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 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE INN RETIREMENT COMMUNITY	826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a Follow Up Survey on 08/01/23 to 08/02/23.	{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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 6 of 6 exit doors on the assisted living (AL) unit had an audible sounding device to alert staff when the doors were opened, which were accessible to the residents who were ambulatory, intermittently, or constantly disoriented, who had a diagnosis of dementia, or wandered had access to the doors and may be exiting the facility. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 122 beds of which 72 were on the AL side of the	D 067		

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D 067	Continued From page 1 facility. Review of the facility's AL census on 08/01/23 revealed there were 34 residents residing on the AL side of the facility. Review of FL-2s for current residents residing on the AL unit on 08/02/23 revealed: -There were 34 resident FL-2s that were reviewed. -There were 18 resident FL-2s with no indication of disorientation. -There were 12 resident FL-2s that indicated intermittent disorientation. -There was 1 resident FL-2 that indicated constant disorientation. -There were 3 resident FL-2s that revealed diagnoses of dementia but did not include their orientation status. Observation of the front entry/exit door at 8:45am on 08/01/23 revealed: -The front entry/exit door was not locked/secured. -There was not a sounding alarm when the front entry/exit door was opened. Observation of the east hall living room exit door on 08/01/23 at 9:35am revealed: -The door was not secured locked. -When the door was closed and reopened it did not make an alarming sound. -It led to the front area of the facility. Observation of the east hall exit door on 08/01/23 at 9:39am revealed the door was closed and secured and could not be opened without assistance from staff. Observation of the exit door on the west hall on 08/01/23 at 9:45am revealed:	D 067		

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D 067	Continued From page 2 -There was not an audible alarm sound when the door was opened. -The door was opened without having to enter a code or use a key to unlock. -There was a 6 foot x 6 foot stoop at the exit with a 4 inch drop off and there are no rails to prevent a trip or fall. -There was a 2 inch drop from the stoop to the ramp and then a steep "ramp" approximately 2 foot to the level sidewalk creating an unsafe transition. -There was 3 inch drop at the ramp before leveling off to a grade. Observation of the facility's door entrance from the living room area on the west hall on 08/01/23 at 9:50am revealed: -The door was ajar. -There was not an audible alarm sound when the door was opened. -It led to a porch area with chairs. Observation of the exit door on the hall near the kitchen staff entrance on 08/01/23 at 1:40pm revealed: -There was not an audible alarm sound when the door was opened. -The door was opened without having to enter a code or use a key to unlock. -The door lead to the gazebos used as the smoking area. -The outdoor area was enclosed with a chain link fence with 2 gates. -The single gate was closed and secured with a steel padlock. -The single gate lock and closures were noted to have debris and cobwebs surrounding them. -The double gates were not completely closed nor secured nor locked. -The double gate latch was askew at a 135°	D 067		

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D 067	Continued From page 3 (degree) angle instead of being fully closed at 180°. Interview with a resident who resided on the AL side on 08/01/23 at 9:15am revealed: -There were several residents who would leave the facility at all times of the day or night. -The residents were allowed to leave the facility even at 2:00am or 3:00am. -They would leave out of the door at the end of the hallway near their rooms or through the door in the living room. -There were no alarms that sounded when the doors were opened. -The other residents feared for their safety when residents would leave in the "middle of the night" because the staff were not aware the residents had left the building nor when they would return. -There were staff (no names were given) who would be asleep and not aware of the residents leaving. -The staff were supposed to check on the residents every 2 hours but they were lucky if the staff checked on them at the beginning and the ends of the shifts. Observation of the five-lane highway in front of the facility on 08/01/23 at 12:56pm revealed: -The road to the facility from the main five-lane highway (US 17) was a two-lane road that was located to the right of the facility. -There was a stop sign at the end of the two-lane road to the right of the facility. -The end of the two-lane road to the right of the facility intersected with a five-lane highway. -There was a turning lane that separated the four lanes on the highway. -The walking distance from the facility to the store that some of the residents walked to was approximately 0.5 miles and crossing the five	D 067		

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D 067	Continued From page 4	D 067		

lanes of the highway and was an estimated 8-minute walk.
-On 08/01/23 for 1 minute, there were 6 vehicles observed traveling the five-lane highway.
-There were 2 automobiles, and 4 transfer trucks were observed during the 1 minute of observation.
-There was a posted speed limit sign of 45 mph to the right of the five-lane highway for traffic moving north.

