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	HAL058010	A. BUILDING: _____ B. WING _____	R 04/08/2022

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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 and the Martin County Department of Social Services conducted an annual and follow-up survey and complaint investigation from April 5, 2022 - April 8, 2022. The complaint investigations were initiated by the Martin County Department of Social Services on March 10, 2022 and March 24, 2022.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the facility was maintained in a clean and orderly manner and free of hazards including mice infestations throughout the facility; personal care hygiene products being stored unlocked in 2 of 2 common spa bathrooms in the special care unit (SCU) resulting in hazardous substances and chemicals being unattended and accessible to the 15 residents residing in the SCU; 3 oxygen canisters being stored in an unsecured manner in two resident rooms in the assisted living (AL) side; a broken ceramic vase and glass candle holder being left on the floor overnight in the common living room in the AL side accessible to residents; and 4 of 4 spa bathrooms in the AL side with	D 079		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Meredith Seals (for Administrator Janet Will) | COO | 05/20/2022

Reviewed and acknowledged – S. Knight 5/24/22

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D 079	Continued From page 1 soiled and dirty toilets, sinks, showers, bath tubs, shower chairs, and floors. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 122 beds including 72 beds for assisted living (AL) and 50 beds for a special care unit (SCU). Review of the facility's census reports provided on 04/05/22 revealed: -The facility's in-house census was 45 residents. -There were 30 residents residing in the AL side of the facility. -There were 15 residents residing in the SCU. Review of the facility's current sanitation report dated 01/29/22 revealed: -The facility's sanitation score was a 95. -The flooring was badly cracked and hard to clean and there were holes in the walls in the spa bathrooms and storage rooms that needed to be patched. -Many of the toilets, sinks, shower seats, and other fixtures of the communal bathrooms and showers were in need of cleaning and not in good repair. 1. Observation of left hall on the AL unit on 04/05/22 from 9:30am to 9:40am revealed: -There was a strong urine smell in the hallway. -There was a small living area mid-way down the hall on the left that also smelled of urine. -One room on the hallway was occupied with two residents (#33); the remaining rooms were vacant. -There were random piles of bedding and clothing on beds and on the floor in several unoccupied	D 079	Administrator conducted walk thru of the community to get complete list of items needing to be repaired and will arrange for them to be fixed. Staff retrained on expectations of cleaning. Administrator/Designee will walk through building weekly to ensure cleanliness of rooms and that oxygen tanks are stored properly as outlined in facility procedures. Anything needing attention will be added to the maintenance log book as outlined in facility procedures. Maintenance/Designee will monitor report any open maintenance items needing attention outside of his scope to the corporate Maintenance Supervisor. Administrator will followup with Maintenance Supervisor on outstanding issues weekly until resolved.	5/23/2022

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D 079	Continued From page 2 rooms. -All rooms on the left hallway, including the occupied room had mouse droppings in the closets, on the floors, on dressers/counters/nightstands, and in the vacant rooms on bedding and clothing. -There were multiple places that the floors appeared dirty and with a thick dark sticky substance on them. Observation of the occupied resident room #33 on the left hall of the AL unit on 04/05/22 at 10:02am revealed: -There was a broom leaning against the wall with a pile of dirt and debris waiting to be cleaned up that appeared to have mouse droppings in it. -There was a plastic food container on the counter above the dresser with a mouse dropping on it next to a daily pill box. -There were three mouse traps along the walls spread out throughout the room that were empty. -There was a film of brown grime along the base of a fan sitting on the floor of the room. Observation on the left hallway in the AL side of the facility on 04/07/22 from 9:45am - 9:51am revealed: -A gray mouse was observed running in the hallway and under the crack of the door to vacant resident room #31. -Upon entering resident room #31, the mouse could not be seen in the room or the adjoining bathroom. -The adjoining vacant resident room #32 had a large stack of plastic bags with clothing covering the middle of the floor and the mouse was could not be seen in the room. Intermittent observations of the SCU on 04/05/22 from 9:32am to 3:48pm revealed:	D 079		

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D 079	Continued From page 3 -At 9:32 am, there was visible trash on floor in the common area and there was a sausage patty on the sofa in the TV room where 2 residents sat. -At 9:47 am, there was food on the floor in the dining room area, under the tables and on the tables and visible spider webs in the window of the dining room. -At 3:48pm, a recheck of SCU dining room revealed there was the same visible food on the floors and tables. Observation of the SCU dining room on 04/06/22 at 8:05am revealed: -There was food on the dining room floor. -The dining room floor was dirty with brown sticky patches intermittently dispersed around the room. -There was debris of an unknown source and food crumbs under most of the tables and in the walkways. -Residents were seated and personal care aides (PCAs) were serving residents breakfast. Observation of the kitchen and surrounding areas within the kitchen on 04/05/22 from 3:30pm to 4:30pm revealed: -There were cardboard boxes of food stored on the floor in the pantry and a sticky mousetrap on the floor under the pantry shelves. -There was a box of saltine crackers sitting on a shelf that had been chewed through with crumbs of debris and dried food that appeared to be okra and noodles sitting on the plastic container next to the box. -The floor had a black and brown thick sticky substance on it and there were copious amounts of mice droppings on top of containers of food and along the edges of the walls under the shelves of food in the entirety of the room. -The oven had a thick black substance caked to the inside of the door which appeared to be dried	D 079		

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D 079	Continued From page 4 cooked food that had spilled. -The floors in the kitchen also had a brown sticky substance on them and there was a dead roach on the floor at the corner of the oven. -The door leading out of the kitchen into the SCU dining room had a brown substance all over the middle portion of the door. -There was a utility room off the kitchen before reaching the SCU dining room door with a computer and keyboard on the floor. -There was a sticky mouse trap on the floor next to the computer covered in dirt, debris, and two dead mice. -There was another sticky mouse trap on the floor behind the computer in the corner behind the door with six dead mice and two dead roaches on it. -There were mice droppings and debris littering the entirety of the floor which also had a sticky brown substance on it in the utility room. Interview with a resident in the occupied room #33 on the left hall on the AL unit on 04/05/22 at 9:40am revealed the housekeeping staff came in to clean his room once weekly. Interview with the resident's roommate in the occupied room on the left hall on the AL unit on 04/05/22 at 9:53am revealed: -He kept traps in his room to try and catch the rats and mice that were in the facility and came into his room. -The purchased some of the traps himself and the exterminator provided the rest of the traps. -Having pests in his room kept him from sleeping restfully and makes him not want to eat the food at the facility because he knew the pests were in the kitchen too and walked all over things. -He kept snacks in his room in plastic food containers to keep the pests out of his personal	D 079		

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D 079	Continued From page 5 food. -He could hear and sometimes see the rats and mice both during the day and at night; but around 7:00pm is when he most often encountered them. -Staff did not clean their room often so he would routinely sweep the room and take the trash out a couple times per week to prevent the mice and rats. -His roommate was mostly bed bound and sometimes, staff would leave his roommate's plates in the room overnight after dinner which he thought was contributing to the problem. Interview with a resident on the right hall of the AL unit on 04/05/22 at 10:28am revealed: -She was uncomfortable and did not like living at the facility. -She saw a mouse in her room two nights ago when someone came in to assist her to the restroom. -The staff member assisting her to the restroom also saw the mouse and opened the door to the bedroom to let it run out while she went to the restroom. Interview with a resident's family member on the right hall on the AL unit on 04/06/22 at 10:12am revealed: -She had not seen any mice or other pests at the facility. -She was not sure how often the facility staff cleaned her family member's room, but she cleaned it last week. -Sometimes when the facility cleaned her family member's room, they would mop without sweeping first making anything on the floor stick. Interview with a second resident on the right hall on the AL unit on 04/06/22 at 10:51am revealed: -She put clean sheets on her bed every day, but	D 079		

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D 079	Continued From page 6 the staff did not help her do it. -She would sweep her room every day because housekeeping would only sweep the walkways of the room if she asked them to. -She also had to dust and fold her laundry herself. Interview with a resident on the SCU on 04/05/22 at 10:03am revealed: -He had not seen any bugs or rodents in his room but had an issue with roaches in another room that he previously occupied. -Housekeeping staff cleaned his room maybe 3 times a week and swept and mopped the room. Interview with a housekeeper on 04/06/22 at 9:18am revealed: -He started working at the facility 2 weeks prior and was responsible to maintain the building, clean resident rooms, fill hand sanitizers, and replace paper towels. -He was not responsible to clean the kitchen or dining room areas; the kitchen staff were responsible to clean those areas. -There were usually 1-2 housekeepers staffed each day from 7:00am to 3:00pm. -He had not seen any mice or other pests and residents had not complained to him about seeing any mice or pests. Interview with a previous employee on 04/06/22 at 10:13am revealed: -She worked at the facility until February 2022. -The facility was never kept clean while she worked there; there was always trash on the floor, dirty bathrooms, and a bad smell. -There were also rats and mice all over the facility to include common areas, residents rooms, and the kitchen. -It was frustrating because she reported her	D 079		

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D 079	Continued From page 7 concerns about the rats and mice to the previous Administrator, but nothing was ever done to get rid of them. -She was always worried that the rats or mice might hurt residents or possibly be cooked in the resident's food. Interview with a PCA on 04/08/22 at 10:36am revealed: -She had not seen any mice herself, but she had noticed mice droppings around the facility, and some residents had complained to her about seeing mice in their rooms. -It was concerning to have mice at the facility because they were scary, and residents should have the right to not have them in their home. -Mice droppings could be dangerous to residents and transmit diseases. Interview with a medication aide (MA) on 04/07/22 at 4:36pm revealed: -The facility had mice and they would run around leaving droppings in the dining room and bathrooms. -She had discussed the issue with a co-worker previously but did not report the issue to management because she was told they already knew about it. Interview with the dietary manager on 04/05/22 at 10:48am and 3:30pm revealed: -He started working at the facility 4 days prior on 04/01/22. -He had never seen mice or other pests in the kitchen since he started working at the facility and he was unaware that the black droppings in the pantry were from mice activity. -He was not aware there were dead mice in traps in the utility room next to the kitchen as he had not been in that room yet.	D 079		

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D 079	Continued From page 8 -He was not sure if the Administrator was aware of the pest issue in the kitchen or if there was a contracted exterminator to treat the issue. Second interview with the dietary manager on 04/08/22 at 11:30am revealed: -It was his responsibility to clean the kitchen and ensure food was protected from contamination. -He did not realize that resident food was contaminated. Review of the facility's contracted extermination receipts revealed: -On 10/19/21, the facility was treated for general pests in the kitchen and dining areas and resident rooms 1-8 (on the right hall). -On 11/22/21, the facility was treated for general pests in the kitchen and dining areas and resident rooms 1-8. -On 12/23/21, the facility was treated for general pests in the kitchen and dining areas and resident rooms 1-8. -On 01/20/22, the facility was treated for general pests in the kitchen and dining areas and resident rooms 1-8. -On 02/26/22, the facility was treated for general pests in the kitchen and dining areas and resident rooms 1-8 and rodent traps were placed in the Administrator's office and the back hall. -On 03/08/22, the technician completed spot treatment for termites using termicide. Interview with the facility's contracted exterminator on 04/08/22 at 9:10am revealed: -He was last at the facility on 03/22/22 and would come in between his monthly visits at the facility's request. -He had serviced the facility for the last several years and the recent construction at the facility had helped with the cleanliness of the facility.	D 079		

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D 079	Continued From page 9 -Cleanliness and sanitation were going to be key for the facility to be rid of pests. -Mice infestations were reported to him 2 months ago and he laid bait outside and traps inside, but there were foundation issues that needed to be corrected if the mice were going to be controlled and there was nothing more he could do to treat them until the facility addressed the issue. -Rats and mice could be harmful to residents in that they could bite them or transfer diseases by crawling across surfaces that residents encounter. -He had made the facility management aware of the issues that needed to be corrected on multiple occasions. Interview with the Administrator on 04/05/22 at 5:23pm revealed: -She was aware there was mice activity in the kitchen and some resident's rooms. -She was told upon starting in February 2022 that mice had always been a problem in the kitchen the exterminator had tried different kinds of traps to control the issue. -The exterminator came once per month and as needed if she called him; he was last at the facility on 03/22/22 and he would laid new traps each time he came and also treated for other pests that had previously been an issue for on-going maintenance such as bed bugs along with the mice in resident rooms. -She was not aware that there were mice droppings in the vacant resident rooms as those rooms had recently been deep cleaned. -Some residents continued to complain of mice being in their rooms, but she had not heard any complaints about mice from the staff. -She was not aware of any dead mice on traps in the kitchen utility room or that mice were in the pantry where food was not being stored correctly.	D 079		

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D 079	Continued From page 10 -She trusted the new dietary manager to throw away food contaminated from mice but was unsure if the cook would know to throw the contaminated food away. -She had not had a conversation about proper food storage or food contamination with the dietary staff yet, but she would train them on contamination and cleanliness. Interview with the Administrator on 04/07/22 at 9:55am revealed: -She saw a mouse in the facility "the other day". -She screamed when she saw the mouse because she did not realize a mouse would come in an open or common area. -She would not specify where she saw the mouse. -She did not know why there were still bags of clothes stored on the floor in vacant resident room #32 but the clothing needed to be removed. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -The housekeeping staff were responsible to ensure cleaning for the entire facility to include the common bathrooms, resident rooms, and removal of trash daily, sweeping, mopping, and dusting weekly, and linens as needed. -The PCAs were generally responsible to change the linens on resident's beds and the kitchen staff were responsible to clean the kitchen and dining areas. -The kitchen and dining areas were expected to be swept in between each meal and mopped after dinner daily. -The dietary staff were also responsible to remove all cardboard from the storage areas and store food properly removing mice droppings and contaminated food as needed daily. -It was important to keep the kitchen, pantry,	D 079		

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D 079	Continued From page 11 food, and resident's rooms clean daily from mice and their droppings to prevent a sanitation issue. Interview with the Administrator on 04/08/22 at 9:37am revealed: -She was not aware there was a foundation issue at the facility that needed to be corrected to treat the mice infestation. -She would have to contact corporate to see if they had been made aware and if anything was being done to correct it. -It was important to fix the root issue for resident safety and cleanliness because not one wanted to live in a home with mice or rats. Telephone interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -She had noticed that general cleanliness of the facility had improved over the last couple of months after the current Administrator started. -She would generally come to the facility early in the mornings when it was still dark outside as residents were waking up and was not aware there was an issue with mice at the facility but was aware of a previous infestation of bed bugs which she thought was under control. -She expected the facility to control pest infestations and ensure trash was dumped daily, floors were cleaned daily and all crumbs and food were cleaned from floors to prevent pests from being attracted. -Mice droppings could cause transmission of diseases through contamination to the residents. -It was especially concerning that the resident's food could be contamination and she expected the facility to employ an exterminator and follow the recommendations to get rid of pests. Telephone interview with the local health	D 079		

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D 079	Continued From page 12 department's sanitation inspector on 04/08/22 at 3:38pm revealed: -The facility was last inspected in January 2022 and the facility was expected to correct issues noted on that report regarding vermin and ensuring holes in walls were fixed to prevent mice from being able to get in. -She did not recall the facility having foundation issues, but she expected the facility to fix the issues at the exterminator's recommendations to help prevent further infestation as well. -If mice continued to infest the facility, it could pose a health risk to residents, staff and visitors. -She expected the facility to store food properly, throw contaminated food away, and ensure floors and surfaces were kept clean and free of crumbs that would continue to attract mice and other pests. -Contact with mouse feces could transmit viruses and bacteria especially if it was ingested through contaminated food such as Listeria (a foodborne illness that could cause headache, stiff neck, and confusion) and Salmonella (a foodborne illness that could cause nausea, vomiting, and diarrhea). -Residents who were elderly, on multiple medications, or immunocompromised were more at risk to issues that could result from mice dropping contamination and proper cleaning and food handling was imperative by the facility. Attempted telephone interview with the facility's corporate representative on 04/08/22 at 1:16pm was unsuccessful. 2. Review of the facility's census reports provided on 04/05/22 revealed there were 15 residents residing in the special care unit (SCU). Observation of the spa bathroom across from the beauty shop in the SCU on 04/05/22 at 3:10pm	D 079		

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D 079	Continued From page 13 revealed: -The door to the room was open and accessible to all 15 residents in the SCU. -There were no staff in the spa bathroom or in the hall in view of the bathroom. -There was a basket on a metal shelf in the bathroom with personal care products including: 2 disposable razors; a 7-ounce (oz.) can of shave gel; and 2.7-oz. container of antiperspirant. -There was a 12-oz bottle of shampoo and a 15-oz. bottle of conditioner on the metal shelf beside the basket. -There was a 34-oz. bottle of body wash on top of the half wall beside the shower. -Warnings for the shave gel included: keep out of reach of children; contents under pressure; do not puncture or incinerate; do not heat. -Warnings for the antiperspirant included: for external use only; do not use on broken skin; keep out of reach of children; if swallowed get medical help or contact a poison control center (PCC) right away. -Warnings for the shampoo included: for external use only; avoid contact with eyes; irritating to eyes. -Warnings for the conditioner included: avoid contact with eyes; if contact occurs, rinse thoroughly with water. -Warnings for the body wash and body gel included: for external use only: avoid contact with eyes; irritating to the eyes. Observation of the spa bathroom on the left hall in the SCU on 04/05/22 at 3:20pm revealed: -The door to the room was open and accessible to all 15 residents in the SCU. -There were no staff in the spa bathroom or in the hall in view of the bathroom. -There was a 24-oz. bottle of toilet bowl cleaner on top of a shower chair.	D 079		

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D 079	Continued From page 14 -There was a 32-oz. bottle of body lotion sitting on the side of the tub. -There were personal care products on top of the half wall of the shower including: two 2-oz containers of antiperspirant/deodorant; a 11-oz. bottle of medication antidandruff shampoo; a 23-oz. bottle of 2-in-1 antidandruff shampoo and conditioner; and a 40-oz. bottle of conditioner. -Warnings for the toilet bowl cleaner included: keep out of reach of children; hazardous to humans and domestic animals; causes substantial but temporary eye injury. -Warnings for the body lotion included: for external use only; if eye contact, rinse thoroughly with water. -Warnings for the antiperspirant/deodorant included: for external use only; do not use on broken skin; keep out of reach of children; if swallowed get medical help or contact a poison control center (PCC) right away. -Warnings for the antidandruff shampoo and 2-in-1 shampoo and conditioner included: for external use only; keep out of reach of children; if swallowed get medical help or contact PCC right away. -Warnings for the conditioner included: avoid contact with eyes; if contact occurs, rinse thoroughly with water. Interview with the Administrator on 04/05/22 at 3:20pm revealed: -The spa bathroom across from the beauty shop was used by the SCU residents including a couple of residents who used the spa bathroom independently without staff assistance. -There were no residents currently living on the left hall in the SCU due to recent renovations but the left hall including the spa bathroom on the left hall in the SCU was unlocked and accessible to the SCU residents.	D 079		

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D 079	Continued From page 15 -Personal care products for residents in the SCU should be kept in a secure place. -The personal care products were supposed to be kept in totes locked in the medication room in the SCU. -Any cleaning products should be locked in the housekeeping closet. -Razors should be locked up whether in the SCU or assisted living (AL) side of the facility. -She was not aware of any residents in the SCU who tried to eat or drink personal care products. -She thought there was a system for staff to check for personal care products daily in the SCU but she was not sure what the system was or who was responsible for it. Second observation of the spa bathroom across from the beauty shop in the SCU on 04/06/22 at 12:19pm revealed: -The door to the room was open and accessible to all 15 residents in the SCU. -There were no staff in the spa bathroom or in the hall in view of the bathroom. -There was still a basket on a metal shelf in the bathroom with personal care products including: 2 disposable razors; a 7-ounce (oz.) can of shave gel; and 2.7-oz. container of antiperspirant. -There was still a 12-oz bottle of shampoo and a 15-oz. bottle of conditioner on the metal shelf beside the basket. -There was still a 34-oz. bottle of body wash on top of the half wall beside the shower. Second observation of the spa bathroom on the left hall in the SCU on 04/06/22 at 12:29pm revealed: -The door to the room was open and accessible to all 15 residents in the SCU. -There were no staff in the spa bathroom or in the hall in view of the bathroom.	D 079		

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D 079	Continued From page 16 -There was still a 24-oz. bottle of toilet bowl cleaner on top of a shower chair. -There was still a 32-oz. bottle of body lotion sitting on the side of the tub. -There were still personal care products on top of the half wall of the shower including: two 2-oz containers of antiperspirant/deodorant; a 11-oz. bottle of medication antidandruff shampoo; a 23-oz. bottle of 2-in-1 antidandruff shampoo and conditioner; and a 40-oz. bottle of conditioner. Interview with a personal care aide (PCA) on 04/06/22 at 12:37pm revealed: -Cleaning products should be locked in the housekeeping closet. -No residents currently used the spa bathroom on the left hall in the SCU but it was open and accessible to the SCU residents. -There were some residents with wandering behaviors in the SCU but no residents had tried to ingest any personal care or cleaning products to her knowledge. -The razors were supposed to be locked in the medication room or the medication cart. -It was not unusual for personal care products like shampoo and body wash to be left in the spa bathrooms. -She had not been instructed by anyone to keep personal care products locked or secured in the SCU. Second interview with the Administrator on 04/06/22 at 1:02pm revealed: -She just reminded the medication aide (MA) in the SCU to tell the PCAs to remove the personal care products from the spa bathrooms in the SCU. -She did not check behind staff in the SCU yesterday, 04/05/22, to make sure the personal care products had been removed.	D 079		

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D 079	Continued From page 17 Interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -It was concerning that the SCU had hazards such as toiletries and items such as razors in common bathroom areas that residents with decreased cognition had access to. -Residents who did not have the mental cognition to know how to use hazards safety could hurt themselves by ingesting the toiletries, or cutting themselves and possible transmitting blood borne diseases such as HIV (human immunodeficiency virus) or Hepatitis B because the razors should be resident specific and supervised. 3. Observation of the living room on the right near the front entrance in the assisted living (AL) side of the facility on 04/06/22 at 8:39am revealed: -There was a straight back chair overturned on its back lying on the floor near the artificial fireplace. -There was a large white ceramic vase broken in multiple pieces with sharp jagged edges on the floor near the artificial fireplace. -There was a bunch of artificial flowers in green craft foam lying on its side on top of the artificial fireplace. -There was a broken clear glass candleholder with a candle lying on the floor behind the artificial fireplace. -There were two residents sitting on the sofas in the living room. Interview with the Administrator on 04/06/22 at 8:39am revealed: -Residents in the AL went into and sat in the living room every day. -The broken vase and candleholder and overturned chair had been that way in the living room since shortly after 6:45pm last night,	D 079		

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D 079	Continued From page 18 04/05/22. -She saw it when she walked by the living room and turned on the light after 6:45pm on 04/05/22. -One of the residents did it but she did not know which resident. -Staff on duty at the time on 04/05/22 did not know what happened or who did it. -She took a picture of the broken items last night and sent it to her corporate office. -She had not instructed housekeeping staff to clean the living room yet. -She was not concerned about the safety of the residents with the broken glass because residents did not usually go in the living room during the night. -If she thought it was "detrimental" to the residents, she would have removed the broken glass last night. -She would have the housekeeping staff to clean the living room. Interview with a resident on 04/06/22 at 8:57am revealed: -He went into the living room in the AL early that morning on 04/06/22 before 7:00am. -There was broken glass on the floor and a chair was overturned. -There was no one else in the room at the time. -He reported it to the medication aide (MA). Another observation of the living room on the right near the front entrance in the AL side of the facility on 04/06/22 at 9:23am revealed there was still a broken clear glass candleholder with a candle lying on the floor behind the artificial fireplace. A second interview the Administrator on 04/06/22 at 9:23am revealed she was not aware the housekeeper did not clean up the broken glass	D 079		

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D 079	Continued From page 19 candle holder and candle behind the artificial fireplace. 4. Observation of vacant resident room #2 on the left hall in the assisted living (AL) side of the facility on 04/05/22 at 9:55am revealed: -The room was open and accessible to residents. -There was a large oxygen canister unsecured on the floor in the corner near the window. -There was no gauge on the canister to determine how much oxygen was in the canister. Observation of resident room #11 on the right hall in the AL side of the facility on 04/05/22 at 10:17am revealed: -There was a small oxygen canister unsecured on the floor beside the resident's bedside table. -There was no gauge on the canister to determine how much oxygen was in the canister. -There was a second small oxygen canister in a carrying bag on the floor unsecured beside the resident's bedside table. Interview with the resident residing in resident room #11 on 04/05/22 at 10:17am revealed: -The small oxygen canister had been in her room for about 2 days. -She thought it was empty but she was not sure. -She used the portable oxygen tank when she went out of her room. -She did not recall having a crate to secure the oxygen tanks. Interview with the Administrator on 04/05/22 at 11:01am revealed: -Oxygen canisters were supposed to be stored securely in holders or crates in the residents' rooms to prevent tipping over. -She was not aware of any unsecured oxygen canisters in the facility.	D 079		

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D 079	Continued From page 20 -She would get the oxygen canisters secured. A second observation of vacant resident room #2 on the left hall in the AL side of the facility on 04/06/22 at 9:41am revealed: -The room was open and accessible to residents. -There was still a large oxygen canister unsecured on the floor in the corner near the window. A second observation of resident room #11 on the right hall in the AL side of the facility on 04/06/22 at 9:45am revealed: -There was a small oxygen canister secured in a crate on the floor beside the resident's bedside table. -There was still a second small oxygen canister in a carrying bag on the floor unsecured beside the resident's bedside table. A second interview with the Administrator on 04/06/22 at 9:48am revealed she was not aware the portable oxygen canister in resident room #11 and the large oxygen canister in vacant resident room #2 had not been crated. 5. Intermittent observations of the Special Care Unit (SCU) on 04/05/22 from 9:32am to 3:48pm revealed: -At 10:03am, resident room #51 had a soiled brief in the trash can and visible trash on the floor. -At 10:20am, resident room #55 had visible trash on the floor throughout the room, had a strong urine smell, had a window blind and a curtain laying against the wall; the bathroom adjoining room #55 and #57 had a large amount of visible dried feces on the toilet and floor, a soap dispenser was laying on the back of the commode, and there was trash on the floor. -At 11:00am, the spa room adjacent to room # 57	D 079		

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D 079	Continued From page 21 on the SCU had feces on the toilet. -At 3:19pm, resident room #54 had a soiled brief on the floor near the bed and the bathroom toilet seat had dried feces on it. -Recheck of bathroom in room #55 and #57 at 3:24pm had the same visible feces on toilet and trash on floor. -At 3:34pm, there was a soiled brief in a box on the counter in the SCU beauty shop. Observation of the spa bathroom beside resident room #8 on the left hall in the assisted living (AL) side on 04/05/22 at 9:37am revealed: -There was a build up of white soap scum on the floor and wall of the tiled shower. -There were dark yellow and brown stains around the edge of the front of the toilet seat. -There was toilet paper with dark brown stains in the toilet bowl. -There was bedside toilet with a white powdery substance on the bars and lid of the seat across from the sink. -There was dirt and debris in the sink and rust around the faucet fixtures. Observation of the spa bathroom beside resident room #7 on the left hall in the AL side on 04/05/22 at 9:42am revealed: -There was a build up of white soap scum on the floor and wall of the tiled shower. -There were multiple dried brown stains on the front of the toilet. -There was a rust colored ring around the inside bowl of the toilet. -There were dried brown stains running down the wall beside the toilet. -There was dirt and debris and crumple up paper towels on the floor. -There were two incontinence pads with brown stains in the bottom of the spa whirlpool tub.	D 079		

