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 03/05/2021

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

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow-up survey and a complaint investigation with onsite visit dates on 02/25/21, 02/26/21 and on 03/01/21. A desk review survey was conducted 03/02/21 through 03/05/21 with a telephone exit on 03/05/21.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 exit doors was equipped with a sounding device that was activated when the door was opened and accessible to residents who were disoriented and one resident with a history of attempted elopement behaviors on the Assisted Living section of the facility. The findings are:	D 067		

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 03/05/2021

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 067	Continued From page 1 Observation of facility's main entrance/exit door of the Assisted Living section (AL) on 02/25/21 at 9:15am revealed: -The main entrance/exit door opened to the front grounds of the facility. -The facility's front grounds were not gated and lead to a high traffic four lane highway. Observation of the facility's main entrance/exit door of the AL section intermittently on 02/25/21 from 9:30am to 6:00pm revealed there was no audible alarm sound when the door was opened, and the door was unlocked. Interview with the Administrator on 02/26/21 at 4:50pm revealed she was aware there must be a sounding device on all exit doors when there was a resident with dementia, residents that wandered or were at risk for elopement. Observation of the facility's main entrance/exit door of the AL section intermittently on 03/01/21 from 9:30am to 4:00pm revealed there was an audible alarm sound when the door was opened, and the door was locked. Confidential staff interview revealed: -Staff at the facility routinely left the facility's main entrance/exit door of the AL section unlocked and the alarm disarmed on the door. -The staff did not know an exact number of residents that were confused or had dementia residing on the AL section of the facility but knew there was one resident with cognitive deficits or some level of dementia that routinely walked the halls without staff. Telephone interview with a personal care aide (PCA) on 03/03/21 at 10:43am revealed: -The front entrance/exit door on the AL section	D 067		

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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 067	Continued From page 2	D 067		

was "usually" locked.
-She was not sure if the main front entrance/exit door of the AL section made an audible sound when it was opened.
-The exit doors on the end of the AL halls were locked and alarmed when opened so the residents would not get out and staff would know where the residents were.

Telephone interview with a medication aide (MA) on 03/04/21 at 9:00am revealed:
-All exit doors on the AL section should always alarm when the door was opened.
-Staff were responsible to ensure the front entrance/exit door of the AL section remained locked at all times.
-She worked 3rd shift and made sure all exit doors of the AL section including the front main entrance/exit door was set to alarm when opened because she was afraid one of the residents might get out of the facility without staff knowing it.
-When an exit door was opened and alarmed, staff were responsible to see why the door was alarming.
-The door alarm panel at the front of the facility would light up when an exit door was opened, however, staff would physically have to check all the exit doors because the panel did not show which exit door was opened.

Telephone interview with the Maintenance Director on 03/03/21 at 12:10pm revealed:
-All the exit doors on the AL section of the facility should have a sounding device on each exit door.
-The facility's front entrance/exit door was the primary door used for staff and visitors.
-The front entrance/exit door of the AL section should have been locked at all times.
-The front entrance/exit door should remain

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 03/05/2021

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

(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 067	Continued From page 3	D 067		

locked with an audible alarm "24/7".
-He posted signs on the front exit door not to leave the door unlocked.
-There had been times staff were disarming the lock and audible door alarm on the front entrance/exit by turning the switch at the panel from on to off, however, staff were not supposed to do that.
-He thought at times staff were not ensuring the front entrance/exit door was "pulled to" and closed to make connection to the locking mechanism when entering the front entrance/exit door.
-Staff were failing to ensure the front entrance/exit door of the AL section was pulled to, sometimes the front entrance/exit door did not lock because "it was how people close it".
-The alarm on the front entrance/exit door of the AL section alarm was not sounding because staff were shutting the alarm off but were not supposed to.
-There was a doorbell on the outside of the facility's front entrance/exit door and there should be no reason to disarm the lock or alarm.
-All staff were responsible for making sure the alarms and exit doors were always locked on the AL section of the facility.

Telephone interview with the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC) on 03/04/21 at 3:34pm revealed:
-All exit doors on the AL section of the facility should always stay locked.
-All the exit doors on the AL section of the facility should always alarm when opened.
-The facility's main front entrance/exit door had to be pulled to for the door to lock.
-She had observed times when staff had disarmed the main front entrance/exit door and she would follow-up and ask staff who turned the

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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 067	Continued From page 4	D 067		

alarm off.
-There were some residents residing on the AL section of the facility that had some dementia but none that had displayed any exit seeking behavior.
-There was one resident that had exit seeking behaviors but was not aware of any specific incidents when she was working.

Telephone interview with the Administrator on 03/04/21 at 1:54pm revealed:
-She expected staff to ensure the door alarms were always on at each exit door.
-Staff were responsible for checking all exit doors on the AL section periodically during their shift to ensure the exit doors remained locked and or armed with a sounding device when opened.
-Staff were responsible for checking the exit door when the audible alarms on the exit doors sounded.
-Once the exit doors alarmed, staff had to reset the alarm at the alarm door panel located at the front of the facility.
-The alarm door panel would display which door was activated.
-The main front entrance/exit door was not locked on 02/25/21 and 02/26/21 because the door was not pushed in a complete closed position.
-It was important to make sure the main entrance/exit door was pushed into a closed position so the door would lock.
-Staff were always aware the main front entrance/exit door had to remain locked, however, there had been incidences when she periodically observed staff had physically disarmed the audible alarm at the alarm door panel and she would re-educate staff present to ensure the alarm doors stayed activated at all times.
-She held a meeting with staff last week (after the

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 067	Continued From page 5	D 067		

survey was initiated on 02/25/21) for only MAs to touch the alarm door panel.
-There were no residents that wandered, no residents that had eloped or had exit seeking behaviors.
-There were two residents residing on the AL section of the facility that were semi-ambulatory and had some dementia, however, the two residents had never raised any concerns regarding exit seeking or leave their room alone.
-Staff were responsible for accounting for all the residents at the beginning, middle and end of each shift and responsible to check on each resident every 2 hours.

Telephone interview with a primary care provider for the facility on 03/03/21 at 3:48pm revealed:
-When she made visits to the facility, she entered though the facility's main front entrance/exit door.
-The facility's front entrance/exit door was sometimes locked and sometimes the door was not locked.
-There was an audible sounding device on the facility's front entrance/exit door when the door was opened when she visited the facility.
-There were some residents residing on the AL section that had "some dementia".
-There was one resident recently admitted to the AL section that had attempted to elope from the facility.
-In general, there were some of her residents with mild dementia but none with exit seeking or elopement behaviors except for the one new resident.
-The one new resident who attempted elopement and exhibited exit seeking behaviors did not have dementia.
-She thought it would be "beneficial" for the safety and protection of all the residents to have a sounding device on all exit doors on the AL

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 067	Continued From page 6 section of the facility.	D 067		
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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews the facility failed to ensure the facility was free of hazards as evidenced by an unlocked common spa room with a sink that leaked water on the floor when the water fixture was turned on and exposed electrical wires from a call bell positioned on the wall beside the toilet were left unsecured and accessible to all residents known to have dementia in the Special Care Unit. The findings are: Observation of an unlocked common spa room on the Special Care Unit (SCU) on 02/25/21 at 5:24pm revealed: -There was a spa room located on the left hallway of the SCU on the right side of the hall. -The spa room's door was in a closed position. -There was a sink with visible pipes underneath	D 079		

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 079	Continued From page 7	D 079		

the sink on the left wall of the room.
-Water flowed from the sink's pipe and onto the floor when the sink's water fixture was turned on causing a slip/fall hazard.
-There was a call light housed in a square box that was pulled away from the wall leaving black and grey color- coded wiring exposed, located on the wall beside the toilet.

Interview with a medication aide (MA) on 02/25/21 at 5:27pm revealed:
-She was not aware the sink in the common spa was leaking when the water at the sink was turned on.
-She was not aware the call light in the spa room had been pulled away from the wall exposing wires.
-The residents in the SCU did not use this spa room and the room was used for storage.
-Staff working on the floor were always responsible for ensuring the spa's door stayed locked.
-Residents on the hall used the other common spa room located on the left side of the hallway.
-She had not been in the spa room on the right side of the hall today, (02/25/21).

Observation of the MA on 02/25/21 at 5:27pm revealed the MA locked the door to the common spa room on the right side of the hallway.

Interview with the Administrator on 02/25/21 at 5:50pm revealed:
-She was not aware the sink was leaking from a pipe when the water was turned on and there were exposed electrical wires in spa room on the SCU.
-She would inform the Maintenance Director.