Observation of the west hall exit door in the living room area on 08/01/23 at 1:18pm revealed:
-The door was not closed and secured.
-The door did not have an alarm sound when the door was opened.

Observation of the west hall exit door area on 08/01/23 at 1:19pm revealed the door was closed and secured and could not be opened without staff assistance.

Observation of the east hall exit door in the living room area on 08/01/23 at 1:26pm revealed:
-The door was closed and secured.
-The door did not have an alarm sound when the door was opened.

Interview the Administrator on 08/01/23 at 1:32pm revealed:
-She was aware of residents leaving the facility during the middle of the night.
-The doors locked from the outside but not from the inside.
-The hallway door alarms were not set but the front door alarm was set at night.
-She could not provide a time when the front entry/exit door was locked, and alarm was turned on daily.

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D 067	Continued From page 5 The facility failed to ensure 6 of 6 exit doors were activated with a sounding device to alert staff when opened which were accessible to the residents assessed and known to be intermittently disoriented, ambulatory with an assistive device and with wandering behaviors left the facility from. This failure was detrimental to the health, safety, and welfare to the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/01/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 16, 2023.	D 067		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW UP TO A TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 7 sampled residents (#1, #6) as	{D 270}		

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{D 270}	Continued From page 6 evidenced by a resident with cognitive disorder and disorientation who left the facility without signing out and without the facility's staff knowledge (#1) and a resident who leaves the facility without signing out and without the knowledge of the facility staff and returns intoxicated (#6). The findings are: 1. Review of Resident #1's previous FL-2 dated 10/24/22 revealed: -Diagnoses included epilepsy, insomnia, disorientation, and alcohol dependency. -The resident was ambulatory with a cane. Review of Resident #1's current FL-2 dated 02/02/23 revealed: -Diagnoses included epilepsy, cognitive disorder, insomnia, and alcohol abuse. -The resident was ambulatory. Observation of Resident #1 on 08/01/23 at 9:00am revealed she was ambulatory and used a quad cane. Review of the facility's resident sign in / sign out logs dated 04/26/23 - 08/02/23 revealed there were no entries listed for Resident #1. Review of the Licensed Health Professional Support document dated 03/16/23 revealed: -Resident #1 required the use of a 4-prong cane. -She required staff supervision for transfers and ambulation. Interview with a resident who resided on the AL side on 08/01/23 at 9:15am revealed: -There were several residents who would leave the facility at all times of the day or night.	{D 270}		

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{D 270}	Continued From page 7 -The residents were allowed to leave the facility even at 2:00am or 3:00 am. -They would leave out of the door at the end of the hallway near their rooms or through the door in the living room. -There were no alarms that sounded when the doors were opened. -The other residents feared for their safety when residents would leave in the "middle of the night" because the staff were not aware the residents had left the building nor when they would return. -There were staff (no names were given) who would be asleep and not aware of the residents leaving. -The staff were supposed to check on the residents every 2 hours, but they were lucky if the staff checked on them at the beginning and the ends of the shifts. Interview with a second resident who resided on the AL side on 08/01/23 at 3:15pm revealed: -There were residents who would leave the facility to go out to smoke at night and would go to the stores nearby. -There was one she identified as Resident #1 who she saw at the store down the road that was in front of the grocery store. -Resident #1 was not allowed to go to the store next door to the facility because she begs the customers for money and the store banned her. -Resident #1 would leave out of the door at the end of the hallway near their rooms or through the door in the living room. -There were no alarms that sounded when the doors were opened until today. -There were staff (no names were given) who would be asleep and not aware of the residents leaving. -She saw 3rd shift staff sleeping in the area where they clocked in and in the living room	{D 270}		