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D 079	Continued From page 22 -There was a film of dirt and debris in the bottom of the spa whirlpool tub. -There was an incontinence pad on the floor beside the whirlpool tub. -There was a trash can near the sink overflowing with trash. -There was dirt and debris in the sink and rust around the faucet fixtures. Interview with a resident residing near the spa bathrooms near room #7 and room #8 on 04/05/22 at 9:48am revealed: -The dried brown stains had been on the toilet for "a couple of months". -There was some dried brown stains on the floor in front of the toilet that he cleaned himself with the shower wand about a month ago. -He did not use the toilet in the spa bathrooms anymore because they were not clean. -He had a toilet in a bathroom in his room and used that toilet most of the time. -He did not know how often housekeeping staff cleaned the bathroom and he did not see housekeeping staff on a daily basis. Interview with a housekeeper on 04/05/22 at 9:58am revealed: -She had worked at the facility for about 2 months and she was responsible for cleaning the entire facility. -She had been working Monday - Friday from 7:00am - 3:00pm and some weekends from 7:00am - 3:00pm. -A second housekeeper was just hired on Friday, 04/01/22. -She was currently cleaning resident rooms on the right hall of the AL side of the facility. -She did not usually clean the spa bathrooms daily on the left hall of the AL side because there were only a few residents currently living on that	D 079		

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D 079	Continued From page 23 hall. -She checked the spa bathrooms on the left hall of the AL side daily to see if they needed to be cleaned. -She had not been to the left hall for the AL side of the facility yet that morning to clean. Observation of the spa bathroom beside resident room #11 on the right hall for the AL side on 04/05/22 at 10:30am revealed: -There were dried brown stains on the front of the toilet and the toilet seat. -There was a build up of white soap scum on the floor and wall of the tiled shower. Observation of the spa bathroom beside resident room #12 on the right hall for the AL side on 04/05/22 at 10:32am revealed: -There was yellow stained incontinence brief on top of the lid of the trash can near the sink. -There was a shower chair with soiled and stained clothing on the seat of the chair and on the floor underneath the chair. -There were bed sheets with yellow stains on the floor on the left side near the tub. -There was an empty plastic soap dispenser bag on the floor beside the stained bed linens. -The bath tub had dirt, debris, and yellow stains. -There was a shower chair with yellow stains on the seat beside the sink. -There were dried brown and yellow stains on the outside and inside of the toilet. -There was a build up of white soap scum on the floor and wall of the tiled shower. -There were six broken wall tiles on the lower left wall of the shower. Interview with a resident residing on the hall with the spa bathrooms near room #11 and room #12 on 04/05/22 at 10:50am revealed:	D 079		

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D 079	Continued From page 24 -The housekeeper used to clean the bathrooms every day. -He did not know what happened but now it seemed the housekeeper only cleaned 2 to 3 times a week. A second observation of the spa bathroom beside resident room #8 on the left hall in the AL side on 04/05/22 at 4:19pm revealed: -The bathroom had not been cleaned. -There was still a build up of white soap scum on the floor and wall of the tiled shower. -There were still dark yellow and brown stains around the edge of the front of the toilet seat. -There was still toilet paper with dark brown stains in the toilet bowl. -There was still a bedside toilet with a white powdery substance on the bars and lid of the seat across from the sink. -There was still dirt and debris in the sink and rust around the faucet fixtures. A second observation of the spa bathroom beside resident room #7 on the left hall in the AL side on 04/05/22 at 4:25pm revealed: -The bathroom had not been cleaned. -There was still a build up of white soap scum on the floor and wall of the tiled shower. -There were still multiple dried brown stains on the front of the toilet. -There was still a rust colored ring around the inside bowl of the toilet. -There were still dried brown stains running down the wall beside the toilet. -There was still dirt and debris and crumpled up paper towels on the floor. -There were still two incontinence pads with brown stains in the bottom of the spa whirlpool tub. -There was still a film of dirt and debris in the	D 079		

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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 079	Continued From page 25 bottom of the spa whirlpool tub. -There was still an incontinence pad on the floor beside the whirlpool tub. -There was a bedside toilet near the whirlpool tub with bed coverings draped over it and lying on the floor around it. -There was still a trash can near the sink overflowing with trash. -There was still dirt and debris in the sink and rust around the faucet fixtures. A second observation of the spa bathroom beside resident room #11 on the right hall for the AL side on 04/05/22 at 4:29pm revealed: -There were still dried brown stains on the front of the toilet and the toilet seat. -There was still a build up of white soap scum on the floor and wall of the tiled shower. A second observation of the spa bathroom beside resident room #12 on the right hall for the AL side on 04/05/22 at 4:33pm revealed: -There was still a shower chair with soiled and stained clothing on the seat of the chair and on the floor underneath the chair. -There were still bed sheets with yellow stains on the floor on the left side near the tub. -There was still an empty plastic soap dispenser bag on the floor beside the stained bed linens. -The bath tub still had dirt, debris, and yellow stains. -The shower chair with yellow stains on the seat was moved in front of the tub. -There were still dried brown and yellow stains on the outside and inside of the toilet. -There was still a build up of white soap scum on the floor and wall of the tiled shower. -There were six broken wall tiles on the lower left wall of the shower.	D 079		

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D 079	Continued From page 26 Interview with the Administrator on 04/05/22 at 6:28pm revealed: -The facility had two housekeepers but one of them called out today, 04/05/22. -The housekeepers were supposed to clean the bathrooms daily including the sinks, showers, tubs, toilets, floors, and empty the trash. -She did a daily walk through the facility but she had not noticed the spa bathrooms in the AL needed cleaning. A second interview with the Administrator on 04/07/22 at 4:10pm revealed: -She thought the housekeeper worked on cleaning the spa bathrooms on the AL side of the facility on Tuesday (04/05/22) and Wednesday (04/06/22). -She had not checked behind the housekeeping staff to see if the spa bathrooms had been cleaned. -The residents used the spa bathrooms and it was "not acceptable" for the bathrooms not to be clean. A third interview with the Administrator on 04/07/22 at 5:35pm revealed: -The housekeeping staff were responsible for keeping the entire facility clean. -The spa bathrooms should be cleaned daily and some needed to be cleaned more often because they had some "messy" residents. -Cleaning bathrooms should include the toilets, showers, tub, sinks, floors, and emptying the trash. A third observation of the spa bathroom beside resident room #8 on the left hall in the AL side on 04/08/22 at 1:23pm revealed: -There was still a build up of white soap scum on the floor and wall of the tiled shower.	D 079		

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D 079	Continued From page 27 -There were still dark yellow and brown stains around the edge of the front of the toilet seat. -There was still toilet paper with dark brown stains in the toilet bowl. -There was still a bedside toilet with a white powdery substance on the bars and lid of the seat across from the sink. -There was still dirt and debris in the sink and rust around the faucet fixtures. A third observation of the spa bathroom beside resident room #7 on the left hall in the AL side on 04/08/22 at 1:26pm revealed: -There was still a build up of white soap scum on the floor and wall of the tiled shower. -There were still multiple dried brown stains on the front of the toilet. -There was still a rust colored ring around the inside bowl of the toilet. -There were still dried brown stains running down the wall beside the toilet. -There were still two incontinence pads with brown stains in the bottom of the spa whirlpool tub. -There was still a film of dirt and debris in the bottom of the spa whirlpool tub. -There was still an incontinence pad on the floor beside the whirlpool tub. -There was a bedside toilet near the whirlpool tub with bed coverings draped over it and lying on the floor around it. -There was still dirt and debris in the sink and rust around the faucet fixtures. A third observation of the spa bathroom beside resident room #11 on the right hall for the AL side on 04/08/22 at 1:36pm revealed the bathroom was occupied by a resident. A third observation of the spa bathroom beside	D 079		

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D 079	Continued From page 28 resident room #12 on the right hall for the AL side on 04/08/22 at 1:31pm revealed: -There was an incontinence brief with yellow stains on top of the trash can. -There was still a shower chair with soiled and stained clothing on the seat of the chair and on the floor underneath the chair. -There were still bed sheets with yellow stains on the floor on the left side near the tub. -There was still an empty plastic soap dispenser bag on the floor beside the stained bed linens. -The bath tub still had dirt, debris, and yellow stains. -The shower chair with yellow stains on the seat was moved in front of the tub. -There were still dried brown and yellow stains on the outside and inside of the toilet. -There was still a build up of white soap scum on the floor and wall of the tiled shower. -There were six broken wall tiles on the lower left wall of the shower. Interview with two personal care aides (PCAs) working in the AL side of the facility on 04/08/22 at 1:31pm revealed; -They were unsure how long the spa bathrooms in the AL side had not been clean. -There were no housekeepers working today, (04/08/22), so no one was cleaning the facility today. A fourth interview with the Administrator on 04/08/22 at 2:13pm revealed: -It appeared no cleaning had been done in the spa bathrooms in the AL side of the facility. -One housekeeper was off today, 04/08/22, because she was supposed to work this weekend. -The other housekeeper "called out" today. -There was no one assigned to do housekeeping	D 079		

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D 079	Continued From page 29 duties in the facility today, 04/08/22. The facility failed to ensure the facility was clean and protected from hazards including mice and mice droppings in resident rooms, common areas, and throughout the kitchen and pantry that could cause injury from bites, viruses, and illness to suseptible residents at the facility. The facility failed to ensure personal care products in 2 of 2 special care unit (SCU) spa bathrooms were kept locked and secured resulting in hazardous substances, razors, and chemicals being unattended and accessible to the 15 residents residing in the SCU, including residents with wandering behaviors. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/06/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 23, 2022.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure toilets in 2 of	D 105		

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D 105	Continued From page 30 4 common spa bathrooms were maintained in operating condition in the assisted living side of the facility. The findings are: Review of the facility's current sanitation report dated 01/29/22 revealed: -The facility's sanitation score was 95. -Many of the toilets and other fixtures of the communal bathrooms and showers were in need of cleaning and not in good repair. Observation of the spa bathroom beside resident room #8 on the left hall in the assisted living (AL) side on 04/05/22 at 9:37am revealed: -There was toilet paper with dark brown stains in the toilet bowl. -There was no water in the toilet bowl. Observation of the spa bathroom beside resident room #12 on the right hall for the AL side on 04/05/22 at 10:32am revealed: -The toilet had a large amount of toilet paper stuck in the bottom of the toilet bowl, clogging the toilet. -There was yellow colored water in the toilet bowl. -There was a urine odor in the bathroom. Interview with a resident residing on the hall with the spa bathroom near room #12 on 04/05/22 at 10:50am revealed: -He did not know how long the toilet had been clogged. -He had a toilet in the bathroom in his room that he could use. A second observation of the spa bathroom beside resident room #8 on the left hall in the AL side on 04/05/22 at 4:21pm revealed:	D 105	Maintenance Supervisor & Administrator conducted walk thru of the community to get complete list of items needing to be repaired and will arrange for them to be fixed. Staff retrained on reporting of any items needing maintenance completed at monthly staff meeting. Administrator/Designee will walk through building weekly to ensure all items needing to be repaired are reported as outlined in facility procedures. Anything needing attention will be added to the maintenance log book as outlined in facility procedures. Maintenance/Designee will monitor report any open maintenance items needing attention outside of his scope to the corporate Maintenance Supervisor. Administrator will followup with Maintenance Supervisor on outstanding issues weekly until resolved.	05/23/2022

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D 105	Continued From page 31 -There was still toilet paper with dark brown stains in the toilet bowl. -There was still no water in the toilet bowl. A second observation of the spa bathroom beside resident room #12 on the right hall for the AL side on 04/05/22 at 4:32pm revealed: -The toilet still had a large amount of toilet paper stuck in the bottom of the toilet bowl, clogging the toilet. -There was still yellow colored water in the toilet bowl. -There was still a urine odor in the bathroom. Interviews with the facility's Maintenance Person on 04/05/22 at 3:43pm and 4:39pm revealed: -He was part-time and had not been to the facility in a couple of weeks. -He usually came to the facility one day every other week. -He was not aware of any issues with the toilets in the spa bathrooms. -No issues with the toilets had been reported to him. Interview with the Administrator on 04/05/22 at 6:28pm revealed: -The facility had two housekeepers but one of them called out today, 04/05/22. -The housekeepers were supposed to check and clean the bathrooms daily including the toilets. -She did a daily walk through the facility but she had not noticed any problems with the toilets in the spa bathrooms. A third observation of the spa bathroom beside resident room #8 on the left hall in the AL side on 04/07/22 at 4:03pm revealed: -There was still toilet paper with dark brown stains in the toilet bowl.	D 105		

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D 105	Continued From page 32 -There was still no water in the toilet bowl. A third observation of the spa bathroom beside resident room #12 on the right hall for the side on 04/07/22 at 4:00pm revealed: -The toilet bowl was full of a dark brown liquid. -The brown liquid was about 2 inches from the top of the toilet bowl just underneath the toilet seat. A second interview with the Administrator on 04/07/22 at 4:10pm revealed: -There was a problem with the toilets in the spa bathrooms getting clogged up because the residents put items in the toilets that should not be put in the toilets. -She had not asked the facility's Maintenance Person to check the toilets because he was not at the facility on a daily basis. -She usually had the housekeepers to check and unclog toilets if needed. -She thought the housekeeper worked on checking and cleaning the spa bathrooms on the AL side of the facility on Tuesday (04/05/22) and Wednesday (04/06/22). -She had not checked behind the housekeeping staff to see if the toilets had been checked and cleaned. -The residents used the spa bathrooms and it was "not acceptable" for the toilets to not be in a clean and working condition. A fourth observation of the spa bathroom beside resident room #8 on the left hall in the AL side on 04/08/22 at 1:23pm revealed: -There was still toilet paper with dark brown stains in the toilet bowl. -There was still no water in the toilet bowl. A fourth observation of the spa bathroom beside	D 105		

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D 105	Continued From page 33 resident room #12 on the right hall for the side on 04/08/22 at 1:32pm revealed: -The toilet bowl was still full of a dark brown liquid. -The brown liquid was still about 2 inches from the top of the toilet bowl just underneath the toilet seat. Interview with two personal care aides (PCAs) working in the AL side of the facility on 04/08/22 at 1:31pm revealed: -They saw the toilets were clogged up in the spa bathrooms in the AL side yesterday, 04/07/22, and reported it to the Administrator. -There were no housekeepers working today, 04/08/22, so no one was checking or cleaning the bathrooms today. A third interview with the Administrator on 04/08/22 at 2:18pm revealed: -A PCA had reported the toilet was "backed up" in the spa bathroom in the AL side of the facility. -She was waiting for the Maintenance Person to come back to the facility to check it. -The toilets needed to be unclogged and in working condition because the residents used the spa bathrooms in the AL side of the facility.	D 105		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and	D 113		

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D 113	Continued From page 34 existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 14 fixtures sampled in the assisted living (AL) side of the facility with hot water temperatures of 118 degrees F and 3 of 4 fixtures sampled in the special care unit (SCU) that were readily accessible and used by residents in the SCU with hot water temperatures ranging from 118 degrees F to 128 degrees F. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 122 beds including 72 beds for assisted living (AL) and 50 beds for a special care unit (SCU). Review of the facility's census reports provided on 04/05/22 revealed: -The facility's in-house census was 45 residents. -There were 30 residents residing in the AL side of the facility. -There were 15 residents residing in the SCU. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed: -A water temperature of 118.4 degrees F could result in a first degree in 15 minutes and a second degree burn in 20 minutes.	D 113	Administrator called repair man to adjust water temperatures immediately. Caution signs were posted at each affected area. In SCU, staff supervised residents at intervals based on each resident's needs (such as every 2 hours, prn) to help with adjusting water to a safe temperature. Care coordinator/ SIC will monitor staff to ensure they are assisting residents as needed. Administrator trained care coordinator/SIC and staff on expectations until hot water temperatures can be adjusted. All staff will immediately report any signs of elevated water temperatures to Administrator or member of management if administrator is not present. Maintenance /Designee will monitor water temperature weekly. If temperatures are not between 100 degrees F - 116 degrees F, they will be adjusted to meet rule and regulations. Maintenance will be notified promptly by member of management of any signs of elevated water temperatures. Administrator will audit temperature logs monthly to ensure water temperatures are being checked.	5/23/2022

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D 113	Continued From page 35 -A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. Observation of the spa bathroom beside resident room #8 in the AL side on 04/05/22 at 9:39am revealed: -The hot water temperature at the bathroom sink and the shower was 118 degrees Fahrenheit (F). -There was no caution sign posted for the hot water temperature. Observation of the spa bathroom beside resident room #7 in the AL side on 04/05/22 at 9:45am revealed: -The hot water temperature at the bathroom sink and the shower was 118 degrees F. -There were no caution signs posted for the hot water temperatures. Interview with a resident residing on the hall with the spa bathrooms near resident rooms #7 and #8 on 04/05/22 at 9:48am revealed the hot water temperature in the spa bathrooms were good for him because he could adjust the temperatures. Observation of the spa bathroom beside resident room #12 in the AL side on 04/05/22 at 10:34am revealed: -The hot water temperature at the bathroom sink was 118 degrees F. -There was a caution - hot water note posted in small writing on the bottom right side of the mirror. Observation of the adjoining bathroom for resident rooms #55 and #57 in the SCU on 04/05/22 at 10:20 am revealed: -There were three ambulatory SCU residents residing in the two rooms.	D 113		

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D 113	Continued From page 36 -The hot water temperature at the bathroom sink was 120 degrees F. -There was no caution sign posted for the hot water temperature. Interview with the Administrator on 04/05/22 at 1:25pm revealed: -She was not aware of any water temperatures in the facility being greater than 116 degrees F. -She asked if the required water temperature range was 116 degrees F. A second observation of the adjoining bathroom for resident rooms #55 and #57 in the SCU on 04/05/22 at 3:27 pm revealed: -There were three ambulatory SCU residents residing in the two rooms. -Recheck of hot water temperature at the bathroom sink was 120 degrees F. -There was no caution sign posted for the hot water temperature. Based on observations, interviews, and record reviews, it was determined the two residents residing in room #55 were not interviewable. Observation of the spa bathroom across from the beauty shop in the SCU on 04/05/22 at 3:10pm revealed: -The hot water temperature at the bathroom sink was 126 degrees F with visible steam. -There was no caution sign posted for the hot water temperature. A second interview with the Administrator on 04/05/22 at 3:20pm revealed: -She was not aware of the hot water temperatures in the spa bathroom in the SCU. -The spa bathroom in the SCU was accessible to and used by the residents in the SCU including a	D 113		

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D 113	Continued From page 37 couple of SCU residents that used the bathroom independently and did not require staff assistance. -A plumber came to the facility the week before last because the facility was having issues with a mixing valve on the hot water heater and the water was too cold. -There were issues with not having hot water in the SCU and staff had to turn on the hot water at the sink and wait for the water at the shower to get warm. -One shower could be taken in the spa bathroom in the SCU and then the water would be cold again. -It had been that way since renovations were made to the floors in the SCU in January 2022 but the residents were living on the left hall in the SCU at that time due to the renovations. -The residents were moved to the hall on the right in the SCU sometime in February 2022 so renovations could be made to the other hall in the SCU. -When the plumber came to the facility the week before last, he replaced a valve on the hot water heater for the SCU because the facility had no way to adjust the water temperatures because the thermostat dials on the hot water heaters were "stripped" and could not be turned. -The facility's Maintenance Person checked the water temperatures once a month. -The facility's Maintenance Person was part-time and only came to the facility on Saturday or Sunday or as needed. -The Maintenance Person did not check the water temperatures this past month because they knew there were water temperature issues. -She was "guessing" the last time the hot water temperatures were checked was in February 2022 when she first started working at the facility. -She did not know where the water temperature	D 113		

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

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D 113	Continued From page 38 logs were located but she would find them. -No water temperatures had been checked since the part was replaced the week before last. -There was a second part for the hot water heater for the AL side of the facility that needed to be replaced but it was on backorder. -She did not know when the part for the hot water heater in the AL was expected to be received. -She was concerned about the hot water temperatures because she would not want anyone to get burned by the hot water. -A plumber was contacted today, 04/05/22, and would be coming to the facility today to check the hot water heaters. Interview with the facility's Maintenance Person on 04/05/22 at 3:43pm revealed: -He was part-time and had not been to the facility in a couple of weeks. -He usually came to the facility one day every other week. -There were 2 hot water heaters for the front hall in the AL side of the facility and 1 big hot water heater for the back hall, or the SCU. -He was not aware of any current problems with the hot water temperatures until today, 04/05/22. -There had been some construction work with renovations recently at the facility. -A few months ago, there was a circuit pump that was not working in the SCU but a plumber came and it had been disconnected by a construction worker. -He had not checked water temperatures "in a while" or "more than a month" but he usually documented and gave the water temperature logs to the Administrator. -He did not keep a copy of the water temperature logs. -He thought the water temperature was supposed to be between 110 degrees F - 116 degrees F.	D 113		

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D 113	Continued From page 39 -He did not remember if the water temperature was too high or too low when he last checked them prior to today, 04/05/22. -He checked the hot water temperatures today, 04/05/22, and got 120 degrees F on both the AL side and the SCU. -The thermostats on the hot water heaters for the SCU and the AL side were all set on 120 degrees F when he checked them today. -The dials on the thermostats on the hot water heaters were difficult to turn even with pliers so he had been unable to adjust the settings. -He called a plumber about 1 to 2 hours ago and the plumber was supposed to come to the facility today, 04/05/22. Review of an invoice from the facility's contracted plumbing company dated 03/22/22 revealed: -The invoice tasks included: replaced burnt up recirculating pump and connected the existing water lines; replaced a missing valve located on top of the water heater; and adjustment handle had been stripped out and broken. -Tankless heaters were flashing code "LC7" and it was recommended each unit be flushed as step 1 and that should "clean out" the code. -If not, the plumbing company would get technical support for help to determine the cause of further problem which could be at an additional charge for parts and labor. -A mixing valve replacement had been ordered and was expected to arrive on 04/06/22. A second observation of the spa bathroom across from the beauty shop in the SCU on 04/06/22 at 12:18pm revealed: -The hot water temperature at the bathroom sink was 128 degrees F with visible steam. -The hot water temperature at the shower was 118 degrees F.	D 113		

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D 113	Continued From page 40 -There was a caution sign posted for the hot water temperature on the wall above the sink. A third interview with the Administrator on 04/06/22 at 1:02pm revealed: -The plumber did not come to the facility yesterday, 04/05/22. -She just received a text message from her corporate office that the plumber would be at the facility tomorrow, 04/07/22, to install a new part on the hot water heater. -The facility's Maintenance Person was not at the facility today, 04/06/22. -The facility's Maintenance Person used his own thermometer to check the hot water temperatures. -She would look for a thermometer so the hot water temperatures could be checked. -She did not find any water temperature logs and the Maintenance Person did not have any. A third observation of the spa bathroom across from the beauty shop in the SCU on 04/07/22 at 2:20pm revealed: -The hot water temperature at the bathroom sink was 124 degrees F with visible steam. -There was a caution sign posted for the hot water temperature on the wall above the sink. Interview with the facility's contracted plumber on 04/07/22 at 4:36pm revealed: -The water temperature valve on the SCU was broken because it appeared someone used a tool to adjust the water temperature and it broke the cap used to adjust the temperature of the water. -He was made aware of the broken valve 2 weeks ago. -He ordered the part to replace the valve 2 weeks ago, but the part did not come in until today. -He had just replaced the broken valve and the	D 113		

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D 113	Continued From page 41 water temperature could now be adjusted by the facility. -The current temperature reading on the valve was 115 degrees F. -The hot water heater needed time to cool down in order to properly adjust the temperature. -The water temperature would need to be regulated by the facility later in the day after the hot water heater had cooled down. -He would speak with the Administrator before leaving to make her aware of how to regulate the water temperature later in the day. -He would leave the printed instructions on how to properly turn the cap to adjust the water temperature with the Administrator. A fourth observation of the spa bathroom across from the beauty shop in the SCU on 04/08/22 at 12:13pm revealed: -The hot water temperature at the bathroom sink was 120 degrees F. -There was a caution sign posted for the hot water temperature on the wall above the sink. A fourth interview with the Administrator on 04/08/22 at 12:40pm revealed: -The hot water temperatures had not been checked at the facility since the plumber made repairs yesterday, 04/07/22. -She had not checked the hot water temperatures since the repairs were made because the plumber checked on 04/07/22 and the water temperatures were "okay". -The plumber left instructions for her on how to regulate the water temperature but she had not done that yet. Observation of thermometers being calibrated on 04/08/22 at 2:01pm revealed: -The Administrator's thermometer and the	D 113		

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D 113	Continued From page 42 surveyor's thermometer were placed in a cup of ice water. -The Administrator's thermometer temperature was 32.2 degrees F. -The surveyor's thermometer temperature was 32 degrees F. A fifth interview with the Administrator on 04/08/22 at 2:09pm revealed: -She asked the plumber yesterday, 04/07/22, to come back to the facility because the water temperatures were still not in the required range. -She had to get approval through the corporate office for the plumber to come back to the facility but she had not done that yet. A second observation of the spa bathroom beside resident room #8 in the AL side with the Administrator on 04/08/22 at 2:12pm revealed: -The hot water temperature at the bathroom sink was 118 degrees F with both thermometers. -There was a caution sign posted for the hot water temperature on the wall. A second observation of the spa bathroom beside resident room #7 in the AL side with the Administrator on 04/08/22 at 2:12pm revealed: -The hot water temperatures at the bathroom sink and shower were 118 degrees F with both thermometers. -There was a caution sign posted for the hot water temperature. Observation of the spa bathroom beside resident room #11 in the AL side with the Administrator on 04/08/22 at 2:16pm revealed: -The hot water temperature at the bathroom sink was 118 degrees F with the surveyor's thermometer and 117 degrees F with the Administrator's thermometer.	D 113		

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D 113	Continued From page 43 -There was a caution sign posted for the hot water temperature. A second observation of spa bathroom beside resident room #12 in the AL side with the Administrator on 04/08/22 at 2:18pm revealed: -The hot water temperature at the bathroom sink was 118 degrees F with the surveyor's thermometer and 117 degrees F with the Administrator's thermometer. -There was a caution - hot water note posted in small writing on the bottom right side of the mirror. A sixth interview with the Administrator on 04/08/22 at 2:18pm revealed: -She was still waiting for the part for the hot water heater for the AL side to come in. -She was not sure when the part would arrive. A fifth observation of the spa bathroom across from the beauty shop in the SCU with the Administrator on 04/08/22 at 2:23pm revealed: -The hot water temperature at the bathroom sink was 120 degrees F with both thermometers. -The hot water temperature at the shower was 78 degrees F with the surveyor's thermometer and 77 degrees F with the Administrator's thermometer. -There was a caution sign posted for the hot water temperature on the wall above the sink. A seventh interview with the Administrator on 04/08/22 at 2:26pm revealed: -The shower in the spa bathroom in the SCU was used to bathe the residents in the SCU. -She thought the hot water at the sink had to be turned on and running in order for the water in the shower to get warmer.	D 113		

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D 113	Continued From page 44 A sixth observation of the spa bathroom across from the beauty shop in the SCU with the Administrator on 04/08/22 at 2:28pm revealed: -The hot water at the sink was turned on and running. -The hot water temperature at the shower was 86 degrees F with the surveyor's thermometer and 84 degrees F with the Administrator's thermometer but did not rise any higher with the water continuing to be turned on and running. Telephone interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -It was concerning that the facility had hot water temperatures above 116 degrees F, especially in the SCU, because those residents did not have the cognitive capacity to know the water was too hot to use. -If residents were exposed to water that was too hot for too long, the residents could get burned. -She expected the facility to routinely test water temperatures and adjust them accordingly to prevent injury to the residents. The facility failed to ensure hot water temperatures for 9 of 18 fixtures sampled in the facility were maintained between 100 - 116 degrees F. This included 3 of 4 fixtures that were accessible to and used by the special care unit (SCU) residents with diagnoses of dementia or other cognitive disorders, including a sink in the SCU spa bathroom with a hot water temperature of 128 degrees F with visible steam. A water temperature of 118.4 degrees F could result in a first degree in 15 minutes and a second degree burn in 20 minutes. A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. This failure of the facility was	D 113		

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D 113	Continued From page 45 detrimental to the safety, health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/07/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 23, 2022.	D 113		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care to 2 of 7 sampled residents (#2, #3) related to oral hygiene care (#2) and bathing, dressing, transferring, and incontinence care (#3). The findings are: 1. Review of Resident #2's closed record FL-2 dated 02/08/21 revealed: -The resident's level of care was special care unit (SCU).	D 269		

