Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	R-C 06/30/2022

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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 29, 2022 to June 30, 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: Based on observations, interviews, and record reviews, the facility failed to ensure the facility was free of hazards including 3 oxygen canisters being stored in an unsecured manner in an empty resident room in the special care unit (SCU); cleaning products and personal care hygiene products being stored in an unlocked medication storage room on the SCU; and personal care hygiene products being stored in residents rooms on the SCU. 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 06/29/22 revealed there were 14 residents residing in the SCU.	D 079	Administrator conducted training with all staff for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled in a separate locked area. Administrator moved oxygen tanks to be stored in approved storage crates. SCUC/SIC will conduct rounds of the unit daily to assure all cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled are stored in a separate locked area. Administrator/Designee will walk through building weekly to ensure all items are stored properly.	6/29/2022 6/29/2022 8/14/2022 8/14/2022

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

Rachel R — 8/9/2022

Reviewed and Acknowledged _____ AVT 08.10.22

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D 079	Continued From page 1 Review of the facility's Physical Environment, Feature Design and Safety Services policy (undated) revealed: -There are several special design features in the Reflections Neighborhood that address the complex needs of residents with Alzheimer's and related dementia. -Any items that are deemed hazardous will be kept secured in our designated storage areas and will only be accessible to staff members. 1. Observation of a resident room #62 on the special care unit (SCU) on 06/29/22 at 9:53am revealed there were 3 unsecured oxygen canisters on the floor. Observation of the Interim Administrator in room #62 on the SCU on 06/29/22 at 11:53am revealed she checked the 3 unsecured oxygen canisters on the floor and they were full. Interview with the lead medication aide on 06/30/22 at 1:30pm revealed: -She was not aware how the oxygen canisters ended up in resident room #62 unless they were left over from a previous resident that was on oxygen. -She could not recall if or when there was a resident on the SCU that was on oxygen. Interview with the interim Administrator on 06/29/22 at 1:18pm revealed: -She was not aware that there were 3 full oxygen canisters left unsecured on the SCU. -Oxygen canisters should be placed in the medication room on the SCU in the oxygen storage crate. -She was not familiar with how the oxygen canisters ended up on the SCU since there were	D 079		

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D 079	Continued From page 2 no residents currently on the SCU that required oxygen. Telephone interview with the facility's contracted primary care provider (PCP) on 06/30/22 at 1:00 pm revealed: -She was not aware that there were any residents on the SCU that had recently used oxygen. -The facility should have secured the 3 oxygen canisters to ensure the safety of residents. 2. Observation of the special care unit (SCU) medication room on 06/29/22 at 9:10am revealed: -The door was opened and was accessible from the SCU hallway. -There was no staff in the medication room. -There was a medication cart that was locked but had unsecured hazardous chemicals on the side including a 56-fluid ounce liquid disinfectant bottle that was half full with a caution statement to keep out of reach of children, do not swallow and may irritate eyes and an 8.8 fluid ounce aerosol spray room deodorizer canister with a caution to keep out of reach of children. -There was a storage closet with the door open and accessible to residents in the medication room with 8 disposable razors with a shield, one pair of pruning clippers and 2 unopened boxes containing 50 disposable razors. Interview with a MA on 06/29/22 at 11:10am revealed: -The medication room should have been locked; it was her mistake that she did not lock it. -She was responsible for locking the medication room to ensure residents were not able to access hazardous materials. A second observation of the SCU medication	D 079		

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D 079	Continued From page 3 room on 06/29/22 at 1:05pm revealed: -The door was open. -There were no staff members or residents present in the SCU medication room. Interview with the interim Administrator on 06/29/22 at 1:22pm revealed: -She expected the staff on SCU to keep the medication room door shut and locked when there were not staff members in the room. -It was important for the door to be locked so that residents did not have access to hazardous or dangerous items that would cause them harm. -She was not aware of any residents ever being in the SCU medication room without staff present. Telephone interview with the facility's contracted primary care provider (PCP) on 06/30/22 at 1:00 pm revealed: -There were times when she was at the facility that the medication room on the SCU was unlocked. -She never witnessed a resident in the medication room without staff on the SCU. -She expected the medication room to be locked for resident safety and to prevent residents from injuring themselves. 3. Observation of resident room #60 on 06/29/22 at 10:04am revealed: -There was a cabinet in the resident's bathroom that contained one 11 fluid ounce aerosol hairspray with a warning that it was flammable until fully dry, do not use near heat, flame or while smoking; could cause serious injury or death; avoid inhalation and spraying in eyes. -There was a one fluid ounce liter of mouthwash with a caution to keep out of reach of children. Observation of resident bathroom between room	D 079		

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D 079	Continued From page 4 #47 and #49 on the SCU on 06/29/22 at 9:45am revealed there was a 7.1 oz. bottle of rinse free-foam cleanser that was 50% full on top of the toilet lid. Interview with the interim Administrator on 06/29/22 at 1:22pm revealed: -She expected the staff on SCU to keep all hygiene products locked in the medication room and not left unattended in resident's rooms or bathrooms. -It was important for hygiene products to be locked up so that the residents did not have access to hazardous or dangerous items that would cause them harm. -She was not aware of any residents ever ingesting hazardous items. Telephone interview with the facility's contracted primary care provider (PCP) on 06/30/22 at 1:00 pm revealed she expected all personal hygiene and cleaning supplies to be kept locked in SCU for resident safety and to prevent residents from injuring themselves.	D 079		
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:	D 451		

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D 451	Continued From page 5 Based on observations, interviews and record reviews the facility failed to notify the county Department of Social Services 1 of 1 sampled resident who required emergency medical evaluation after the resident was sent to the hospital and admitted for a fall that resulted in a head injury (#1). The findings are: Review of Resident #1 current FL-2 dated 04/11/22 revealed diagnoses of dementia with behavioral disturbances, Parkinson's disease and diabetes. Review of Resident #1's Incident and Accident (I/A) Report dated 06/24/22 revealed: -Resident #1 fell in the dining room on 06/24/22 at 6:10pm. -Resident #1 had a skin tear above his left eye. -Resident #1 was transported to the hospital. Telephone interview with the previous adult home specialist (AHS) for the county Department of Social Services (DSS) on 06/30/22 at 10:17am revealed she had not received any I/A report from Resident #1's fall and subsequent hospitalization on 06/24/22. Telephone interview with the county DSS Supervisor on 06/30/22 at 10:45am revealed: -He received the I/A report for Resident #1 via fax from the facility this morning (06/30/22) at 10:30am. -All incoming faxes for the county DSS go to the main administration number and there was nothing from the facility prior to 06/30/22 for Resident #1. Interview with the Interim Administrator on	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 in accordance to rule area 10A NCAC 13F .1212 Resident Care Coordinator/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.	8/14/2022 8/14/2022 8/14/2022

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D 451	Continued From page 6 06/30/22 at 10:20am revealed: -She was responsible for sending the I/A reports to the county DSS. -She was not at the facility on 06/24/22 when Resident #1 went to the hospital. -She did not have the DSS Supervisor's information until yesterday (06/29/22) to send because there was not an AHS currently for the county. -She did not send the I/A report to the DSS Supervisor until 06/30/22.	D 451		