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{D 270}	Continued From page 8 areas. -She had woke them up when she had heard call lights going off in the middle of the night. -The facility used to have a "security" person who would be at the front to direct people when they came in to visit but now people were in and out at all times of the day and night. -She was a light sleeper and residents going in and out all night and call lights going off kept her up. Interview with a personal care aide (PCA) on 08/02/23 at 8:05am revealed: -Resident #1 was ambulatory with a cane. -Resident #1 would go outside frequently at night to smoke. -Resident #1 did not realize it was dangerous for her to leave the facility at night and go down the highway to the store. -Resident #1 would leave the facility from the exit nearest her room and go down the hill through the grass and cross the highway to the store down in front of the grocery store. -She was not sure how or where Resident #1 crossed the highway. Observation of the five-lane highway in front of the facility on 08/01/23 at 12:56pm revealed: -The road to the facility from the main five-lane highway (US 17) was a two-lane road that was located to the right of the facility. -There was a stop sign at the end of the two-lane road to the right of the facility. -The end of the two-lane road to the right of the facility intersected with a five-lane highway. -There was a turning lane that separated the four lanes on the highway. -The walking distance from the facility to business (approximately 0.5 miles) crossing the five lanes of the highway where Resident #1 had been	{D 270}		

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{D 270}	Continued From page 9 located on 07/27/23 at 3:30am was an estimated 8-minute walk. -On 08/01/23 for 1 minute, there were 6 vehicles observed traveling the five-lane highway. -There were 2 automobiles, and 4 transfer trucks observed during the 1 minute of observation. Interview with the Supervisor on 08/02/23 at 7:04am revealed: -She worked on the assisted living (AL) side as the personal care aide (PCA) from 11:00pm to 7:00am on 07/27/23. -Resident #1 had been up all night stating that she could not sleep. -Resident #1 was not given any medications to help her sleep because she did not have as needed (prn) medications. -She had gone to the memory care unit around 3:00am on 07/27/23 and when she had returned to the AL side, Resident #1 had left the facility. -Resident #1's PCP had called the facility around 3:30am to report that Resident #1 was at the office and was seen at one of the local stores. -Resident #1's PCP brought her back to the facility. -She was concerned that residents leaving facility alone between the hours of 12:00am to 5:00am was risky and unsafe but had been told (did not say who told her) it was the AL residents' right to leave the facility. A second interview with the Supervisor on 08/02/23 at 7:20am revealed: -Resident #1 would leave the facility to go to the store next door. -July 27, 2023, was the first time she had known Resident #1 to go all the way to the store down in front of the grocery store. -Normally, Resident #1 just went outside to smoke on third shift because she could not sleep.	{D 270}		

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{D 270}	Continued From page 10 Interview with the mental health care provider on 08/01/23 at 4:12pm revealed: -She was informed that Resident #1 was found at her PCP's office down the road. -She was not aware that Resident #1 was out of the facility at 3:00am on 07/27/23. -She was not aware that Resident #1 was at the store in front of the grocery store. -The psychiatrist with the facility's contracted mental health provider evaluated Resident #1 for her ability to live on her own. -She was not sure of the findings or when the evaluation was done. -This "wandering" behavior was a new behavior that Resident #1 had begun to exhibit. Interview with the Executive Director (ED) on 08/01/23 at 1:32pm revealed: -She knew about Resident #1 leaving the facility around the 3:00am hour on 07/27/23. -She was informed by the 1st shift SIC on 07/27/23 at 8:30am -Resident #1 was a "walker" who liked to go to the local stores and restaurants. -Staff was made aware of Resident #1 being out of the facility on 07/27/23 by her PCP after calling the facility stating Resident #1 was found across the street at the PCP's office. -She was not familiar with Resident #1 diagnosis. -Staff had not documented that Resident #1 left the facility around the 3:00am hour on 07/27/23. -Residents who lived on the AL side had the right to leave the facility when they chose to leave. -The side exits doors' alarm on the AL side were not turned on at night. -The front entry/exit door alarm was turned on at night. -She could not provide a time when the front entry/exit door alarm was turned on at night.	{D 270}		