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D 269	Continued From page 46 -Diagnoses included dementia, hypothyroidism, hypertension, Vitamin B12 deficiency, and osteoarthritis of the knee. -The resident was constantly disoriented and required total care assistance with activities of daily living. -The resident was non-ambulatory and incontinent of bladder and bowel. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 02/25/14. -The resident required staff assistance with oral care, dressing, bathing, nail care, getting in and out of bed, toileting, hair/grooming, skin care, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. Review of Resident #2's current assessment and care plan dated 02/07/21 revealed: -The resident required the use of a wheelchair and had limited range of motion in her upper extremities. -The resident was incontinent of bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident was documented as having no speech. -The resident required total assistance by staff for eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident #2's primary care provider (PCP) order dated 02/16/22 revealed a verbal order for evaluation and treatment for hospice care due to the resident experiencing a decline.	D 269	Administrator/RN retrained Personal Care Aides to provide personal care including toileting, bathing, face & oral care, 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, face & oral care, etc. according to the needs of residents and frequency, identified on their care plan. Documentation of personal care provided will be made on PCS documentation. Supervisor In Charge/Care Coordinator will monitor daily to ensure personal care tasks are being completed on including toileting, bathing, face & oral care, etc. according to the needs of residents and frequency, identified on their care plan. SIC/Administrator will audit PCS documentation daily to assure that personal care tasks are being completed 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. Administrator will conduct walk throughs of the facility x 5 days per week to assure that residents care needs are being met.	5/08/2022

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D 269	Continued From page 47 Telephone interview with Resident #2's family member on 04/06/22 at 7:18pm revealed: -Resident #2 was on hospice previously and then started back on 02/16/22. -She was concerned about the resident's mouth and teeth. -On 02/19/22, the resident was moaning and had "dried blood" on her gums and teeth. -When she asked staff about the condition of the resident's mouth, staff reported the resident "fights them" when trying to provide care to the resident. -She removed the dried blood from the resident's teeth with a mouth swab. Observation of a video of Resident #2 on 02/19/22 at 10:40am revealed: -The resident was extremely thin and frail. -The resident was lying on her back in bed with her mouth open. -The resident's upper and lower lips were dry and cracked with pieces of skin peeling from her lips with some areas having sores or scabs. -The resident's upper teeth were visibly soiled and stained with dark brown stains from the gums over halfway down the resident's teeth. -There was one tooth in the front middle that was broken off to the gum line with brown stains around the remaining piece of tooth. -There was a build up of a brown substance between her upper teeth. -The resident's lower teeth could not be seen in the video. -The resident moaned constantly during the video with the moaning becoming a distressful louder moan at times. Review of Resident #2's personal care records and weekly tasks log in the closed record	D 269		

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D 269	Continued From page 48 revealed: -There were no personal care records or weekly task logs for 02/02/22 - 02/22/22. -The most current weekly personal care task log was dated 01/26/22 - 02/01/22 for first, second, and third shifts. -There was a section for documenting staff assistance with mouth/oral care. -Providing mouth/oral care was not documented as completed on one occasion for first shift on 02/01/22 with no reason documented. -There were no personal care records or weekly task logs for 02/02/22 - 02/22/22 so there was no documentation to indicate if mouth/oral care was provided to the resident. Review of Resident #2's facility staff care notes dated 03/23/21 - 02/18/22 revealed no documentation of the resident refusing personal care including mouth care. Interview with a medication aide (MA) on 04/06/22 at 2:17pm revealed: -Resident #2 required total assistance with all personal care tasks. -Resident #2 would bite down on the mouth swabs used to clean her mouth. -She did not know if that had been reported to anyone or if the personal care aides (PCAs) documented it on the personal care logs. Telephone interview with a former MA on 04/07/22 at 10:41am revealed: -Resident #2 required assistance from staff for all personal care tasks. -The resident's lips were peeling and dry. -The resident's teeth were "brown looking" and her breath smelled "horrible". -The PCAs had to swab her mouth. -The resident would bite down on a tooth brush	D 269		

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D 269	Continued From page 49 when the PCAs tried to brush her teeth. -She did not recall seeing blood in the resident's mouth. -The PCAs were supposed to document on the personal care logs. Interview with a PCA on 04/07/22 at 2:30pm revealed: -Resident #2 required total assistance with personal care for all tasks, including mouth care. -The resident was non-verbal but she could sometimes shake her head to indicate yes or no. -When the resident started on hospice, she was not as alert and less interactive. -Resident #2's teeth were yellowish brown and she had very bad breath. -The resident would dig in her stool so her nails had to be cleaned "so many times". -They used mouth swabs to clean the resident's mouth but if the resident was irritated, she would swat with her hand and turn her head. -The PCAs documented on the personal care logs when a task was completed and they should also document if a resident refused. Interview with a third MA on 04/07/22 at 5:17pm revealed: -Resident #2 required total care for all personal care tasks. -The resident's teeth were "bad"; they were brown. -The facility staff used mouth swabs usually only on first shift once a day to clean the resident's mouth because the resident would bite down on the swab. -The facility staff could not brush the resident's teeth because she would bite down on the tooth brush. Interview with a fourth MA on 04/07/22 at 5:17pm	D 269		

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D 269	Continued From page 50 revealed: -Resident #2 needed assistance with everything. -The resident always had an odor to her mouth and her teeth were stained even in the past. -The resident was combative with brushing her teeth. Interview with the Administrator on 04/07/22 at 5:35pm revealed: -She knew nothing about the condition of Resident #2's mouth. -The PCAs were responsible for providing mouth care to Resident #2 because she was totally dependent for all personal care tasks. -If a resident was refusing personal care, the PCAs should let her or their supervisor know about the refusals. -The PCAs were supposed to document personal care assistance on the resident's personal care logs. A second interview with the Administrator on 04/08/22 at 2:35pm revealed: -She could not find any other personal care logs for Resident #2. -The resident's personal care logs should have been in the closed record. Telephone interview with Resident #2's PCP on 04/07/22 at 1:00pm revealed: -Resident #2 had chronic issues with her teeth with a lot of plaque build up that could be seen on the teeth and bad breath. -She did not know if staff had issues with the resident refusing mouth care. -Mouth care was important to prevent plaque build up and issues with the gums. Telephone interview with Resident #2's hospice nurse on 04/08/22 at 9:05am revealed:	D 269		

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D 269	Continued From page 51 -She admitted Resident #2 to hospice services on Friday night, 02/18/22. -To her knowledge, the only time the resident received mouth care was when the hospice aide provided mouth care to the resident. -The family reported that facility staff was not providing personal care to the resident. -The resident's teeth were "awful", never looked like they were brushed and were very stained and brown. -She did not think it was food in the resident's teeth because the resident had not been eating since on hospice to her knowledge. -The facility staff did not report the resident refusing care. Review of Resident #2's hospice note report dated 02/22/22 revealed a hospice nurse pronounced the resident deceased at 1:26pm on 02/22/22. 2. Review of Resident #3's current FL-2 dated 03/28/22 revealed: -Diagnoses included heart failure, hypertensive heart disease, chronic obstructive pulmonary disease (COPD), anxiety, spondylosis without myelopathy or radiolopathy, and a history of pulmonary embolism. -There was no other assessment information documented. Review of a physician's note dated 11/11/19 revealed the resident had a history of a cardiovascular accident (CVA) with lasting hemiplegia and required the use of a walker to ambulate safely. Review of Resident #'3 history and profile form dated 01/17/20 revealed: -The resident preferred to have a shower using a	D 269		

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D 269	Continued From page 52 shower chair and required assistance getting set up and washing his backside. -The resident preferred to get dressed after breakfast and to wear pajamas or sweat suits requiring assistance getting his limbs into the clothing. -The resident required incontinence briefs for toileting. Review of Resident #3's current care plan dated 03/28/22 revealed: -The resident had limited strength and was ambulatory with a wheelchair or walker. -The resident was incontinent of bladder and bowel. -The resident was sometimes disoriented, forgetful, and required reminders. -The resident required his meat to be cut up and limited assistance with eating, ambulating, and transferring and extensive assistance with toileting, bathing, dressing, and grooming. Review of Resident #3's primary care provider (PCP) note dated 02/24/22 revealed: -The facility was to use the hoyer lift every day to assist in transferring the resident safely. -The resident was unable to assist in pivoting or standing for transfer and required 2-3 people to assist with transferring. Review of Resident #3's PCP note dated 03/24/22 revealed: -The resident's body mass index (BMI) was above normal with the facility controlling meals and portions but the resident also consumed outside food and drink. -She was unable to counsel the resident on his food and drink intake due to his inability to understand and retain information and would continue to monitor him.	D 269		

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D 269	Continued From page 53 -There was an order for a trapeze bar to be used daily to assist the resident in position changes and relieving pressure areas. Review of Resident #3's progress note dated 03/28/22 revealed: -While resident was being provided incontinence care there was a small amount of blood noted on the wipe when cleaning the resident. -There were two small areas of skin breakdown on the resident's left and right buttocks that appeared healed and unopened and irritation noted on the resident's bottom. Review of Resident #3's February 2022 personal care record revealed: -There were entries for personal hygiene to include shower/bath, shampoo, nail care, grooming or shaving, mobility, dressing/undressing, and toileting. -The personal hygiene, mobility, dressing/undressing, and toileting were documented as completed daily from 02/01/22-02/28/22 on first shift (7:00am-3:00pm), from 02/01/22-02/17/22 and 02/19/22-02/28/22 on second shift (3:00pm-11:00pm), and from 02/05/22-02/08/22, 02/10/22, 02/15/22, and 02/24/22-02/27/22 on third shift (11:00pm-7:00am). -Personal hygiene, mobility, dressing/undressing, and toileting were documented as completed 65 of 84 opportunities in February 2022. Review of Resident #3's March 2022 personal care record revealed: -There were entries for personal hygiene to include shower/bath, shampoo, nail care, grooming or shaving, mobility, dressing/undressing, and toileting. -The personal hygiene, mobility,	D 269		

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D 269	Continued From page 54 dressing/undressing, and toileting were documented as completed daily from 03/01/22-03/26/22 and 03/28/22-03/3122 on first shift, from 03/01/22-03/02/22 and 03/04/22-03/31/22 on second shift, and from 03/01/22-03/02/22, 03/05/22-03/06/22, 03/08/22-03/11/22, 03/14/22-03/15/22, 03/18/22-03/20/22, 03/22/22-03/23/22, 03/25/22, and 03/28/22 on third shift. -Personal hygiene, mobility, dressing/undressing, and toileting were documented as completed 67 of 84 opportunities in March 2022. Review of Resident #3's April 2022 personal care record revealed: -There were entries for personal hygiene to include shower/bath, shampoo, nail care, grooming or shaving, mobility, dressing/undressing, and toileting. -The personal hygiene, mobility, dressing/undressing, and toileting were documented as completed daily from 04/01/22-04/07/22 on first shift, from 04/01/22-04/06/22 on second shift, and on 04/02/22 and 04/05/22 on third shift. -Personal hygiene, mobility, dressing/undressing, and toileting were documented as completed 15 of 21 opportunities in April 2022. Observation of Resident #3 on 04/05/22 at 9:40am revealed: -He was in a hospital bed with a trapeze bar above his head and a hoyer lift (a device used to assist in lifting a resident for transfers or position changes) in the hallway outside of his door. -He was lying in bed watching television with the covers up to his chest; he wore a black shirt that was covered in dried food and a large amount of white powdery debris.	D 269		

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D 269	Continued From page 55 Interview with Resident #3 on 04/05/22 at 9:40am revealed: -He required assistance with bathing, dressing, and incontinence care. -Staff were supposed to come in once daily to help him with bathing and dressing, but he was unable to say how often staff assisted him with incontinence care. -He was unable to identify what a call bell was and when prompted to pull it, he was unable to reach it. Observation of Resident #3 on 04/06/22 at 11:18am revealed the resident was in the same shirt he wore on the previous day and smelled of feces. Interview with Resident #3's roommate on 04/05/22 at 10:10am revealed: -Resident #3 was bedbound, unable to reposition himself on his own, and the staff did not get the resident out of bed each day as his family desired. -Resident #3 would often go as long a one month before staff would change his sheets. -Sometimes staff would not provide a bath or change Resident #3's clothes for up to 3-4 days at a time. -Staff would round on Resident #3 for his needs and incontinence care on an average of every 4 hours during the day and often not at all at night so he ended up with soaked incontinence briefs in the mornings. -If he was not in the room with Resident #3, the resident would be unable to reach the call bell and could not remember how to use the call bell if he needed help or assistance. -He would often pull the call bell for Resident #3 when in the room to ensure he got assistance with incontinence care as needed.	D 269		

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D 269	Continued From page 56 -He looked out for Resident #3 to ensure the resident had what he needed. Interview with a personal care aide (PCA) on 04/05/22 at 10:02am revealed: -She was responsible to assist residents in getting dressed, bathing, dressing, serving and cleaning up meals, laundry, and any other needs the residents may have. -PCAs were responsible to round on all residents on the Assisted Living (AL) unit every 2 hours and on bed bound residents every 30-minutes. -Resident #3 was realistically rounded on approximately 3 times per shift because she had so many tasks and residents to round on and answering resident call bells often prevented her from checking on Resident #3 as often as she would like to. -She was bathing Resident #3 that day (04/05/22) has part of her normal routine. -The staff did not take Resident #3 to the shower and only provided him bed baths because it was difficult to get him in and out of his bed. -Resident #3 had the same clothes on that she had dressed him in two days prior when she last worked. -She often came on her shift to find Resident #3 with soaking wet incontinence briefs as if he had not been changed at all on the previous shift. -Often times, when she gave Resident #3 a bath, it was difficult to even find clean towels, wash cloths, and linens to complete the task and provide a bed linen change. -Resident #3 required two people to use the hoyer lift and assist him in getting out of his bed and the facility was always short staffed on the AL unit making it difficult to get help to get him up. -The medication aide (MA) was the only staff member that were educated and knew how to use a hoyer lift and the MAs were often busy	D 269		

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D 269	Continued From page 57 passing medications and unable to assist in getting Resident #3 out of bed. -Resident #3's family had requested that the facility ensure the resident got out of bed each day but because she was not allowed to touch the hoyer lift and often did not have enough help, the resident did not always get out of bed as requested. Interview with Resident #3 on 04/06/22 at 11:18am revealed: -No one had been in to assist him with bathing, changing clothes, or incontinence care yet that day. -He wanted to brush his teeth because they were bothering him. -If he did not have his roommate, he would not get the help or care that he needed. Observation of Resident #3 on 04/06/22 at 1:30pm revealed: -A PCA served him lunch and assisted him to eat his food over a 9-minute period. -The resident stated his incontinence brief was wet when asked, but the PCA did not change his brief and left the room to continue handing out lunch trays. Interview with a second PCA on 04/06/22 at 1:44pm revealed: -She started her shift at 7:00am and first checked on Resident #3 around 9:00am but he was clean and did not need anything. -She checked on Resident #3 again at 12:30pm right before lunch and provided him incontinence care at that time. -She did not offer Resident #3 incontinence care when she served him lunch because she needed to finish handing out lunch trays to the other bedbound residents in their rooms, but would go	D 269		

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D 269	Continued From page 58 back and do it after all the lunch meals had been delivered. Interview with Resident #3's roommate on 04/06/22 at 2:15pm revealed he was in the room most of the morning around 9:00am and not had checked on Resident #3 until they changed him before lunch. Interview with Resident #3 on 04/06/22 at 2:16pm revealed: -His incontinence brief was still wet and needed to be changed. -It was uncomfortable to have to sit in a wet incontinence brief. Telephone interview with Resident #3's member on 04/06/22 at 8:35pm revealed: -Resident #3 was immobile and required maximum assistance in his care and transferring. -The facility lacked providing incontinence care, baths, and clothing changes to Resident #3. -She would visit the resident twice weekly and he seemed to always have the shirt on with dried food down the front and routinely looked like he had not been bathed. -There was an incident a few weeks ago, she could not recall when, when Resident #3 "passed out" and had to be sent to the hospital, it was upsetting to her when she arrived and he had arrived at the hospital with no clothing, just an incontinence brief. -Resident #3's roommate helped him do everything, more than the staff help the resident, such as brushing his teeth and helping the family make sure the resident gets enough water and fluids to drink. -She expected the resident to be clean and have fresh clothing on each day. -She bought the resident pajamas but was unsure	D 269		

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D 269	Continued From page 59 if he ever used them. -She took her concerns about Resident #3's care to the office manager and Administrator approximately one month ago but had not received any follow up. -She was not sure if there was enough staff at the facility to provide his care because when she visited it was difficult to find someone to help. Telephone interview with Resident #3's legal guardian on 04/08/22 at 7:52am revealed: -The resident was sometimes confused and needed a guardian because he was unable to always make appropriate decisions for himself. -Due to his "state of mind", the resident was unable to remember to use his call bell when he needed assistance and the string for the bell was too short for him to reach on top of him being immobile. -The resident was unable to transfer or walk and relied on the staff to check on him to meet his needs. -It was hard to find staff for assistance when she visited and sometimes 4-5 hours would go by before anyone would check on the resident. -The resident's skin was dry and flakey and he was oftentimes in the same clothing we wore the previous day. -The resident did not always get a bath or have his incontinence brief changed like he was supposed to and they leave him in the bed a lot instead of using the hoyer lift to get him out of bed. -She had discussed her concerns with the facilty's Administrator but had not received any follow-up. Interview with a third PCA on 04/07/22 at 3:45pm revealed: -Resident #3 was to be bathed every other day per the facility's bath book.	D 269		

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D 269	Continued From page 60 -She was unsure if Resident #3 missed any baths as scheduled, but when she worked (first shift 7:00am to 3:00pm) he would often be in the same shirt and socks from the previous day and was not usually in pajamas. -Staff were expected to provide incontinence care to Resident #3 every 2 hours but she would sometimes find the resident in a very wet incontinence brief that would be overflowing and soaked through to his sheets when she began her shift. -Resident #3 did not currently have any skin breakdown that she was aware of. -It was difficult to provide care to all the residents on the Assisted Living (AL) unit as needed and expected because she was the only aide on the unit, and it was difficult to juggle everything causing some things to go undone. -All staff were trained to use the hoyer lift for Resident #3, but she did not think the resident was assisted out of bed every day and was unsure how many times per week he was accommodated with that. Interview with a fourth PCA on 04/08/22 at 10:36 revealed: -Resident #3 was dependent on facility staff to assist him with dressing, bathing, and feeding and he was unable to get up or meet his own needs. -Resident #3 was forgetful and disoriented much of the time and he would forget to consistently remember to use his call bell or reach it if he needed anything. -She tried to check on Resident #3 every 30-minutes when she worked to see if he needed anything, and she tried to provide position changes and incontinence care every 1-2 hours and as needed. -Staffing at the facility was appropriate on paper,	D 269		

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D 269	Continued From page 61 but there was usually not enough staff present to actually meet residents' needs and things often got missed on first and second shift because it was busier due to residents being awake and some residents required a lot of care such as Resident #3. -Tasks that often went undone due to not having enough time included making beds, offering hydration in between meals, and other things. Confidential interview on 04/08/22 at 1:18pm revealed some staff at the facility did not provide personal care to residents as they were expected to include incontinence care and changing resident's clothes. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -She expected residents to receive incontinent care every two hours and as needed in between. -If incontinent care was not done as expected, it could cause residents to develop skin breakdown and it was important to change residents to keep them clean as often as they wanted and needed to ensure they were honored with respect and dignity. -It was reported to her by staff that there were concerns a single shift was not providing Resident #3 incontinence care as expected or needed, but she had already investigated the issue and corrected it. -She was not aware that Resident #3 and his family were concerned about him not being provided personal care as needed and expected the residents needs and desires to be honored. -Resident #3 never refused care and required more help than some other residents due to being immobile and staff were expected to ensure he had access to assistance in a timely manner.	D 269		

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D 269	Continued From page 62 -It was concerning that Resident #3 was not receiving showers and clothing changes once daily or every other day, or incontinence care as expected every two hours and she would need to address the issue. Telephone interview with Resident #3's primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -She expected Resident #3 to be provided with a bath, change of clothes, and assisted out of bed every day unless he refused, and to be changed into pajamas every night. -She expected all residents who required assistance with incontinence care to be changed every two hours, especially on the Special Care Unit (SCU) where residents had cognitive decline and would not know to request assistance. -She expected Resident #3 to be checked and repositioned frequently and to be cleaned daily for hygienic purposes and dignity. -She also expected the facility to assist Resident #3 to the common bathroom to receive a shower at least every other day; being bedbound did not prevent him from needing a shower and it was degrading for him to not receive one like every other resident. -She expected the facility to provide enough staff to provide care to residents according their needs to maintain their dignity and respect. The facility failed to ensure mouth care was provided according to the resident's needs for a terminally ill hospice resident actively dying resulting in the resident having brown stained teeth, malodorous breath, and a build up of a brown substance between her teeth. The facility failed to ensure bathing, dressing, transferring, and incontinence care were provided according to the resident's care plan and needs for a	D 269		

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D 269	Continued From page 63 non-ambulatory resident with a history of stroke with hemiplegia (paralysis) who required the use of a hoyer lift to get in and out of bed resulting in the resident's care being delayed for hours or days at a time. This failure of the facility resulted in substantial risk of serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/07/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 8, 2022.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#1) who resided in the Special Care Unit (SCU), with a diagnosis of dementia and known disorientation who eloped from the facility on multiple occasions without staff knowledge and was located by the police walking down a road, off a four lane highway on one occasion.	D 270		

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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 270	Continued From page 64 The findings are: Review of the facility's missing residents' policy dated 07/07/12 revealed: -A resident will be considered missing when he/she is not in the facility and the facility cannot verify their whereabouts; and in addition, there is reason to be concerned for the resident's safety. -1. If the facility discovers a resident is missing, we will: a) notify the supervisor and all other staff immediately b) perform a hasty search of the building and the immediate areas outside the building c) notify project life safety. -2. If the resident is not found, we will immediately notify: a) law enforcement-call 911 b) the resident's family member/responsible person c) the county department of social services. -Cooperate fully with law enforcement and or authority in charge of search and rescue. Review of the facility's policy dated 07/07/12 on identification and supervision of wandering residents revealed: -Community will not admit residents that are wanderers or at high risk for wandering. Should a current resident begin to exhibit signs of wandering, the resident will be reassessed for appropriate placement and an immediate discharge notice will be issued. As long as the resident remains in the facility the remainder of this policy will apply. -The facility will identify residents who walk or wheel around unrestricted and are a threat to leave the facility unattended due to their confusion. -Pre-admissions screening will be as follows: review of FL-2, hospital discharge summary or other written information. -Obtain and review information from family	D 270	Facility will respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the residents, (such as obtaining assistive devices, increased supervision, seeking advice from physician/OT/PT, etc.) Administrator retrained staff to ensure that staff are providing supervision in accordance with each resident's needs as identified in their care plan. Administrator re-trained staff on expectations of responding to door alarms. 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. Administrator will monitor supervision provided to residents based on need identified in the care plan x 5 days per week Administrator/Designee will conduct door alarm drills randomly weekly to monitor staff response to door alarms.	05/08/2022

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D 270	Continued From page 65 members and responsible persons, and /or placement agencies; regarding any history or the risk of wandering. -After admissions safeguards/assessments will be as follows: implementation of a wandering resident list; the list will be made available to staff. -Inform staff upon admission and as necessary if the potential exist for a resident to wander. -Perform a reassessment and change the care plan accordingly when significant change occurs which may indicate the potential to wander. -Supervise and implement routine checks, monitoring devices and/or techniques according to the need of each resident. -Environment safeguards; check door alarms regularly to assure they are working properly. -Notify staff when alarms fail and request staff to assure extra precautions for residents at risk of wandering. -Repair alarm system as soon as practicable. Observation of the door leading from the kitchen to the Special Care Unit (SCU) dining room on 04/05/22 at 4:30pm revealed: -The door was unlocked and did not alarm when opened. -There was a magnet at the top of the door that did not latch when the door closed. -There was a keypad to the side of the door on both sides of the wall that did not alarm when the door was opened. -There were two separate doors leading from the SCU halls into the dining room that were propped open with one resident walking in the hallway and several residents sitting in the living area nearby. -There was one staff member in the living area with the residents who did not have a direct line of sight to the dining room doors. Observation of the door leading from the kitchen	D 270		

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D 270	Continued From page 66 to the SCU dining room on 04/08/22 at 11:00am revealed: -The door was still unlocked and did not alarm. -The doors to the dining room leading to the hallways of the SCU unit where residents could be observed sitting or walking around were also unlocked and propped open. Observation of the exit door leading to the courtyard on 04/05/22 at 10:26 am revealed: -The handle on the exit door on the right hall that led to the gated courtyard was held for 15 seconds. -The door released and opened. -The alarm sounded. -Staff responded to the alarm at 10:29 am and asked if they should reset the alarm. -The staff entered the security code on the keypad to reset the alarm and secured the door. -The staff was unsure if he needed to respond to the alarm. -There was a personal care aide (PCA) near the day room, a PCA on the hall providing care to residents and a Medication Aide/Supervisor passing medications on the SCU. Review of Resident #1's current FL-2 dated 12/02/21 revealed: -Diagnoses of dementia, disorientation, Cerebral Vascular Accident (CVA), frontal lobe CVA and metabolic encephalopathy. -Resident #1 was constantly disoriented. -Resident #1's status was ambulatory. -Resident #1 had wandering behaviors. -Resident #1's documented level of care was a SCU. Review of Resident #1's Resident Register revealed he was admitted on 11/22/21.	D 270		

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D 270	Continued From page 67 Review of Resident #1's Care Plan dated 11/29/21 revealed: -Resident #1 wandered throughout the halls, in other resident's rooms and often stood at the door trying to get out. -He was sometimes disoriented and forgetful. -Resident #1 was able to read, write, speak and understand language. -Resident #1 was ambulatory. -He communicated his wants and needs, likes and dislikes and followed instructions. -Resident #1 had no delusions, hallucinations or paranoia. -He was referred to mental health services on 11/29/21 for wandering and aggressive behaviors. Review of Resident #1's progress notes dated 01/01/22 revealed: -Resident #1 tried to get out of the SCU exit door on 01/01/22. -He constantly pushed up against the door until it released so he could get out. -Resident #1 became combative and used profanity when staff tried to redirect him away from the door. Review of Resident #1's progress note date 01/02/22 revealed: -Resident #1 got out of the door on 01/02/22. -The action taken by staff was to call the Primary Care Provider (PCP). -On 01/02/22, the PCP ordered Resident #1 Clonazepam 0.5 mg as needed (a medication used to treat anxiety). -There was no documentation in Resident #1's record that staff increased supervision as ordered by PCP. -No incident report was completed for Resident #1 exiting the SCU.	D 270		

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D 270	Continued From page 68 Review of an Accident/Incident report dated 02/03/22 for Resident #1 revealed: -Resident #1 eloped from the SCU. -Staff searched the facility thoroughly and the grounds at approximately 2:00 pm. -Staff informed the Administrator. -Staff contacted the local police. -Resident #1 was returned to facility at 2:40 pm by local police. -Action taken by staff were vital signs and staff checked for injury. -Resident #1's family was called but there was no answer. -The PCP and Mental Health Provider (MHP) were called. -Resident #1 was placed on increased supervision with 30 minute checks while awake and 60-minute checks when sleeping. Interview with the local police department dispatcher on 04/06/22 at 10:52 am revealed: -On 02/03/22, they received a call from this facility for a missing resident. -On 02/03/22, a person fitting Resident #1's description was seen walking down the highway. -On 02/03/22 at 2:45 pm, Resident #1 was located down a street (named street) that was one street over and returned to facility and identified as the missing resident. -There was no police report on file because no crime was committed. -The incident was logged by the officer in his daily log. -There was no name mentioned in the daily log. Observation on 04/08/22 of the outside area where Resident #1 eloped revealed: -The facility was approximately a total distance of 550 feet from a four lane highway divided by a median with a speed limit of 45 mph.	D 270		

