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	HAL021008	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

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D 000	Initial Comments The Adult Care Licensure Section and the Chowan County Department of Social Services conducted an annual survey on 04/29/25 through 05/01/25.	D 000		
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: Based on interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 1 of 5 sampled residents (#1) following a suspected fall, low blood pressure and weakness. The findings are: Review of Resident #1's current FL-2 dated 07/12/24 revealed diagnoses included dementia, hypertension and type II diabetes. Review of an Incident Accident report for Resident #1 dated 03/29/25 revealed: -Resident #1 was found on the floor in his room at 2:00pm. -There was a skin tear on his right arm. -Resident #1's blood pressure was 102/56. -There was documentation the physician was called and Resident #1 was not sent to the local emergency room for evaluation. Review of a nursing care note dated 03/29/25 at 3:00pm revealed: -There was documentation Resident #1 was	D 273		

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found on the floor and had a skin tear to his right arm.
-Resident #1's blood pressure was 102/56.
-There was documentation Resident #1 had weakness in his legs when staff attempted to assist him to stand.
-There was documentation the primary care provider was not contacted because it was a Saturday.

Interview with the medication aide (MA) supervisor on 04/30/25 at 1:51pm revealed:
-A patient care aide (PCA) reported to her on 03/29/25 that Resident #1 was found on the floor of his room.
-Resident #1's blood pressure was 102/56 which was low.
-Resident #1's primary care provider (PCP) was not notified because it was a Saturday and Resident #1's outside provider's office was closed.
-She did not know if Resident #1's PCP office had an on-call provider or way to notify a provider after hours.
-Resident #1's family member was notified of the incident and said not to send him out for evaluation and would be coming to check on him later that day.
-If Resident #1 was seen by the in-house provider, she would have notified the provider of the incident but a resident's responsible person had the last say in whether to send a resident out for evaluation.

Telephone interview with Resident #1's power of attorney (POA) on 05/01/25 at 8:57am revealed:
-He was notified of the incident with Resident #1 being found on the floor on 03/29/25.
-He did not remember all the information that was relayed to him by staff during the call but he told

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staff not to send him out.
-He thought Resident #1 was "probably just dehydrated" on 03/29/25.
-He thought Resident #1's PCP was aware of the incident but he was not sure.

Telephone interview with the practice manager with Resident #1's PCP office on 05/01/25 at 9:28am revealed:
-She was a liaison for Resident #1's PCP.
-There was an option on the main office number voicemail for notifications to the PCP after hours.
-The practice was closed on Saturdays but were available on weekends and encouraged patients to contact the office prior to going to the local hospital emergency room (ER) when possible.

Second telephone interview with the practice manager with Resident #1's PCP office on 05/01/25 at 10:30am revealed:
-The PCP was not notified of the incident on 03/29/25 but would have expected to be.
-The PCP would have had a telemedicine visit with Resident #1 to determine what was going on with him especially given his blood pressure and weakness.
-The PCP would have determined whether Resident #1 needed to be sent out to the local ER for evaluation or were there other options to prevent him from having to go out to the hospital.

Interview with the Administrator on 05/01/25 at 9:08am and 9:43am revealed:
-Residents should automatically be sent to the local ER for evaluation when there was an unwitnessed fall.
-A resident's PCP should be contacted and may be contacted prior to calling emergency medical services (EMS).
-A resident's PCP needed to be kept in the loop

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D 273	Continued From page 3 about falls and may have other recommendations rather than sending them to the hospital. -Staff should always notify a resident's PCP even if the PCP was an outside provider. -Staff should at least make an attempt, leave a voicemail and document the attempt. -She was not aware Resident #1's PCP was not notified of the incident that occurred on 03/29/25.	D 273		
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 any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to have a matching therapeutic diet menu for the guidance of food service staff for 1 of 5 sampled residents (#3) who had a physician ordered pureed diet. The findings are: Review of Resident #3's current FL2 dated 03/03/25 revealed: -Diagnoses included dementia, essential hypertension, and primary osteoarthritis. -There was an order for a pureed diet.	D 296		

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Review of Resident #3's diet order sheet dated 01/06/25 revealed an order for a pureed diet.

Review of the therapeutic diet list posted in the kitchen revealed Resident #3 received a pureed diet.

Observation of the kitchen on 04/29/25 at 9:15am revealed there was no therapeutic diet menu available for a pureed diet.

Interview with a facility cook on 04/29/25 at 9:20am revealed:
-The facility did not have a dietary manager.
-She did not know if the facility had a therapeutic diet menu.
-When she prepared food she did not use a therapeutic diet menu for reference.
-There was a therapeutic diet list posted in the kitchen with each resident's diet.
-There was a folder in the kitchen that contained each resident's diet orders.
-The cooks in the facility know each resident's diet.

Interview with a second facility cook on 04/29/25 at 9:45am and 1:34pm revealed:
-The facility did not have a dietary manager.
-There was no therapeutic menu available in the kitchen for the cooks to use for the residents on pureed diets.
-When there was an item on the menu that she cannot puree she found something she could substitute it for.