Observation of the common spa room and the left

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 079	Continued From page 8	D 079		

hallway of the SCU on 02/26/21 from 11:14am to 11:26am revealed:
-There was a posted sign "out of order" on the spa room door located on the right side on the left hallway.
-At 11:14am the door was unlocked, and the call light housed in a square box was pulled away from the wall exposing two electrical wires, located on the wall beside the toilet.
-At 11:15am, there was a resident without staff in the spa room on the left side of the hallway (no hazards observed in the left spa on the left hallway of the SCU) which was directly across the hallway from the spa room on the right.
-At 11:16am, the resident walked out of the left spa room, entered the hallway and proceeded down the hallway.
-At 11:16am, a personal care aide (PCA) was in the hallway passing out plated meals to some of the resident's in their rooms.
-At 11:18am, there was a male resident in the left hallway of the SCU.
-At 11:20am there was a housekeeper in and out of a room located at the end of the SCU's left hallway.
-A staff walked passed the spa room on the right side of the hallway.
-At 11:24am, a staff was in the hallway advising the residents it was time for lunch.
-At 11:26am, there were three staff in in the dining room and three residents in rooms down the left hallway.
-The SCU's left hallway was not visible from the dining room.

Interview with the housekeeper on 02/26/21 at 11:20am revealed:
-Approximately two months ago, she noticed the call light box in the spa room on the right side of the hallway had pulled away from the wall.

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 03/05/2021

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

(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 9	D 079		

-She had not reported the call light box to maintenance but thought she had reported the call light's box to another housekeeper.
-Approximately 1-2 weeks ago she had noticed the sink's under mount pipe was leaking when the water was turned on in the spa room (on the right side of the hallway) when she washed her hands in the room, however, she did not report the leaking pipe to anyone.
-The spa room door on the right was not always locked.
-She thought the room was used for storage.
-She had never seen any residents in the spa room, but it was possible some of the residents in the SCU could enter the room and touch the electrical wires and cause the residents harm.

Interview with the Administrator on 02/26/21 at 11:30am revealed she would have a staff member stand at the door until maintenance could secure the door.

Telephone interview with a PCA on 03/03/21 at 10:43am revealed:
-She had worked at the facility for one month and was routinely assigned to care for the residents on the left hallway in the SCU.
-She had never been in the spa room on the right side of the hallway.
-She had never seen any residents in the spa room on the right side of the hallway.
-Staff did not use the spa room on the right side and she was not sure why.
-She was not sure if the door to the spa room on the right side was locked.
-She had not been told by other staff to ensure the door stayed locked.

Telephone interview with the Maintenance Director on 03/03/21 at 12:23pm revealed:

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 03/05/2021

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

(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 10 -He worked at the facility one time a week for 8 hours or more. -There was one week out of the month he was at the facility two times a week. -He was responsible for completing needed repairs within the facility. -All staff were responsible to either contact him for needed repairs by telephone or document the needed repair in a repair book stored in a cabinet in the front office of the facility. -He was not aware of the sink's leaking pipe or the exposed wires from the call light in the spa room on the SCU. -There was no contact made by telephone or a repair request documented in the facility's repair book to repair the sink's leaking pipe or repair the exposed wires from the call light detached from the wall in the spa room on the SCU. -He would have expected staff to contact him about the needed repairs in the SCU's spa room. -The spa in the SCU with the leaking sink and the exposed wiring was only used for storage and the spa door should have stayed locked. -He was told by staff Friday, 02/26/21, the door to the spa would not stay in a locked position, he assessed the lock to the spa and found the latch was bent down so he repaired the spa door's latch and now the door stayed in a locked position. -When he worked with the wires to the call light system he done so with his bare hands and if there was any electrical shock from the call light wires it would only produce a "very, very small" low shock voltage. -He would have concerns if a resident was shocked from the electrical wires to the call light and had concerns for hazard risks for the residents when the pipe from the sink leaked when the water was turned on causing a wet floor or wet feet.	D 079		

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 03/05/2021

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

(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 11	D 079		

-It was important to ensure repairs were done and to ensure the spa door was always locked and secured.
-It was better to be "safe than sorry" of an accident.

Telephone interview with the Administrator on 03/04/21 at 1:54pm revealed:
-All staff were responsible to ensure the facility was free of any and all hazards.
-Staff were responsible to document facility repair requests in a repair book for the Maintenance Director.
-If staff recognized a hazard that was detrimental to someone's health or cause danger, then the staff would have been responsible to immediately report the concern for the emergent repair to her or the Maintenance Director.
-She was not aware the door to the spa room on the left hallway of the SCU was not locking.
-She started working at the facility in November 2020 and since then the spa on the right side had never been used by staff to assist the residents and the residents had never used that spa room because it was used for storage.
-Staff were always responsible to ensure the door to the spa room on the right side of the hallway remained locked.
-The leaking pipe from the sink and the exposed wires from the call light had never been reported to her but should have been reported to her immediately.
-She was concerned that a resident could have been hurt if a resident went into the spa room.
-The exposed wires was a hazard alone.
-There were residents in the SCU that could ambulate without staff.

Telephone interview with a primary care provider for the facility on 03/03/21 at 3:48pm revealed

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 03/05/2021

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

(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 12 she would have concerns that a resident with dementia and decreased cognitive abilities would be at risk to enter the spa room in the SCU, touch the electrical wiring and with a wet floor there was a potential that a resident could suffer an electrical burn or harm.	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an adequate supply of washcloths and towels, for residents' use at all times. The findings are: Interview with the Administrator on 02/25/21 at 9:35 am revealed: -There was a current census of 48 residents in the facility. -There were 29 residents residing in the assisted living side of the facility. -There were 19 residents residing in the special care until (SCU). Observation of the clean linen supply closet on the assisted living unit (AL) on 02/26/21 at 8:16	D 080		

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 03/05/2021

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

(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 080	Continued From page 13	D 080		

am revealed there were no towels on the shelves and 1 washcloth on the shelves.

Observation of the clean linen supply closet on the AL unit on 02/26/21 at 9:59 am revealed there were no towels on the shelves and 9 washcloths on the shelves.

Observation of the laundry room on 02/26/21 at 8:27 am revealed:
-There were 2 towels folded on the laundry table.
-There was 1 washcloth folded up on the laundry table.
-There were 2 towels and 1 washcloth in the clothes drier.

Observation of the clean linen supply closet on the special care unit (SCU) on 02/26/21 at 8:26 am revealed there were no towels and no washcloths.

Observation of the medication room located in the SCU on 02/26/21 at 8:17 am revealed there were 2 washcloths and 4 towels folded on the counter.

Observation of the Administrator's office on 02/26/21 at 11:11 am revealed:
-There were 6 wash cloths in a bag on top of the desk.
-There were 48 towels in the closet in the Administrator's office.

Review of linen supply invoice dated 11/16/20 revealed there was an order for 120 washcloths and 96 towels.

Review of a store receipt dated 02/23/21 revealed 30 washcloths were purchased.

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 080	Continued From page 14 Interview with a personal care aide (PCA) on 02/26/21 at 9:50 am revealed: -The towels and wash cloths were kept in the clean linen closet in the assisted living unit (AL). -There could have been some in the laundry room if there were any. -The facility did not have many towels and washcloths. Interview with a second PCA on 03/01/21 at 2:29 pm revealed: -The facility did not have enough towels and washcloths. -She last bought towels and washcloths to bathe the residents in December 2020 out of her own money. -She had to use baby wipes because there were no towels and washcloths. -She did not know there were towels and washcloths in the Administrator's office. -She could not remember when she had told management about not having enough towels and washcloths, but nothing was done. Interview with a third PCA on 03/01/21 at 3:24 pm revealed: -The facility did not have enough towels and washcloths. -She had to use baby wipes to bathe residents. -Staff had to buy baby wipes for the residents to use to bathe. Interview with a medication aide (MA) on 02/26/21 at 2:25 pm revealed: -The facility did not have enough washcloths and towels. -She had to use a chux pads to wash two residents about 2 weeks ago. -Sometimes there were towels in the Administrator's office but if it was after 5:00 pm	D 080		

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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 080	Continued From page 15 and Administrator was gone then she had to use the chux pads. Interview with the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC) on 02/26/21 at 9:59am revealed: -The towels were usually kept in the clean linen closet on the AL unit. -Staff had to ask for the towels and washcloths that were kept in the Administrator's office. -She did not have a key to the Administrator's office. -Only the Administrator and maintenance had a key to the Administrator's office. -She did not know how staff were supposed to access the towels and washcloths when the office was locked. Interview with the Administrator on 02/26/21 at 11:07 am revealed: -The towels and washcloths had been "disappearing". -A shipment of towels and washcloths were delivered in November 2020. -All the washcloths that were ordered were put in the clean linen closet in November 2020. -Half of the towels that were ordered were put in the clean linen closet in November 2020. -The other half of the towels were stored in her office in a closet. -There were washcloths in a bag under her desk that she purchased earlier in the week. -She and the maintenance staff were the only staff that had a key to her office.	D 080		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 269		