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{D 270}	Continued From page 11 -All the exit doors on the AL side only locked from the outside. A second interview with the Executive Director (ED) on 08/02/23 at 2:41pm revealed: -The ED had not notified the family of Resident #1 leaving the facility at 3:00am and found by the PCP at the store ½ mile away as Resident #1 was her own responsible party. -Resident #1 had requested to live independantly in the community. -She said the mental health providers were working on the evaluation for Resident #1. -The ED realized residents may not be safe leaving the facility at 3:00am to go to the stores. -The ED would not acknowledge whether or not she had received any incident reports regarding any resident leaving the facility on 3rd shift. Interview with the primary care provider (PCP) on 08/01/23 at 12:10pm revealed: -She found Resident #1 a half mile down the road at the store in front of the grocery store on 07/27/23 at 3:00am. -Resident #1 was seen talking to a transfer truck driver. -When the PCP questioned Resident #1 about her conversation with the truck driver, Resident #1 said she was asking him to purchase a soda for her. -She contacted the facility staff regarding Resident #1 being out of the facility. -The facility staff was not aware that Resident #1 was out of the facility at 3:00am on 07/27/23. -The PCP returned Resident #1 to the facility. -Resident #1 was not aware of the dangers of talking to strangers especially since no one at the facility was aware of her whereabouts. -The PCP tried to explain to Resident #1 that strangers may have bad or negative intentions or	{D 270}		

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{D 270}	Continued From page 12 may want something in return for buying her a soda. -The PCP was not able to make Resident #1 understand the dangers of her being out alone at night. -The PCP did not think Resident #1 was able to defend herself if anyone were to have attacked her. -Resident #1 told the PCP the psychiatrist had given her a test to see if she could live on her own and was told by Resident #1 that she scored 100 on the test. 2. Review of Resident #6's current FL-2 dated 03/02/23 revealed: -Diagnoses included history of alcohol abuse and paranoid schizophrenia. -The resident was ambulatory. -There was no disorientation status documented on his FL-2. -There was an order for Invega Sustenna injection 234/1.5 mL (used to treat certain mental/mood disorders, such as schizophrenia, schizoaffective disorder) IM every 3 weeks (administered at the psychiatrist office). -There was an order for benztropine 0.5mg (used to treat symptoms of the side effects of certain psychiatric drugs). one twice a day. -There was an order for Latuda 80mg (used to treat schizophrenia) one every day at supper. -There was an order for aspirin 325mg (used to lower the risk of heart attack and stroke) one every day. -There was an order for divalproex 500mg (used to treat seizure disorders, mental/mood conditions) 2 tabs=1000mg at bedtime. -There was an order for tamsulosin 0.4mg (used by men to treat the symptoms of an enlarged prostate) one every day 30 minutes after a meal.	{D 270}		

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

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{D 270}	Continued From page 13 Review of Resident #6's care notes dated 04/13/23-05/03/23 revealed: -On 04/18/23, Resident #6 was not in or at the facility to take his bedtime medications and that the Administrator had been notified. -On 04/19/23, Resident #6 was not in the facility to take his bedtime medications. -He had returned around 9:30pm and was drunk and he went into another resident's room to smoke marijuana. -The Primary Care Provider (PCP) and Resident Care Coordinator (RCC) were notified. -On 04/20/23, Resident #6 received his Invega injection. -On 04/24/23, Resident #6 was not in the facility to take his evening or bedtime medications. -The PCP and RCC were informed. -On 05/01/23, Resident #6 was not in or at the facility to take any of his evening medications. -The PCP, RCC and Administrator were notified. -Resident #6 had returned to the facility (no time was noted) and he was staggering, could barely walk, smelled like alcohol; "it's clear that he had been drinking". -Resident #6 began cursing and fussing with staff. -On 05/03/23, Resident #6 took his evening pill but refused his bedtime medication and then left the facility. Review of the facility's resident sign in / sign out logs dated 04/26/23 - 08/02/23 revealed there were no entries listed for Resident #6. Review of Resident #6's psychiatrist's letter dated 05/02/23 revealed: -It was addressed to Resident #6's guardian. -It documented Resident #6 suffered from mild to moderate mental retardation, early signs of dementia, schizoid-affective disorder, and chronic	{D 270}		