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D 270	Continued From page 69 -There was a plaza and restaurants across the four lane highway with heavy traffic which is adjacent to the facility. -There was no sidewalk down either side of the four lane highway. -Out of the facility driveway, to the left, down the four lane road was an intersection to the named road the resident was found on. Review of Google Maps revealed from the facility to the intersection of the named street was at least .3 miles. Interview with a personal care aide (PCA) on 04/06/22 at 8:50am revealed: -PCAs were responsible to assist with dietary duties, bath, cloth, feed, provide incontinence care, and assist residents as needed, checking on residents every 2 hours. -There was no process in place to provide any residents with increased supervision; PCAs were to try and keep an eye of everyone and try not to leave any resident alone on the SCU. Interview with a second PCA on 04/06/22 at 8:55am revealed: -PCAs were responsible to assist residents with all needs and check on them every 2 hours. -There was no process in place to provide increased supervision to any residents and staff were always expected to keep an eye on all residents as much as possible. -The kitchen door leading into the SCU had always been unlocked for as long as she could remember; but she thought she heard it alarm last week, she was unsure when the alarm stopped working. Interview with a MA/Supervisor on 04/06/22 at 2:30 pm revealed:	D 270		

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D 270	Continued From page 70 -The exit doors on the SCU would release and alarm if held for 15 seconds. -All staff on the SCU were responsible for checking the exit doors but there was no system in place for who would check them. -For resident's safety, all staff on the SCU were to respond to any sounding alarm. -The exit doors were checked every 2 hours by staff looking for a green light on the door and no alarm sounding. -She would take a head count of residents when working on the unit for accountability at the start of her shift. -The PCAs were to always monitor the common area and hallways. -Resident #1 had been wandering up and down the hall and in and out of rooms on 02/03/22. -Staff would attempt to redirect Resident #1, however Resident #1 was not easily redirected and was combative at times. -Resident #1 had not attempted to exit the SCU on 02/03/22 prior to MA leaving the SCU. -She left the SCU and when she returned, she noticed the green light on the rear exit door was on but there was no alarm sounding. -She noticed Resident #1 was not sitting in the area she had last seen him. -Staff began an immediate search for residents in bathrooms, closets and residents rooms throughout the SCU. -On 02/03/22 at 2:00 pm, Resident #1 was identified as missing -She immediately notified the Administrator. -She and staff searched the grounds. -She called local police department. -She got in her vehicle to search nearby area. -She called Resident #1's responsible party but there was no answer. -Resident #1 was located by the local police department nearby and returned to facility at 2:40	D 270		

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D 270	Continued From page 71 pm. -She assessed Resident #1 for injury and vital signs were checked. -Resident #1 did not require medical attention. -She called the resident's PCP and MHP. -Resident #1 was placed on 30-minute checks by the PCP to monitor Resident #1 every 30 minutes for 24 hours. -There was no documentation completed for 30 minute safety checks for Resident #1. -Resident #1 was seen by the MHP on 02/04/22 for the elopement on 02/03/22. -She completed an accident and incident report of the elopement on 02/03/22. -She not aware of any other elopements. -After Resident #1 eloped on 02/03/22, she was made aware by maintenance staff the locking system on the exit doors in the SCU would release in 15 seconds when pushed. Interview with another MA/Supervisor on the SCU on 04/08/22 at 9:37 am revealed: -Resident #1 wandered and stood by the rear exit door often. -Staff attempted to redirect Resident #1 when he was near exit doors. -She was not working on 02/03/22 the day Resident #1 eloped and left the facility grounds. -When she returned to work Resident #1 had been placed on 1 hour safety checks for 48 hours by the MHP. -She had witnessed other times Resident #1 got out outside from the SCU but was not sure of the dates. -She did not complete an accident and incident report when Resident #1 exited the SCU and was brought back by staff because it was not considered an elopement according to the Administrator. -Resident #1 knew how to hold the back-exit door	D 270		

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D 270	Continued From page 72 for 15 seconds to exit the facility, so staff would monitor his whereabouts when he was out of bed. -On one occaasion, two PCAs were working along with her and Resident #1 got out of the SCU leading to the rear parking lot, however staff were able to return him back to the SCU. -On on another date, the door was not alarming and Resident #1 got out of the facility but he was located in the rear parking lot of the facility. -The Administrator was notified when Resident #1 got out of the building. -The staff were instructed by the Administrator after he exited the SCU to watch doors and Resident #1 by sitting in the middle of the hallway to monitor all doors. Telephone interview with a PCA on 04/08/22 at 1:42 pm revealed: -She was working on 02/03/22 the day Resident #1 got out of the building. -Resident #1 wandered a lot and would go into other residents' rooms. -Resident #1 had exited the building other times and the door alarms alerted staff so he was found on the grounds. -Resident #1 kept going to the exit door and he would also sit and watch people as they went to the exit. -She kept an eye on him at all times while he was sitting in the living area. -On 02/03/22, she left to assist another resident and there were only two staff on the hall at the time because the MA/Supervisor was up front. -Resident #1 knew that holding the door, it would automatically release because Resident #1 had done it plenty of times. -On 02/03/22, the door did not alarm but the green light was flashing to notify staff when Resident #1 exited the building. -Staff were not aware the doors would	D 270		

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D 270	Continued From page 73	D 270		

automatically release after 15 seconds until after the elopement on 02/03/22.
-Staff searched all of the rooms and the grounds however, they were unable to find Resident #1.
-Staff informed the Administrator once the incident happened.
-Resident #1 was brought back to the facility by the police about 30 minutes after he left the facility.
-Staff were told by the Administrator to monitor Resident #1 every 30 minutes to ensure he was safe.
-Staff on the SCU provided 30 minute safety checks for Resident #1 but did not document the safety checks.

Telephone interview with Resident #1's MHP on 04/07/22 at 10:19 am revealed:
-Resident #1 was seen by MHP monthly in-person and by telehealth as needed for behaviors.
-Resident #1's initial assessment was done on 12/08/21 at the facility.
-Resident #1 stared at the exit doors on the (SCU) and exhibited wandering, exit seeking behaviors.
-She ordered to increase medication on 12/08/21 to Seroquel 150 mg at bedtime for agitation.
-On a follow up visit on 12/23/21 with Resident #1, he was refusing medication, agitated and guarded, there were no medication changes made at that time.
-On a follow up visit on 01/12/21 with Resident #1 he was doing well. He was distracted and guarded on exam. There were no medication changes made at that time.
-On 01/16/22, the facility contacted the MHP to report Resident #1 was agitated and exit seeking.
-She ordered medication on 01/16/22 for Clonazepam 0.25 mg daily at 4:00pm for

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D 270	Continued From page 74 agitation. -On 02/04/22, Resident #1 was seen in facility and during this visit the MHP was informed that Resident #1 had eloped from SCU on 02/03/22 by holding door handle for 15 seconds. -Resident #1 reported he was depressed. -The facility staff informed the MHP that Resident #1 exit seeks daily. -She ordered increased supervision of Resident #1 for 1 hour safety checks for 48 hours. -She ordered a medication on 02/04/22 for Sertraline 25 mg daily for mood. -Documented hourly safety checks were ordered by the MHP on 02/04/22 and began on 02/05/22 through 02/07/22. -The staff completed documented 30 minute safety checks ordered by MHP and kept them in Resident #1's personal care log beginning on 02/05/22 through 02/07/22. -On 02/11/22, staff reported to the MHP that Resident #1 checked out windows to exit, and that he assaulted a staff member. -On 02/11/22, she ordered Resident #1 Rivastigmine 1.5 mg twice a day for dementia. -On 02/17/22, the staff reported Resident #1 was more aggressive in evenings and distracted. -On 02/17/22, she ordered Seroquel 200 mg at bedtime for agitation. -On 02/23/22 the staff reported to the MHP that Resident #1 was taking off his clothes and standing on a table; She ordered Seroquel 50 mg daily as needed for agitation. -On 03/04/22, the MHP received a call from the facility reporting that Resident #1 had eloped out of the rear exit door on the SCU by holding the handle 15 seconds. -Resident #1 was placed on 1 hour safety checks for 48 hours. -Resident #1 may need placement at a more secure special care unit.	D 270		

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D 270	Continued From page 75 Interview with Resident #1's PCP on 04/07/22 at 1:01 pm revealed. -She had not witnessed any behaviors from Resident #1. -She visited the facility between the hours of 5:45 am and 6:30 am on Thursdays. Resident #1 was usually asleep during visits. -On 02/03/22, the PCP was notified of Resident #1's elopement. -She ordered 30-minute checks for Resident #1 for 1 day after the 02/03/22 elopement until he was seen by MHP on 02/04/22. -The staff had reported to the PCP multiple attempts of elopement by Resident #1. -Behaviors and medication changes for Resident #1 were handled by the MHP. -The expectation was for the facility to monitor Resident #1 closely, one PCA near the SCU day room and one PCA on the hall at all times. Interview with Administrator on 04/07/22 at 4:30 pm revealed: -Resident #1 had eloped once from the facility but had gotten out of exit doors on the SCU several times. -She defined an elopement as leaving the facility grounds which was the reason incident reports were not completed each time Resident #1 exited the building. -She thought the times Resident #1 got out of the exit door but did not leave the grounds were not elopements. -Resident #1 got out the exit doors by holding the exit door handle for 15 seconds until it released. -On 02/03/22, she implemented documented daily door alarm checks on the Special Care Unit for 7 days and once weekly for 2 weeks thereafter for safety. -Documented door alarm checks for the SCU	D 270		

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D 270	Continued From page 76 revealed door alarm checks were completed on 02/03/22, 02/04/22, 02/05/22, 02/06/22, 02/07/22, 02/08/22 and 02/09/22 and 02/16/22 and 02/23/22. -On 02/04/22, she in-serviced staff on the SCU on the Missing Residents Policy. Based on observations, interviews and record reviews, it was determined that Resident #1 was not interviewable. The failure of the facility to supervise Resident #1 who resided in the special care unit with a diagnosis of dementia, disorientation and a recent history of wandering and exit seeking behaviors. The facility's failure resulted in the resident leaving the facility on multiple occasions, including an elopement whereby the resident was found approximately .3 miles from the facility after walking near a high traffic, four lane highway. This failure resulted in substantial risk of serious physical harm which constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S.131D on 04/05/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 8, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 04/08/2022

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 273	Continued From page 77 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 1 of 6 sampled resident's (#11) related to decreased intake of fluids and foods with cognitive changes for approximately two weeks. The findings are: Review of the facility's Policies Agreement revealed: -All residents had the freedom of movement unless restricted by appropriate written orders by a physician. -State regulation required that residents residing in an Assisted Living (AL) community be served 4 ounces of water along with the residents preferred 8-ounce beverage. Review of Resident #11's current FL-2 dated 12/08/21 revealed: -The resident resided on the Special Care Unit (SCU). -Diagnoses included mixed Alzheimer's disease and vascular dementia, major neurocognitive disorder, hypertension, and diabetes mellitus. -She was constantly disoriented, had wandering behaviors, ambulated with a walker and required total care assistance with bathing, feeding, and dressing. Review of Resident #11's Resident Register dated 12/09/21 revealed: -She was admitted to the facility on 12/09/21. -The resident required assistance with dressing, bathing, toileting, grooming, and orientation to time and place. -The resident had significant memory loss and	D 273	Administrator retrained staff on noticing change in conditions with residents and the procedures of notifying responsible parties and management staff of changes in resident conditions. Facility reviewed all recent (30 days) discharge summaries & orders and assure any orders needing to be referred to outside agencies or providers are completed. All referrals will be followed-up on immediately to ensure accuracy and correct documentation. SIC/Designee will notify responsible parties and primary care provider of any changes in care, condition, and/or services to residents. SIC/Designee will review new orders daily to ensure each order is referred to and appropriate agency if indicated. RCC and/or Designee to audit all orders once per week x 4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed.	5/23/2022

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D 273	Continued From page 78 required direction. Attempted review of Resident #11's care plan revealed there was not one available. Review of Resident #11's Primary Care Provider (PCP) note dated 12/16/21 revealed: -The resident was seen by her PCP for an admission assessment to the SCU. -The resident was alert, in no distress, oriented to person only, and with an unsteady gait. -The family was to bring the resident a walker to assist her with her unsteady gait. Review of Resident #11's January 2022 personal care record revealed: -There was an entry for feeding assistance with breakfast, lunch, dinner, and 3 snacks per day. -The feeding assistance was documented as completed daily on 01/01/22-01/07/22, 01/10/22-01/13/22, 01/15/22-01/22/22, and 01/24/22-01/31/22 on first shift (7:00am-3:00pm), 01/01/22-01/16/22 and 01/17/22-01/31/22 on second shift (3:00pm-11:00pm), and 01/01/22-01/06/22, 01/08/22-01/09/22, and 01/11/22-01/24/22, and 01/26/22-01/31/22 on third shift (11:00pm-7:00am). -The resident was provided feeding assistance for 85 of 93 opportunities. -There was no documentation of the amount the resident ate or drank at each meal or snack. Attempted review of Resident #11's February 2022 personal care record revealed there was not one available. Review of Resident #11's hospital emergency physician documentation note dated 02/11/22 revealed: -The resident was sent to the emergency	D 273		

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D 273	Continued From page 79 department (ED) due to the resident's blood pressure being excessively low. -The resident's family member reported the facility called him and told him that the resident had been refusing food and water for the previous week and had declined over the week to a point of being less responsive. -When the family member had visited the resident at the facility that day, 02/11/22, he barely recognized the resident and after getting her to come around he finally got her to take a drink of water. -At that point, the family member insisted that the facility call an ambulance and transport the resident to the ED for further evaluation. -The resident appeared frail and obviously ill with dry oral mucosa, decreased breath sounds, diminished bowel sounds, and being otherwise unable to cooperate with the exam. -The resident's blood pressure was 82/30 (normal range 90/60 - 120/80) at 6:02pm upon arrival with a pulse of 105 (normal range 60-100). -The resident was diagnosed with dehydration, sepsis (a life-threatening response to infection), pneumonia, and a urinary tract infection (UTI) and was admitted as an in-patient to the hospital. Review of Resident #11's hospital Admission and History and Physical report dated 02/12/22 revealed the resident remained hospitalized and sedated while being treated for diagnoses that included a UTI, acute renal failure syndrome, dehydration, pneumonia, and hypernatremia (a high concentration of salt in the blood often caused by not drinking enough water). Review of Resident #11's hospital progress note dated 02/14/22 revealed: -The resident was diagnosed with and being treated for poor oral intake, acute renal failure (a	D 273		

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D 273	Continued From page 80 condition of decreased blood flow to the kidneys preventing the filtering of waste from the blood), volume depletion (condition in which the liquid portion of the blood is too low), hypernatremia (too much sodium in the blood possibly causing strong feelings of thirst, weakness, confusion, and bleeding around the brain), UTI, pneumonia (infection of the air sacs in the lung that may fill with fluid or pus) secondary to aspiration (when food, liquid, or other material enters a person's airway), metabolic acidosis (a serious electrolyte disorder), elevated troponin secondary to myocardial demand ischemia (oxygen requirements of the heart are not met), and delirium (extreme confusion). -The resident was receiving antibiotics for the UTI which was likely caused by acute renal failure secondary to volume depletion, which also caused hyponatremia. -The resident was receiving intravenous fluids (IVF) to treat the volume depletion and sodium bicarbonate to treat the metabolic acidosis secondary to acute kidney disease. -The resident required a speech therapy evaluation secondary to aspiration pneumonia when appropriate. Review of Resident #11's hospital progress note dated 03/17/22 revealed: -The resident remained hospitalized and despite being treated with IV antibiotics, volume resuscitation, and UTI, the resident remained confused requiring total assistance and 1:1 feeding assistance and requiring a gastrostomy tube (feeding tube). -After discussion with the family, the resident's status was changed to comfort care only and her advanced directives were changed to a Do Not Resuscitate (DNR) status in the event of a cardiac arrest.	D 273		

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D 273	Continued From page 81 -The plan was to continue supportive care until the resident could be placed in a skilled nursing facility. Review of Resident #11's hospital discharge note dated 03/18/22 revealed the resident was cleared to discharge to a skilled nursing facility after 35 days of hospitalization in stable condition on comfort care. Review of Resident #11's hospital discharge planning summary dated 03/21/22 revealed the resident was discharge to a skilled nursing facility on 03/21/22 at 1:25pm. Interview with a personal care aide (PCA) on 04/07/22 at 3:45pm revealed: -Resident #11 resided on the Special Care Unit (SCU) and sometimes exhibited behaviors requiring redirection and patience by staff members. -Resident #11 required ambulatory assistance, sometimes had a good appetite, and would drink most of a beverage if offered to her but would not know to ask for them and would sometimes spit it out. -She was unsure how often Resident #11 was offered water with meals or if she was ever offered fluids between meals; she did not offer water between meals and was not aware residents were supposed to be offered water with all meals until being made aware. -She was not working the day that Resident #11 went to the hospital and did not recall how well the resident was eating or drinking in the days prior to her hospitalization because she had not cared for her during that time period. Confidential interview on 04/08/22 at 1:18pm revealed:	D 273		

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D 273	Continued From page 82 -Resident #11 would often refuse food, water, and medications but she was unsure if it had been reported to the resident's primary care provider (PCP) or the Administrator. -It was the medication aide's (MA) responsibility to report issues to the PCP. -A MA sent Resident #11 out to the hospital on 02/11/22 due to a change in the resident's status but she was not sure of the details. Interview with a MA on 04/07/22 at 4:36pm revealed: -She offered residents water with meals but not in between meals or with snacks unless they asked or spontaneously if she thought a resident might want it; she was able to look at residents and tell if they were thirsty; she did not recall Resident #11 looking thirsty. -She was not present when Resident #11 went to the hospital but noticed that the resident began sleeping a lot and her meal intake decreased from 100% to about 70% about two weeks prior to the incident. -She reported the decreased intake and increased sleep along with a heel wound to another MA one day, but not to the PCP or anyone else because she was not concerned about the behaviors since the resident was still eating some, and was not sure why Resident #11 became so sick so quickly. -If she had been concerned, she would have reported her concerns to the resident's PCP. Interview with a second supervisor/MA on 04/08/22 at 11:01am revealed: -She did not recall Resident #11 having any obvious changes in her status or behavior in the week prior to her hospitalization. -Sometimes Resident #11 did not eat or drink well and the staff would try to encourage her to take	D 273		

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D 273	Continued From page 83 more at the request of the resident's family member. -Sometimes Resident #11 had behaviors in which she would refuse to eat or drink when she was first admitted to the facility, but that seemed to improve as time went on and her behaviors calmed down. -She reported decreased intake of food and drink to the previous Administrator, but she had not reported it to the resident's primary care provider (PCP), she did not know why. -It was the supervisor/MA's responsibility to report resident issues to their PCP and she was usually on top of that but could not find any documentation that she had done so on behalf of Resident #11. Telephone interview with a previous MA on 04/08/22 at 11:53am revealed: -Resident #11 was only at the facility for two months and she was feisty and talkative upon admission and would eat or drink water if it was offered but would not know to request it and she required encouragement to do so due to her cognitive status. -Resident #11 would not realize she was hungry and would think she already ate when it was mealtime. -She would try to ensure the residents were offered water when she worked as much as possible because she knew it was important from training she received when she worked at a different facility, but there were not enough cups in the kitchen to provide it to all residents along with their normal beverage. -She had gone out of medical leave for 3-4 days and when she returned to work, she realized she had not seen Resident #11 and went looking for her and found her in her room asleep. -Resident #11 was different and had slurred	D 273		

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D 273	Continued From page 84 speech being unable to complete a sentence with decreased interaction and was no longer able to walk, eat, or drink without complete assistance. -She notified Resident #11's primary care provider (PCP) and sent the resident to the emergency department (ED) on 02/11/22 for the slurred speech and change in status. -The previous shift had not reported any changes with Resident #11 when she came on shift that day but the resident had seemed normal on the previous shift she had worked and it was a significant change for the resident who was also wearing the same clothes (a green shirt and purple pants) that the resident was wearing when she had worked 3 or 4 days prior. Review of the facility's census reports provided on 04/05/22 revealed: -The facility's in-house census was 45 residents. -There were 30 residents residing in the AL side of the facility. -There were 15 residents residing in the SCU Observation of the kitchen during preparation of lunch on 04/06/22 at 12:40pm revealed: -There were not enough cups for each resident to have more than one beverage with the meal service. -The office manager was in the kitchen helping the dietary manager prepare food and drinks. -The dietary manager prepared 6 cups of water and 16 cups of sweet tea for the SCU cart and 9 cups of water and 13 cups of sweet tea for the AL cart. -There were 23 other smaller cups on the shelf empty and not in use. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -Documentation of feeding and beverage	D 273		

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D 273	Continued From page 85 assistance was documented on all residents' personal care records. -Any change in resident condition was expected to be reported by the MA to the PCP as soon as possible to obtain orders and move forward. -She could not recall if the staff reported any changes in Resident #11's status, but she expected staff to report any issues and was not sure why they did not prior to the day the resident was hospitalized. -She did not recall being concerned about Resident #11 prior to her hospitalization, but she had just started on 02/02/22 and was still getting to know the residents at that time. -She did not realize that Resident #11's PCP was unaware of any concerns that staff had for Resident #11. -She expected all staff to push and encourage fluid intake to try and prevent dehydration. -She expected staff to report residents with decreased intake to the PCP and she did not want residents to miss meals. Interview with a second PCA on 04/07/22 at 4:22pm revealed: -Resident #11 walked and talked independently when she began working at the facility 2 months ago. -Resident #11 would sometimes refuse showers and did not always eat or drink well requiring encouragement when feeding her. -Resident #11 only drank tea with her meals and residents were not offered water in between meals, at snack time, or before bed automatically, but some residents would ask for it. -She did not recall if Resident #11 ever complained of being thirsty, she only offered the resident water with dinner, the resident did not like to drink water, and she did not offer the resident water between meals, with snacks, or	D 273		

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D 273	Continued From page 86 before bed. -She was not present when the resident went to the hospital, but she was told the resident just stopped being responsive and she was not sure what happened. -She noticed a decline in Resident #11 on second shift (3:00pm - 11:00pm) the day before she was hospitalized in the common area and the resident did not look happy and was not talking or interacting with anyone like she normally would; she figured the resident was just tired but reported the behavior verbally to the next shift. Telephone interview with Resident #11's PCP on 04/07/22 at 1:00pm revealed: -She saw the resident the day prior (02/10/22) to her going to the hospital for a wound of her foot at the request of the facility. -It would have been hard to assess whether the resident was having issues during her assessment on 02/10/22 because she visited the facility between the hours of 5:45 am and 6:30 am on Thursdays and residents were usually still asleep or just waking up. -It would have been hard to know if the resident was experiencing complications from decreased intake without being notified because of her diagnosis of dementia and diabetes; diabetic residents often compensated well and could become acidotic more quickly than a healthier resident until they crash and decline quickly and she may not have realized there was a change in the resident on that day, 02/10/22. -Resident #11 would not have known to ask for food and water due to her cognitive decline and she would have expected the facility to encourage her intake of both. -It was concerning that the resident had such severe diagnoses upon admission to the hospital and the length of her stay in the hospital indicated	D 273		

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D 273	Continued From page 87 a severe scenario. -It was concerning that she was not made aware of the resident's decreased intake and cognitive changes and expected to have been notified within 24-48 hours of it becoming an issue. -If she had been made aware that the resident had a decreased intake in food and fluids, she would have intervened sooner, possibly sent her to the hospital sooner, ordered lab work, assessed her medications and intake, and tried to prevent the severity of her symptoms and admission to the hospital all together. -If the facility had offered fluids to the resident at every meal and snack, and encouraged them in between, if may have prevented the resident's decline or severity of complications. -It would have taken at least 2-3 days and up to 7 days of decrease intake to have caused the severity of symptoms that Resident #11 experienced. The facility failed to notify the PCP of Resident #11's change in condition during an approximately two week period in which the resident declined with a decreased intake in eating and drinking, sleeping more frequently, and decreased social interaction. The resident was admitted to the hospital for 35 days related to diagnoses of urinary tract infection (UTI), dehydration, metabolic encephalitis, and penumonia. This failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 04/29/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 23, 2022	D 273		

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 7 sampled resident's (#3, #13) orders were implemented related to feeding assistance and increased food intake (#13) and being provided fluids to drink (#3, #13). The findings are: Review of the facility's Declaration of Residents' Rights policy revealed each resident had the right to: -Be treated with respect, considerations, dignity, and full recognition of his or her individuality and right to privacy. -To receive care and services which that were adequate, appropriate, and in compliance with relevant Federal and State laws and rules and regulations. -To be free of mental and physical abuse, neglect, and exploitation. -To receive reasonable response to his or her requests from the facility administrator and staff. Review of the facility's Policies Agreement	D 276	All Medication Aides completed training for implementation of new orders, documenting vitals and treatments as per physician's orders. RCC and/or Designee reviewed MARs weekly to ensure documentation of vitals and treatments are being completed. Administrator will audit MARS twice monthly x2 months, randomly thereafter, to ensure documentation is completed for procedures, orders and treatment as per physician's orders. QI department will conduct audits at least quarterly or on an as needed basis, to ensure documentation of vitals and treatments as being completed. 6/1/2022 & Ongoing	5/23/2022

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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 276	Continued From page 89 revealed: -All residents had the freedom of movement unless restricted by appropriate written orders by a physician. -State regulation required that residents residing in an Assisted Living (AL) community be served 4 ounces of water along with the residents preferred 8-ounce beverage. 1. Review of the facility's weight loss policy revealed every resident was to receive a monthly weight and if there was any loss or gain of 5% or more within a 30-day period or 10% or more in a 6-month period the resident's primary care provider (PCP) would be notified and documented in the resident's chart and a reassessment of the resident's condition would be performed. Review of Resident #13's current FL-2 dated 02/12/21 revealed: -The resident resided on the Special Care Unit (SCU). -Diagnoses included dementia, hyperlipidemia, hypertension, osteoporosis, edema, and venous insufficiency. -The resident was constantly disoriented, had wandering behaviors, and was ambulatory. -The resident was on a regular diet with no added salt and there was an order for supplemental shakes twice daily. Review of Resident #13's current assessment and care plan dated 02/19/22 revealed: -The resident was always disoriented and had significant memory loss requiring direction. -The resident required supervision with eating and transferring and extensive assistance with toileting, ambulation, bathing, dressing and grooming.	D 276		

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D 276	Continued From page 90 Review of Resident #13's current physician's orders dated 02/19/21 revealed: -There was an order to have the resident drink 50 ounces of fluids daily. -There was an order for supplemental shakes twice daily. Review of Resident #13's vital signs report revealed: -On 10/27/21, the resident weighed 114 pounds. -On 11/24/21, the resident weighed 103 pounds. -On 12/29/21, the resident weighed 103 pounds. -On 01/26/22, the resident weighed 98 pounds. -On 02/23/22, the resident weighed 97 pounds. -On 03/30/22, the resident weighed 99 pounds. Observation of breakfast on the SCU on 04/06/22 from 8:09am to 9:00am revealed: -A PCA was seated at eye level with Resident #13 who required feeding assistance and was served breakfast at 8:10am consisting of a cheese omelet, one sausage link, 1 cup of oatmeal, 1 slice of toast, and 8 ounces of orange juice. -Resident #13 was fidgety and unable to sit still, mumbling, grabbed at the plate, and had to be reminded and redirected to eat. -Resident #13 would willingly take bites when offered and would sometimes point to the plate when she was ready for another bite of food; the resident was not offered any of her orange juice and did not have any other drinks in front of her. -At 8:27am, when the surveyor walked across the room, the PCA no longer redirected the Resident #13 to eat any more of her breakfast and escorted her out of the dining room; she consumed 50% of the breakfast and 0% of the orange juice she was served. -Resident #13 was not served any milk, water, or supplement shake at the meal service.	D 276		

