns/issues and other medical/physical conditions.	6/23/2021 & 6/28/2021 & 7/1/2021 6/18/2021 & Ongoing 7/15/2021 & Ongoing 7/15/2021 & Ongoing

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{D 269}	Continued From page 10 -It was the facility's protocol to provide incontinence care to the residents every two hours. -She provided incontinence care to the residents every two hours. -She changed residents' adult incontinence briefs every two hours whether the adult brief was dry or wet. -Resident #1 had not received incontinence care since before breakfast. Observations of Resident #1 on 06/17/21 between 8:24am-10:58am revealed: -Resident #1 was sitting in the residents' lounge. -At 10:58am, a third PCA pushed Resident #1 in her wheelchair to the dining room for lunch. Observation of Resident #1 on 06/17/21 at 11:49am revealed: -The third PCA took Resident #1 to the resident's room to provide incontinence care. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Refer to interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 9:20am. Refer to interview with the Administrator on 06/30/21 at 9:34am. Refer to interview with the Primary Care Provider (PCP) on 06/17/21 at 1:06pm. 2. Review of Resident #5's current FL-2 dated 02/08/21 revealed: -Diagnoses included dementia, diabetes, hypertension, hyperlipidemia, and depression. -Resident #5 was ambulatory.	{D 269}		

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{D 269}	Continued From page 11 -Resident #5 was constantly disoriented. -Resident #5 was incontinent of ladder and bowel. Review of Resident #5's care plan dated 02/05/21 revealed Resident #5 was totally dependent upon staff for toileting needs. Observation of Resident #5 on 06/17/21 at 6:54am revealed Resident #5 was sitting in the dining room for breakfast. Observations of Resident #5 on 06/17/21 between 7:47-7:55am revealed: -A personal care aide (PCA) walked with Resident #5 to the dining room. -When the assigned PCA to Resident #5 assisted Resident #5 with standing, the back of Resident #5's pants were soaked with urine. -The assigned PCA to Resident #5 had to be prompted that Resident #5's pants were wet in the back. -The assigned PCA to Resident #5 took Resident #5 to the resident's room to provide incontinence care. -Resident #5's adult incontinence brief was soaked with urine. Interview with the assigned PCA to Resident #5 on 06/17/21 at 7:47am revealed: -Resident #5 was sitting in the dining room for breakfast when she arrived this morning, (06/17/21), in the Special Care Unit (SCU). -She did not know the last time incontinence care was provided to Resident #5. Observations of Resident #5 on 06/17/21 between 8:24am-10:58am revealed: -Resident #5 was sitting in the residents' lounge. -At 10:58am, the PCA assigned to Resident #5 was taking her to the dining room for lunch.	{D 269}		

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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 269}	Continued From page 12 However, the PCA noticed Resident #5's pants were wet from behind. -The PCA took Resident #5 to the resident's room to provide incontinence care. Interview with the assigned PCA to Resident #5 on 06/17/21 at 11:02am revealed: -She provided incontinence care to residents every two hours. -She did not realize it had been three hours since she last changed Resident #5. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Refer to interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 9:20am. Refer to interview with the Administrator on 06/30/21 at 9:34am. Refer to interview with the Primary Care Provider (PCP) on 06/17/21 at 1:06pm. 3. Review of Resident #6's current FL-2 dated 02/08/21 revealed diagnoses included dementia, hypothyroidism, hypertension, vitamin B 12 deficiency and osteoarthritis. Review of Resident #6's current care plan dated 02/08/21 revealed: -Resident #6 was always disoriented and had significant memory loss. -Resident #6 was ambulatory with a wheelchair and had limited upper extremity strength. -Resident #6 had daily bowel and bladder incontinence. -Resident #6 was totally dependent on staff for assistance with ambulation and	{D 269}		