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{D 270}	Continued From page 14 alcohol dependence. -It documented that Resident #6 went out on his own and would get intoxicated and this put the resident in danger. -It documented to consider moving Resident #6 to a secured facility so that he could be safe. Telephone interview with Resident #6's psychiatrist on 08/02/23 at 12:12pm revealed: -He had written the letter back in May 2023 to the guardian of Resident #6 since he had tried several times in calling them without reaching them. -The facility Executive Director had told him the facility staff could not prevent Resident #6 from leaving. -He recommended someone accompany Resident #6 when he left the facility. -He was concerned that the current medications Resident #6 was receiving could be effected by his consumption of alcohol. -Resident #6 consumption of alcohol along with his current medications could cause him to have increased drowsiness, potentially aspirate, fall, and have a head injury or if he fell in the highway, potentially being struck by oncoming traffic. -There was a time (not sure of the exact date) that Resident #6 was brought back to the facility by the police. -He had given the letter to the staff member who accompanied Resident #6 to his appointment in May 2023 to be directed to Resident #6's guardian. -He requested that Resident #6 be moved to a closed/secured facility where his needs could be met and the potential for his continued alcohol consumption would be avoided. -He had expected the facility to act on it as soon as possible placement was found. -He had not had any response from the facility	{D 270}		

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{D 270}	Continued From page 15	{D 270}		

regarding the letter.
-He had thought they would have found placement or be working on finding a suitable facility for Resident #6.

Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/02/23 at 12:10pm revealed:
-She had been told (no name given) of Resident #6 going out of the facility unaccompanied.
-She did not recommend placement to the SCU at the facility due to Resident #6's familiarity with the facility.
-She feared he would become irate and would seek a way out of the facility since he knew the layout of the facility and the staff.

Attempted interview with Resident #6 on 08/02/23 at 8:25am was unsuccessful as resident wanted to sleep and refused to answer questions.

Interview with the Supervisor on 08/02/23 at 7:20am revealed:
-Resident #6 would leave the facility during second shift.
-He would go anytime he got money and go and get drunk.
-She had written numerous incident reports documenting Resident #6 leaving the facility and not signing out then returning to the facility intoxicated.
-These incident reports were placed in a box outside the Executive Director's (ED) office.
-She has had to send staff out at 2:00-3:00am to pick up Resident #6 and return him to the facility.
-There were times when the staff went to pick up Resident #6 from the store, he stumbled, had urinated on himself, slurred his words, and smelled of alcohol.
-She worried for his safety, but it was hard to

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{D 270}	Continued From page 16 keep up with all the residents who leave the facility when there were only 3 staff there and 2 had to be in the SCU (SCU census was 20). Interview with the personal care aide (PCA) on 08/02/23 at 8:05am revealed: -Resident #6 would leave the facility during second shift. -He came back usually on 3rd shift. -He would be intoxicated and sometimes talked loudly when he came back in the facility. -There were times he would get irate and cuss at the staff. -The staff tried to keep up with where the residents were but with only 3 people working 3rd shift, it was hard to keep up with everyone going in and out. Interview with the ED on 08/02/23 at 2:41pm revealed: -She realized residents may not be safe leaving the facility at 3:00am to go to the stores. -She would not acknowledge whether or not she had received of any of the incidents reports regarding any resident leaving the facility on 3rd shift. _____ The facility failed to provide supervision for 3 sampled residents (#1 & #6) who leave the facility late at night without signing out and without the knowledge of the facility staff. One resident, left the facility and walked to a store which was 1/2 mile away at 2-3am, solicited people in the community for money and soda, and identified by the PCP as not being aware of the dangers of talking to strangers and had on one occasion been returned to the facility by her PCP at approximately 3:00am (Resident #1). Another resident with a history of alcohol dependence, cognitive disorder, and disorientation would leave	{D 270}		