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D 276	Continued From page 91 Observations of lunch on SCU on 04/06/22 at 11:30am revealed: -Staff began prepping and setting the tables for lunch at 11:49 am while residents waited in the TV room across from dining room for lunch to be served. -At 12:35pm, staff knocked on the kitchen door and asked Dietary Manager what time lunch would be served. -Lunch was served to independent feeders at 12:54pm. -Residents were served Steak Sub sandwiches with mixed vegetables and 8 ounces sweet tea. -There were eight 8 ounce cups of ice water on a cart but they were not offered to the residents. -Staff began assisting and feeding Resident #13 at 1:04pm and ended at 1:17pm; she consumed 30% of her meal, 50% of her tea and she was not offered water. Review of Resident #13 primary care provider (PCP) visit note dated 12/17/21 revealed: -The resident's family member reported the resident was sleeping more that she had been previously. -The resident had a 12-pound weight loss in the previous 6 months but did not appear to be dehydrated and was not alert to person, place, time, or communicative. Review of Resident #13's PCP physician consultation report dated 12/17/21 revealed: -The resident had a 12-pound weight loss in 6 months. -There was an order to increase the resident's portion sizes and add a supplemental shake at 4:00pm daily. Review of Resident #13's February, March, and	D 276		

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D 276	Continued From page 92 April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for 50 ounces of fluid intake daily. -The 50 ounces of fluid intake was documented as administered on first shift (7:00am-3:00pm) daily from 02/01/22-04/06/22. -There was an entry for a supplemental shake at 7:30am, 12:30pm, and 4:00pm daily. -The supplemental shakes were documented as administered at 7:30am, 12:30pm, and 4:00pm daily from 02/01/22-04/06/22. Review of Resident #13's PCP visit note dated 01/28/22 revealed: -The resident was taken to the emergency department (ED) 2-3 weeks ago due to being unresponsive. -The resident's family member and caregiver were unable to provide details of the incident. -It was reported that the resident ate well but would sometimes refuse to eat all of her food. -The resident appeared thin, was alert but no communicative, and was not oriented to person, place or time. -There was a plan to have the facility document the resident's food intake and to start feeding the resident if she ate less than 50% of her food. -She was unable to access the resident's recent hospital records but there was a possibility that the incident was caused by lack of intake with hydration and/or food. Review of Resident #13's PCP physician consultation report dated 01/28/22 revealed: -The resident had a 16-pound weight loss in 6 months. -There was an order to document the percentage of daily food intake for each meal. -There was an order for supplemental shakes	D 276		

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D 276	Continued From page 93 three times daily. -There was an order to assist and feed the resident if she began eating less than 50% of her meal. Review of Resident #13's record revealed there was no documentation of food intake or notification of weight loss to Resident #13's PCP. Review of Resident #13's hospital emergency department (ED) physician documentation note dated 04/08/22 revealed: -The resident presented to the ED via ambulance with generalized weakness and dehydration. -The resident was admitted to the hospital with diagnoses of altered mental status, hyperosmolality and hypernatremia (often caused by insufficient fluid intake), dehydration, hypokalemia (low potassium levels that could cause weakness, abnormal heart rhythms, or cardiac arrest), and adult failure to thrive. Review of Resident #13's hospital progress note dated 04/09/22 revealed: -The resident was being treated for hypernatremia, volume depletion, acute renal failure, metabolic encephalopathy, advanced dementia, severe malnutrition, and hypokalemia. -The resident's metabolic encephalopathy was likely secondary to the advanced dementia, hyponatremia, and volume depletion. -The resident likely had a poor prognosis due to advanced dementia. Review of Resident #13's hospital progress note dated 04/10/22 revealed: -The residents acute renal failure lab work showed improvement. -The resident was to continue treatment of IVF over the next 24-48 hours until the resident was	D 276		

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D 276	Continued From page 94 able to eat by mouth. -The provider discussed placing a feeding tube in the resident's stomach or placing the resident on hospice due to the high probability the resident would have to be readmitted for the same issues. Interview with a PCA on 04/06/22 at 8:55am revealed: -She was taught to feed residents by sitting at eye level, talk to the residents during the meal, not to rush the meal, and to offer drinks in between bites. -Some days Resident #13 would eat well, sometimes not; she would usually drink more than she ate. -Resident #13 did receive mighty shakes with her medications as scheduled. -She was not aware Resident #13 was to eat 50% or more of her food and drink. Interview with a personal care aide (PCA) on 04/08/22 at 10:36am revealed: -She was taught to provide feeding assistance to residents by sitting with them at eye level in a comfortable setting, to encourage independence in eating as able or assist as needed, encourage drinks in between bites, and to allow the resident to take as much time as they needed to eat without rushing them. -She was also taught encourage, remind, and redirect residents to eat and ensure their intake was enough trying to get them to eat at least 50% of their meal which could often take up to an hour. Confidential interview on 04/08/22 at 1:18pm revealed: -Resident #13 was able to feed herself and eat independently until March 2022 when staff had to begin assisting her.	D 276		

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D 276	Continued From page 95 -If you place a glass to Resident #13's mouth, she would drink, but she was unable to ask for it or do it herself due to her cognition and had to be offered. -Resident #13 was only offered water with her medications and was only served tea with her meals. -Staff had never been trained to provide water with meals and snacks. Interview with a supervisor/medication aide (MA) on 04/08/22 at 11:01am revealed: -She had just called the Resident #13's primary care provider (PCP) because the facility had just sent her out to the emergency department (ED) due to dehydration at the family's request. -She was not sure why the family felt Resident #13 was dehydrated or what prompted their concerns. -Resident #13 was able to walk with assistance that morning, but recently she had been sleeping a lot. -Resident #13 used to be able to feed herself but now the staff had to assist her with eating and ensure she received plenty to drink. -Resident #13 was offered supplement shakes four times as scheduled throughout the day and other fluids intermittently but on no schedule or time frame; she was not sure if there was a standard expectation or what was done on other shifts. -Administration of supplement shakes were documented on eMARs. Interview with the Administrator on 04/08/22 at 1:52pm revealed: -Resident #13's family member called the facility that morning, 04/08/22, stating concerns over the fact the resident was not eating or drinking and requested she be sent to the ED; she was not	D 276		

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D 276	Continued From page 96 sure why the family became concerned about the resident. -The staff had not reported any issues regarding Resident #13 to her, but she instructed the staff to send the supervisor/MA to send the resident out per the family's request. -Resident #13 was still at the ED and when she talked to the family, they were concerned the resident was failing to thrive. Telephone interview with the facility's contracted PCP on 04/07/22 at 1:00pm revealed: -She expected resident who required feeding assistance to be fed with dignity to include offering drinks in between bites. -She also expected staff to encourage residents to eat as much as possible over a one-hour time frame. -She expected to be notified if a resident was having issues eating to prevent weight loss, but she was not notified of Resident #13's weight loss because she had never seen the resident before. Telephone interview with Resident #13's PCP's registered nurse on 04/08/22 at 2:36pm revealed: -The resident's family member had called the triage nurse that morning, 04/08/22, expressing concerns about dehydration, lethargy, and weight loss and the resident was sent to the ED. -The resident was last seen by the PCP on 01/28/22 and weighed 103 pounds which was a 13-pound weight loss from her previous appointment 6 months prior. -The PCP ordered for staff to assist the resident with eating if she ate 50% or less of her meals on 01/28/22 to increase intake due to concerns from the resident's weight loss. Telephone interview with Resident #13's PCP on 04/08/22 at 4:17pm revealed:	D 276		

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D 276	Continued From page 97 -The resident had lost 13 pounds over a 6-month period when she last saw her in January 2022 and the facility failed to provide the meal and fluid intake logs to her as requested and ordered. -She expected the facility to feed the resident if the resident was taking 50% or less of her food encouraging her to eat and drink as much as possible, minimum of 40 ounces of fluid per day, and keep accurate logs for her to assess at follow up appointments. -If the resident began taking less than 50% of her meals or expected fluid intake, she expected to be notified within one week so she could assess her. -She was not notified that the resident had decreased intake of meals and fluids as ordered. -She also ordered and expected the facility to have the resident followed by the facility's contracted PCP as well because that provider was frequently onsite and able to follow the resident more closely. -The resident was not being seen by the contracted PCP and the facility had not provided intake logs for the resident as ordered. -It was a delicate balance to assess and treat the resident's disease process of natural decline versus lack of care being provided by the facility. -Decreased intake by the resident could lead to kidney failure, syncope (passing out), and dehydration. -If the resident was not getting enough to drink it would cause her mouth to be dry and therefor cause the her to have a decreased appetite and desire to eat. -She expected the facility to push fluids and serve water to the resident at least 6-8 times per day and anytime in between if the resident appeared thirsty due to the resident's decreased drive to drink. -It was difficult to assess the resident or intervene	D 276		

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D 276	Continued From page 98 when the facility did not communicate, provide documentation, or follow orders as written making it difficult to guide the resident's care and prevent deterioration and hospitalization. -If she had received the documentation or notification that the resident was experiencing continued decreased intake or change in status, she would have assessed the resident to reevaluate her needs. -Continued weight loss would increase the resident's frailty, which would lead to decreased movement, leading to an increased possibility of falls which could all potentially lead to the resident's demise. Refer to interview with the Administrator on 04/07/22 at 5:00pm. 2. Review of Resident #3's current FL-2 dated 03/28/22 revealed: -Diagnoses included heart failure, hypertensive heart disease, chronic obstructive pulmonary disease (COPD), anxiety, spondylosis without myelopathy or radiculopathy, and a history of pulmonary embolism. -There was no other assessment information located on the document. Review of a physician's note dated 11/11/19 revealed the resident had a history of a cardiovascular accident (CVA) with lasting hemiplegia and required the use of a walker to ambulate safely. Review of Resident #3's current care plan dated 03/28/22 revealed: -The resident had limited strength and was ambulatory with a wheelchair or walker. -The resident was sometimes disoriented, forgetful, and required reminders.	D 276		

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D 276	Continued From page 99 -The resident required his meat to be cut up and limited assistance with eating, ambulating, and transferring and extensive assistance with toileting, bathing, dressing, and grooming. Review of Resident #3's progress notes dated 02/26/22 revealed: -The resident was sent to the emergency department (ED) that day due to being unresponsive. -The resident became responsive when emergency medical services (EMS) arrived stating he did not feel well and was transported to the ED for further evaluation. Review of a hospital discharge note for Resident #3 dated 02/26/22 revealed: -The resident was diagnosed with syncope (passing out) and was to follow up with his primary care provider (PCP) in 1-2 days. -The resident was to drink plenty of fluids and stay well hydrated. Review of Resident #3's progress noted dated 02/26/22 at 4:00pm revealed the resident had returned to the facility from the hospital and was advised to drink plenty of fluids. Review of a PCP order for Resident #3 dated 02/26/22 revealed there was an order for hydration with water by mouth regularly. Review of Resident #3's record revealed there was not documentation of the resident's water intake. Review of Resident #3's primary care provider (PCP) note dated 03/03/22 revealed: -He was assessed as a follow-up to a visit to the ED in which he had a syncopal episode on	D 276		

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D 276	Continued From page 100 02/26/22 in which he was noted to have a heart rate of 55 on an EKG and 50 upon admission (normal 60-100). -There was an order to change a blood pressure medication and to obtain a blood pressure and heart daily for two weeks alternating times on day and evening shifts. Review of Resident #3's PCP note dated 03/24/22 revealed: -The resident's daily heart rate and blood pressure values had been assessed as stable with a heart rate ranging from 61-80 after his medication change. -The resident's body mass index (BMI) was above normal with the facility controlling meals and portions but the resident also consumed outside food and drink. -She was unable to counsel the resident on his food and drink intake due to his inability to understand and retain information and would continue to monitor him. Observation of breakfast on 04/06/22 from 8:01am to 9:08am revealed: -Resident #3 was served his breakfast at 9:08am, over one hour later than residents in the dining room were served their breakfast. -Resident #3's breakfast consisted of 1 piece of toast, 1 cup of oatmeal, 1 pat of jelly, 1 cheese omelet, 1 sausage link, and 8 ounces of orange juice. -Resident #3 fed himself his breakfast consuming 50% of the meal and orange juice but was not offered or served any milk or water with the breakfast. Interview with Resident #3 on 04/06/22 at 9:08am revealed: -He normally received his breakfast late, but he	D 276		

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D 276	Continued From page 101 did not know why. -He was still hungry after his breakfast but would not ask for more. -Previously, when he asked for more food, he had been told there was no more or that he was only allowed one plate and would not offer to make him anything else. -If he was given more to drink, he would consume it. -He was bedbound and unable to get food and drink for himself. observation of Resident #3 on 04/06/22 at 11:18am revealed: -There was a water bottle on his bedside table with a pink liquid in it. -The water bottle had a was open and had a straw in it and was ¾ full. Interview with Resident #3 on 04/06/22 at 11:18 revealed: -His roommate got him some lemonade to drink because he was thirsty. -No one had been in his room to check on him since breakfast. -If he did not have his roommate, he would not get enough to drink. Interview with Resident #3's roommate on 04/05/22 at 10:10am revealed: -Resident #3 was bedbound, unable to reposition himself on his own, and the staff did not get the resident out of bed each day as his family desired. in the room with Resident #3, the resident would be unable to reach the call bell and could not remember how to use the call bell if he needed help or assistance. -He looked out for Resident #3 to ensure the resident had what he needed.	D 276		

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D 276	Continued From page 102 Observation of lunch on 04/06/22 from 12:45pm to 1:39pm on the Assisted Living (AL) unit revealed: -Lunch was served to the residents seated in the dining room at 12:45pm. -It was realized that there were no plates prepared for bedbound residents in their rooms at 1:20pm. -Plates were placed on a wheeled cart and served to the bedbound residents at 1:30pm. -Resident #3 was offered his lunch consisting of a bowl of chicken noodle soup, a steak sandwich, mixed vegetables, and a cup of tea. -A PCA stood over Resident #3 at his bedside to assist him and feed him his lunch. -Resident #3 declined his chicken noodle soup, took large bites of the steak sandwich before finishing the previous bite, coughed while chewing at 1:32pm, chewed quickly, declined his vegetables, and drank the tea at the end after declining the tea in between bites. -Resident #3 finished his lunch meal in 9 minutes at 1:39pm and was not offered any water with his lunch. Interview with a personal care aide (PCA) on 04/07/22 at 3:45pm revealed: -PCAs were responsible to help prepare and serve food as needed and lack of kitchen staff contributed to delays in resident's receiving food on time. -The facility only offered water with breakfast or lunch and it was only offered to a few residents and she was unsure how they were identified to receive the water. -She was not aware that water was expected to be served daily with all meals and snacks and did not know why the facility did not train the staff to do so.	D 276		

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D 276	Continued From page 103 -Resident #3 had never asked her for water and she was unsure if he would be able to know to ask. -Resident #3's family provided water and snacks to him because they had been worried about dehydration. -She did not recall Resident #3 having an order to administer water. Interview with a medication aide (MA) on 04/07/22 at 4:22pm revealed: -She did not recall Resident #3 having an order to administer water. -Resident #3 did not use his call bell or request water that she could recall but thought he could if he wanted to. Telephone interview with Resident #3's family member on 04/08/22 at 7:52am revealed: -The family had been concerned the resident was not getting enough to drink after he was sent to the hospital on 02/26/22. -It was hard to find staff for assistance when she visited and sometimes 4-5 hours would go by before anyone would check on the resident. -The resident's skin was dry and flakey and the resident was not served water by the facility, only tea with meals. -She had been buying water bottled for the last month and the resident's roommate was ensuring he got enough to drink. -Since the resident had been drinking more water his skin had improved. -The resident was unable to transfer or walk and relied on the staff to check on him to meet his needs. Interview with a fourth PCA on 04/08/22 at 10:36 revealed: -Resident #3 was dependent on facility staff to	D 276		

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D 276	Continued From page 104 assist him with dressing, bathing, and feeding and he was unable to get up or meet his own needs. -Resident #3 was forgetful and disoriented much of the time and he would forget to consistently remember to use his call bell or reach it if he needed anything. -She tried to check on Resident #3 every 30-minutes when she worked to see if he needed anything, but his family provided water to the resident and his roommate ensured he drank it. -Tasks that often went undone due to not having enough time included making beds, offering hydration in between meals, and other things. -She tried to offer water every 30-minutes if the resident requested it and it was available with every meal and snack in the dining room; the resident would have to request it or get it themselves. Interview with the Administrator on 04/07/22 at 3:30pm revealed: -She was unable to find an I/A report for Resident #3's syncopal episode on 02/26/22 and could not recall specific details about the event. -She was not sure if the primary care provider (PCP) was notified of Resident #3's episode on 02/26/22 but expected the supervisor/MA to ensure the PCP was notified once the immediate needs of the resident were met. Telephone interview with Resident #3's primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -She expected orders to be clarified and implemented as written and was not aware the facility was not offering Resident #3 water regularly. -Not offering the residents water or other fluids could lead to dehydration, UTIs, acute renal	D 276		

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D 276	Continued From page 105 failure, syncope (passing out), decreased blood pressure - especially in residents who were on multiple medications, and could also lead to constipation which was often seen in facilities. -If residents were immobile, she expected the facility to encourage water intake and offer it in between meals if able. -Resident #3 would not always be able to realize or request fluids when needed and would sometimes require encouragement to drink enough, but if he was offered it regularly, he would likely drink it. -When Resident #3 went to the hospital on 02/26/22 for a syncopal episode, he was dehydrated but not to the point of having acute renal injury. -Lack of fluids could have contributed to Resident #3's syncope, but he also had bradycardia (low heart rate) in which she recently adjusted some of his medications to treat, so it was hard to say if the episode was completely caused by lack of fluids or if his previous medications also played a role. Refer to interview with the Administrator on 04/07/22 at 5:00pm. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -She expected residents to be fed at eye level in an unrushed manner and to be served at the same times as the rest of the residents, being offered all the same foods and drinks that were offered to everyone else, and being offered drinks in between bites of food. -She expected all staff to push and encourage fluid intake to try and prevent dehydration. -It was also important for residents who required assistance with feeding to be supervised for safety and to have company for socialization,	D 276		

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D 276	Continued From page 106 especially if they were unable to come to the dining room for the meal on their own. -It was concerning that residents had decreased intake and she did not want residents to miss meals but would have to investigate the issues further. The facility failed to ensure 2 of 6 sampled residents (#3, #13) had orders implemented related to feeding assistance and food intake documentation (#13) and fluid intake (#3, #13), resulting in failure of prevention in weight loss (#13), dehydration (#3, #13), severe malnutrition, and hospitalization (#13), and decreased fluid volume (#3, #13) and syncopal episodes requiring evaluation at the emergency department (ED) (#3). This failure was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 04/29/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 23, 2022	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.	D 282		

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D 282	Continued From page 107 This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the kitchen was clean and protected from contamination related to a mice infestation and mice droppings in and around improperly stored food. The findings are: Review of the facility's current food establishment sanitation report dated 01/29/22 revealed: -The facility's sanitation score was a 97. -All food items were to be removed from the floor and stored at least 6 inches above the floor. Review of the facility's current sanitation report dated 01/29/22 revealed: -The facility's sanitation score was a 95. -The flooring was badly cracked and hard to clean and there were holes in the walls in the spa bathrooms and storage rooms that needed to be patched. Observation of the kitchen and surrounding areas within the kitchen on 04/05/22 from 3:30pm to 4:30pm revealed: -There were cardboard boxes of food stored on the floor in the pantry and a sticky mousetrap on the floor under the pantry shelves. -There was a box of saltine crackers sitting on a shelf that had been chewed through with crumbs of debris and dried food that appeared to be okra and noodles sitting on the plastic container next to the box. -The floor had a black and brown thick sticky substance on it and there were copious amounts of mice droppings on top of containers of food and along the edges of the walls under the shelves of food in the entirety of the room. -The oven had a thick black substance caked to	D 282		

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D 282	Continued From page 108 the inside of the door which appeared to be dried cooked food that had spilled. -The floors in the kitchen also had a brown sticky substance on them and there was a dead roach on the floor at the corner of the oven. -The door leading out of the kitchen into the special care unit (SCU) dining room had a brown substance all over the middle portion of the door. -There was a utility room off the kitchen before reaching the SCU dining room door with a computer and keyboard on the floor. -There was a sticky mouse trap on the floor next to the computer covered in dirt, debris, and two dead mice. -There was another sticky mouse trap on the floor behind the computer in the corner behind the door with six dead mice and two dead roaches on it. -There were mice droppings and debris littering the entirety of the floor which also had a sticky brown substance on it in the utility room. Interview with the dietary manager on 04/05/22 at 10:48am and 3:30pm revealed: -He started working at the facility 4 days prior on 04/01/22. -He had never seen mice or other pests in the kitchen since he started working at the facility and he was unaware that the black droppings in the pantry were from mice activity. -He was not aware there were dead mice on traps in the utility room next to the kitchen as he had not been in that room yet. -He was not sure if the Administrator was aware of the pest issue in the kitchen or if there was a contracted exterminator to treat the issue. -He was not completely aware of how food should be stored but was concerned that there was mice activity in a room where there was open food.	D 282	Food that was uncovered, no label or date, expired or spoiled were disposed of immediately. Dietary Staff were re-trained by Administrator in Charge and Compliance Director on cleaning expectations and procedures to ensure foods are free from contamination, expired and spoiled food are disposed of, open food packages that are labeled or dated, food in the refrigerator is covered. Administrator will monitor to ensure foods are free from contamination, expired and spoiled food are disposed of, open food packages that are labeled or dated, food in the refrigerator is covered.	5/23/2022

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D 282	Continued From page 109 Observation of the kitchen pantry on 04/06/22 at 12:02pm revealed there was no change from the previous day. Interview with the dietary manager on 04/06/22 at 12:02pm revealed: -He had not had time to clean the pantry because he was the only person working in the kitchen that day. -He asked the Administrator for permission to come in the following weekend on his day off to clean the pantry when someone else would be present to prepare food for the residents. -He was not aware of dead mice in the utility room; he had not gone in that room before. Interview with the Administrator on 04/05/22 at 5:23pm revealed: -She was aware there was mice activity in the kitchen and some resident's rooms. -She was told upon starting in February 2022 that mice had always been a problem in the kitchen and the exterminator had tried different kinds of traps to control the issue. -She was not aware of any dead mice on traps in the kitchen utility room and it was concerning that mice were in the pantry where food was not being stored correctly being left open or stored on the floor. -She was not concerned about food contamination from the mice with the open food that was not stored properly because she trusted the new dietary manager to throw it away if it had been contaminated. -She had not had a conversation about proper food storage or food contamination with the dietary staff yet, but she would train them on contamination and cleanliness. Interview with the facility's contracted primary	D 282		

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D 282	Continued From page 110 care provider (PCP) on 04/07/22 at 1:00pm revealed: -She would generally come to the facility early in the mornings when it was still dark outside as residents were waking up and was not aware there was an issue with mice at the facility but was aware of a previous infestation of bed bugs which she thought was under control. -She expected the facility to control pest infestations and store food to prevent contamination because mice droppings could cause transmission of diseases through contamination to the residents. -It was especially concerning that the resident's food could be contaminated, and she expected the facility to employ an exterminator and follow the recommendations to get rid of pests to prevent complications. Telephone interview with the local health department's sanitation inspector on 04/08/22 at 3:38pm revealed: -She expected the facility to store food properly, throw contaminated food away, and ensure floors and surfaces were kept clean and free of crumbs that would continue to attract mice and other pests. -Contact with mouse feces could transmit viruses and bacteria especially if it was ingested through contaminated food such as Listeria (a foodborne illness that could cause headache, stiff neck, and confusion) and Salmonella (a foodborne illness that could cause nausea, vomiting, and diarrhea). -Residents who were elderly, on multiple medications, or immunocompromised were more at risk to issues that could result from mice dropping contamination and proper cleaning and food handling was imperative by the facility.	D 282		

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D 296	Continued From page 111	D 296		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve therapeutic diets as compared to the menus available for use and guidance by the dietary staff as ordered by the primary care provider (PCP) for 4 of 5 sampled residents (#1, #3, #4, and #11) who had diet orders for no concentrated sweets (NCS) (#1), no added table salt (NATS) (#3, #11), and renal (#4). The findings are: Review of the facility's regular weekly diet menu revealed: -The breakfast menu for 04/06/22 included juice of choice, fresh fruit, cereal of choice, egg, breakfast meat, assorted breakfast bread, margarine, jelly or syrup, milk, coffee or hot tea. -There was a therapeutic diet menu available to serve breakfast as a pureed diet, but there were no therapeutic diet menus available to prepare and serve breakfast as a NCS, NATS, or renal diet. -The lunch menu for 04/06/22 included fried chicken, mashed potatoes, brown gravy, mixed vegetables, wheat dinner roll or bread, margarine, vanilla ice cream, and beverage of choice.	D 296	Menus for each therapeutic diet were in the kitchen notebook. Administrator in Charge re-trained dietary staff on preparing meals according to each therapeutic diet. Dietary Manager/Designee monitored 2 meals per week x3 weeks, then randomly thereafter to ensure meals are prepared according to each therapeutic diet. Administrator will monitor meals randomly to ensure meals are prepared according to each therapeutic diet.	5/23/2022

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D 296	Continued From page 112 -There was a therapeutic diet menu available to serve lunch as a pureed diet, but there were no therapeutic diet menus available to prepare and serve lunch as a NCS, NATS, or renal diet. Interview with the dietary manager on 04/05/22 at 3:30pm revealed: -The Administrator had posted an updated therapeutic diet list that morning, 04/05/22. -He was unsure if the facility had therapeutic diet menus and he was unsure if he was to prepare food differently for the resident's therapeutic diets listed with the exception of pureed diets in which he had been trained by another staff member to do. -He had not received any training yet on the preparation of therapeutic diets. -He cooked all meals with minimal salt and there was salt in the spices he used to season food. -He used sugar to make sweet tea that was served to all residents at lunch and dinner. Interview with the dietary manager on 04/06/22 at 7:30am revealed: -He was making substitutions to the regular breakfast and lunch menus that day due to not having the ingredients on hand to cook those meals. -Breakfast would consist of orange juice, pork sausage links, egg and cheese omelets, toast, oatmeal, and cereal. -Lunch would consist of tea or water, steak and cheese subs, vegetable medley, chicken noodle soup, and tropical fruit salad. Interview with the dietary manager on 04/05/22 at 10:48am and 3:30pm revealed: -He started working at the facility 4 days prior on 04/01/22. -He was in the process of getting everything	D 296		

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D 296	Continued From page 113 straightened out and was responsible to ensure all meals were prepared and served as ordered. -There were only two dietary staff members hired at the facility; him and one other cook who came in at 1:00pm. -He knew there were a lot of things that needed to be fixed but needed guidance and educated on how to go about doing things the right way per rules and regulations as he was unsure where to even find the rules for guidance. -The Administrator had just updated the resident's therapeutic diet order list that day, 04/05/22, and posted it in the kitchen. -To his knowledge, there were no therapeutic diet menus to match the therapeutic diets residents were ordered and he was unaware of where to find the guidance to prepare meals for residents on therapeutic diets. -He was still in training and had not yet received any training on therapeutic diets for residents and was unsure what to do differently to ensure therapeutic diets were served correctly as ordered in regard to NCS, NATS, and renal therapeutic diets. 1. Resident #4's current FL-2 dated 01/27/22 revealed: -Diagnoses included diabetes mellitus, hypertension, arthritis, gout, muscle weakness, congestive heart failure, hyperlipidemia, and Alzheimer's disease. -There was an order for the resident to be served a renal diet (a diet commonly used for residents with kidney issues and/or requiring dialysis). Review of Resident #4's record revealed she attended dialysis three times weekly. Review of the facility's therapeutic diet list revealed Resident #4 revealed the resident was	D 296		