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{D 269}	Continued From page 13 toileting/incontinence care. Observations on 06/17/21 at 10:47am revealed: -A personal care aide (PCA) and medication aide (MA) attempted to assist Resident #6 out of her wheelchair. -Resident #6 resisted staff by pushing staff away and grabbing at the MA's hands. -The PCA and MA assisted Resident #6 from the wheelchair to her bed by helping the resident to stand and turn holding her under her arms. -The PCA and MA assisted Resident #6 with incontinence care. -Resident #6's brief was moderately wet with strong smelling odor and there was slight redness to her perineum and buttocks. -The MA placed a tape closure incontinence brief lined with an opened pull on brief under Resident #6. -The tape of the incontinence brief was secured close to Resident #6's left hip. Interview with the MA on 06/17/21 at 10:47am revealed: -She and the PCA did not place a double brief on Resident #6. -The tape closure incontinence brief was so thin they placed the open pull up brief as an insert. Interview with the first shift PCA on 06/17/21 at 2:48pm revealed she had last changed Resident #6's incontinence brief at 2:30pm. Observations on 06/17/21 at 3:24pm revealed: -The PCA told Resident #6 it was time to change her brief and the resident smiled. -The PCA put her hands out, Resident #6 took the PCA's hands and after prompting stood from her wheelchair. -The PCA assisted Resident #6 to walk to and lie	{D 269}		

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{D 269}	Continued From page 14 down on her bed for incontinence care. -The incontinence brief was taped toward Resident #6's left hip in the same fashion as the observation at 10:47am on 06/17/21. -The PCA removed the tape closure brief lined with an opened pull on brief; the briefs were moderately to heavily saturated with strong smelling urine. Interview with the second shift PCA on 06/17/21 at 3:24pm revealed: -She did not put two incontinence briefs on Resident #6; she always used one incontinence brief with incontinence care. -"They" put two incontinence briefs on Resident #6; she did not know who "they" were. -"They" were the ones who put the two briefs on Resident #6. -She did not remember if she had seen two briefs on residents before. Interview with a second PCA on 06/17/21 at 4:02pm revealed: -He had seen a double incontinence brief placed on a resident before. -It had not happened often, and he did not notice it with any specific staff or resident. -He had seen two extra large size incontinence briefs on a resident that wore a medium size. -He did not think it was comfortable for residents to wear two briefs; he did not wear two pairs of underwear. -PCAs had been instructed by supervisors to use one incontinence brief at a time. Interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 3:42pm revealed: -Staff were not supposed to put two incontinence briefs on residents because it increased the risk of skin breakdown.	{D 269}		

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{D 269}	Continued From page 15 -Residents could not have both types of incontinence briefs ordered; it was either the tape closure brief or the pull on brief. Interview with the Administrator on 06/17/21 at 4:10pm revealed: -No staff had reported finding any resident in two incontinence briefs. -She was not aware of Resident #6 having any behaviors where staff might avoid changing her. -No staff had been instructed to use two incontinence briefs. -Resident #6 nor any other resident should have two incontinence briefs on. -Residents who were double briefed were at risk for skin breakdown due to excessive moisture. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Refer to interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 9:20am. Refer to interview with the Administrator on 06/30/21 at 9:34am. Refer to interview with the Primary Care Provider (PCP) on 06/17/21 at 1:06pm. Interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 9:20am revealed: -The facility's policy was to provide incontinence care to the residents every 2 hours. -If a resident needed incontinence care more often, she expected the facility staff to do so.	{D 269}		

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{D 269}	Continued From page 16 -There were no exceptions when staff should not provide incontinence care every two hours. -Residents who were wet for an extended time were at risk of skin breakdown. Interview with the Administrator on 06/17/21 at 9:34am revealed: -She expected the facility staff to provide incontinence care every two hours. -If a resident needed incontinence care more often, she expected the facility staff to do so. -If a resident was wet for an extended time, it could cause skin breakdown. Interview with the Primary Care Provider (PCP) on 06/17/21 at 1:06pm revealed: -"Female residents were at risk for urinary tract infections" if they were wet or soiled for an extended time. -Residents who were "wet or soiled for too long would be at risk for irritation of the skin, redness of the skin, skin breakdown or worse." -She hoped the facility would provide incontinence care to the residents in the facility at least every hour or follow their facility protocol. -She expected the facility not to allow residents to be wet or soiled for an extended time.	{D 269}		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.	D 312		