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{D 270}	Continued From page 17 the facility without signing out, return to the facility, intoxicated, belligerent, and with urinary incontinence (Resident #6). The failure of the facility resulted in the serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/02/23 for this violation.	{D 270}		
{D 283}	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to prepared food. The findings are:	{D 283}		

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{D 283}	Continued From page 18 Review of the facility's Food Establishment Inspection Report dated 02/01/23 revealed: -The score grade was 92.0 with a status code of A. -There were 8 points deducted from the total score. -One point was deducted for contamination prevented during food preparation, storage, and display. -One point was deducted for wiping cloths and properly used and stored. -A half point was deducted for equipment, food and nonfood contact surfaces approved, cleanable, properly designed, constructed, and used. -One point was deducted for non-food contact surfaces clean. -One point was deducted for physical facilities installed, maintained and clean. Observation of the kitchen area on 08/01/23 at 9:56am revealed: -There were two rolls of stacked trays of coffee cups. -The cups were turned down on the trays. -The top trays had small yellow particles on the cups and alongside of the trays. Observation of the kitchen area on 08/01/23 at 12:21pm revealed: -There was a four-well electric hot food table unit in the kitchen used to keep prepared food hot. -There were four individual controls valves with black and brown particles on each control valve. Observation of the kitchen area on 08/02/23 at 7:34am revealed: -There was a red tray placed on the kitchen table with two bowls of dry cereal stacked on top of each other and a pitcher of water.	{D 283}		

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{D 283}	Continued From page 19 -The two bowls of dry cereal and the pitcher of water were not covered. Observation of the kitchen area on 08/02/23 at 7:37am revealed: -There was a cleaning cloth placed on the prep table. -The cloth was stained with a black substance and was used to wiped down the table and electric hot food table. Observation of the kitchen area on 08/02/23 at 11:03am revealed: -There was a back wall that had a set of knives and telephone attached to the wall. -The wall was covered with small black and brown stains. -The telephone was covered with a greasy substance and black particles. Observation of the kitchen area on 08/02/23 at 11:04am revealed: -There was a deep fryer stored beside the stove. -The deep fryer had splattered greasy stains along on each side, the front, and the top of the fryer. -There was a large trash can place beside the fryer and was touching the fryer. Observation of the kitchen area on 08/02/23 at 11:05am revealed: -There were two three shelve rolling carts in the kitchen. -Each cart had black stains and black and brown particles along its sides, the handles, and the shelves. Observation of the kitchen area on 08/02/23 at 11:10am revealed: -There was a table with a large beverage	{D 283}		

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{D 283}	Continued From page 20 container, a box of covered straws, cups, and a bag of sugar. -The table had sugar white particles and the cups were not placed in a cup holding plate and was not covered. Interview with the Cook on 08/01/23 at 9:58am revealed: -She had received training by the former Dietary Manager in February 2023. -She cleaned the kitchen each time she was scheduled to prepare meals. -She cleaned by wiping down all the tables, swept and mopped the floors and washed the dishes. Interview with the Interim Dietary Manager on 08/02/23 at 11:01am revealed: -There was not a cleaning schedule for the kitchen staff. -The dietary staff were to wipe down the tables, sweep and mop daily. -The deep fryer had not been cleaned because it was broken and had not been used. -She had not identified what the greasy stains were on the deep fryer. -The cleaning cloths were changed out daily and washed daily. -The Executive Director (ED) and the Business Office Manager (BOM) did a walk-through of the kitchen daily. Interview with the BOM on 08/02/23 at 11:10am revealed: -She manage the kitchen staff. -She went to the kitchen at least 3 times weekly to greet the dietary staff and to review the menu. -She had not completed walk throughs of the kitchen to review for cleanliness and -There was not a daily cleaning schedule.	{D 283}		

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{D 283}	Continued From page 21 Interview with the ED on 08/02/23 at 11:12am revealed: -She and the BOM managed the dietary staff. -She did not know if there was a cleaning schedule for the staff. -The dietary staff were doing what they were expected to do.	{D 283}		
{D 287}	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were maintained hot until residents were ready to eat their meals. The findings are: Review of the dietary services training handout revealed: -The topics stated residents should be served restaurant style.	{D 287}		