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D 296	Continued From page 114 to be served a renal diet. Observation of Resident #4's breakfast meal preparation in the main kitchen on 04/06/22 at 7:52am revealed the dietary manager prepared a plate of toast, oatmeal, cheese omelet, sausage link, 1 packet of jelly, cereal with milk, and 8 ounces of orange juice for Resident #4. Observation of Resident #4 on 04/06/22 from 8:01am to 8:20am revealed the resident ate 100% of the food and beverages she was served for breakfast. Observation of Resident #4's lunch meal preparation in the main kitchen on 04/06/22 at 12:40pm revealed the dietary manager prepared a plate of steak and cheese sub, vegetable medley, chicken noodle soup, and 8 ounces of sweet tea for Resident #4. Observation of Resident #4 on 04/06/22 from 12:45pm to 1:14pm revealed the resident consumed 100% of the food and beverages she was served. Refer to interview with the Administrator on 04/05/22 at 5:23pm. Refer to interview with the corporate food service director on 04/08/22 at 11:23am. Refer to interview with an Administrator from a sister facility on 04/08/22 at 4:40pm. Refer to interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm. 2. Review of Resident #1's FL-2 dated 12/02/21	D 296		

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D 296	Continued From page 115 revealed: -Resident #1 had diagnoses of dementia, disorientation, cardiovascular accident (CVA), frontal lobe CVA and metabolic encephalopathy. -Resident #1 resided on the special care unit and there was an order for a no concentrated sweets (NCS) therapeutic diet. Review of the facility's therapeutic diet list revealed Resident #1 was to be served a no concentrated sweets diet. Observation of Resident #1's breakfast meal preparation in the main kitchen on 04/06/22 at 7:52am revealed the dietary manager prepared a plate of toast, oatmeal, cheese omelet, sausage link, 1 packet of jelly (regular - not sugar free), 8 ounces of orange juice, and 8 ounces of water for Resident #1. Observation of Resident #1 on 04/06/22 from 8:09am to 8:35am revealed the resident ate 100% of the food and beverages he was served for breakfast. Observation of Resident #1's lunch meal preparation in the main kitchen on 04/06/22 at 12:40pm revealed the dietary manager prepared a plate of steak and cheese sub, vegetable medley, chicken noodle soup, and tropical fruit salad with 8 ounces of sweet tea and 8 ounces of water for Resident #1. Observation of Resident #1 on 04/06/22 from 11:30am to 1:17pm revealed Resident #1 consumed 100% of the food and beverages he was served. Refer to interview with the Administrator on 04/05/22 at 5:23pm.	D 296		

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D 296	Continued From page 116 Refer to interview with the corporate food service director on 04/08/22 at 11:23am. Refer to interview with an Administrator from a sister facility on 04/08/22 at 4:40pm. Refer to interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm. 3. Resident #3's current FL-2 dated 03/28/22 revealed: -Diagnoses included heart failure, hypertensive heart disease, chronic obstructive pulmonary disease (COPD), anxiety, spondylosis without myelopathy or radiculopathy, and a history of pulmonary embolism. -There was no other assessment information located on the document. Review of Resident #3's diet order dated 03/28/22 revealed the resident was to be served a no added table salt (NATS) diet. Review of the facility's therapeutic diet list dated 04/05/22 revealed Resident #3 revealed the resident was to be served a NATS diet. Observation of Resident #3's breakfast meal preparation in the main kitchen on 04/06/22 at 7:52am revealed the dietary manager prepared a plate of toast, oatmeal, cheese omelet, sausage link, 1 packet of jelly, and 8 ounces of orange juice for Resident #1. Observation of Resident #3 on 04/06/22 from 8:09am to 8:35am revealed the resident ate 50% of the food and beverages he was served for breakfast leaving the oatmeal, jelly, and the toast	D 296		

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D 296	Continued From page 117 untouched. Observation of Resident #3's lunch meal preparation in the main kitchen on 04/06/22 at 1:20pm revealed the dietary manager prepared a plate of steak and cheese sub, vegetable medley, chicken noodle soup, and 8 ounces of sweet tea for Resident #3. Observation of Resident #3 on 04/06/22 from 1:30pm to 1:39pm revealed the resident consumed 100% of the steak sandwich, 10% of the vegetable medley, 0% of the chicken noodle soup, and 100% of the sweet tea he was served. Refer to interview with the Administrator on 04/05/22 at 5:23pm. Refer to interview with the corporate food service director on 04/08/22 at 11:23am. Refer to interview with an Administrator from a sister facility on 04/08/22 at 4:40pm. Refer to interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm. 4. Review of Resident #13's current FL-2 dated 02/12/21 revealed: -Diagnoses included dementia, hyperlipidemia, hypertension, osteoporosis, edema, and venous insufficiency. -The resident was on a regular diet with no added table salt (NATS). Review of the facility's therapeutic diet list dated 04/05/22 revealed Resident #13 was to be served a NATS diet.	D 296		

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D 296	Continued From page 118 Observation of Resident #13's breakfast meal preparation in the main kitchen on 04/06/22 at 7:52am revealed the dietary manager prepared a plate of toast, oatmeal, cheese omelet, sausage link, 1 packet of jelly, 8 ounces of orange juice, and 8 ounces of water for Resident #13. Observation of Resident #13 on 04/06/22 from 8:10am to 8:27am revealed the resident ate 50% of the food and 0% of the beverages he was served for breakfast. Observation of Resident #13's lunch meal preparation in the main kitchen on 04/06/22 at 12:40pm revealed the dietary manager prepared a plate of steak and cheese sub, vegetable medley, chicken noodle soup, and tropical fruit salad with 8 ounces of sweet tea for Resident #13. Observation of Resident #13 on 04/06/22 from 1:04pm to 1:17pm revealed the resident consumed 30% of the food and 50% of beverages she was served. Refer to interview with the Administrator on 04/05/22 at 5:23pm. Refer to interview with the corporate food service director on 04/08/22 at 11:23am. Refer to interview with an Administrator from a sister facility on 04/08/22 at 4:40pm. Refer to interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm. Interview with the Administrator on 04/05/22 at 5:23pm revealed:	D 296		

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D 296	Continued From page 119 -She had updated the resident therapeutic diet list in the kitchen that day, 04/05/22, for the dietary staff to reference. -She was not sure if the facility had therapeutic diet menus or if they had been reviewed by a dietician and would have to look for them. -The only food service orientation the dietary manager had receive thus far was the online module provided by the state; he had not received any training on therapeutic diets yet. -It was important to serve therapeutic diets as ordered because the doctor ordered it for the resident for a reason. Interview with the facility's corporate food service director on 04/08/22 at 11:23am revealed: -Therapeutic diet menus were expected to be accessible to dietary staff and they should be trained to use them based on the menu being prepared. -It was important for dietary staff to prepare therapeutic diets as ordered by resident's physicians. Interview with an Administrator from a sister facility on 04/08/22 at 4:40pm revealed: -She was able to find therapeutic diets menus in the kitchen on a lower shelf in another book that matched the therapeutic diets for NCS, NATS, and renal diets. -She was not sure why the dietary manager and staff were unaware of where to find the menus but were expected to have training and serve therapeutic diets per the therapeutic diets menus accurately as ordered. Interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -It was concerning that the facility was not aware	D 296		

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D 296	Continued From page 120 to reference the therapeutic diet menus and that the kitchen staff had not been trained to prepare therapeutic diets as ordered. -Not serving therapeutic diets as ordered could affect residents' blood sugar, blood pressure, and contribute to end state renal disease depending on their diagnoses. -She expected the facility staff to be trained to prepare and serve therapeutic diets as ordered accurately because there were residents at the facility who were diabetic who's blood sugars could be affected and residents who required dialysis due to renal issues who could get too much salt causing retention of too much fluid.	D 296		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 8 ounces of milk was offered twice daily to residents residing in the Assisted Living (AL) and Special Care Unit (SCU) of the facility.	D 299	Staff were retrained on serving milk to residents at least twice per day. Dietary Staff will offer milk twice per day to each resident as per rule area. Dietary Manager/Designee will monitor meals x2 per week x3 weeks then randomly thereafter, to ensure milk is included in daily menus as per rule 10A NCAC 13F .0904(d)(3)(A) Administrator will audit randomly to ensure milk is included in daily menus as per rule 10A NCAC 13F .0904(d)(3)(A)	5/23/2022

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D 299	Continued From page 121 The findings are: Review of the facility's census on 04/05/22-04/08/22 revealed: -There were 47 residents total. -There were 15 residents residing on the Special Care Unit (SCU) and 32 residents residing on the Assisted Living (AL) unit. Review of the week-at-glance menu posted in the kitchen for 04/06/22 revealed: -There was a listing for coffee or hot tea and milk for the breakfast meal. -There was a listing for a beverage of choice for the lunch meal. -There was no milk listed for a second meal on the menu on any day of the week. Observation of the breakfast meal service on the Assisted Living (AL) unit on 04/06/22 revealed: -Breakfast was served by the personal care aides (PCAs) to the residents at 8:01am and was completed at 8:45am. -There were 0 of 32 residents observed to be served or offered milk as a beverage. Observation of the breakfast meal service on the Special Care Unit (SCU) on 04/06/22 revealed: -Breakfast was served by the PCAs to the residents at 8:09am and was completed at 8:48am. -There were 0 of 15 residents observed to be served or offered milk. Observation of the lunch meal service on the AL unit on 04/06/22 revealed: -Lunch was served by the personal care aides (PCAs) to the residents at 12:45pm and was completed at 1:39pm. -There were 0 of 32 residents observed to be	D 299		

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D 299	Continued From page 122 served or offered milk. Observation of the lunch meal service on the SCU on 04/06/22 revealed: -Lunch was served to independent residents at 12:54pm and residents requiring assistance at 1:04pm. -There were 0 of 15 residents observed to be served or offered milk. Interview with a resident on 04/06/22 at 10:25am revealed: -The facility staff served milk only to add to cereal. -Resident's practically had to beg to get enough to drink and only received milk if they ask for it. Interview with a second resident on 04/06/22 at 11:05am revealed: -He did not like to drink out of the facility cups because they were not clean, stained brown, and there were not enough cups to go around. -Milk was never offered to residents unless they asked for it, but he would drink milk if it was offered to him. Interview with a medication aide (MA) on 04/08/22 at 11:01am revealed: -Milk was only offered to residents to add to cereal. -She was not aware of a rule to offer milk twice daily and was never trained to do so. Interview with the dietary manager on 04/05/22 at 10:48am and 3:30pm revealed: -He needed guidance and education on how to go about doing things the right way per rules and regulations as he was unsure where to even find the rules for guidance. -The facility only served milk to residents who ate	D 299		

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D 299	Continued From page 123 cereal in the morning. -He was not aware there was a rule to serve milk to residents twice daily. Interview with the dietary manager on 04/08/22 at 11:30am revealed: -He did not know to serve milk twice daily until being made aware on 04/05/22. -It was frustrating because he did not have enough cups in the kitchen to serve residents their normal beverage along with water/milk with each meal. -He would have to report the need for more cups to the Administrator because he really wanted to do what was right for the residents. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -She did not realize staff were not offering milk as expected to residents twice daily. -She was not sure why milk was not being offered as expected because staff should have been trained to offer milk twice daily upon hire. -The facility's dietary manager was new and still in training so he might not have known to serve milk. Interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -She expected milk to be served at least twice daily. -Milk was an important component to maintain residents' nutrition status and having it regularly could help prevent osteoporosis (degenerative bone disease).	D 299		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service	D 306		

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D 306	Continued From page 124 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure water was served with meals to all residents. The findings are: Review of the facility's census on 04/05/22-04/08/22 revealed: -There were 47 residents total. -There were 15 residents residing on the Special Care Unit (SCU) and 32 residents residing on the Assisted Living (AL) unit. Review of the week-at-glance menu posted in the kitchen for 04/06/22 revealed: -There was a listing for coffee or hot tea and milk for the breakfast meal. -There was a listing for a beverage of choice for the lunch meal. -There was no water listed on the menu for any meal or snack on any day of the week. Observation of the breakfast meal service on the Assisted Living (AL) unit on 04/06/22 revealed: -Breakfast was served by the personal care aides (PCAs) to the residents at 8:01am and was completed at 8:45am. -There were 0 of 32 residents observed to be	D 306		

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D 306	Continued From page 125 served or offered water as a beverage. Observation of the breakfast meal service on the Special Care Unit (SCU) revealed: -Breakfast was served by the personal care aides (PCAs) to the residents at 8:09am and was completed at 8:48am. -There were 3 of 15 residents observed to be served water and there was no water served or offered to the other 12 residents. Observation of the lunch meal service on the AL unit on 04/06/22 revealed: -Lunch was served by the PCAs to the residents at 12:45pm and was completed at 1:39pm. -There were 6 of 32 residents observed to be served or offered water and there was no water or served to the other 39 residents. Observation of the lunch meal service on the SCU on 04/06/22 revealed: -Lunch was served to independent residents at 12:54pm and residents requiring assistance at 1:04pm. -There were eight 8-ounce cups on ice water on a cart, but they were not offered to the residents. -There were 0 of 15 residents observed to be served or offered water. Interview with a resident on 04/06/22 at 9:08am revealed: -The facility never offered any water with meals or throughout the day unless residents asked for it. -If there was a snack offered, it would be in a bowl in the dining room and the resident would have to get it themselves, there was never anything offered to drink with snacks. Interview with a second resident on 04/06/22 at 10:25am revealed:	D 306	Staff were retrained on serving water to each resident at each meal. Dietary Staff will offer water to each resident as per rule area. Dietary Manager/Designee will monitor meals x2 per week x3 weeks then randomly thereafter, to ensure water is included in daily menus as per rule 10A NCAC 13F .0904(d)(3)(H) Administrator will audit randomly to ensure water is included in daily menus as per rule 10A NCAC 13F .0904(d)(3)(H)	5/23/2022

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D 306	Continued From page 126 -The facility staff knew to serve water with every meal and snack, and they used to do so before COVID-19. -Resident's practically had to beg to get enough to drink and only receive water if they ask for it. Interview with a third resident on 04/06/22 at 11:05am revealed: -He did not like to drink out of the facility cups because they were not clean, stained brown, and there were not enough cups to go around. -Water was never offered to residents unless they asked for it, so he bought his own bottled water and kept it in his room to drink when he was thirsty. Observation of the kitchen during preparation of lunch on 04/06/22 at 12:40pm revealed: -There were not enough cups for each resident to have more than one beverage with the meal service. -The office manager was in the kitchen helping the dietary manager prepare food and drinks. -The dietary manager prepared 6 cups of water and 16 cups of sweet tea for the SCU cart and 9 cups of water and 13 cups of sweet tea for the AL cart. -There were 23 other smaller cups on the shelf empty and not in use. Interview with a PCA on 04/07/22 at 3:45pm revealed: -PCAs were responsible to help prepare and serve food as needed and lack of kitchen staff contributed to delays in resident's receiving food on time. -The facility only offered water with breakfast or lunch and it was only offered to a few residents; she was unsure how they were identified to receive the water.	D 306		

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D 306	Continued From page 127 -She was not aware that water was expected to be served daily with meals and did not know why the facility did not train the staff to do so. Interview with a medication aide (MA) on 04/08/22 at 11:01am revealed: -Residents were offered fluids intermittently but on no schedule or time frame; she was not sure if there was a standard expectation or what was done on other shifts. -She was not sure why water had not been served as expected. -Water should be offered with meals, snacks, and in between if the residents asked for it or if staff knew they would drink. -She was not aware of a rule to offer water with all meals and was never trained to do so. Interview with a previous staff member on 04/06/22 at 10:13am revealed: -She worked at the facility until February 2022. -The facility never served water to residents on a regular basis or with meals. -Water was only served to residents upon request. Interview with the dietary manager on 04/05/22 at 10:48am and 3:30pm revealed: -He needed guidance and education on how to go about doing things the right way per rules and regulations as he was unsure where to even find the rules for guidance. -He did not know how the cook or PCAs decided to who would be served water, but it was normal to only see them prepare minimal cups of water to be passed out with each meal service. -He was not aware there was a rule to serve water to all residents with every meal and snack service.	D 306		

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D 306	Continued From page 128 Second interview with the dietary manager on 04/08/22 at 11:30am revealed: -He was not aware to serve water until being made aware on 04/05/22. -It was frustrating because he did not have enough cups in the kitchen to serve residents their normal beverage along with water/milk with each meal. -He would have to report the need for more cups to the Administrator because he really wanted to do what was right for the residents. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -She thought staff were offering water at every meal service. -She expected staff to offer water with every meal because it was important for the residents to stay hydrated and no one should eat something without a drink. -Water was not being offered as expected because staff should have been trained to offer water with meals. -The facility's dietary manager was new and still in training so he might not have known to serve water. -She also expected all staff to try to push and encourage water intake to prevent dehydration. Interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -It was concerning that the facility was not offering water to residents regularly and she expected the facility to offer water with every meal and upon request to the residents. -Not offering the residents water could lead to dehydration, UTIs, acute renal failure, syncope (passing out), decreased blood pressure - especially in residents who were on multiple	D 306		

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D 306	Continued From page 129 medications, and could also lead to constipation which was often seen in facilities. -If residents were immobile, she expected the facility to encourage water intake and offer it in between meals if able.	D 306		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) Sufficient staff shall be available for individual feeding assistance as needed. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was sufficient staff available to provide feeding assistance for 2 of 5 sampled residents who required (#3, #13) resulting in delayed assistance and being rushed with eating meals while waiting to be served in his room (#3) and being rushed through a meal without being offered fluids and encouragement to eat 50% or more of the meal (#13). The findings are: Observation of a personal care aide (PCA) in the kitchen on 04/06/22 at 7:30am revealed: -She was preparing bowls of cereal and milk to be served for breakfast. -She was preparing orange juice to be served for breakfast. Observation of a second PCA on 04/06/22 at 8:50am revealed she was spraying and wiping	D 311	Special Care Unit Coordinator and Administrator will assess to see how many residents need assistance with eating. Administrator will schedule adequate staff to meet the needs of residents needing assistance with eating. Special Care Unit Coordinator will ensure that all residents needing assistance with eating receive help upon receipt of the meal.	5/23/2022

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D 311	Continued From page 130 down tables after the breakfast meal service was completed. 1. Review of Resident #3's current FL-2 dated 03/28/22 revealed: -Diagnoses included heart failure, hypertensive heart disease, chronic obstructive pulmonary disease (COPD), anxiety, spondylosis without myelopathy or radiculopathy, and a history of pulmonary embolism. -There was no other assessment information located on the document. Review of a physician's note dated 11/11/19 revealed the resident had a history of a cardiovascular accident (CVA) with lasting hemiplegia and required the use of a walker to ambulate safely. Review of Resident #3's current care plan dated 03/28/22 revealed: -The resident had limited strength and was ambulatory with a wheelchair or walker. -The resident was sometimes disoriented, forgetful, and required reminders. -The resident required his meat to be cut up and limited assistance with eating, ambulating, and transferring and extensive assistance with toileting, bathing, dressing, and grooming. Interview with the dietary manager on 04/06/22 at 11:26am revealed: -He was not going to be service the lunch meal posted on the menu for that day because he did not have the ingredients. -The lunch meal to be served that day, 04/06/22, was going to be tea/water, Philly steak subs, vegetable medley, chicken noodle soup, and tropical fruit salad.	D 311		

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D 311	Continued From page 131 Observation of the lunch meal service on 04/06/22 from 12:45pm to 1:39pm on the Assisted Living (AL) unit revealed: -Lunch was served to the residents seated in the dining room at 12:45pm. -It was realized that there were no plates prepared for bedbound residents in their rooms at 1:20pm. -Plates were placed on a wheeled cart and lunch was served to Resident #3 at 1:30pm. -Resident #3 was offered his lunch consisting of a bowl of chicken noodle soup, a steak sandwich, mixed vegetables, and a cup of tea. -The food prepared for Resident #3 was a limited menu as compared to the meal offered to the residents in the dining room and omitted a cup of fruit as offered to the other residents in the dining room. -Resident #3 declined his chicken noodle soup, was fed large bites of the steak sandwich (approximately 1.5 x 1.5 inches) by a PCA before finishing the previous bite, coughed while chewing at 1:32pm, chewed quickly, declined his vegetables, and drank the tea at the end after declining the tea in between bites. -The PCA stood over Resident #3 at his bedside to assist him and fed him his lunch in a hurried manner (9 minutes), repeatedly asking him if he was ready for the next bite, then hurriedly moved on to assist and serve the next bedbound resident. -Resident #3 ate 100% of his steak sandwich and tea, 0% of his vegetable medley and chicken noodle soup, and was not served the fruit that was on the menu. Interview with Resident #3 on 04/06/22 at 9:08am and 2:16pm revealed: -If he did not have staff or his roommate to help him, he would not get what he needed.	D 311		

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D 311	Continued From page 132 -He did not like to eat fast, but he did not mind too much that day, 04/06/22, because lunch was late and he was really hungry. -If he had been offered fruit at lunch that day, he would have eaten it. -Sometimes he did not get enough to eat and stayed hungry most days. -If he were to ask for more to eat, the facility staff would tell him he was only allowed one plate or it was all gone. -The last time he asked for more to eat when he was still hungry was a couple of days ago and they did not offer to get him anything else, so he just stopped asking. Interview with a third PCA on 04/06/22 at 1:22pm and 1:44pm revealed: -There were three residents on the AL unit who required assistance with eating and two were bedbound, one of which included Resident #3. -Resident #3 required assistance eating small items and using utensils along with thin foods like soup; she would always ask him if he needed assistance prior to feeding him a meal. -She did not realize that the bedbound residents had not been offered fruit as the residents in the dining room had been but assumed there was no more fruit left and that was why. -She was trained to assist resident with eating by allowing them to take their time and not make the resident wait to eat, she was not trained to sit at eye level with a resident to feed them. Second interview with a third PCA on 04/07/22 at 3:45pm revealed: -There was no reason she did not serve fruit with lunch Resident #3 on the previous day (04/06/22) except she did not think about it and the kitchen did not provide it to her to offer it. -It was her priority to ensure bedbound residents	D 311		

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D 311	Continued From page 133 ate that day, 04/06/22, and she did not realize he did not get everything he should have. Refer to interview with a PCA on 04/06/22 at 7:40am. Refer to interview with a second PCA on 04/06/22 at 8:50am. Refer to interview with a third PCA on 04/07/22 at 3:45pm. Refer to interview with a fourth PCA on 04/08/22 at 10:36. Refer to interview with a supervisor/medication aide (MA) on 04/06/22 at 1:00pm. Refer to interview with a second supervisor/MA on 04/07/22 at 4:22pm. Refer to interview with the dietary manager on 04/05/22 at 10:48am. Refer to second interview with the dietary manager on 04/06/22 at 7:30am. Refer to interview with the Administrator on 04/07/22 at 5:00pm. Refer to interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm. 2. Review of Resident #13's current FL-2 dated 02/12/21 revealed: -The resident resided on the Special Care Unit (SCU). -Diagnoses included dementia, hyperlipidemia, hypertension, osteoporosis, edema, and venous	D 311		

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D 311	Continued From page 134 insufficiency. -The resident was on a regular diet with no added salt and there was an order for supplemental shakes twice daily. Review of Resident #13's current assessment and care plan dated 02/19/22 revealed the resident required supervision with eating. Review of Resident #13 primary care provider (PCP) visit note dated 12/17/21 revealed the resident had a 12-pound weight loss in the previous 6 months but did not appear to be dehydrated and was not alert to person, place, time, or communicative. Review of Resident #13's PCP physician consultation report dated 12/17/21 revealed: -The resident had a 12-pound weight loss in 6 months. -There was an order to increase the resident's portion sizes. Review of Resident #13's PCP physician consultation report dated 01/28/22 revealed: -The resident had a 16-pound weight loss in 6 months. -There was an order to document the percentage of daily food intake for each meal. -There was an order to assist and feed the resident if she began eating less than 50% of her meal. Observation of the breakfast meal service on the SCU on 04/06/22 from 8:09am to 9:00am revealed: -A PCA was seated at eye level with Resident #13 who required feeding assistance and was served breakfast at 8:10am consisting of a cheese omelet, one sausage link, 1 cup of oatmeal, 1	D 311		

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D 311	Continued From page 135 slice of toast, and 8 ounces of orange juice. -Resident #13 was fidgety and unable to sit still, mumbling, grabbed at the plate, and had to be reminded and redirected to eat. -Resident #13 would willingly take bites when offered and would sometimes point to the plate when she was ready for another bite of food; the resident was not offered any of her orange juice and did not have any other drinks in front of her. -At 8:27am, when the surveyor walked away, the PCA no longer redirected the Resident #13 to eat any more of her breakfast and escorted her out of the dining room; she consumed 50% of the breakfast and 0% of the orange juice she was served. Observations of the lunch meal service on the SCU on 04/06/22 at 11:30am revealed: -Staff began prepping and setting the tables for lunch at 11:49am while residents waited in the TV room across from dining room for lunch to be served. -At 12:35pm, staff knocked on the kitchen door and asked Dietary Manager what time lunch would be served. -Lunch was served to independent feeders at 12:54pm. -Residents were served steak sandwiches with mixed vegetables and 8 ounces sweet tea. -Staff began assisting and feeding Resident #13 at 1:04pm and ended at 1:17pm; she consumed 30% of her meal, 50% of her tea and she was not offered water. Telephone interview with Resident #11's PCP's registered nurse on 04/08/22 at 2:36pm revealed the resident had been followed for weight loss and the PCP ordered for staff to assist the resident with eating if she ate 50% or less of her meals on 01/28/22 to increase intake due to	D 311		

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D 311	Continued From page 136 concerns from the resident's weight loss. Telephone interview with Resident #11's PCP on 04/08/22 at 4:17pm revealed: -The resident had lost 13 pounds over a 6-month period when she last saw her in January 2022 and the facility failed to provide the meal and fluid intake logs to her as requested and ordered. -She expected the facility provide enough staff to feed the resident if the resident was taking 50% or less of her food encouraging her to eat and drink as much as possible, minimum of 40 ounces of fluid per day, and keep accurate logs for her to assess at follow up appointments. -If the resident began taking less than 50% of her meals or expected fluid intake, she expected to be notified within one week so she could assess her. -Continued weight loss would increase the resident's frailty, which would lead to decreased movement, leading to an increased possibility of falls which could all potentially lead to the resident's demise. Attempted interview with Resident #11's family member on 04/07/22 at 10:17am and 11:51am were unsuccessful. Refer to interview with a PCA on 04/06/22 at 7:40am. Refer to interview with a second PCA on 04/06/22 at 8:50am. Refer to interview with a third PCA on 04/07/22 at 3:45pm. Refer to interview with a fourth PCA on 04/08/22 at 10:36.	D 311		

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D 311	Continued From page 137 Refer to interview with a supervisor/medication aide (MA) on 04/06/22 at 1:00pm. Refer to interview with a second supervisor/MA on 04/07/22 at 4:22pm. Refer to interview with the dietary manager on 04/05/22 at 10:48am. Refer to second interview with the dietary manager on 04/06/22 at 7:30am. Refer to interview with the Administrator on 04/07/22 at 5:00pm. Refer to interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm. Interview with a PCA on 04/06/22 at 7:40am revealed: -She had been working at the facility since January 2022. -Staffing on the Assisted Living (AL) unit consisted on 1 medication aide (MA) and 1-2 PCAs. -There was only 1 PCA scheduled on the AL unit that day, 04/06/22. -It was the facility's expectation for PCAs to help assist with preparing and serving breakfast and lunch daily due to there not being any other kitchen staff. -The PCAs did not cook the food, but they would prepare non-cooked foods and drinks, set up tables and dining service, serve residents, and clean up after the meal. -PCAs were also responsible to wash the laundry and answer resident call bells and assist residents with all their needs to include make beds, tidy up resident rooms, dress and bath	D 311		

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D 311	Continued From page 138 residents who required assistance, and provide feeding assistance to residents who could not eat independently. Interview with a second PCA on 04/06/22 at 8:50am revealed: -There had been no dietary wait staff at the facility for approximately one month. -It was the PCAs responsibility to set up, serve, and clean up at each meal service daily. Interview with a third PCA on 04/07/22 at 3:45pm revealed: -Lack of kitchen staff contributed to delays in resident's receiving food on time. -There were several residents who required feeding assistance there was not enough staff to assist everyone at the same time and she could not do two things at once. Interview with a fourth PCA on 04/08/22 at 10:36 revealed: -Staffing at the facility was appropriate on paper, but there was usually not enough staff present to actually meet residents' needs and things often got missed on first and second shift because it was busier due to residents being awake and some residents required a lot of care. -Tasks that often went undone due to not having enough time included making beds, offering hydration in between meals, and other things. Interview with a medication aide (MA) on 04/06/22 at 1:00pm revealed: -It was difficult not having any dietary wait staff because the PCAs had to fulfill those duties which sometimes prevented them from being able to assist resident who required help eating or helping residents on the floor as needed. -Residents sometimes had to wait to eat or be	D 311		