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D 312	Continued From page 17 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed ensure 3 of 3 sampled residents (#1, #6 and #7) requiring assistance with eating meals were served their meals and received timely, respectful and unhurried assistance with eating when the meal was served to other residents in the dining room. The findings are: 1. Review of Resident #6's current FL-2 dated 02/08/21 revealed diagnoses included dementia, hypothyroidism, hypertension, vitamin B 12 deficiency and osteoarthritis. Review of Resident #6's current care plan dated 02/08/21 revealed: -Resident #6 was always disoriented and had significant memory loss. -Resident #6 was ambulatory with a wheelchair and had limited upper extremity strength. -Resident #6 was totally dependent on staff for assistance with ambulation and eating. Observations on 06/16/21 from 6:22am until 8:14am revealed: -A PCA brought Resident #6 who was seated in her wheelchair to a table in the dining room in at 6:22am. -Resident #6 remained seated in her wheelchair in the dining room from 6:22am through 7:43am. -At 7:43am, two PCAs began serving breakfast trays to sixteen residents seated in the dining room on the special care unit (SCU). -At 7:49am, all residents in the dining room had received a breakfast tray except Resident #6 and another resident. -Resident #6 watched the PCA sit down and	D 312	SCU Coordinator will ensure that all residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Staff were retrained on the expectation of residents who need help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. SCUD/Administrator will monitor meals x2 per week x3 weeks then randomly thereafter, to ensure that all residents needing assistance with eating receive help upon receipt of the meal. tag number D312 Addendum per telephone conversation with Ms. Meredith Sea on 04/01/22 revealed change of completion date. Theresa A. Floyd, 04/01/22	6/18/2021 ~~6/17/2021~~ & Ongoing 7/1/2021 6/18/21 ~~6/17/2021~~ & Ongoing

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D 312	Continued From page 18 assist a third resident with eating breakfast. -The second PCA and MA left the dining room to assist another resident in their room. -At 7:55am, the PCA and MA returned to the dining room with a resident in a wheelchair. -At 7:58am, another resident was served a breakfast tray and the second PCA assisted the resident with eating breakfast. -Resident #6 remained in the dining room without a breakfast plate watching the PCA assist another resident. -At 8:00am, the MA informed the kitchen there was not a pureed breakfast plate for Resident #6. -Resident #6 continued to watch other residents eat breakfast and licked her lips several times from 8:00am until 8:12am. -At 8:08am, the first PCA removed dirty dishes from the table and assisted the resident she had been helping to eat breakfast out of the dining room. -At 8:12am, staff placed Resident #6's plate on the table in front of her but there were no utensils. -At 8:12am, the resident seated at the table with Resident #6 began tapping on the table with her hands and said to staff, help her, pointing to Resident #6. -At 8:14am, the first PCA sat down to assist Resident #6 with eating the breakfast meal. Attempted interview with Resident #6 on 06/16/21 at 8:08am revealed the resident did not have a verbal response but nodded yes, she was hungry. Interview with the cook on 06/16/21 at 10:13am revealed: -There were always three pureed trays for the SCU, but a couple of days ago a staff told her the SCU only needed two pureed plates because one resident (#5) went to the hospital. -She did not find out the resident returned from	D 312		

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D 312	Continued From page 19 the hospital until after breakfast was served that morning. -She did not remember when she was told or by which staff. Interview with the MA on 06/16/21 at 10:34am revealed: -On 06/15/21, SCU staff told the kitchen staff Resident #5 was sent out of the facility. -She had to tell the kitchen staff that morning because only two pureed breakfast plates were sent. -Resident #6 was fed late because the resident did not have a breakfast plate. -Usually the two PCAs and the MA assisted the four residents who needed help eating breakfast at the time the breakfast meal was served to all residents. -That morning third shift was not able to get all residents up so she and one of the PCAs had to assist other residents with getting up and getting to the dining room. -Third shift staff reported several residents refused to get up that morning. -It happened often that first shift had to get residents up for breakfast because third shift was not able to. -There was no one to ask for help with breakfast and getting residents to the dining room; there were just two PCAs and one MA on the SCU. -She talked to the Administrator about residents not being up for breakfast and the Administrator had talked to third shift staff. -She had not considered feeding residents present in the dining room and then getting other residents up for breakfast. Interview with the SCU Coordinator on 06/17/21 at 8:40am revealed: -She was new to the position of SCU Coordinator	D 312		