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 03/05/2021

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 269	Continued From page 16 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 B VIOLATION Based on observations and interviews, the facility failed to ensure personal care was provided for 2 of 7 sampled residents (#1, #7) related to a skin rash in the inguinal area, groin and buttocks (#7) and staff not shaving a resident, who required assistance (#1). 1.Review of Resident #7's current FL-2 dated 02/08/21 revealed diagnoses included dementia, fracture pelvis, history of COVID-19, advanced aged, debility and glaucoma. Review of Resident #7's care plan dated 02/08/21 revealed: -Resident #7 was always disoriented. -Resident #7 needed extensive assistance with toileting, bathing, dressing and grooming. Review of Resident #7's Primary Care Physician (PCP) Subjective, Objective, Assessment and Plan (SOAP) notes dated 01/13/21 revealed Resident #7 had a moderate yeast rash in groin (front and back). Review of Resident #7's physician's order dated 01/13/21 revealed staff were to clean Resident #7's inguinal area, groin and buttocks well and pat dry twice per day.	D 269		

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 03/05/2021

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 269	Continued From page 17 Review of Resident #7's PCP SOAP notes dated 01/20/21 revealed Resident #7 had a moderate yeast rash in her groin (front and back). Review of SOAP notes dated 01/27/21 revealed: -Resident #7 had a moderate yeast rash in her groin (front and back). -Staff were to clean Resident #7's bottom area, apply the cream and keep her bottom area dry. Review of Resident #7's physician's order dated 01/27/21 revealed: -The facility staff were to ensure the inguinal area, groin and buttocks were cleaned and washed with soap and water and dried well twice per day. -The facility staff were to ensure Resident #7's brief was checked and changed regularly to keep her dry. Review of Resident #7's PCP SOAP notes dated 02/10/21 revealed: -Resident #7 had a moderate yeast rash in her groin and on buttocks (front and back). -Resident #7's rash had not improved. Review of Resident #7's facility's care notes dated 02/07/21 revealed: -Resident #7's back area was worsening. -The PCP and the Resident Care Coordinator (RCC)/ Special Care Unit Coordinator (SCUC) were notified. Review of Resident #7's physician's order dated 02/10/21 revealed: -The facility staff were to ensure the inguinal area, groin and buttocks were cleaned and washed with soap and water and dried well twice per day. - "It was very important" to check Resident #7's	D 269		

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 18	D 269		

incontinent brief regularly and keep her dry.

Review of facility's care notes dated 02/23/21 revealed:
-Resident #7's rash on her bottom was getting worse.
-The PCP and the RCC/SCUC were notified.
-The facility staff were waiting on PCP for recommendations.

Review of Resident #7's facility's care notes dated 02/28/21 revealed:
-Resident #7's backside was worsening.
-The PCP and the RCC/SCUC were notified.

Review of Resident #7's physician's order dated 03/01/21 revealed:
-Staff were to clean Resident #7's bottom, perineum and groin area well with soap and water and dry the area well.
-Staff were to check Resident #7 regularly for soiled/wet incontinent brief and keep Resident #7 dry and leave brief open to allow air dry when she was in bed.

Observation on 03/01/21 at 2:26pm revealed:
-Resident #7 was lying on her back in a hospital bed in her room.
-The medication aide (MA) provided the resident's incontinent care and removed the wet soiled linen saver from underneath the resident's buttocks.
-The resident's perineal area was in an inflamed, solid red color starting around the pubic area and extending to the perineum, upper inner sides of her legs and buttocks.
-The resident's skin had a wet macerated appearance in two areas on both sides of the labia.
-The MA used patting motions while cleansing the

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 19	D 269		

resident's skin with an incontinent wipe.
-The resident cried and moaned while the MA was cleansing her perineal area.
-The MA positioned a clean incontinent linen saver underneath the resident.

Telephone interview with a MA on 03/04/21 at 6:00am revealed:
-Resident #7 had a perineal "rash" for about 2 months.
-Resident #7's perineal redness worsened a couple of weeks ago and she reported it to the RCC/SCUC.
-The RCC/SCUC told staff not to "double up", meaning not to place two pull-up incontinent briefs on Resident #7 and to leave the resident's buttocks open to air without an incontinent brief.
-Resident #7 was a "heavy wetter", staff normally placed two incontinent briefs on the resident at a time.
-She thought the purpose of placing two incontinent briefs on Resident #7 was to prevent a "bigger mess" and the brief would catch the urine and feces.
-Double briefing was helpful to the staff and was common with all the residents that were "heavy wetter's".

Telephone interview with a second MA on 03/04/21 at 9:00am revealed:
-Resident #7's "bottom just had a small red spot" that gradually worsened covering her entire perineal and buttock area.
-The areas on Resident #7's groin and buttocks was treated with ordered medicated creams twice daily and applied by the MAs.
-All staff knew what the residents' personal care needs were from the "tasks sheets" stored in a book in the SCU.
-Staff were responsible for providing incontinence

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 20	D 269		

care to Resident #7 every 2 hours.
-Resident #7 wore a pull-up type incontinence brief.
-She had never observed Resident #7 wearing two incontinent briefs at a time.
-There should never be an incident when a resident would wear two incontinent briefs at one time because that would increase moisture and heat against the residents' skin and cause skin breakdown.
-There had been times when she had found Resident #7 not changed every 2 hours by staff which left the resident heavily soiled in urine.
-The last time this occurred was approximately 2-3 weeks ago and she located the resident's personal care aide (PCA) and told her to go ahead and change the resident.
-She did not ask the PCA why Resident #7 had not been changed and she did not report the incident to the RCC/SCUC.
-She thought the PCA had not changed Resident #7 because they were so busy doing so many things.
-She was concerned because she knew Resident #7's skin was already irritated, red and painful and urine would further damage and breakdown the resident's skin.

Confidential interview with a staff revealed:
-The staff was concerned Resident #7 was not receiving incontinent care from staff every 2 hours or whenever soiled which was causing a rash on the resident's bottom to worsen.
-The staff had found Resident #7 soiled at times in urine which was concerning because of the amount of redness the resident already had on her bottom.

Confidential interview with a second staff revealed there had been times (no estimation of

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 21 how many times provided) when she found the resident soiled in urine and was concerned because the irritation on the resident's bottom was getting worse. Telephone interview with Resident #7's family member on 03/03/21 at 8:45am revealed: -The family member was made aware Resident #7 had a rash three weeks ago (not sure of the exact date). -The family member was not aware of who called three weeks ago but was told the rash had improved. Telephone interview with the RCC/SCUC on 03/03/21 at 1:07pm revealed: -She was aware of the rash on Resident #7's bottom area. -She completed a skin assessment on 01/12/21 for Resident #7. -She notified Resident #7's PCP. -The facility staff were told by the PCP to clean and wash the area daily and keep the area dry. -Resident #7 had been treated with oral medications three times and two different creams since the rash began. -She notified the PCP Resident #7's rash was worsening. -The PCP said the rash was not going to heal if the facility staff did not keep Resident #7's bottom cleaned and dried. -The PCAs were responsible for keeping Resident #7 cleaned and dried every 2 hours. -Resident #7's rash had not improved as of 03/03/21. Telephone interview with Resident #7's PCP on 03/03/21 at 3:54pm revealed: -Resident #7 had been treated for the rash on her bottom.	D 269		

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 22	D 269		

-The rash would cause Resident #7 to be uncomfortable, itchy in the area, and affect her quality of care and would potentially cause a wound if her skin were to breakdown.
-The more moisture exposed to Resident #7's area would cause the area to be worsen.
-As of today, 03/03/21, the area should have gotten better.
-Resident #7's rash would have healed if her inguinal area, groin and buttocks were kept cleaned and dried.

Telephone interview with the RCC/SCUC on 03/04/21 at 9:07am revealed:
-She was notified (not sure of the date) the PCA staff were adding two briefs to Resident #7 during incontinent care.
-She immediately informed PCA staff not to use two briefs for Resident #7 during incontinent care.
-She had not notified the PCP of the facility staff adding two briefs to Resident #7 during incontinent care.

Telephone interview with the Administrator on 03/04/21 at 9:38am revealed:
-The RCC/SCUC informed her Resident #7's bottom was worsening.
-She was not aware the facility staff were placing two briefs on Resident #7 during incontinent care.
-She expected the facility staff to check Resident #7 every 2 hours and provide incontinent care.
-She did not expect the facility staff to put two briefs on Resident #7.