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D 311	Continued From page 139 assisted on the floor. -She was not sure why the facility no longer had dietary wait staff, but it was frustrating because she was only able to assist and help when she was not passing medications and there was not enough staff to do everything in a timely manner. -Bedbound residents who ate in their rooms did not always get served late, only when the shortage of dietary staff became an issue. Interview with a second MA on 04/07/22 at 4:22pm revealed: -The staffing numbers had been decreased since she began working at the facility one and a half years ago and it affected resident care because it was difficult to supervise and assist everyone and complete tasks such as laundry, showers, baths, and feeding assistance at the same time. -Sometimes residents who required feeding assistance would have to wait to be fed until there was a staff member available to do so. Interview with the dietary manager on 04/05/22 at 10:48am revealed: -He started working at the facility 4 days prior on 04/01/22. -He was in the process of getting everything straightened out and was responsible to ensure all meals were prepared and served as ordered. -There were only two dietary staff members hired at the facility; him and one other cook who came in at 1:00pm. Second interview with the dietary manager on 04/06/22 at 7:30am revealed one of the personal care aides (PCAs) was helping him in the kitchen that morning because there was no other kitchen staff available that day and he could not prepare and serve all the meals on his own.	D 311		

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D 311	Continued From page 140 Interview with the Administrator on 04/07/22 at 5:00pm revealed: -She expected residents to be fed at eye level in an unrushed manner and to be served at the same times as the rest of the residents, being offered all the same foods and drinks that were offered to everyone else, and being offered drinks in between bites of food. -It was also important for residents who required assistance with feeding to be supervised for safety and to have company for socialization, especially if they were unable to come to the dining room for the meal on their own. Interview with the facility's contracted primary care provider (PCP) on 04/07/22 at 1:00pm revealed: -Residents who required assistance to eat should not have to wait until a staff member was available to assist them. -Residents who had to wait for feeding assistance could lose interest in wanting to eat due to having to wait which could contribute to weight loss. -She expected the facility to have enough staff to feed all residents who required assistance in a timely manner within the same hour that all other residents were served meals, for resident's food to not get cold because they had to wait to eat, and expected all residents to be served the same meal options despite being bed bound or requiring feeding assistance. -She expected resident who required feeding assistance to be fed with dignity to include offering drinks in between bites. -She also expected staff to encourage residents to eat as much as possible over a one-hour time frame.	D 311		

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D 312	Continued From page 141	D 312		
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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 residents (#3) sampled was treated with respect, consideration and dignity as evidence by rushing meals (#3) and staff standing while providing feeding assistance to the resident (#3). The findings are: Review of Resident #3's current FL-2 dated 03/28/22 revealed: -Diagnoses included heart failure, hypertensive heart disease, chronic obstructive pulmonary disease (COPD), anxiety, spondylosis without myelopathy or radiculopathy, and a history of pulmonary embolism. -There was no other assessment information located on the document. Review of a physician's note dated 11/11/19 revealed the resident had a history of a cardiovascular accident (CVA) with lasting hemiplegia and required the use of a walker to ambulate safely. Review of Resident #3's current care plan dated 03/28/22 revealed:	D 312	Staff were retrained on assisting residents with eating 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. 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. SCUC/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.	5/23/2022

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	HAL058010	A. BUILDING: _____ B. WING _____	R 04/08/2022

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 312	Continued From page 142 -The resident had limited strength and was ambulatory with a wheelchair or walker. -The resident was sometimes disoriented, forgetful, and required reminders. -The resident required his meat to be cut up and limited assistance with eating. Observation of the lunch meal service on 04/06/22 from 12:45pm to 1:39pm on the Assisted Living (AL) unit revealed: -Resident #3 was offered his lunch consisting of a bowl of chicken noodle soup, a steak sandwich, mixed vegetables, and a cup of tea while in his hospital bed which was in low/medium position. -The food prepared for Resident #3 was a limited menu as compared to the meal offered to the residents in the dining room and omitted a cup of fruit as offered to the other residents in the dining room. -Resident #3 declined his chicken noodle soup, was fed large bites of the steak sandwich (approximately 1.5 x 1.5 inches) by a PCA before swallowing the previous bite, coughed while chewing at 1:32pm, chewed quickly, declined his vegetables, and drank the tea at the end after declining the tea in between bites. -The PCA stood over Resident #3 at his bedside to assist him and fed him his lunch in a hurried manner (9 minutes), repeatedly asking him if he was ready for the next bite, then hurriedly moved on to assist and serve the next bedbound resident. -Resident #3 ate 100% of his steak sandwich and tea, 0% of his vegetable medley and chicken noodle soup, and was not served the fruit that was on the menu. Interview with Resident #3 on 04/06/22 at 9:08am and 2:16pm revealed: -If he did not have staff or his roommate to help	D 312		

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D 312	Continued From page 143 him, he would not get what he needed. -He did not like to eat fast, but he did not mind too much that day, 04/06/22, because lunch was late and he was really hungry. -If he had been offered fruit at lunch that day, he would have eaten it. -Sometimes he did not get enough to eat and stayed hungry most days. -If he were to ask for more to eat, the facility staff would tell him he was only allowed one plate or it was all gone. -The last time he asked for more to eat when he was still hungry was a couple of days ago and they did not offer to get him anything else, so he just stopped asking. Interview with the PCA on 04/06/22 at 1:44pm revealed: -She assisted the resident with lunch by standing at his bedside as she normally did that day. -The resident would have told her if he did not want her help with eating. -She was never taught to assist resident to eat any other way. Second interview with the PCA on 04/07/22 at 3:45pm revealed: -She fed all residents who required feeding assistance as needed and should allow them to take their time to eat offering drinks in between bites. -She was never trained to sit down with residents at eye level, not to rush them, or make a resident wait to eat but realized after being made aware how not doing those things might make a resident feel rushed. Interview with a second PCA on 04/06/22 at 8:55am revealed she was taught to feed residents by sitting at eye level, talk to the	D 312		

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D 312	Continued From page 144 residents during the meal, not to rush the meal, and to offer drinks in between bites. Interview with a third PCA on 04/08/22 at 10:36am revealed: -She was taught to provide feeding assistance to residents by sitting with them at eye level in a comfortable setting, to encourage independence in eating as able or assist as needed, encourage drinks in between bites, and to allow the resident to take as much time as they needed to eat without rushing them. -She was also taught encourage, remind, and redirect residents to eat and ensure their intake was enough trying to get them to eat at least 50% of their meal which could often take up to an hour. Interview with a medication aide (MA) on 04/07/22 at 4:22pm revealed: -Staff were trained and expected to assistance residents who required feeding assistance without rushing them while sitting at eye level. -Sometimes residents would have to wait to eat until a staff member was available to assist them, but it was important to encourage food intake and to feed them as trained out of respect. Interview with the Administrator on 04/07/22 at 5:00pm revealed: -She expected all PCAs and MAs to assist in feeding residents who required assistance. -All staff had been trained to and were expected to feed residents as eye level, in a non-rushed manner, offer drinks in between bites, and encourage increased food intake. -She also expected all staff to push water intake to help prevent dehydration. Interview with the facility's contracted primary	D 312		

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D 312	Continued From page 145 care provider (PCP) on 04/07/22 at 1:00pm revealed: -She expected resident who required feeding assistance to be fed with dignity to include having a staff member sit with them at eye level, offering drinks in between bites, to interact engage with the resident during the meal, to ensure the meal was not rushed, and ensure resident were fed in a timely manner so as to not contribute to weight loss from losing interest in eating.	D 312		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#2) related to scheduled and as needed (prn) orders for a controlled substance anti-anxiety medication for a resident receiving hospice services. The findings are:	D 344	SCUC/designee will compare physician's orders to medication administration record to ensure residents receive medications as ordered. For physicians orders that need clarification the physician will be contacted by SIC/SCUC. SIC/SCUC will document clarification of orders in resident chart. Administrator will audit orders monthly to ensure verification and clarification of orders is being completed as needed.	5/23/2022

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D 344	Continued From page 146 Review of Resident #2's most current FL-2 dated 02/08/21 revealed: -The resident's level of care was special care unit (SCU). -Diagnoses included dementia, hypothyroidism, hypertension, Vitamin B12 deficiency, and osteoarthritis of the knee. -The resident was constantly disoriented and required total care assistance with activities of daily living. Review of Resident #2's care note dated 02/15/22 revealed: -The Supervisor spoke with the primary care provider (PCP) about Resident #2 being agitated and experiencing some deep breathing. -The PCP stated she would send an order for Lorazepam as needed (prn). (Lorazepam is a controlled substance used for anxiety and agitation.) Review of Resident #2's PCP orders dated 02/15/22 revealed a prescription hardcopy order for Lorazepam 0.5mg take 1 tablet oral or sublingual (under the tongue) every 4 hours prn for anxiety/agitation/restlessness. Review of Resident #2's hospice note report dated 02/18/22 revealed: -The resident was admitted to hospice services on 02/18/22 with a terminal diagnosis of Alzheimer's disease. -The resident was lying in bed supine with eyes closed, nonresponsive and obviously imminent. -The resident was very wasted with sunken temples and cheekbones. -The resident was breathing very shallow at 24 breaths per minute. -The resident's lung sounds were diminished in	D 344		

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D 344	Continued From page 147 all lobes. -The resident's family reported the resident would moan out in pain if touched. Review of Resident #2's PCP orders dated 02/18/22 revealed a prescription hardcopy order for Lorazepam 0.5mg take 1 tablet oral or sublingual every 2 hours as needed for anxiety/agitation/restlessness. Review of Resident #2's hospice note report dated 02/19/22 revealed: -The resident was lying in bed supine with eyes closed, nonresponsive and obviously imminent. -The resident was breathing very shallow at 22 breaths per minute. -The resident was tachycardic (fast heart rate) and tachypneic (fast breathing). -The resident's lung sounds were diminished in the lower lobes. -The resident's family reported the resident would moan out in pain if touched. -The resident's family requested the Morphine (a controlled substance for severe pain) and Lorazepam be increased. -The hospice nurse contacted the hospice physician and a new order was sent to the pharmacy. -Lorazepam was increased to 1mg every 2 hours. Review of Resident #2's hospice provider orders dated 02/19/22 revealed: -There was a verbal order taken by the hospice nurse to increase Lorazepam to 1mg by mouth every 2 hours. -There was a prescription hardcopy order for Lorazepam 1mg every 2 hours as needed for terminal anxiety. -There was pharmacy printed note on the verbal order sheet that read, "the hardcopies we	D 344		

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D 344	Continued From page 148 received were for prn. Do they need to be scheduled?" -There was no response documented on the verbal order sheet. Review of Resident #2's physician's orders and care notes for February 2022 revealed no documentation the hospice provider was contacted to clarify the Lorazepam orders. Review of Resident #2's hospice note report dated 02/20/22 revealed: -The resident was lying in bed supine with eyes closed, nonresponsive and peaceful. -The resident was breathing very shallow at 24 breaths per minute. -The resident was tachycardic and tachypneic. -The resident's family reported the resident would moan out in pain if touched but seemed to be more comfortable with the increased medications. Review of Resident #2's hospice note report dated 02/21/22 revealed: -The resident was lying in bed supine with eyes closed, nonresponsive and peaceful. -The resident was breathing very shallow. -The resident was bradycardic (slow heart rate) at 33 beats per minute and tachypneic at 30 breaths per minute. Review of Resident #2's hospice provider orders dated 02/21/22 revealed there was a prescription hardcopy order for Lorazepam 1mg take 1 tablet every 2 hours as needed for terminal anxiety. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry dated 02/15/22 for Lorazepam 0.5mg take 1 tablet by mouth or	D 344		

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D 344	Continued From page 149 under tongue every 4 hours prn for anxiety or agitation or restlessness. -Lorazepam 0.5mg was documented as administered prn on 4 occasions for anxiety: 02/15/22 at 2:17pm; 02/17/22 at 7:58am and 11:50pm; and 02/18/22 at 2:11pm. -There was an entry dated 02/18/22 for Lorazepam 0.5mg take 1 tablet by mouth or under tongue every 2 hours prn for anxiety, agitation, or restlessness. -Lorazepam 0.5mg was documented as administered prn on 02/19/22 at 10:39am for "shortness of air". -There was an entry dated 02/19/22 for Lorazepam 1mg take 1 tablet by mouth every 2 hours prn for terminal anxiety. -No prn Lorazepam 1mg was documented as administered and this entry was documented as discontinued on 02/21/22 at 8:25am. -There was an entry dated 02/21/22 for Lorazepam 1mg take 1 tablet by mouth every 2 hours prn for terminal anxiety. -No prn Lorazepam 1mg was documented as administered and this entry was documented as discontinued on 02/22/22 at 1:29pm. -There was a total of 4 Lorazepam 0.5mg tablets and 1 Lorazepam 1mg tablet documented as administered in February 2022. -There was no entry for a scheduled dose of Lorazepam to be administered. Review of Resident #2's controlled substance (CS) records for Lorazepam revealed: -There was a CS record for 6 Lorazepam 0.5mg tablets dispensed on 02/15/22. -All 6 doses were documented as administered prn from 02/15/22 at 2:17pm through 02/18/22 at 2:11pm. -There was a CS record for 24 Lorazepam 0.5mg tablets dispensed on 02/15/22 and 1 dose was	D 344		

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D 344	Continued From page 150 documented as administered on 02/18/22 at 3:00 (am or pm not specified). -There was a CS record for 30 Lorazepam 0.5mg tablets dispensed on 02/18/22. -There were 29 doses documented as administered prn from 02/19/22 at 10:30 (am or pm not specified) through 02/20/22 at 4:30 (am or pm not specified). -There was a CS record for 30 Lorazepam 1mg tablets dispensed on 02/19/22. -There were 14 doses documented as administered prn from 02/20/22 at 6:30 (am or pm not specified) through 02/22/22 at 5:30 (am or pm not specified). -There was no CS record for any scheduled doses of Lorazepam being administered. Observation of a video of Resident #2 on 02/19/22 at 10:40am revealed: -The resident was extremely thin and frail. -The resident was lying on her back in bed with her mouth open. -The resident moaned constantly during the video with the moaning becoming a distressful louder moan at times. -The resident's eyes and mouth would open wider when her moaning became louder. -The resident was taking shallow breaths. Review of Resident #2's hospice note report dated 02/22/22 revealed a hospice nurse pronounced the resident deceased at 1:26pm on 02/22/22. Interview with the Administrator on 04/07/22 at 4:10pm revealed: -The MAs were responsible for clarifying medication orders. -She did not know why the 02/19/22 order for scheduled Lorazepam was not on the eMAR.	D 344		

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D 344	Continued From page 151 -There was no paper MAR for the administration of Resident #2's Lorazepam. Interview with a MA on 04/07/22 at 5:17pm revealed: -Resident #2 was administered Lorazepam every 2 hours with Morphine. -She administered Lorazepam to the resident in case the resident was in pain. -She could not tell if the resident was in pain. Interview with a second MA on 04/08/22 at 11:33am revealed she did not recall if Resident #2's Lorazepam was scheduled or prn but "every so often" she would crush a Lorazepam tablet and administer it mixed with the resident's Morphine. Telephone interview with a former MA on 04/07/22 at 10:41am revealed: -About a week before Resident #2 passed, the resident was in bed breathing hard and gasping for air. -The resident usually made a moaning and high-pitched screaming noise, "a horrible noise". -Resident #2's Lorazepam was every 4 hours then it changed to every 2 hours and it was prn then scheduled. -She administered the Lorazepam for anxiety which she thought was when the resident made a humming sound and rubbed her hands together. Telephone interview with Resident #2's hospice nurse on 04/08/22 at 9:05am revealed: -She admitted Resident #2 to hospice services on Friday, 02/18/22. -The resident's Lorazepam should have been administered scheduled and prn. -No one at the facility contacted hospice to clarify or verify the orders for Lorazepam.	D 344		

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D 344	Continued From page 152 -Not receiving Lorazepam on a scheduled basis could have caused the resident to experience anxiety, discomfort, and air hunger.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 1 of 5 residents sampled (#2) for record review related to errors with a controlled substance medication used to relieve severe pain and breathing difficulties associated with end of life symptoms for a hospice resident including missed doses of the medication when it was unavailable for administration. The findings are: Review of Resident #2's closed record FL-2 dated 02/08/21 revealed: -The resident's level of care was special care unit (SCU). -Diagnoses included dementia, hypothyroidism, hypertension, Vitamin B12 deficiency, and	D 358	Administrator/Designee retrained Med Aides on medication administration, processes for sending new orders to pharmacy, obtaining medications from backup and medications errors. Administrator/Designee conducted cart audit to assure that all medications on MAR are in the facility and available to administer. Administrator/Designee will observe two medication passes weekly for four weeks to ensure medication is administered as ordered by the physician. If Medication Aides do not administer medications as ordered by the physician, they will be retrained by RCC/ Designee. Further failure to administer medications as ordered will result in Medication Aide being removed from the cart.	5/8/2022

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D 358	Continued From page 153 osteoarthritis of the knee. -The resident was constantly disoriented and required total care assistance with activities of daily living. Review of Resident #2's primary care provider (PCP) orders dated 02/15/22 revealed: -There was a prescription hardcopy order for Morphine Concentrate 20mg/ml Solution, administer 0.5ml by mouth/sublingual (under the tongue) every 1 hour as needed (prn) for pain/shortness of breath/air hunger (feeling of severe breathlessness). -Please dispense in prefilled/premeasured syringes. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.) Review of Resident #2's PCP orders dated 02/18/22 revealed: -There was a verbal order for Morphine Concentrate 20mg/ml take 0.5ml by mouth or sublingual every 1 hour for pain, shortness of breath, air hunger. -There was a prescription hardcopy order for Morphine Concentrate 20mg/ml Solution take 0.5ml by mouth/sublingual every 1 hour scheduled. Please dispense prefilled/premeasured syringes. Continue prn order as well. Use quantity on cart before sending more. Review of Resident #2's hospice note report dated 02/18/22 revealed: -The resident was admitted to hospice services on 02/18/22 with a terminal diagnosis of Alzheimer's disease. -The resident's family reported the resident would moan out in pain if touched.	D 358		

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

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D 358	Continued From page 154 Review of Resident #2's hospice provider orders dated 02/19/22 revealed: -There was an order to increase Morphine to 20mg by mouth/sublingual every 30 minutes. -There was a second order for Morphine Concentrate 20mg/ml Solution take 1ml prefilled syringe sublingual or by mouth every 30 minutes prn for unrelieved pain, air hunger, or restlessness. Review of Resident #2's hospice note report dated 02/20/22 revealed: -The medication aide (MA) reported the resident was still requiring scheduled doses of Morphine but appeared to be resting better since doubling the Morphine. -The resident was lying in bed supine with eyes closed, nonresponsive, and peaceful. -The resident was breathing very shallow at 24 breaths per minute. -The resident was tachycardic (fast heart rate) and tachypneic (fast breathing). -The resident's family reported the resident would moan out in pain if touched but seemed to be more comfortable with the increased medication. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There were two entries for Morphine 10mg/0.5ml syringe give 1 prefilled syringe (0.5ml = 10mg) by mouth or under tongue every hour prn for pain, air hunger or shortness of breath. -Morphine 10mg prefilled syringe was documented as administered prn for "shortness of air" on 02/17/22 at 7:58am, 10:15am, 11:45am, and 12:48pm and on 02/18/22 at 11:19am and 12:39pm. -Morphine 10mg prefilled syringe was documented as administered prn for pain on	D 358		

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D 358	Continued From page 155 02/17/22 at 11:50pm and 02/18/22 at 2:11pm (for a total of 8 prn doses). -There was an entry dated 02/18/22 for Morphine 10mg/0.5ml syringe take 1 prefilled syringe (0.5ml = 10mg) by mouth or under tongue every hour scheduled. -There was no documentation that scheduled Morphine 10mg every hour was administered at 11:00pm on 02/18/22. -The entry for Morphine 10mg prefilled syringes scheduled every hour was documented as discontinued on 02/19/22 at 3:25pm. -There was an entry dated 02/19/22 for Morphine 20mg/ml Solution give 1 prefilled syringe (20mg = 1ml) by mouth / under the tongue every 30 minutes. -There was no Morphine 20mg documented as administered every 30 minutes on 02/19/22 on the eMAR. -Morphine 20mg prefilled syringe was documented as administered every 30 minutes starting at 5:30am on 02/20/22 through 11:30am on 02/21/22. -Morphine 20mg prefilled syringe was documented as not administered at 4:30pm on 02/20/22 and from 12:00pm on 02/21/22 through 5:30pm on 02/21/22 for a total of 13 missed doses with 12 of the 13 being consecutive doses due to the medication being unavailable, waiting on pharmacy. -Morphine 20mg prefilled syringe was documented as administered every 30 minutes from 6:00pm on 02/21/22 through 12:00pm on 02/22/22. -No Morphine was documented as administered after 12:00pm on 02/22/22 due to the resident being deceased. Review of Resident #2's February 2022 handwritten paper MAR revealed:	D 358		

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D 358	Continued From page 156 -There was a handwritten entry for Morphine 20mg by mouth/sublingual every 30 minutes. -Morphine 20mg was documented as administered every 30 minutes from 3:00pm on 02/19/22 through 02/21/22 at 7:00am. Review of Resident #2's February 2022 controlled substance (CS) records for Morphine revealed: -There were 6 doses of Morphine 10mg documented as administered scheduled every hour on 02/18/22 from 4:00pm - 9:00pm but there were no scheduled doses documented as administered for 10:00pm and 11:00pm on 02/18/22. -Three doses of Morphine 10mg were documented as administered on 02/19/22 at 3:00pm and 4:00pm for total of 30mg instead of 20mg as ordered. -There were no doses of Morphine documented as administered to the resident on 02/21/22 from 6:30am through 6:30pm, a 12-hour time frame, when the Morphine was ordered to be administered every 30 minutes. Review of Resident #2's pharmacy dispensing records from the facility's contracted pharmacy for Morphine for February 2022 revealed: -There were 20 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/15/22 and received by the facility on 02/16/22 at 2:02am. -There were 60 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/17/22 and received by the facility on 02/18/22 at 4:40am. -There were 30 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/18/22 and received by the facility on 02/18/22 at 9:53pm. -There were 42 prefilled syringes of Morphine 20mg/1ml dispensed on 02/19/22 and received by the facility on 02/19/22 at 10:56pm. -There were 18 prefilled syringes of Morphine	D 358		

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D 358	Continued From page 157 20mg/1ml dispensed on 02/20/22 and received by the facility on 02/20/22 at 3:37am. -There were 60 prefilled syringes of Morphine 20mg/1ml dispensed on 02/21/22 and received by the facility on 02/22/22 at 3:37am. Review of Resident #2's pharmacy dispensing records from the facility's back up pharmacy for Morphine for February 2022 revealed a 30ml bottle of Morphine Sulfate 20mg/ml Concentrate was dispensed on 02/21/22. Observation of a video of Resident #2 on 02/19/22 at 10:40am revealed: -The resident was extremely thin and frail. -The resident was lying on her back in bed with her mouth open. -The resident moaned constantly during the video with the moaning becoming a distressful, louder moan at times. -The resident's eyes and mouth would open wider when her moaning became louder. -The resident was taking shallow breaths. -Narration with the video indicated the date and time was 02/19/22 at 10:40am and the resident had just received Morphine at the family's request. Telephone interview with Resident #2's family member on 04/06/22 at 7:18pm revealed: -The facility ran out of Resident #2's Morphine (02/21/22) and when she got to the facility, the Administrator said she was working on getting some Morphine for the resident. -The facility got a supply of Morphine in a bottle from the back up pharmacy because the back up pharmacy did not provide prefilled syringes. -The resident could not speak but she frowned, moaned, and screamed all the time when she was out of Morphine.	D 358		

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D 358	Continued From page 158 -On 02/18/22, the MA was spacing out the Morphine so the resident would not run out. -She would have to remind the MAs to administer the Morphine because they waited too long between the doses. Interview with a MA on 04/06/22 at 2:17pm revealed: -Resident #2 was supposed to be administered Morphine every 30 minutes. -Resident #2 could not talk but she would make a moaning or groaning noise. -The resident would hum and moan and sometimes it changed to a "distress" moan. -The "distress" moan would get better after the resident received Morphine. -Resident #2 ran out of Morphine on 02/21/22, the day before the resident passed. -She thought the hospice nurse was made aware when the resident ran out of Morphine. -The facility's contracted pharmacy sent an order to the back up pharmacy and the facility staff picked up some Morphine from the back up pharmacy. -A supply of Morphine also came later that night (02/21/22) from the facility's contracted pharmacy. Telephone interview with a former MA on 04/07/22 at 10:41am revealed: -About a week before Resident #2 passed, the resident was in bed breathing hard and gasping for air. -The resident's family wanted the MAs to give Morphine to the resident every time the resident moaned. -The resident was started on hospice and the resident had an order from the PCP to administer Morphine every hour. -She was off for 2 days and when she came back	D 358		

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D 358	Continued From page 159 the order had changed to every 30 minutes. -The resident ran out of Morphine for "a whole day" (could not recall the date) so she called the pharmacy and the Administrator picked up a bottle of Morphine from the back up pharmacy. -The MAs were responsible for ordering medication when the supply got "low" (could not specify a time frame). -They documented the administration of Resident #2's Morphine on the eMAR and on a paper MAR and the CS record. -She was not sure why Morphine was documented on a paper MAR and eMAR. -The resident's family would come out of the room every 30 minutes and reminded her to administer the Morphine. -There was one night another resident was acting up in the SCU dining room and Resident #2's family member came in and said Resident #2 needed her medication. -She told the family member she could not come to administer it at that time. -About 10 minutes later, the family member came back and said Resident #2 was dying and needed her medication. -She was late administering the medication that night (could not say how late). -The resident usually made a moaning and high-pitched screaming noise, "a horrible noise". -When the resident was administered Morphine, the resident would stop making the noise. Interview with the Administrator on 04/07/22 at 11:26am revealed: -Resident #2 ran out of Morphine on Monday, 02/21/22, because the dosage had increased. -The MAs should have ordered the Morphine on Saturday, 02/19/22. -On Monday morning (02/21/22), the MAs realized the resident would run out of Morphine at	D 358		

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D 358	Continued From page 160 lunch time around 12:00pm or 1:00pm. -The MAs ordered the Morphine from the facility's contracted pharmacy but it would not be delivered to the facility until later that night. -The Administrator contacted the hospice provider and an order from the hospice provider was sent to the back up pharmacy. -The Administrator picked up a bottle of Morphine from the back up pharmacy on 02/21/22 around 5:30pm. -As soon as the Administrator got to the facility with the Morphine, the MA administered it to the resident. -The supply of Morphine with prefilled syringes from the contracted pharmacy was delivered to the facility that night, 02/21/22, so the MAs stopped using the bottled Morphine and started back using the prefilled syringes. -She never observed the resident when she was out of Morphine so she did not know what effect the missed doses of Morphine had on the resident. -The MAs should have ordered the Morphine sooner. Interview with a third MA on 04/08/22 at 11:33am revealed: -The resident's Morphine was always available when she worked. -When a MA received a hard copy prescription for a controlled substance, the MA would fax the order to the pharmacy and attach confirmation to the hard script and put it in the resident's record. -The medication usually came in the pharmacy tote that same night and the pharmacy entered the order into the eMAR system. -The MAs were responsible for approving the orders in the eMAR system and making sure everything matched. -When she documented 3 doses of Morphine	D 358		