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D 312	Continued From page 20 (May 2021) and had been able to observe one meal on the SCU. -There were four residents who needed staff assistance to eat meals. -There were two PCAs to assist residents with eating meals; she did not know what the PCAs system was for assisting residents to eat meals. -Staff had not reported any issues with assisting residents with eating meals. -She expected the MA and PCAs to assist residents with eating meals. -No resident should be waiting 30 minutes in the dining room to eat. -The resident might feel they were treated unfairly and left out if everyone was eating around them and they were not. Interview with the Administrator on 06/16/21 at 10:54am revealed: -She did not know there were delays in providing assistance with eating meals. -She expected staff to report issues causing delays in providing care to her or the SCU Coordinator. -Staff had not reported any concerns with not having enough staff and/or having to assist residents to the dining room. -She expected staff to assist Resident #6 with eating a meal when all other residents were eating their meals. -If staff were not able to provide assistance for Resident #6, the staff should have let her know within minutes. 2. a. Review of Resident #7's current FL-2 dated 02/08/21 revealed diagnoses included dementia, paranoid schizophrenia and hypertension. Review of Resident #7's current care plan dated 02/08/21 revealed:	D 312		

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D 312	Continued From page 21 -Resident #7 was always disoriented and had significant memory loss. -Resident #7 was ambulatory with a wheelchair. -Resident #7 was totally dependent on staff for assistance with ambulation and required extensive assistance eating. Observations during the lunch meal on 06/17/21 from 11:07am until 11:12am revealed: -At 11:07am, the medication aide (MA) brought Resident #7 to the dining room in her wheelchair. -The MA stood next to an empty chair at the table and began assisting Resident #7 to eat lunch. -From 11:08am until 11:12am the MA stood over Resident #7 while assisting the resident to eat. -At 11:12am, after prompting, the MA sat down in the chair at the table to assist Resident #7 with eating lunch. Interview with the MA on 06/17/21 at 11:12am revealed: -She stood while assisting residents to eat because she moved around frequently. -She had not considered it disrespectful to stand over Resident #7 while assisting her to eat lunch. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. b. Review of Resident #1's current FL-2 dated 02/03/21 revealed: -Diagnoses included dementia, insomnia, anxiety, and hypertension. -Resident #1 was constantly disoriented. Observation during the lunch meal on 06/17/21 at 11:42am revealed: -The PCA was standing while feeding Resident #1.	D 312		

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D 312	Continued From page 22 -At 11:42am, after prompting the PCA, the PCA stopped assisting Resident #1 with feeding and left the dining room. Interview with the PCA on 06/17/21 at 11:42am revealed: -She always stood while assisting residents with feeding. -She had been trained on the proper way to offer feeding assistance to residents. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 11:13am revealed: -Staff were expected to be sitting down with residents while assisting them to eat a meal. -It was disrespectful for staff to stand while assisting a resident with a meal; it was rushing the resident to eat. Interview with the Administrator on 06/17/21 at 11:53am revealed: -She expected staff to sit with residents while assisting the resident to eat a meal for the resident's comfort and ease while eating. -Sitting with the resident made the resident feel like staff were sitting and eating with them.	D 312		
{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:	{D 358}		