A second telephone interview with the PCP on 03/04/21 at 11:42am revealed:
-She was not aware the facility staff were putting two briefs on Resident #7 during incontinent care.
-She had written numerous orders for facility staff to ensure incontinent care was provided and

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 23 Resident #7's bottom was checked and dried. -Resident #7's rash would worsen adding two briefs which would result in more warmth and moisture in the area as well as resulting in more wetness to the rash. 2. Review of Resident #1's current FL-2 dated 02/17/21 revealed diagnoses of an acute encephalopathy, depressions, diabetes mellitus, hypertension, osteoarthritis, and stage 5 chronic kidney disease. Review of Resident #1's care plan dated 02/17/21 revealed: -Resident #1 was forgetful and needed reminders. -Resident #1 had limited vision and used glasses. -Resident #1 required extensive assistance with grooming, bathing, and dressing. Review of the PCA Assignment Sheet on 03/01/21 revealed Resident #1 was supposed to be shaved on Monday and Fridays. Observation on the assisted living (AL) unit on 02/25/21 at 11:40 am revealed: -Resident #1 was sitting on her bed in her room. -Resident #1 had facial on her chin that continued down her neck. -Resident #1 had a white bandage covered with a clear dressing on the right side of her neck. Interview with a personal care assistant (PCA) on 03/01/21 at 2:05pm revealed: -She did not help Resident #1 shave her facial hair. -Resident #1 did not like to shave her facial hair. -She did not report to anyone that Resident #1 refused to shave her facial hair.	D 269		

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 24 Interview with Resident #1 on 03/01/21 at 3:44pm revealed: -She shaved her facial hair on her own. -The PCA did not help her shave her facial hair. -The PCA did not like to help her shave her facial hair. -The PCA refused to help her shave she asked for help. -She did not know if the PCAs were supposed to help her. -She had trouble when she shaved her facial hair on her own. -She cut her neck when she shaved her facial hair last week. -She tried to shave her facial hair every day on her own because her hair grew so fast. Telephone interview with Resident #1's Primary Care Provider (PCP) on 03/03/21 at 3:57pm revealed Resident #1 appeared to cognitively be able to shave her facial hair. Interview with the RCC/SCUC on 03/01/21 at 10:03am revealed: -Resident #1 refused to shave her facial hair. -The PCA was supposed to shave Resident #1 on her shower days on Monday and Friday. -She had to encourage Resident #1 to shave her facial hair on her shower days. -Resident #1 required assistance with shaving her facial hair. -The PCA would review the PCA assignment sheet to know which day Resident #1 was supposed to be shaved. _____ The facility failed to provide incontinent care to a resident (#7) who had a diagnosis of dementia and a hip fracture and rash in her groin area that worsened due to prolonged periods in soiled/wet incontinent briefs and a resident (#1) who had	D 269		

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 25 facial hair that was not shaved by facility staff every Monday and Friday that resulted in the resident (#1) cutting her neck when she shaved. The facility's failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 3, 2021, for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 19, 2021.	D 269		
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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect or exploitation. THIS IS A TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the primary care provider (PCP) and wound clinic was notified of changes in condition for 1 of 5 sampled residents, (#4) for increased leg pain to wound, increased drainage and development of a foul odor.	D 273		

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 03/05/2021

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

(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 273	Continued From page 26 The findings are: Review of Resident #4's current FL-2 dated 12/20/19 revealed a diagnosis of atrial fibrillation. Review of Resident #4's current care plan dated 02/27/20 revealed: -The resident was sometimes disoriented. -The resident required limited staff assistance with eating and bathing. -The resident required supervision for dressing and grooming. Review of Resident #4's physician's order dated 10/14/20 revealed: -There was a wound care order to clean wound on right lateral calf with wound cleanser and cover with optifoam, using clean/aseptic technique. -Wound dressing was to be changed twice a week and as needed for soilage. -Home Health was to visit one time per week for dressing changes. -The facility staff were to perform dressing changes one time per week and as needed for soilage. Review of a home health visit note dated 10/09/20 revealed: -Resident #4 had a venous stasis ulcer to right lower leg. -The wound was partial thickness in depth. -The wound was 75-100% granulation (new vascular tissue that form on the healing surface of a wound) tissue. -The wound had a scant amount of serosanguinous (thin, watery, clear) drainage. thin, watery, clear -The wound had no necrotic (dead cell) tissue. -Pain was rated as a 6 on a 0-10 pain scale.	D 273		

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 27 -Caregivers were instructed on wound care. Review of a home health visit note dated 10/13/20 revealed: -Resident #4 had a venous stasis ulcer to right lower leg. -The wound was full thickness in depth. -The wound was less than 25% granulation tissue. -The wound had a moderate amount of purulent (thick, creamy, cloudy or grey, yellow or green) drainage. -The wound had necrotic tissue 25-50%. -There was no pain scale rating documented. -Caregivers were instructed on wound care and on signs and symptoms of infection to wound. Review of a home health visit note dated 10/26/20 revealed: -Resident #4 had a venous stasis ulcer to right lower leg. -Wound care was performed by caregiver. Review of a home health visit note dated 11/09/20 revealed: -Resident #4 had a venous stasis ulcer to right lower leg. -The wound measured 5cm x 3.5cm x 0cm. -The depth was described as necrotic. -The wound was none granulation tissue. -The wound had a large amount of purulent (thick, creamy, cloudy or grey, yellow or green) drainage. -The odor was strong. -There was no pan scale rating documented. Telephone interview with a home health nurse on 03/02/21 at 4:29 pm revealed: -Home health started providing wound care for the resident on 10/09/20.	D 273		

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 03/05/2021

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

(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 273	Continued From page 28	D 273		

-Home health was ordered to see Resident #4 one time per week.
-Even though home health provided wound care for Resident #4, the facility was responsible for contacting the PCP of reports of increased pain and changes in wound status between home health visits.
-Staff did not notify home health nurse of Resident #4's reports of pain, crying out in pain, nor a change in wound status.

Telephone interview with a second home health nurse on 03/03/21 at 10:17 am revealed:
-Resident #4's home health visits were increased to 2 times per week due to dressing change orders that had to be performed by home health (11/12/20).
-Staff at the facility was expected to notify the provider and home health with any concerns with Resident #4.

Review of Resident #4's current Licensed Health Professional Support (LHPS) evaluation dated 11/03/20 revealed:
-The resident had a wound to the right lateral calf that was to be clean with wound cleanser, cover with optifoam twice weekly.
-The resident complained of pain in the wound area on right leg.
-Recommendations were to monitor for and report changes in skin integrity.
-There was no documentation of staff competency validation.
-It was signed by the LHPS nurse.

Review of Resident #4's care notes revealed:
-On 11/02/20 Resident #4's wound dressing was changed at 2:15 pm and 3:10 pm and had yellow drainage, home health was called.
-On 11/08/20 Resident #4 complained of pain and

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 03/05/2021

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

(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 273	Continued From page 29	D 273		

required assistance to the bathroom and to the bed.
-On 11/09/20 Resident #4 was in continuous extreme pain and the primary care provider (PCP) was notified.

Review of Resident #4's wound clinic visit noted dated 11/05/20 revealed:
-Resident #4 was referred by podiatry.
-Resident #4 was accompanied by facility staff and transportation to the visit.
-The plan of care was discussed with Resident #4's nurse.
-Resident #4 had a right lateral leg full thickness ulcer measured 7 cm x 3 cm x 0.3 cm with moderate serosanguinous (thin, watery, clear) drainage, minimal pink granulation (new vascular tissue that form on the healing surface of a wound) tissue and moderate necrotic (dead cell) tissue of unknown chronicity.

Review of Resident #4's wound clinic visit noted dated 11/12/20 revealed after visit instructions to call the wound clinic if you are experiencing any of the following: increased pain, increased drainage and drainage with foul odor.

Telephone interview with registered nurse at Resident #4's wound clinic on 03/02/21 at 2:54 pm revealed:
-Resident #4 was first seen at the wound clinic on 11/05/20.
-Resident #4 complained of pain to the touch of the right leg.
-The provider had not been notified of increased pain nor worsening of the resident's leg wound after 11/05/20.

Review of Resident #4's hospital discharge summary dated 11/21/20 revealed:

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 30	D 273		

-Resident #4 was admitted on 11/17/20.
-Resident #4 passed away on 11/21/20.
-Resident #4 admission diagnoses included sepsis, cellulitis, abscess of right leg, ulcer of right lower extremity, limited breakdown of skin and intractable pain.
-Wound cultures of the resident's leg wound revealed E. coli Pseudomonas and Proteus.
-Resident #4's lab showed white blood count (WBC) (an increased production of white blood cells to fight an infection) was 12.27 (range 4.5-11.0).
-The facility reported Resident #4 had nearly intractable right-side pain for the past several weeks, in addition to cellulitis and an abscess to the right leg, Fentanyl patch was added; still had pain.
-Resident #4's extremities assessment revealed decreased pulses, right side of the lower leg with approximately 7 cm x 4 cm full thickness wound with some drainage and back of the right foot with a 3 x 1 cm wound that was full-thickness.

Interview with a personal care aide (PCA) on 03/01/21 at 2:29 pm revealed:
-Resident #4's wound on her leg was "terrible".
-Resident #4's wound started as a small area about the size of a quarter.
-Resident #4's wound went from a small area to the wound being green and purple on her leg about 3 weeks before she went to the hospital the last time (11/19/20).
-The medication aides (MAs) were supposed to have been wrapping it but they did not.
-Resident #4's dressing looked "really wet" and would have greenish drainage that had an odor.
-Resident #4's wound was so bad she could no longer walk because of the pain in her leg.
-Resident #4 would cry out in pain from her leg so loud that you could hear her cries from across the

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 03/05/2021

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

(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 273	Continued From page 31	D 273		

building down another hallway.
-Resident #4 cried and did not want to eat because her leg was hurting so bad.
-She told the lead medication aide about Resident #4's dressing and her crying out in pain.
-The Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC) knew about Resident #4's leg wounds and pain because her cries could be heard from the other end of the facility.