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D 358	Continued From page 161 were administered at the same time on the CS record, she may have administered a scheduled dose and a prn dose to Resident #2 at the same time. Telephone interview with Resident #2's PCP on 04/07/22 at 1:00pm revealed: -Resident #2 had advanced dementia and had been declining for a long time. -The facility had called her about the resident being less alert, her breathing was abnormal, and they were trying to get hospice services for the resident so she could get Morphine. -It was her understanding that the family wanted to keep the resident comfortable. -She ordered Morphine and another medication for the resident for respiratory distress, agitation, and restlessness. -She was concerned if the resident was uncomfortable or in distress the resident would not be able to relay that information. -Signs that the resident was uncomfortable, in distress, or in pain would include grimacing, gasping for breath, moaning, and rising her body. -Morphine was administered to prevent distress and pain and provide comfort. -The MAs were calling her multiple times a day because the family wanted the Morphine dosage increased. -There were frequent changes in the dose of Morphine which could have contributed to the medication running out. -She did not recall if the facility notified her about the resident's Morphine being unavailable. -Not receiving the Morphine as ordered could have caused the resident to be in pain or distress and uncomfortable. Telephone interview with Resident #2's hospice nurse on 04/08/22 at 9:05am revealed:	D 358		

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D 358	Continued From page 162 -She admitted Resident #2 to hospice services on Friday, 02/18/22. -Each visit to the facility, she counted the Morphine on hand with the MAs to make sure they were not going to run out. -She was not sure why the facility ran out of the Morphine. -The MAs should have notified hospice when there was at least a day supply remaining that they needed a new order. -She thought the resident was already out of Morphine when the facility contacted hospice for a new order on 02/21/22. -It was her understanding that the resident missed doses of Morphine for about 3 hours. -By the time she arrived to the facility on the night of 02/21/22, the resident had started back receiving Morphine (could not recall the time). -When the resident missed the doses of Morphine, she could have died or been in agonizing pain especially if she was moved; it could have caused anxiety, agitation, restlessness, and discomfort. -On one occasion, the resident's Morphine was overdue and she had to get the MA to administer it. -The MA told her she was busy and she would "be there when I can". -The resident went 40 minutes between the doses instead of 30 minutes as ordered. -The resident passed on 02/22/22. The facility failed to administer Morphine, a controlled substance used to relieve end of life symptoms such as severe pain, shortness of breath, air hunger, and restlessness, as ordered to Resident #2 who was receiving terminal hospice services. According to the medication aides (MAs) and the resident's family, Resident #2 made a moaning and high-pitched screaming	D 358		

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D 358	Continued From page 163 noise that would improve or stop when she received Morphine. Resident #2's scheduled hourly dose of Morphine was not administered on 02/18/22 at 11:00pm. Resident #2's supply of Morphine ran out and was unavailable on 02/21/22 for either 13 doses according to the medication administration record (MAR) or 25 doses according to the controlled substance record when the resident should have received Morphine every 30 minutes scheduled for severe pain, discomfort, shortness of breath, air hunger, and restlessness. The facility's failure resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/07/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 8, 2022.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure controlled substance records for 1 of 4 residents sampled	D 392		

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D 392	Continued From page 164 (#2) accurately reconciled with the administration of a controlled substance used for severe pain and a controlled substance used for anxiety and agitation for a resident receiving hospice services. The findings are: Review of Resident #2's most current FL-2 dated 02/08/21 revealed: -The resident's level of care was special care unit (SCU). -Diagnoses included dementia, hypothyroidism, hypertension, Vitamin B12 deficiency, and osteoarthritis of the knee. Review of Resident #2's hospice note report dated 02/18/22 revealed the resident was admitted to hospice services on 02/18/22 with a terminal diagnosis of Alzheimer's disease. a. Review of Resident #2's primary care provider (PCP) orders dated 02/15/22 revealed a prescription hardcopy order for Morphine Concentrate 20mg/ml Solution, administer 0.5ml by mouth/sublingual (under the tongue) every 1 hour as needed (prn) pain/shortness of breath/air hunger (feeling of severe breathlessness). Please dispense in prefilled/premeasured syringes. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.) Review of Resident #2's PCP orders dated 02/18/22 revealed: -There was a verbal order for Morphine Concentrate 20mg/ml take 0.5ml by mouth or sublingual every 1 hour for pain, shortness of breath, air hunger (supply on hand). -There was a prescription hardcopy order for	D 392	Administrator retrained Med Aides on Narcotic Policies to include signing the MAR and control sheets when administering narcotics. SCUC/Designee audited all narcotics in facility to ensure the pill count is correct by the narcotic count sheet and documentation matches the MAR and effectiveness documented for all PRN narcotics. SCUC will audit all narcotic controls sheets and MARS for complete documentation weekly.	5/23/2022

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D 392	Continued From page 165 Morphine Concentrate 20mg/ml Solution take 0.5ml by mouth/sublingual every 1 hour scheduled. Please dispense prefilled/premeasured syringes. Continue prn order as well. Use quantity on cart before sending more. Review of Resident #2's hospice provider orders dated 02/19/22 revealed: -There was a verbal order taken by the hospice nurse to increase Morphine to 20mg by mouth/sublingual every 30 minutes. -There was a prescription hardcopy order for Morphine Concentrate 20mg/ml Solution take 1ml prefilled syringe sublingual or by mouth every 30 minutes as needed for unrelieved pain, air hunger, or restlessness. Review of Resident #2's hospice provider orders dated 02/21/22 revealed a prescription hardcopy order for Morphine Concentrate 20mg/ml Solution 1ml prefilled syringe sublingual or by mouth every 30 minutes prn for unrelieved pain, air hunger, or restlessness. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry dated 02/15/22 for Morphine 10mg/0.5ml syringe give 1 prefilled syringe (0.5ml = 10mg) by mouth or under tongue every hour prn for pain/air hunger or shortness of breath and 4 doses were documented as administered prn on 02/17/22 at 7:58am, 10:15am, 11:45am, and 12:48pm. -There was an entry dated 02/17/22 for Morphine 10mg/0.5ml syringe give 1 prefilled syringe (0.5ml = 10mg) by mouth or under tongue every hour prn for pain/ shortness of breath or air hunger and 4 doses were documented as administered	D 392		

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D 392	Continued From page 166 prn: 02/17/22 at 11:50pm; 02/18/22 at 11:19am and 12:39pm. -There was an entry dated 02/18/22 for Morphine 10mg/0.5ml syringe take 1 prefilled syringe (0.5ml = 10mg) by mouth or under tongue every hour scheduled and it was documented as administered at 7:00pm and 8:00pm on 02/18/22; and at 12:00am, 8:00am, 9:00am, 10:00am, 11:00am, 1:00pm, 2:00pm, and 3:00pm on 02/19/22 for a total of 10 doses. -There was an entry dated 02/19/22 for Morphine 20mg/ml Solution give 1 prefilled syringe (20mg = 1ml) by mouth / under the tongue every 30 minutes and it was documented as administered every 30 minutes starting at 5:30am on 02/20/22 through 11:30am on 02/21/22 for a total of 60 doses. -Morphine 20mg prefilled syringe was documented as administered every 30 minutes from 6:00pm on 02/21/22 through 12:00pm on 02/22/22 for a total of 37 doses. -There was a total of 115 doses of Morphine documented as administered on the eMAR. Review of Resident #2's February 2022 handwritten paper MAR revealed: -There was a handwritten entry for Morphine 20mg by mouth/sublingual every 30 minutes. -Morphine 20mg was documented as administered every 30 minutes from 3:00pm on 02/19/22 through 02/21/22 at 7:00am. -There was a total of 81 doses of Morphine 20mg documented as administered on the paper MAR. Review of Resident #2's controlled substance (CS) records for Morphine revealed: -There was a CS record for 20 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/15/22. -All 20 doses were documented as administered from 02/16/22 at 4:26 (am or pm not specified)	D 392		

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D 392	Continued From page 167 through 02/18/22 at 12:39pm, leaving a balance of 0. -There was a CS record for 60 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/17/22. -All 60 doses were documented as administered from 02/16/22 at 2:11pm through 02/20/22 at 12:00am, leaving a balance of 0. -There was a CS record for 30 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/18/22. -There were 10 doses documented as administered from 02/18/22 at 10:00 (am or pm not specified) through 02/19/22 at 4:00 (am or pm not specified), leaving a balance of 20 prefilled syringes. -There was a CS record for 42 prefilled syringes of Morphine 20mg/1ml dispensed on 02/19/22. -All 42 doses were documented as administered from 02/20/22 at 12:30am through 02/20/22 at 9:00pm, leaving a balance of 0. -There was a CS record for 18 prefilled syringes of Morphine 20mg/1ml dispensed on 02/20/22. -All 18 doses were documented as administered from 02/20/22 at 9:30pm through 02/21/22 at 6:00am, leaving a balance of 0. -There was a CS record for a 30ml bottle of Morphine 20mg/1ml dispensed on 02/21/22. -There were 16 doses (16ml) documented as administered from 02/21/22 at 7:00pm through 02/22/22 at 2:30am, leaving a balance of 14ml. -The first eight entries for administration of the 30ml bottle of Morphine did not have a signature of the medication aide (MA) who administered the Morphine. -There was a CS record for 60 prefilled syringes of Morphine 20mg/1ml dispensed on 02/21/22. -There were 10 doses documented as administered from 02/22/22 at 7:30am through 02/22/22 at 12:00pm, leaving a balance of 50. Review of Resident #2's pharmacy dispensing	D 392		

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D 392	Continued From page 168 records from the facility's contracted pharmacy for Morphine for February 2022 revealed: -There were 20 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/15/22 and received by the facility on 02/16/22 at 2:02am. -There were 60 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/17/22 and received by the facility on 02/18/22 at 4:40am. -There were 30 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/18/22 and received by the facility on 02/18/22 at 9:53pm. -There were 42 prefilled syringes of Morphine 20mg/1ml dispensed on 02/19/22 and received by the facility on 02/19/22 at 10:56pm. -There were 18 prefilled syringes of Morphine 20mg/1ml dispensed on 02/20/22 and received by the facility on 02/20/22 at 3:37am. -There were 60 prefilled syringes of Morphine 20mg/1ml dispensed on 02/21/22 and received by the facility on 02/22/22 at 3:37am. Review of Resident #2's pharmacy dispensing records from the facility's back up pharmacy for Morphine for February 2022 revealed a 30ml bottle of Morphine Sulfate 20mg/ml Concentrate was dispensed on 02/21/22. Review of Resident #2's pharmacy return records for Morphine for February 2022 revealed: -There were 50 prefilled syringes of Morphine 20mg/1ml dispensed on 02/21/22 returned to the pharmacy on 02/22/22. -There were 16ml of Morphine 20mg/ml Solution in the bottle dispensed from the back up pharmacy on 02/21/22 returned to the pharmacy on 03/18/22. -There was no documentation of the remaining balance of 20 prefilled syringes of Morphine 10mg/0.5ml dispensed on 02/18/22 being returned to the pharmacy.	D 392		

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D 392	Continued From page 169 -The 20 prefilled syringes of Morphine 10mg could not be accounted for. Review of Resident #2's medication orders, eMARs, CS records, and pharmacy dispensing and return records revealed: -There were 176 doses of Morphine documented as administered to Resident #2 on the CS records. -There were 115 doses of Morphine documented as administered to Resident #2 on the eMAR. -There was a total of 61 doses of Morphine documented as administered on the CS records that were not documented on the eMARs. -The CS records did not accurately reconcile with the eMARs. -There were 20 prefilled syringes of Morphine 10mg not documented as administered on the CS records and not documented as returned to the pharmacy and could not be accounted for. Interview with a medication aide (MA) on 04/07/22 at 5:17pm revealed: -The MAs were supposed to document the administration of controlled substances on the CS record and the eMAR. -She was not aware of any discrepancies with Resident #2's CS record for Morphine. -She did not know the documentation on the CS record did not match documentation on the eMAR. Interview with a second MA on 04/08/22 at 11:33am revealed: -When she administered a controlled substance, she would document it on the eMAR and the CS record. -She did not know why the documentation on the CS record for Resident #2's Morphine did not match documentation on the eMAR.	D 392		

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D 392	Continued From page 170 Interview with the Administrator on 04/07/22 at 4:10pm revealed: -She could not find a CS return record for Resident #2's Morphine supply dispensed on 02/18/22. -There was no CS record or return record to account for 20 of 30 Morphine 10mg prefilled syringes dispensed on 02/18/22. -She thought the MAs administered the 20 doses of Morphine but forgot to document it on the CS records. -Any remaining medications for Resident #2 were returned to the pharmacy after the resident passed on 02/22/22. A second interview with the Administrator on 04/07/22 at 5:35pm revealed: -The MAs were supposed to document their signature on the CS record each time they administered a controlled substance. -The MA who administered Resident #2's Morphine on 02/21/22 but left the signature section blank on the CS record should have signed the CS record each time she administered the Morphine. -Documentation on the CS record should accurately reflect the administration of the controlled substance and match the eMAR. Refer to telephone interview with a former MA on 04/08/22 at 11:53am. Refer to interview with the Administrator on 04/07/22 at 4:10pm. b. Review of Resident #2's primary care provider (PCP) orders dated 02/15/22 revealed a prescription hardcopy order for Lorazepam 0.5mg take 1 tablet oral or sublingual every 4 hours as	D 392		

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D 392	Continued From page 171 needed (prn) for anxiety/agitation/restlessness. (Lorazepam is a controlled substance used to treat anxiety and agitation.) Review of Resident #2's PCP orders dated 02/18/22 revealed a prescription hardcopy order for Lorazepam 0.5mg take 1 tablet oral or sublingual every 2 hours prn for anxiety/agitation/restlessness. Review of Resident #2's hospice provider orders dated 02/19/22 revealed: -There was a verbal order taken by the hospice nurse to increase Lorazepam to 1mg by mouth every 2 hours. -There was a prescription hardcopy order for Lorazepam 1mg every 2 hours prn for terminal anxiety. Review of Resident #2's hospice provider orders dated 02/21/22 revealed a prescription hardcopy order for Lorazepam 1mg take 1 tablet every 2 hours prn for terminal anxiety. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry dated 02/15/22 for Lorazepam 0.5mg take 1 tablet by mouth or under tongue every 4 hours prn for anxiety or agitation or restlessness. -Lorazepam 0.5mg was documented as administered prn on 4 occasions: 02/15/22 at 2:17pm; 02/17/22 at 7:58am and 11:50pm; and 02/18/22 at 2:11pm. -There was an entry dated 02/18/22 for Lorazepam 0.5mg take 1 tablet by mouth or under tongue every 2 hours prn for anxiety, agitation, or restlessness and it was documented as administered on 02/19/22 at 10:39am.	D 392		

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D 392	Continued From page 172 -There was an entry dated 02/19/22 for Lorazepam 1mg take 1 tablet by mouth every 2 hours prn for terminal anxiety and none was documented as administered. -There was an entry dated 02/21/22 for Lorazepam 1mg take 1 tablet by mouth every 2 hours prn for terminal anxiety and none was documented as administered. -There was a total of 4 Lorazepam 0.5mg tablets and 1 Lorazepam 1mg tablet documented as administered in February 2022. -There was no entry for a scheduled dose of Lorazepam to be administered. Review of Resident #2's controlled substance (CS) records for Lorazepam revealed: -There was a CS record for 6 Lorazepam 0.5mg tablets dispensed on 02/15/22 and all 6 doses were documented as administered from 02/15/22 at 2:17pm through 02/18/22 at 2:11pm. -There was a CS record for 24 Lorazepam 0.5mg tablets dispensed on 02/15/22 and 1 dose was documented as administered on 02/18/22 at 3:00 (am or pm not specified). -There was a CS record for 30 Lorazepam 0.5mg tablets dispensed on 02/18/22 and 29 doses were documented as administered from 02/19/22 at 10:30 (am or pm not specified) through 02/20/22 at 4:30 (am or pm not specified). -There was a CS record for 30 Lorazepam 1mg tablets dispensed on 02/19/22 and 14 doses were documented as administered from 02/20/22 at 6:30 (am or pm not specified) through 02/22/22 at 5:30 (am or pm not specified). -There was a CS record for 30 Lorazepam 1mg tablets dispensed on 02/21/22 and no doses were documented as administered. -There was a total of 37 doses of Lorazepam documented as administered on the CS records.	D 392		

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D 392	Continued From page 173 Review of Resident #2's pharmacy dispensing records from the facility's contracted pharmacy for Lorazepam for February 2022 revealed: -There were 6 tablets of Lorazepam 0.5mg called into the back up pharmacy and 24 tablets of Lorazepam 0.5mg dispensed on 02/15/22 and received by the facility on 02/16/22 at 2:02am. -There were 30 tablets of Lorazepam 0.5mg dispensed on 02/18/22 and received by the facility on 02/18/22 at 9:53pm. -There were 30 tablets of Lorazepam 1mg dispensed on 02/19/22 and received by the facility on 02/19/22 at 10:56pm. -There were 30 tablets of Lorazepam 1mg dispensed on 02/21/22 and received by the facility on 02/22/22 at 3:37am. Review of Resident #2's pharmacy return records for Lorazepam for February 2022 revealed the remaining balance of 70 Lorazepam tablets was returned to the pharmacy on 02/22/22. Review of Resident #2's medication orders, eMARs, CS records, and pharmacy dispensing and return records revealed: -There were 37 doses of Lorazepam documented as administered to Resident #2 on the CS records. -There were 5 doses of Lorazepam documented as administered to Resident #2 on the eMAR. -There was a total of 32 doses of Lorazepam documented as administered on the CS records that were not documented on the eMARs. -The CS records did not accurately reconcile with the eMARs. Interview with a medication aide (MA) on 04/07/22 at 5:17pm revealed: -The MAs were supposed to document the administration of controlled substances on the CS	D 392		

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D 392	Continued From page 174 record and the eMAR. -She was not aware of any discrepancies with Resident #2's CS record for Lorazepam. -She did not know the documentation on the CS record did not match documentation on the eMAR. Interview with a second MA on 04/08/22 at 11:33am revealed: -When she administered a controlled substance, she would document it on the eMAR and the CS record. -She did not know why the documentation on the CS record for Lorazepam did not match documentation on the eMAR. Refer to telephone interview with a former MA on 04/08/22 at 11:53am. Refer to interview with the Administrator on 04/07/22 at 4:10pm. Telephone interview with a former MA on 04/08/22 at 11:53am revealed: -When she administered controlled substances, she would document the administration of the medication on the resident's eMAR and on the CS record with her name, date, time, amount of medication administered and how much of the medication was remaining every time. -It was important to document all the details of the controlled substance medication administration to ensure it was administered properly and to ensure none of the medication was lost or stolen. Interview with the Administrator on 04/07/22 at 4:10pm revealed: -When a controlled substance was administered, the MAs were supposed to document it on the CS record and the eMAR.	D 392		

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D 392	Continued From page 175 -The CS record should be accurate and it should match the eMAR. -The MAs did CS medication counts at the change of each shift. -The MAs had not reported any discrepancies with Resident #2's CS records.	D 392		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to notify the county Department of Social Services 2 of 2 sampled residents (#1, #3) immediately of an elopement (#1) and of a resident passing out and required emergent hospital attention (#3). 1.Review of the facility's missing residents' policy revealed: -A resident will be considered missing when he/she is not in the facility and the facility cannot verify their whereabouts; and in addition, there is reason to be concerned for the resident's safety. -If the facility discovers a resident is missing, we will: a) notify the supervisor and all other staff immediately b) perform a hasty search of the building and the immediate areas outside the building c) notify project life safety.	D 451		

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D 451	Continued From page 176 -The facility would immediately notify: a) law enforcement-call 911 b) the resident's family member/responsible person c) the county department of social services. Review of Resident #1's current FL-2 dated 12/02/21 revealed: -Resident #1 had diagnoses of dementia, disorientation, CVA, frontal lobe CVA and metabolic encephalopathy. -His level of care was on the special care unit. Review of Resident #1's progress notes dated 01/01/22 revealed: -Resident #1 tried to get out of exit door 01/01/22. -He constantly pushed up against the door until it releases so resident can get out. -Resident #1 becomes combative and uses profanity when trying to redirect him away from the door. Review of Resident #1's progress note date 01/02/22 for Resident #1 revealed: -Resident #1 got out the door 01/02/22. -Initial actions taken by staff were to call the contracted primary care provider (PCP). -There was no incident report completed. Review of Resident #1's Accident/Incident (A/I) report dated 02/03/22 revealed: -Resident #1 eloped from the SCU and was discovered missing at 2:00pm. -Staff searched the facility thoroughly and the grounds. -Staff informed the Administrator and contacted the local police. -Resident #1 was returned to facility at 2:40pm by local police. -Resident #1's family was called but no answer. -The contracted PCP and contracted Mental	D 451	Facility will respond immediately in the case of an accident or incident involving a resident, to provide care and intervention according to the facility policies and procedures and report abuse in accordance to rule area 10A NCAC 13F .1212 SCUC/Administrator will submit incident reports to DSS that require referral for emergency medical evaluation, hospitalization or medical treatment other than first aid. Quality Improvement Department/Compliance Department will conduct audits of the facility to include review of incident reports at least quarterly or as needed basis to monitor resident rights and ensure compliance.	5/23/2022

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D 451	Continued From page 177 Health Provider were notified. -The Administrator notified The Department of Social Services on 02/07/22 at 10:25 am via fax. Interview with the Administrator on 04/07/22 at 3:30pm revealed: -If the local AHS was not aware of the incident, it had not been reported as it should have been. -She expected the medication aides (MA) to ensure an I/A report was completed and reported to a resident's PCP, family member, and the local AHS per rules and regulations. 2. Review of Resident #3's current FL-2 dated 03/28/22 revealed: -Diagnoses included heart failure, hypertensive heart disease, chronic obstructive pulmonary disease (COPD), anxiety, spondylosis without myelopathy or radiculopathy, and a history of pulmonary embolism. -There was no other assessment information located on the document. Review of Resident #3's progress notes dated 02/26/22 revealed: -The resident was sent to the emergency department (ED) that day due to being unresponsive other than breathing. -The resident became responsive when emergency medical services (EMS) arrived stating he did not feel well and was transported to the ED for further evaluation. Review of a hospital discharge note for Resident #3 dated 02/26/22 revealed: -The resident was diagnosed with syncope (passing out) and was to follow up with his primary care provider (PCP) in 1-2 days. Review of Resident #3's record revealed there	D 451		

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D 451	Continued From page 178 was no documentation that the local adult home specialist (AHS) had been notified of the resident's need to be sent to the ED on 02/26/22 or had been sent an incident/accident (I/A) report. Interview with the local AHS on 04/07/22 at 9:00am revealed she did not have any documentation of an I/A report or correspondence of notification for Resident #3's needs to go to the hospital on 02/26/22. Interview with the Administrator on 04/07/22 at 3:30pm revealed: -She was unable to find an I/A report for Resident #3's syncopal episode on 02/26/22. -If the local AHS was not aware of the incident, it had not been reported as it should have been. -She was not sure if the primary care provider (PCP) was notified of Resident #3's episode on 02/26/22 either. -She expected the medication aides (MA) to ensure an I/A report was completed and reported to a resident's PCP, family member, and the local AHS per rules and regulations.	D 451		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by:	D 466		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 04/08/2022

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D 466	Continued From page 179 Based on observations, interviews, and record review, the facility failed to ensure a care coordinator was on duty in the special care unit (SCU) at least eight hours a day, five days a week. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 122 beds including 72 beds for the assisted living (AL) area and 50 beds for the special care unit (SCU). Review of the facility's SCU Care Coordinator (SCC) job description revealed: -The role of the SCC was to assist the Administrator in performing management duties, routinely supervise other staff, and maintain the facility's operations in compliance with licensing rules. -The SCC was to assume full management of the facility in the absence of an Administrator. -The SCC was to report errors in medication administration and develop and implement procedures and programs to determine what medication errors were taking place and how they could be prevented. -The SCC was to follow established safety precautions and report all hazardous conditions and equipment. -The SCC was to monitor the halls continuously. -The SCC was to assure that the care plans of all residents were appropriately implemented. -The SCC was to be familiar with the resident's bill of rights and assist residents in exercising those rights. Observations in the SCU on 04/06/22 at 12:27pm revealed:	D 466	Administrator will assure that there is a person assigned as the SCU Coordinator on the SCU 8 hours per day, five days a week. Administrator/Designee will monitor to ensure SCUC is on the unit at least 8 hours a day, 5 days per weeks. QI department/Compliance department/COO will conduct audits of facility at least quarterly or as needed basis to monitor rule areas and ensure compliance.	5/23/2022

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D 466	Continued From page 180 -There were 15 residents residing in the SCU. -There were 2 personal care aides (PCAs) on duty in the SCU. -There was 1 medication aide (MA) on duty in the SCU. -There was no designated SCC on duty. Observations in the SCU on 04/08/22 at 9:45am revealed: -There were 15 residents residing in the SCU. -There were 2 PCAs on duty in the SCU. -There was 1 MA on duty in the SCU. -There was no designated SCC on duty. Interview with the Administrator on 04/06/22 at 3:05pm revealed: -There had been no Special Care Coordinator (SCC) for the SCU since she started working at the facility in February 2022. -The previous Administrator left some time in December 2021. -She had been trying to hire a SCC but the position was currently still vacant. Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings. Refer to Tag 113, 10A NCAC 13F .0311(d) Other Requirements. Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision. Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision. Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care. Refer to Tag 276, 10A NCAC 13F .0902(c)(3)(4)	D 466		

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D 466	Continued From page 181 Health Care. Refer to Tag 296, 10A NCAC 13F .0904(c)(7) Nutrition and Food Service. Refer to Tag 299, 10A NCAC 13F .0904(d)(3)(A) Nutrition and Food Service. Refer to Tag 306, 10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service. Refer to Tag 311, 10A NCAC 13F .0904(f)(1) Nutrition and Food Service. Refer to Tag 344, 10A NCAC 13F .1002(a) Medication Orders. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration. Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances. Refer to Tag 451, 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents.	D 466		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents	D912		

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D912	Continued From page 182 received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to housekeeping and furnishings, other requirements, personal care and supervision, and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the facility was maintained in a clean and orderly manner and free of hazards including mice infestations throughout the facility; personal care hygiene products being stored unlocked in 2 of 2 common spa bathrooms in the special care unit (SCU) resulting in hazardous substances and chemicals being unattended and accessible to the 15 residents residing in the SCU; 3 oxygen canisters being stored in an unsecured manner in two resident rooms in the assisted living (AL) side; a broken ceramic vase and glass candle holder being left on the floor overnight in the common living room in the AL side accessible to residents; and 4 of 4 spa bathrooms in the AL side with soiled and dirty toilets, sinks, showers, bath tubs, shower chairs, and floors. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 14 fixtures sampled in the assisted living (AL) side of the facility with hot water temperatures of 118 degrees F and 3 of 4 fixtures sampled in the special care unit (SCU) that were readily accessible and used by residents in the SCU with hot water temperatures	D912		

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D912	Continued From page 183 ranging from 118 degrees F to 128 degrees F. [Refer to Tag 113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to provide personal care to 2 of 7 sampled residents (#2, #3) related to oral hygiene care (#2) and bathing, dressing, transferring, and incontinence care (#3). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#1) who resided in the Special Care Unit (SCU), with a diagnosis of dementia and known disorientation who eloped from the facility on multiple occasions without staff knowledge and was located by the police walking down a road, off a four lane highway on one occasion. [Refer to tag 270, 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 1 of 6 sampled resident's (#11) related to decreased intake of fluids and foods with cognitive changes for approximately two weeks. [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)] 6. Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 7 sampled resident's (#3, #13) orders were implemented related to feeding assistance and increased food intake (#13) and being provided fluids to drink (#3, #13). [Refer to tag 276, 10A NCAC 13F .0902(c) Health Care (Type B	D912		

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D912	Continued From page 184 Violation)]	D912		
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 Resident #2 was free of neglect as related to missed doses of a controlled substance medication used to relieve severe pain and breathing difficulties associated with end of life symptoms. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 1 of 5 residents sampled (#2) for record review related to errors with a controlled substance medication used to relieve severe pain and breathing difficulties associated with end of life symptoms for a hospice resident including missed doses of the medication when it was unavailable for administration. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)].	D914		