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{D 358}	Continued From page 23 (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: Based on observations, interviews and record reviews, the facility failed to administer an oral antifungal (fluconazole) as ordered by the primary care provider for 1 of 5 sampled residents (#2) who had a worsening of redness and irritation previously treated as yeast dermatitis. The findings are: Review of Resident #2's current FL-2 dated 02/08/21 revealed diagnoses included dementia, history of pelvis fracture, history of coronavirus pneumonia, debility and glaucoma. Review of a physician's order dated 04/06/21 for Resident #2 revealed an order for fluconazole 150mg daily for ten days. Review of a primary care provider (PCP) visit note for Resident #2 dated 04/22/21 revealed: -There was documentation Resident #2 was seen by a dermatologist on 04/06/21. -The dermatologist ordered fluconazole 150mg daily for ten days. -The PCP did not see documentation on Resident #2's medication administration record (MAR) for the fluconazole. -The PCP was going to re-order the fluconazole on 04/22/21. Review of a telephone order dated 06/05/21 for Resident #2 revealed an order for fluconazole 40mg/ml liquid 5ml daily for two weeks.	{D 358}	Med Aides were retrained on medication administration and procedures for sending new orders to the pharmacy. SCUC/Designee will audit MARs to ensure they match all current orders at least monthly SCUC/Designee will observe medication passes randomly to ensure medication passes randomly to ensure medication is administered as ordered by the physician.	6/28/2021 7/15/2021 & Ongoing 7/15/2021 & Ongoing

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{D 358}	Continued From page 24 Review of a care note dated 06/05/21 for Resident #2 revealed: -Staff documented Resident #2's groin, inner thighs and buttocks were "very, very" red. -Staff sent a text message to Resident #2's PCP and received an order for fluconazole 40mg/ml liquid 5ml daily for two weeks in a return text from the PCP. Review of Resident #2's June 2021 electronic MAR revealed there was no entry for fluconazole. Interview with a medication aide (MA) on 06/16/21 at 10:25am revealed: -She wrote the care note dated 06/05/21 for Resident #2. -She was concerned because Resident #2 had increased redness at her groin, perineum and buttocks. -She contacted Resident #2's PCP and received a telephone order for fluconazole. -She faxed the telephone order to the pharmacy and placed the written order in a folder for the PCP to sign when she visited the facility on Thursdays. -The folder for the PCP was kept in the medication room on the assisted living (AL) side. -She was not sure if the medication was in the facility because there had been problems before with getting liquid fluconazole from the pharmacy for Resident #2. Telephone interview with Resident #2's PCP on 06/16/21 at 1:50pm revealed: -Resident #2 had been experiencing a yeast dermatitis which was hard to heal. -Staff had contacted her on 06/05/21 that Resident #2 had increased redness and irritation. -She gave a telephone order for liquid fluconazole	{D 358}		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 06/17/2021

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VINTAGE INN RETIREMENT COMMUNITY	826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892

(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 on 06/05/21. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/17/21 at 10:14am revealed: -The last order for liquid fluconazole for Resident #2 was on 04/22/21 for 10 days. -There was no record of an order dated 06/05/21 for fluconazole for Resident #2. Interview with the Special Care Unit (SCU) Coordinator on 06/17/21 at 8:40am revealed: -She did not recall staff reporting contacting Resident #2's PCP regarding concerns for increased redness. -She did not know there was a telephone order given for an oral antifungal. -She was new to the role of SCU Coordinator and was working on a system to monitor staff compliance with PCP orders. -MAs were expected to fax all PCP orders to the pharmacy. -After faxing orders, MAs put a copy of the order and fax confirmation in her box which was in the medication room on the AL side. Second telephone interview with Resident #2's PCP on 06/17/21 at 11:37am revealed: -She saw Resident #2 early that morning (06/17/21) and had seen in her record that the fluconazole ordered on 06/05/21 was not given. -She had not seen the irritation on 06/05/21 so she could not say if the area was the same, worse or improved on 06/17/21. -It was concerning to her that an order she put in place was not followed. -She re-ordered the fluconazole on 06/17/21 for seven days. Interview with the Administrator on 06/17/21 at	{D 358}		

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 _____	R 06/17/2021

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{D 358}	Continued From page 26 11:53am revealed: -MAs were expected to fax telephone orders from the PCP to the pharmacy and place the written order in the PCP folder. -If a medication was not delivered to the facility or entered on the medication administration, MAs would know to follow up from verbal communication and a copy of the order in the control log book. -MAs usually reviewed and checked off medications at shift change from the control log book. -There were folders in the medication room for pending orders, orders that needed the PCP's signature, and orders to be filed. -MAs were expected to check the folders daily. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	{D 358}		