Interview with a MA on 02/26/21 at 2:25 pm revealed:
-Resident #4 complained a lot about her leg hurting.
-The wound on Resident #4's leg continued to get worse until she was sent to the hospital (11/19/20).
-She had not changed the dressing on Resident #4's leg and thought it was only due on first shift.
-The MAs were responsible for notifying the PCP when there was a change in the resident's status.
-Communication with the PCP was to be documented in the resident's care notes.
-If the wound got worse, that was supposed to be documented in the resident's care notes.
-She did not remember notifying Resident #4's PCP of the increased pain in her leg nor the worsening of her leg wound.

Telephone interview with second MA on 03/02/21 at 1:42pm revealed:
-Resident #4's wound on her leg looked "terrible" and had a "bad" odor.
-Resident #4 cried a long time at least 2 weeks before she was sent out of the facility (11/19/20).
-The MAs were responsible for notifying the PCP of Resident #4 crying out in pain and the worsening of her leg wound and document in the resident's care notes.

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 03/05/2021

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

(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 273	Continued From page 32 -She did not remember notifying the PCP about the resident's pain nor worsening of the wound. Interview with third MA on 03/01/21 at 10:33 am revealed: -The wound on Resident #4's right lower leg was "terrible". -Resident #4 would tell the MAs that her leg wound dressing needed to be changed and she was in pain and the MAs would not check on the resident. -Resident #4 cried out in pain from her leg every day. -The wound was purple, brown, yellow and swollen. -The wound was approximately 4 inches round in circumference by the time she was sent to the hospital (11/19/20). -The wound had thin yellow drainage and a "bad" odor. Telephone interview with fourth MA on 03/04/21 at 8:59 am revealed: -Resident #4's leg would hurt so bad she would cry out in pain. -Resident #4 cried out all day and all night, everyday about the pain in her leg. -Resident #4's leg wound had a very bad odor and yellow drainage that fully saturated the wound dressing. -She told the RCC/SCUC Resident #4 was crying out in pain. -She did not notify the PCP office of Resident #4's reports of pain and wound because the PCP's office was not open during her shift, so she passed the reports on to first shift. -The RCC/SCUC was responsible for notifying Resident #4's PCP about the reports of pain because the PCP office was not open on third shift.	D 273		

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 03/05/2021

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

(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 273	Continued From page 33 Telephone interview of Resident #4's PCP on 03/02/21 at 3:22 pm revealed: -Resident #4 was last seen on 10/09/20. -The facility did not notify the PCP Resident #4 had pain in her leg. -The PCP expected to be notified. Confidential interview with staff revealed: -Resident #4 cried out in pain from the pain in her leg every day for two weeks. -The week before Resident #4 she was sent to the hospital (11/19/20) she told staff all night her leg was hurting. -She would cry out in pain and asked the staff to help her. -Resident #4 begged the MAs to help with her leg and the pain in it. -The MAs just would not help her. -The staff informed the RCC/SCUC of Resident #4's was hollering out in pain. -Resident #4's wounds turned black in color. Attempted interview with the RCC/SCUC on 03/01/21 at 10:57 am was unsuccessful due to staff's refusal to interview related to Resident #4. Interview with the Administrator on 02/26/21 at 11:07 am revealed: -The RCC/SCUC was responsible for notifying the PCP when there was a change in status in the residents. -Staff were supposed to document contacts with the PCP in the resident's care notes. Telephone interview with the Administrator on 03/01/21 at 1:53 pm revealed: -She expected the MAs to notify the RCC/SCUC of reports of pain and the RCC/SCUC was responsible for contacting the PCP.	D 273		

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 03/05/2021

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

(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 273	Continued From page 34 -Once home health was involved the staff were not expected to notify the PCP of reports of changes in wound status. -She expected staff to notify home health of change in wound status. _____ The facility failed to ensure referral and follow up by failing to report increase in pain and development of a wound with no healing tissue, with a large amount of thick, creamy, cloudy or grey, yellow or green drainage with a strong foul odor to the PCP and wound clinic resulting in delays in medical evaluation and treatment. The resident cried out in pain for at least two weeks prior to being sent to the hospital. The resident was admitted to the hospital for sepsis, cellulitis and intractable pain. The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 04, 2021.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338		

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 03/05/2021

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

(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 338	Continued From page 35	D 338		

Based on observations, interviews, and record reviews, the facility failed to provide privacy to a resident by not closing the room door while performing incontinent care (#9) and failing to provide tables to residents during meal service when residents were in their rooms in the Assisted Living section of the facility.

The findings are:

1. Review of Resident #9's current FL-2 dated 02/03/21 revealed:
-Diagnoses included dementia, chronic obstructive pulmonary disease, hypertension, diabetes, and asthma.
-The resident was intermittently disoriented.
-The resident's ambulatory status was not documented.
-The resident required total assistance from staff for personal care.
-The resident was incontinent of bladder and bowel.

Review of Resident #9's current assessment and care plan dated 02/03/21 revealed:
-The resident was sometimes disoriented, forgetful and required reminders.
-The resident had daily incontinence of bladder and bowel.
-The resident was totally dependent on staff for toileting, bathing, dressing, grooming, and transferring.

Observation of Resident #9 on 02/26/21 at 10:45am on the Assisted Living (AL) section of the facility revealed:
-The resident's room door was not in a closed position and the resident was in view from the hallway while laying on her back in bed with no clothing on.

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 03/05/2021

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

(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 338	Continued From page 36 -There were two personal care aides (PCAs) in the resident's room assisting the resident with bathing. -The resident's roommate was in the room. -There were residents walking up and down the hallway passing the residents' room. -A medication aide (MA) walked into Resident #9's room and closed the residents' room door. Interview with the two PCAs on 02/26/21 at 10:46am revealed the resident did not have any clothes on and was not covered with anything because they were washing the resident. Telephone interview with a PCA on 03/03/21 at 10:43am revealed: -She had worked at the facility for about one month. -On 02/25/21, she and another PCA went into Resident #9's room to assist the resident with incontinent care. -Resident #9's room door was not closed because she thought the MA was "right" behind her when she entered the resident's room. -She did not notice the door was left in an opened position when she and another PCA provided incontinent care for Resident #9. -She was trained to always ensure the door was closed for privacy when a residents' personal care was provided. -She was not sure how long the door had been opened to Resident #9's room after she entered the room. -Resident #9 was not draped to cover the remainder of her body that was not being bathed because all the linens were soiled and removed from the resident's bed. -She was trained to only expose the residents' body section being bathed and cover all other areas when assisting residents with personal	D 338		

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 03/05/2021

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

(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 338	Continued From page 37	D 338		

care.
-Bath towels were in the room and Resident #9 should have been "draped" until her incontinent care and dressing was completed.
-She and the other PCA were in a hurry because Resident #9 stated that she was not feeling well and was she was cold.

Telephone interview with Resident #9's primary care provider (PCP) on 03/03/21 at 3:48pm revealed:
-She would have concerns if the resident's room door was not closed while incontinent care was being provided to the resident.
-Resident #9 was generally alert and oriented to place and self, however, occasionally not oriented to exact date and year.
-Resident #9 was "mostly cognitive" enough to carry on a conversation most of the time.
-Resident #9 was fully dependent on staff for bathing and incontinent care.
-She was not sure if leaving the door open would affect the resident cognitively.
-There should always be some level of privacy when staff provide personal care for residents whether the resident was coherent or not.
-She was concerned for the resident's privacy and dignity when the resident's room door was left open when staff were providing care especially on the front hall of the AL section where there were residents that walk up and down the hall and there could have been residents in the hall that would be alert enough to look in the room when personal care was being provided to the resident.

Telephone interview with the Administrator on 03/04/21 at 1:54pm revealed:
-All facility staff had received resident rights training that included resident privacy, respect

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 338	Continued From page 38	D 338		

and dignity.
-She provided the resident rights training to all staff on 01/19/21 and had planned on an all staff resident rights training again last week, however, she had to cancel the training.
-She expected the staff to ensure Resident #9's resident room door was closed before providing the resident's incontinent care.
-She was concerned that Resident #9's body was exposed, and other residents might had viewed the resident's body from the hallway.
-Staff should always drape the resident and expose only sections of the body being bathed.
-It was important for staff to ensure the residents' privacy and dignity was maintained.

Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable.

Attempted interview with the MA that entered Resident #9's room and closed the room door on 03/03/21 at 11:56am was unsuccessful.

Attempted telephone interview with Resident #9's family member on 03/03/21 at 11:57am was unsuccessful.

2. Observation on 02/25/21 at 5:59pm revealed there was a plate of food placed on a resident's bed and the resident was sitting in a recliner chair next to the bed.

Observation on 02/26/21 at 11:26am revealed there was a second resident sitting in a chair in their room holding a plate of food in their hands while eating.

Observation on 02/26/21 at 11:30am revealed there was a third resident in their room with a

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 03/05/2021

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

(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 338	Continued From page 39	D 338		

plate of food in their lap while eating.