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{D 287}	Continued From page 22 -Hot food should be served hot and cold food should be served cold. -Food should be kept at appropriate temperatures until ready to serve. -There required temperature for serving hot and cold foods was not on the handout. Observation of the kitchen during the preparation of the lunch meal on 08/01/23 at 12:05pm revealed: -There was a large pot with green beans placed over a small fire on the stove. -There was a four well electric hot food table unit with the temperature set at 10. -There was a pan of mixed vegetables and two pans of fish sticks placed in each pan holder. Observation of the water for the electric hot food serving table on 08/01/23 at 12:41pm revealed the water temperature was 158.9°F. Interview with a resident on 08/01/23 at 12:30pm revealed the food was warm but the fish sticks were cold. Interview with a second resident on 08/01/23 at 12:32pm revealed the food would do but was not cold. Interview with a third resident on 08/01/23 at 12:32pm revealed the food was not real hot but warm and the fish sticks were a little cool. Interview with the dietary wait staff on 08/01/23 at 12:01pm revealed: -She did not have a food handlers' certification. -She was trained for the facility's dietary service in May 2023. Interview with the Cook on 08/01/23 at 12:20pm	{D 287}		

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{D 287}	Continued From page 23 revealed: -She last was trained for the facility's dietary services in February 2023 by the former Dietary Manager. -All hot food should be served at 150°F. -She did not take the temperature of the food before plating. -She did not take the temperature of the water in the electric hot serving tray. -She thought the electric hot food serving table was 175°F. Observation of the kitchen during the preparation of the breakfast meal on 08/02/23 at 7:50am revealed: -There was a medium size pot with oak meal place under a small fire on the stove. -There was a pan of bacon placed on the stove. -The pot of oak meal was moved and placed on top of one of the electric hot serving table. -There was a four well electric hot food table unit with the temperature set at the 10 dial. -There was a pan of scrambled eggs and a pan of bacon placed in each pan holder. Interview with a resident on 08/02/23 at 8:18am revealed: -Her breakfast food was cold. -Most of the meals were served cold. -She have complained to management, but nothing had been done about the meals being served hot. Interview with a second resident on 08/02/23 at 8:19am revealed: -His breakfast food was cold. -The breakfast meal served on 08/01/23 was cold too. Interview with a third resident on 08/02/23 at	{D 287}		

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{D 287}	Continued From page 24 8:21am revealed: -Most of the time the food was served cold. -He and other residents had complained about the breakfast meal being served cold, but nothing was done about it. Interview with a fourth resident on 08/02/23 at 8:22am revealed the meals were served cold a lot of times. Interview with a fifth resident on 08/02/23 at 9:03am revealed the breakfast meal tasted good but the food was lukewarm. Interview with the Interim Dietary Manager on 08/02/23 at 7:28pm revealed: -She did take the food service orientation training and test. -Hot food was to be served between 140°F and 160°F. -She had not checked the hot water temperature for the electric hot food serving table. Interview with the Executive Director (ED) on 08/01/23 at 5:18pm revealed: -The dietary staff had not completed any formal food handlers' certification trainings. -She completed a food service training for the facility staff on May 24, 2023. -She had monitored the dietary staff to ensure the food was plated and served properly. -She had not known the required temperature for serving food.	{D 287}		
D 327	10A NCAC 13F .0906 (f-3) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services	D 327		

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D 327	Continued From page 25 Visting (3) A signout register shall be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to maintain an accurate sign-out/sign-in register for 1 of 3 residents sampled (Resident #7) who left the facility alone with no indications of location and return time. The findings are: Review of Resident #7's current FL-2 dated 03/02/23 revealed diagnoses included chronic kidney disease, anemia, heart failure, alcohol dependence and withdrawal, history of transient ischemic attack, cerebral infarction, reflux, and severe protein and calorie malnutrition. Review of a mental health provider visit note dated 05/22/23 revealed: -Resident #7 had "multiple chronic and progressive disorders necessitating psychiatric management for continued treatment to mitigate threat to life or bodily function associated with decompensation or lack of continued treatment." -Resident #7's interview with the provider was limited due to the resident's "limited insight and cognitive impairment." -Resident #7 did not volunteer information. Review of a primary care provider (PCP) visit	D 327		

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D 327	Continued From page 26	D 327		

note dated 06/15/23 revealed Resident #7 was assessed to have a cognitive deficit, history of alcoholism, and polysubstance abuse, for which he continued to be followed with a mental health provider.