Second interview with the second cook on 04/30/25 at 9:30am revealed:
-When there was a meal on the menu she could not puree she found something to substitute.
-She could not puree taco pie, which was on the

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D 296	Continued From page 5 menu for dinner the previous evening. -She substituted the taco pie with pureed roast beef and mashed potatoes. -She did not have a therapeutic diet menu to for options to use for substitutions for a pureed diet. Interview with the Administrator on 04/30/25 at 1:55pm revealed: -The facility did not have a kitchen manager. -The facility recently switched to a new company to do their menus. -She was not aware that the therapeutic diet menus did not include pureed diets. -Therapeutic diet menus were important to ensure all residents got the proper nutrients and quality food they deserved.	D 296		
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, interviews and record review, the facility failed to ensure 1 of 1 residents (#3) that required assistance in eating was assisted upon receipt of the meal and the assistance was unhurried and in a manner that maintained each resident's dignity and respect. The findings are:	D 312		

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Review of Resident #3's current FL-2 dated 03/03/25 revealed diagnoses included osteoarthritis and dementia.

Resident #3's current assessment and care plan dated 11/17/24 revealed that she required extensive assistance from staff for eating.

Review of Resident #3's diet order dated 01/06/25 revealed:
-Resident #3 was ordered a regular diet with pureed consistency.
-Resident #3 was to be assisted with feeding.

Observation of the lunch meal service on 04/29/25 from 11:50am to 12:15pm revealed:
-Resident #3 was seated at the short end of the table in her wheelchair.
-Resident #3 was served a pureed diet at 11:55am.
-A personal care aide (PCA) and a medication aide (MA) were standing at the each corner of the table feeding residents to the left and right of Resident #3 with gloved hands.
-At 12:05pm, the PCA on the right took Resident #3's spoon and gave her a bite before returning to the other resident to offer her bites of food.
-The PCA continued to offer bites of food to each resident in turn until Resident #3 picked up her spoon and began feeding herself at 12:11pm.
-Both staff remained standing over each resident as they assisted with feeding.

Interview with a PCA on 04/29/25 at 2:11pm revealed Resident #3 was able to feed herself but kept her eyes closed a lot and needed prompts.

Interview with the MA on 05/01/25 at 8:39am revealed:
-Resident #3 did not always require assistance

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D 312	Continued From page 7 eating. -When assisting residents to eat, staff should be seated beside the resident. -Staff should sit with the resident being assisted with feeding to provide a more personable experience and the resident does not feel rushed while eating. -She was not sure why she and the PCA did not sit along side the resident on 04/29/25 but they were nervous and wanted to ensure residents were fed and not having to wait on their meals. Interview with the Administrator on 05/01/25 at 9:08am revealed: -Staff were trained to place a chair infront or beside a resident when assisting with feeding so as not to hover over the resident and to show respect and dignity during feeding. -She thought the staff were nervous and did not want Resident #3's food to get cold during the lunch meal service on 04/29/25.	D 312		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that	D 610		

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D 610	Continued From page 8 shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure infection prevention and control policies and procedures were implemented for 1 of 1 residents (#3) that required feeding assistance. The findings are:	D 610		

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Review of the facility's Infection Control Policies and Procedures dated 02/20/25 revealed:
-Standard precautions were used for all residents regardless of known or unknown infectious status and applied to all body fluid, secretions and excretions regardless of whether they contain visible blood and mucus membranes.
-Hand hygiene was to be performed after touching body fluids, secretions and contaminated items even if gloves were worn and immediately after gloves were removed, between resident contacts and after the resident's environment.
-Gloves were to be worn for all residents when contact with body fluids secretions, excretions and mucus membranes is anticipated and should be removed promptly after use with a resident.

Review of Resident #3's current FL-2 dated 03/03/25 revealed diagnoses included osteoarthritis and dementia.

Resident #3's current assessment and care plan dated 11/17/25 revealed that she required extensive assistance from staff for eating.

Review of Resident #3's diet order dated 01/06/25 revealed:
-Resident #3 was ordered a regular diet with pureed consistency.
-Resident #3 was to be assisted with feeding.

Observation of the lunch meal service on 04/29/25 from 11:50am to 12:15pm revealed:
-There was a hand sink and gloves available in the cabinet in the dining area.
-Resident #3 was seated at the short end of the table in her wheelchair.
-Resident #3 was served a pureed diet at 11:55am.

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D 610	Continued From page 10 -A personal care aide (PCA) and a medication aide (MA) were standing at the each corner of the table feeding residents to the left and right of Resident #3 with gloved hands. -At 12:05pm, the PCA on the right took Resident #3's spoon and gave her a bite before returning to the other resident to offer her bites of food. -The PCA continued to offer bites of food to each resident in turn until Resident #3 picked up her spoon and began feeding herself at 12:11pm. -The PCA's gloves were torn at the wrist and she did not change gloves or wash her hands between feeding each resident. Interview with the personal care aide (PCA) on 04/29/25 at 12:11pm revealed she did not realize her glove was torn. Interview with the MA on 05/01/25 at 8:39am revealed: -When assisting residents to eat, staff should be wearing gloves. -Staff should wear gloves while feeding a resident and change gloves between feeding different residents so there was no cross contamination of germs. -She was not sure why she and the PCA did not change gloves on 04/29/25 but they were nervous and wanted to ensure residents were fed in a timely manner and not having to wait on their meals. Interview with the Administrator on 05/01/25 at 9:08am revealed: -Staff should assist one resident at the time with feeding while wearing gloves and change gloves before moving on to assist another resident for sanitary reasons and not share germs. -Staff were trained on infection control policies upon hire and annually.	D 610		

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D 610	Continued From page 11 -She thought the staff were nervous and did not want Resident #3's food to get cold during the lunch meal service on 04/29/25.	D 610		