Observation on 02/26/21 at 11:31am revealed there was a fourth resident in their room sitting in a chair with a plate of food in their lap while eating.

Observation on 03/01/21 at 11:25am revealed there was a fifth resident in their room with a plate of food in their lap while eating.

Interview with the fifth resident on 03/01/21 at 11:25am revealed:
-She preferred her plate to be on a table or to eat in the dining room.
-She was not comfortable holding her plate of food in her hands while eating.
-She did not want to eat with her plate in her lap because some days her food spilled onto her clothes.
-She had not informed anyone of her concern about eating while holding her plate of food in her hands.

Interview with a resident on the Assisted Living (AL) section of the facility on 02/25/21 at 10:35am revealed:
-The resident ate his meals in his room.
-He did not require staff assistance to feed himself during meals.
-He did not have a table to use when he ate his meals in his room.
-He held his plate in his lap while sitting in his recliner and balanced the plate "best" he could while he ate.
-Staff at the facility never offered a table for him to use when he ate his meals in his room.

Interview with a second resident on the AL section of the facility on 02/25/21 at 11:30am

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 03/05/2021

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

(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 338	Continued From page 40	D 338		

revealed:
-The resident ate her meals in her room.
-She was not provided a table from staff and held her plate of food when she ate her meals.
-She did not have any problems eating her meals in bed, however, some of the other residents might.

Interview with a third resident on the AL section of the facility on 02/26/21 at 9:00am revealed:
-The resident ate his meals in his room.
-He held his plate on his lap or in his hand while he ate.
-There was a small table at the foot of his bed.
-The table was broken and had caused his plate to fall to the floor on more than one occasion.

Interview with a personal care aide (PCA) on 02/26/21 at 2:34pm revealed:
-All residents did not have an overbed table or a tray table in their rooms.
-She placed residents' plates of food on their stools, bed or lap if there was not an overbed table or tray table in their rooms.

Interview with the Administrator on 02/26/21 at 10:15am revealed:
-She was not aware residents' plates of food were placed on their beds.
-Residents' plates of food should not be placed on their beds.
-The personal care aides should ask the residents where they would like their plate of food placed.
-All residents did not have overbed tables/tray tables in their room.

Interview with the Administrator on 03/01/21 at 10:00am revealed:
-Overbed tables/tray tables were not included in a

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 03/05/2021

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

(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 338	Continued From page 41 residents' room upon admission. -She had not offered the residents who did not have an overbed table/tray table the option to purchase. _____ The facility failed to treat residents with respect, privacy and dignity by leaving the door open while providing personal care to a resident which led to Resident #9 being exposed and visible to individuals in the hallway and not providing a table for residents to eat which caused the residents to be uncomfortable. The facility's failure 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 03/01/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2021.	D 338		
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:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 42	D 358		

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by the primary care provider and in accordance with the facility's policies for 3 of 4 sampled residents (#2, #10, #11) observed during the medication pass including errors with a hormone replacement medication (#2), a medication used to lower blood sugar (#10), and a medication used to decrease stomach acid (#11).

The findings are:

The medication error rate was 8% as evidenced by the observation of 3 errors out of 34 opportunities during the 7:00am and 8:00am medication pass on 02/26/21.

Review of the facility's Medication Policies revealed:
-The effective date for the Medication Policy Review was 06/01/10.
-Medications, prescriptions, non-prescription, and treatments would be administered in accordance with the prescribing practitioner's orders.
-Medications would be administered within one hour before or one hour after the prescribed or scheduled time unless an emergency precludes the administration.

a. Review of Resident #2's current FL-2 dated 02/08/21 revealed:
-Diagnoses included dementia, hypothyroidism, hypertension, B-12 deficiency, and osteoarthritis of the knee.
-There was an order for Levothyroxine 50mcg take 1 tablet daily. (Levothyroxine is a medication used to replace a hormone that is produced by the thyroid).

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 43	D 358		

Review of a medication order for Resident #2 dated 02/08/21 revealed an order Levothyroxine 50mcg take 1 tablet daily with a scheduled administration of 6:00am.

Observation of the 8:00am medication pass on 02/26/21 in the Special Care Unit (SCU) revealed:
-The medication aide (MA) prepared Resident #2's medications for administration, including Levothyroxine at 7:23am.
-Resident #2 was sitting in the dining room when the MA entered the dining room and administered the resident's medications, including Levothyroxine 50mcg at 7:26am.
-The MA gave the resident water and observed the resident swallow the medications.

Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 50mcg daily with a scheduled administration time of 6:00am.
-Levothyroxine 50mcg was documented as administered daily at 6:00am from 02/01/21 - 02/26/21.

Interview with the MA observed at the 8:00am medication pass on 02/26/21 on 02/26/21 at 7:27am revealed the eMAR system displayed the residents' name and each medication due to be administered to the resident at that time.

Attempted follow-up telephone interview with the MA on 03/03/21 at 11:47am was unsuccessful.

Telephone interview with a second MA on 03/04/21 at 9:00am revealed:
-She usually worked 3rd shift as a MA.
-Medications scheduled at 6:00am were given by

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 44	D 358		

third shift.
-She was not sure why Resident #2 received Levothyroxine 50mcg with her 8:00am medications.
-When she worked 3rd shift, she administered Resident #2's Levothyroxine 50mcg at 6:00am.
-The MAs were responsible for ensuring the residents' medication orders were followed as written.

Telephone interview with the Resident Care Coordinator /Special Care Unit Coordinator (RCC/SCUC) on 03/04/21 at 3:34pm revealed:
-All MAs had been trained on the facility's Medication Policy.
-Resident #2's Levothyroxine should have been given to the resident on an empty stomach.
-The third shift MA should have administered Resident #2's Levothyroxine for the medication to be given within allowed time (one hour before or after the scheduled time of 6:00am).

Telephone interview with the Administrator on 03/04/21 at 1:54pm revealed:
-Residents' medications should be administered within one hour before or after the scheduled administration times.
-The third shift MA would have been responsible for administering Resident #2's Levothyroxine 50mcg at 6:00am.
-She expected the residents' medications to be administered as ordered.

Telephone interview with Resident #2's primary care provider (PCP) on 03/03/21 at 3:48pm revealed:
-Resident #2 was prescribed Levothyroxine 50mcg for treatment of an underactive thyroid.
-Resident #2's Levothyroxine was scheduled at 6:00am because the medication absorbed better

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 45	D 358		

in the body when given before food and scheduled to be administered at 6:00am because generally breakfast was served around 7:00am in the SCU.
-If Resident #2 received Levothyroxine 50mcg with other medication or at a meal, the medication would not have been absorbed quite as well.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

b. Review of Resident #10's current FL-2 dated 02/03/21 revealed:
-Diagnoses included dementia, diabetes, hypertension, and history of right hip pain.
-There was an order for Glipizide 2.5mg take 1 tablet daily with breakfast. (Glipizide is a medication used to lower the blood sugar).
-There was an order to check fingerstick blood sugars (FSBS) twice a day before breakfast and supper.

Observation of the 8:00am medication pass on 02/26/21 in the Special Care Unit (SCU) revealed:
-Resident #10 was sitting in her room in a chair when the medication aide (MA) entered the resident's room.
-The MA checked Resident #10's blood sugar at 7:28am and it was 116.
-The MA returned to the medication cart and prepared Resident #10's medication at 7:30am, including Glipizide ER 2.5mg.
-The MA entered Resident #10's room and administered the resident's medications, including Glipizide ER 2.5mg at 7:37am.
-The MA gave the resident water and observed the resident swallow the medications.
-Resident #10 had not been served breakfast.
-The MA stated the resident would be served

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 46	D 358		

breakfast in her room when the plated foods were available from the kitchen.

Review of Resident #10's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Glipizide ER 2.5mg daily with breakfast with a scheduled administration time of 8:00am.
-Glipizide ER 2.5mg was documented as administered daily at 8:00am from 02/01/21 - 02/26/21.
-There was an entry for a FSBS twice a day before breakfast and supper with a scheduled administration time of 7:30am and 5:00pm.
-The resident's documented FSBS ranged from 87 - 229 at 7:30am and 110 - 292 at 5:00pm from 02/01/21 - 02/26/21.

Review of Resident #10's primary care provider (PCP) progress visit note dated 02/17/21 revealed:
-The resident was diagnosed with Type 2 diabetes.
-The resident's FSBS were reviewed and ranged from 100-300 and fluctuated greatly.
-The resident's lab work done on 02/03/21 revealed the results of a hemoglobin A1C (Hgb A1C) level was 7.0%. (Hgb A1C is a blood test to measure the average blood sugars over the past 3 months. A normal Hgb A1C would be below 5.7%).

Observation of Resident #10 on 02/26/21 at 7:39am revealed:
-The resident was offered breakfast by a personal care aide (PCA), however, the resident told the MA she did not want anything to eat.
-The resident asked for a cup of water.