Review of facility staff Care Notes revealed:
-The last care note documented was dated 01/19/23.
-On 08/03/22, staff documented Resident #7 bought an alcoholic beverage back to the facility.

Interview with a medication aide/supervisor (MA/S) on 08/02/23 at 7:05am revealed:
-Resident #7 sometimes left the facility at night.
-The resident sometimes left 2-3 times a night.
-She was told (no name provided) that Resident #7 could sign out when leaving the facility.

Review of the Resident Sign Out/In sheets revealed:
-Resident #7 signed himself out on seventeen times from 06/01/23 through 06/30/23 including two times on 06/09/23 and 06/17/23, and three times on 06/21/23. There were no estimated return times or return times documented.
-Resident #7 signed himself out on seventeen times from 07/01/23 through 07/31/23. There were no estimated return times or return times documented.
-Resident #7 signed himself out on 08/01/23. There was no estimated return time or return time documented.
-Resident #7 documented his destination as "out" and "self" for with whom.
-It could not be determined the exact time of day Resident #7 left the facility on any of the occasions as morning (am) or evening (pm) was not indicated.

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 08/02/2023

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 327	Continued From page 27 Interview with Resident #7 on 08/02/23 at 11:20am revealed: -He left the facility at least every other day to visit relatives and go to the store. -He walked to visit family and to the store. -He left the facility as late as 11:00pm and stayed out for at least 1 ½ hours. -He did not sign out when he left the facility. -Staff had not tried to stop him from leaving the facility late at night or ask where he was going. -He left the facility by using the east side hallway living area exit door at 11:00pm. -The front entry/exit door and the hallway living area exit door did alarm when opened. -He thought he last left the facility on 07/31/23. Telephone interview with the PCP on 08/02/23 at 12:02pm revealed: -She had been notified Resident #7 was leaving the facility and was aware of his history of alcohol abuse. -There had not been any recent reports from the facility of Resident #7 leaving. -She would recommend that Resident #7 not drink alcohol given his current medical conditions and history of alcoholism. -With Resident #7 having a history of alcoholism, drinking alcohol could result in a relapse. -Resident #7 has a diagnosis of chronic kidney disease. Alcohol can act like a diuretic which could lead to fluid loss. -She would not recommend any person, and not just the assisted living residents, to be out walking after 11:00pm at night due to safety concerns. The highway was busy and there were "shady people". Telephone interview with a Nurse Practitioner from the psychiatric provider on 08/02/23 at 1:04pm revealed:	D 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 327	Continued From page 28 -She was aware Resident #7 left the facility to go to the store. -Resident #7 was not on any restrictions. -She did not have any concerns for Resident #7's safety. -There had not been any concerns bought to her attention regarding the residents' behavior or cognition. -Her expectation for the frequency of supervision Resident #7 needed would be the same as required for everybody else living in the assisted living unit. -She would expect the facility to make sure Resident #7 signed in and out when leaving the facility. Interview with the Executive Director (ED) on 08/02/23 at 2:42pm revealed: -Resident #7 was quiet and kept to himself. -She was aware Resident #7 would leave the facility and return. -She had not received any reports from staff that Resident #7 had left the facility and returned with symptoms of alcohol intoxication. -She had not observed any sign or symptoms of alcohol intoxication in Resident #7. -She expected all residents to sign out when leaving the facility. -Sometimes the residents may require reminders to sign out when leaving the facility. -She did not have any information about Resident #7 leaving the facility in the evening hours. -The facility did not have a process in place to review the sign out/in logs for accuracy and complete information. -She did not know where Resident #7 was in the evening, nor was she sure how long Resident #7 was gone from the facility. -She did not have any concern for Resident #7's safety.	D 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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