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 47 Interview with Resident #10 on 02/26/21 revealed she was not hungry and did not want any breakfast, she just drank some water. Interview with the MA who administered Resident #10's 8:00am medication on 02/26/21 at 10:00am on 02/26/21 revealed: -Resident #10 refused to eat breakfast at times. -When Resident #10 refused breakfast staff would encourage the resident to eat something and staff would offer a snack 30 minutes later after breakfast. -Resident #10 ate 2 granola bars around 9:00am on 02/26/21 after refusing breakfast. Telephone interview with a second MA on 03/04/21 at 9:00am revealed when a resident had an order for a medication to be given with meals, the MA should administer the medication after the resident had been served their meal and when the resident began to eat the meal. Telephone interview with the Resident Care Coordinator /Special Care Unit Coordinator (RCC/SCUC) on 03/04/21 at 3:34pm revealed when a resident had a medication ordered with a meal, the MA was responsible for administering Resident #10's medication after the resident took a few bites of the food. Telephone interview with the Administrator on 03/04/21 at 1:54pm revealed: -She expected the MA observed during the 8:00am medication pass on 02/26/21 to ensure Resident #10 was served breakfast and wait for the resident to take the first bite of breakfast before administering the resident's Glipizide 2.5mg. -She expected Resident #10's medications to be administered as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 48 Interview with the Administrator on 02/26/21 at 4:45pm revealed Resident #10's PCP was contacted, and an order was received to change the resident's administration schedule of Glipizide 2.5mg to lunch since the resident occasionally refused to eat breakfast. Telephone interview with Resident #10's PCP on 03/03/21 at 3:48pm revealed: -Resident #10 was prescribed Glipizide due to her diagnosis of diabetes. -Glipizide could sometimes cause a drop or a low blood sugar and it was ideal to administer the medication around meal time to avoid dropping the residents' blood sugar levels. -She thought Resident #10 would have been able to alert staff if she had any signs and symptoms of hypoglycemia such as shaking. -She was aware that the resident occasionally didn't eat breakfast. -She gave an order last week to change the resident's Glipizide 2.5mg to be administered at lunch to ensure she took the medication with a meal. c. Review of Resident #11's current FL-2 dated 02/26/21 revealed: -Diagnoses included diabetes type 2, hypertension, schizophrenia and overactive bladder. -There was an order for Protonix 40mg every day 30 minutes before breakfast. (Protonix is a medication used to decrease stomach acid). Observation of the 8:00am medication pass on 02/26/21 on the Assisted Living (AL) section of the facility revealed: -The medication aide (MA) prepared Resident #11's 8:00am medications for administration,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 49	D 358		

including Protonix 40mg.
-Resident #11 was sitting in his room eating breakfast with approximately 50 percent of the food remaining on the resident's plate when the MA entered the room and administered the resident's medications, including Protonix 40mg at 8:15am.
-The MA gave the resident water and observed the resident swallow the medications.

Review of Resident #11's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Protonix 40mg daily, 30 minutes before breakfast with a scheduled administration time of 7:00am.
-Protonix 40mg was documented as administered daily at 7:00am from 02/01/21 - 02/26/21.

Attempted telephone interview with the MA observed during the 8:00am medication pass on 02/26/21 on the Assisted Living (AL) section was unsuccessful on 03/03/21 at 11:56am.

Telephone interview with the Administrator on 03/04/21 at 1:54pm revealed:
-Resident #11's Protonix 40 mg should have been administered as ordered which was 30 minutes prior to the resident's meal.
-Residents' with scheduled 7:00am medications should have been administered by the third shift MA to ensure the scheduled 7:00am Protonix was given 30 minutes prior to a meal.
-She expected the residents' medications to be administered as ordered.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 03/03/21 at 11:34am revealed:
-The residents' medications were added to the

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 03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 eMAR with a scheduled administration time by the pharmacy once the residents' order was received from the facility or provider. -Once the medication order was entered into the system, designated facility staff were responsible for reviewing, accepting, declining or making changes to the medication order on the eMAR. -Protonix was used to decrease the secretion of stomach acid. -Resident #11's Protonix 40mg was ordered 30 minutes prior to a meal to control stomach acid that would have been produced to digest a meal. -Resident #11's Protonix 40mg was in an enteric coated form and if given with a meal, the medication would not dissolve as well while the residents stomach was churning to digest food, the tablet was designed for administering prior to a meal. -Resident #11's Protonix was a 24-hour acting medication and once a resident was on the medication day after day, there would have been a "steady state" of the medication already in the blood to work effectively. Attempted telephone interview with Resident #11's primary care provider (PCP) was unsuccessful on 03/03/21 at 8:00am.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior	D 366		

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 03/05/2021

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

(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 366	Continued From page 51 to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed a resident taking their medication for 1 of 5 resident sampled (#8) who was on the special care unit (SCU). The findings are: Review of Resident #8's current FL-2 dated 01/07/21 revealed: -Diagnoses included dementia, a chronic obstructive pulmonary disorder, encephalopathy, hypertension, and anxiety. -The documented level of care for Resident #8 was a special care unit (SCU). -There was an order for Tylenol (a pain reliever to treat minor aches and pains, and a reduces fever) 325 mg with instructions to administer 2 tablets three times a day. Observation on the special care unit (SCU) on 03/01/21 at 10:23am revealed Resident #8 was in the TV room sitting in her wheelchair playing with a half dissolved white tablet in her hand. Interview with a medication aide (MA) on 03/01/21 at 10:23 am revealed: -The pill in Resident #8's hand looked like a Tylenol that she had administered to her earlier today around 7:45 am. -Resident #8 would swallow the medication but sometimes she would chew them up, like today. -She has not swallowed her medications before and she would spit them in the cup of water.	D 366		

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 03/05/2021

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

(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 366	Continued From page 52	D 366		

Review of Resident #8's March 2021 electronic medication administration record (eMAR) revealed there was an entry for medication aide (MA) administered Tylenol 325 mg at 8:00am on 03/01/21.

Second interview with MA on 03/01/21 at 2:10 pm revealed:
-She placed Resident #8's medications in a medication cup.
-Resident #8 would take her medications herself and sometimes she had to help her take her medications by placing the medication on Resident #8's mouth.
-Resident #8 usually took her medications without any incident and swallowed all of her medicaions
-She would check behind Resident #8 to ensure she swallowed her medications after she administed each medication separately.

Observation of a MA on 03/01/21 at 2:15 pm revealed:
-She gave Resident #8 a medication cup that contained two Tylenol 325mg tablet and a cup of water.
-Resident #8 put the tablets in her hand.
-The MA reminded Resident #8 to take her medication.
-Resident #8 took her Tylenol 325 mg tablets and drank her water.
-The MA checked Resident #8's mouth after she swallowed her medication to ensure the medication was not in her mouth.

Interview with personal care aide (PCA) on 03/01/21 at 2:25 pm revealed:
-She was aware that Resident #8 would hold her medication in her hand without taking the medication.
-She had last saw Resident #8 hold on to her

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 03/05/2021

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

(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 366	Continued From page 53	D 366		

medications a week ago.
-She threw away the pills that Resident #8 did not take.
-She did not notify anyone that Resident #8 did not take her medications a week ago.
-She did not know why she did not know notify the MA or RCC.

Interview with Resident #8's primary care physician (PCP) on 03/03/21 at 3:57 pm revealed:
-She had not been notified that Resident #8 would not take her Tylenol 325mg.
-If she was notified she could have changed Resident #8's medications.
-She was concerned that Resident #8 could negatively impact her health if she did not take her medications as prescribed.
-The MA's should have watched Resident #8 to ensure she swallowed her medications when they were administered.
-She was concerned that if Resident #8 was holding on to her medication that another resident in the SCU could take medication that Resident #8 held onto.

Interview with the Resident Care Coordinator (RCC) on 03/01/21 at 11:00 am revealed:
-MA's were supposed to place a resident's medications in the pill cup.
-MA's were supposed to give the resident a few of their pills followed by a cup of water.
-The MA's were supposed to check the resident's mouth to ensure their mouth was clear of any medication before they administered more medication.
-If a MA found a resident with medication in their hand after they already administered the medication, the MA was supposed to take the medication and administer it to the resident.
-The MA should also notify her immediately if they

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 03/05/2021

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

(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 366	Continued From page 54 found a resident that did not take their medication. -She had not been notified that Resident #8 held onto her Tylenol 325mg.	D 366		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure recommendations and guidelines established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS), and the local county health department (LHD) were implemented and maintained to protect residents during the global pandemic of COVID-19 related to the screening of staff and visitors and communal dining of residents in a special care unit (SCU). The findings are:	D 612		

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 03/05/2021

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

(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 612	Continued From page 55 Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the Coronavirus Disease in long-term care (LTC) facilities dated 11/20/20 revealed personnel should be screened for the presence of fever and symptoms of COVID-19 before starting each shift. Review of the CDC's Considerations for Memory Care Units in Long-term Care Facilities dated 05/12/20 revealed: -Facilities should limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area. -Gently redirect residents who are ambulatory and are close to other residents or personnel. -Try to keep residents' environment and routine as consistent as possible while still reminding and assisting them with social distancing. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of coronavirus in LTC facilities dated 12/22/20 revealed: -Screening of all individuals who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions, or observations about signs or symptoms). -Facility must conduct daily screening for the presence of symptoms, and known exposure to COVID-19 and temperature check of all residents and staff, and social distancing at least six feet between persons. -Ensure 6 feet of space between each individual and each table. -If possible, space should be marked designating 6 feet of separating between tables. -Stagger mealtimes.	D 612		

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	HAL058010	A. BUILDING: _____ B. WING _____	R-C 03/05/2021

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

(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 612	Continued From page 56 Review of the facility's infection control COVID-19 policies and procedures dated 10/23/20 revealed: -Ensure screening of all staff and essential visitors by checking before entry for symptoms of respiratory infection, fever, dry cough and shortness of breath, diarrhea/nausea/vomiting, loss of taste/smell, chills/shakes, muscle pain, headache, and sore throat. -Staff and essential visitors with any symptoms should not enter the community until 24 hours after symptoms have resolved. -All communal dining was canceled until further notice. -All residents should be served meals in their rooms. -Mealtimes may need to be staggered based on the needs of the residents to make sure that all meals served are adequate and palatable. Interview with the Administrator on 03/01/21 at 2:28pm revealed: -She had a staff member test positive for COVID-19 on 02/15/21. -She had a second staff member that tested positive for COVID-19 on 02/23/21. -She was notified by corporate that the facility was considered in outbreak status on 02/25/21. -She had received all of the residents' COVID-19 test results from the last testing completed on 03/02/21 and all results were negative. -She had received all of the staffs' COVID-19 tests results with the exception of two staff from the last testing completed on 03/02/21 and all results were negative. -The two staff with pending results were completed by an outside provider. 1. Review of the facility's staff screening log revealed there were fourteen columns on the staff screening log titled staff signature, date, time,	D 612		

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 03/05/2021

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

(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 612	Continued From page 57	D 612		

temperature, dry cough (Y/N), shortness of breath(SOB) (Y/N), nausea (Y/N), diarrhea (Y/N), vomiting (Y/N), chills/shakes (Y/N), muscle pain (Y/N), headache (Y/N), sore throat (Y/N), and new loss of taste/smell (Y/N).

Review of the facility's staff screening logs dated 02/10/21 through 02/15/21 revealed:
-On 02/14/21, there were 2 of 9 entries that documented an "N" under the temperature column.
-There was no temperature documented for 2 of 9 staff members.

Review of the facility's visitor sign-in sheet revealed there were ten columns on the Visitor Sign-In sheet titled date, visitor's name, company/reason for visit, resident visiting, time in, time out, do you have symptoms of fever/cough/shortness of breath, recently traveled outside of the country, exposed to anyone testing positive for COVID-19, and temperature that required visitors to write in a response.

Review of the facility's Visitor Sign-In Sheet logs dated 02/06/21 through 02/16/21 revealed:
-There were 41 names listed on the Visitor Sign-In Sheet.
-On 02/12/21, there were 3 entries on the sign-in sheet, 1 of 3 entries did not have any documentation under the resident visiting, time in, time out, and no response related to symptoms of fever/cough/shortness of breath, recent travel outside of the country, exposure to anyone testing positive for COVID-19, and no tempature was documented.
-On 02/15/21, there were 5 entries on the sign-in sheet, there was 1 of 5 entries that did not have any documentation under the company/reason for visit, resident visiting, time in, time out, no

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 03/05/2021

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

(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 612	Continued From page 58	D 612		

response related to symptoms of fever/cough/shortness of breath, recent travel outside of the country, exposure to anyone testing positive for COVID-19, and no temperature was documented.

Interview with the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC) on 03/01/21 at 10:27am revealed the medication aide/supervisor (MA/S) was responsible for screening all staff and visitors on all shifts before they entered the facility.

Interview with the Administrator on 03/01/21 at 2:28pm revealed:
-Staff were supposed to ring the doorbell to enter the facility.
-The MA/S were responsible to screen all staff and visitors before they entered the facility.
-If a staff member other than the MA/S responded to the doorbell, they were supposed to get the MA/S to screen the staff member or visitor that entered the building.
-She and the Business Office Manager (BOM) would screen staff or visitors if they were in the facility and the MA/S was not available.
-She was not aware that staff was self-screening before they entered the facility.
-She was concerned that staff could document inaccurate information on the screening log if they had screened themselves.

Telephone interview with the Administrator on 03/05/21 at 3:35pm revealed:
-The facility had a monitoring system in place to ensure all staff were completing the COVID-19 screening questionnaires and obtaining a temperature check prior to each shift.
-The RCC/SCUC was responsible to review the COVID-19 screening questionnaires with

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 612	Continued From page 59	D 612		

temperature checks daily and she reviewed them weekly.
-She had not recognized any concerns with staff not completing the COVID-19 screening questionnaires and temperature checks prior to the start of their shift.

2. Observation of the special care unit (SCU) dinning room on 02/25/21 at 5:19pm revealed seven residents eating in the dining room.

Observation of the SCU multipurpose room on 02/25/21 at 5:23 revealed four residents eating in the multipurpose room.

Observation of the special care unit (SCU) dining room on 03/01/21 at 11:08am revealed:
-There were 14 residents in the SCU dining room.
-Four of the residents were observed seated directly next to each other and not 6 feet apart.

Interview with the personal care aide (PCA) on 03/01/21 at 11:10am revealed:
-There were 18 residents that resided in the SCU.
-Two residents in the SCU requested to eat in their rooms during mealtimes.
-One resident did not want to eat lunch.
-One resident liked to eat in the television room at the end of the hall during mealtimes.
-The SCU still had communal dining.
-The SCU did not have staggered mealtimes.

Interview with the Resident Care Coordinator/Special Care Unity Coordinator (RCC/SCUC) on 03/01/32 at 10:27am revealed the facility stopped communal dining since the start of COVID-19 in the SCU.

Interview with the Administrator on 03/01/21 at 2:28pm revealed:

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 03/05/2021

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

(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 612	Continued From page 60	D 612		

-Residents in the SCU were still communal dining.
-She did not stop communal dining in the SCU on 02/25/21 when she was notified that the facility was in outbreak status.
-She did not know why she did not stop communal dining in the SCU on 02/25/21.

Telephone interview with the Administrator on 03/05/21 at 3:35pm revealed:
-Communal dining for the Assisted Living (AL) section had never resumed for residents since the beginning of the global pandemic of March 2020.
-The residents in the SCU resumed communal dining with social distancing in January 2021 by staff bringing the residents into the dining room who required staff assistance with feeding, and residents on a pureed and mechanical soft diet to allow more staff supervision during the residents' meals.
-The remainder of the residents in the SCU continued to eat in their room in January 2021.
-The RCC/SCUC would have been responsible for ensuring the residents needing assistance were no longer served their meal in the dining room and should have been assisted in the residents' rooms beginning on 02/26/21.

Telephone interview with the facility contracted Primary Care Physician (PCP) on 03/03/21 at 3:57pm revealed:
-She was not aware that residents in the SCU were still communal dining.
-The CDC recommended that communal dining should be stopped and the facility should have followed the CDC guidelines.

Telephone interview with the communicable disease nurse at the local health department

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 03/05/2021

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

(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 612	Continued From page 61 (LHD) on 03/01/21 at 9:35am revealed: -The facility had a "major" COVID-19 outbreak on 09/30/20. -Three residents died due to COVID-19 during the outbreak on 09/30/20. -The facility was considered "cleared" of COVID-19 on 11/17/20. -She forwarded guidance from the CDC on COVID-19 to staff at the facility during the outbreak on 09/30/20. -She was not aware that the SCU still had communal dining. -The facility should have stopped communal dining when the second staff member tested positive for COVID-19 on 02/23/21. -The facility should have stopped communal dining to prevent the spread of COVID-19 until they retested all staff and residents for COVID-19. -She was not aware that visitors and staff had self-screened before they entered the facility. -Facility staff should screen all visitors before they entered the facility to track COVID-19 symptoms. -Facility staff were able to self-screen before they entered the facility.	D 612		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by:	D911		

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 03/05/2021

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

(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
D911	Continued From page 62 Based on observations, interviews and record reviews, the facility failed to ensure all residents were treated with privacy, respect, consideration and dignity. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide privacy to a resident by not closing the room door while performing incontinent care (#9) and failing to provide tables to residents during meal service when residents were in their rooms in the Assisted Living section of the facility. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		
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 interviews, observations and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to health care and personal care. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure the primary care provider (PCP) and wound clinic was notified	D912		

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 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
D912	Continued From page 63 of changes in condition for 1 of 5 sampled residents, (#4) for increased leg pain to wound, increased drainage and development of a foul odor. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on observations and interviews, the facility failed to ensure personal care was provided for 2 of 7 sampled residents (#1, #7) related to a skin rash in the inguinal area, groin and buttocks (#7) and staff not shaving a resident, who required assistance (#1). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)].	D912		