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 11/17/2023

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 000	Initial Comments The Adult Care Licensure Section conducted a complaint and state involved complaint investigation from 11/15/23 through 11/17/23. The Martin County Department of Social Services initiated the complaint on 11/13/23.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide a safe and clean environment free of hazards related to bed bugs, mice, and a snake being in the facility and failure to provide cigarette receptacles for proper disposal of cigarettes by residents. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 122 beds including 72 beds for the assisted living (AL) unit and 50 beds for a special care unit (SCU). Review of the facility's census reports provided on 11/15/23 revealed: -The facility's in-house census was 57 residents.	D 079		

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D 079	Continued From page 1 -There were 34 residents residing in the AL side of the facility. -There were 23 residents residing in the SCU. Review of the facility's Bed Bug Policy dated 08/18/16 for residents revealed: -Due to increasing occurrence of bed bugs, the facility adopted a proactive approach to address the potential problem to protect the residents. -The facility required clothing or bed linens brought into the facility to be dried by staff before being worn or used by the resident. -Dried, cleaned clothing was acceptable if the clothing was sealed in the dry cleaner's bag and proof that the clothing was dry cleaned within the past twenty-four hours. -Bringing furniture and mattresses in the facility by residents were prohibited unless purchased new. -Cardboard boxes, including shoe boxes, were prohibited from being brought in the facility for storage. -Residents should ensure clothing and non-clothing items brought in the facility were stored in plastic containers. -All food items must be kept in sealed air-tight containers. -The resident was to report bed bug sightings to the supervisor-in-charge. -Staff were trained to detect bed bug sightings and to follow preventative protocol of vacuuming around furniture and baseboards, bagging all bed linens and clothing prior to removing from residents' rooms, and cleaning mattresses/furniture with vinegar-based solution. 1. Observation of a resident's room #1 on the assisted living (AL) unit on 11/15/23 at 9:30am revealed: -The resident was sitting in a recliner.	D 079		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 079	Continued From page 2 -Bed linens had been taken off the bed and placed on a nearby chair in the room leaving the mattress exposed. -There were dead bed bugs, which were reddish in color, wingless, and the shape of an apple seed, and bed bug carcasses, excrement, and dried blood on the mattress. -There was a mattress bag that looked new and had not been taken out of the plastic bag that was lying on the nightstand. Interview with the resident in room #1 on the AL unit on 11/15/23 at 9:30am revealed: -He removed the bed linens and placed them on a nearby chair because the mattress had bed bugs. -He told management about the bed bugs in his room. -A "man" came out and sprayed the room about a week and a half ago. -The pest control company only sprayed or treated those rooms where residents saw bed bugs. -He had been sleeping in his recliner for about a month because he did not feel comfortable sleeping in the bed due to the bed bugs. -Sometimes he "smashed" the bed bugs with his finger when he saw them, and blood came out. -The facility bought him a bed cover/bag for the mattress, but it had not been put on yet. -He would prefer to sleep in his bed and would be more comfortable sleeping in his bed if there were no bed bugs. Observation of a second resident in room #36 on the AL unit on 11/15/23 at 10:05am revealed: -There were red pinpoint spots, scratches and scabbed areas on a resident's arms and legs consistent with bed bug bites and where the resident might have been scratching.	D 079		

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D 079	Continued From page 3 -Bed linens had been taken off her bed. Interview with the second resident in room #36 on the AL unit on 11/15/23 at 10:05am revealed: -The facility had bed bugs. -She last saw a bed bug yesterday. -She had been bitten by bed bugs. -She showed the surveyor areas on her legs and arms where she had been bitten by bed bugs. -Her sheets had been taken off her bed today and and washed almost every day because of bed bugs. -Sometimes the facility would take their clothes out of the closet and wash them or threw them away. -Someone was in the family yesterday to spray for bed bugs. Observation of a third resident's room #3 on the AL unit on 11/15/23 at 10:10am revealed: -There was a bed bug crawling on the resident's right pant leg while sitting in his recliner watching television, he was unaware of the bed bug. -The resident's bed had been stripped and bed linens taken off. Interview with the third resident in room #3 on the AL unit 11/15/23 at 10:10am revealed: -There were bed bugs in the facility. -His bed linens had been taken off the mattress and were being washed due to bed bugs. -His room had been sprayed or treated for bed bugs about 2-3 days ago. Interview with the resident's family member that resided on the AL unit on 11/15/23 at 3:40pm revealed: -She had a family member that resided in the facility for about a month and a half -There had been reports of bed bugs in the facility	D 079		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 079	Continued From page 4	D 079		

by her family member and other residents.
-She reported the bed bugs to the Executive Director (ED).

Telephone interview with the facility's contracted pest control representative on 11/16/23 at 12:10pm revealed:
-The company provided pest control services to the facility for approximately three and a half years, including bed bug treatments.
-The company treated bed bugs at the facility with a residual chemical, which killed bed bugs up to 90 days after application.
-The first time the company provided treatment, every room in the facility was treated.
-Treatment included spraying window seals, walls, baseboards, mattresses, bed frames and headboards.
-After the first visit, the company came out monthly to treat those rooms that were identified by residents or staff as having active bed bug activity.
-The facility had come a "long way" in that there was no longer an "infestation" of bed bugs, but there was bed bug activity currently in some rooms at the facility.
-An "infestation" was an "undesirable and uncontrollable" activity of bed bugs.
-The company recommended that the facility follow sanitation protocol in between treatments which included drying, washing, and drying bed linens and clothing where bedbugs were found and keeping the rooms clean and free of clutter.
-The "best" solution would be to throw everything away in the rooms that had bed bug activity.
-Bed bugs could not be 100% eradicated because they were "hitchhikers" and staff and residents were constantly coming in and out of the facility.

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 079	Continued From page 5 Review of the facility's contracted pest control monthly report revealed: -On 05/01/23, the comments on the service report included rooms 10, 21, 26, 29, 31, 34, and 36 were treated for bed bugs, activity was reported in rooms 21, 26, 29, and 36, mattress, box spring and bed frame in room 36 was discarded, technician treated laundry room, kitchen, and dining room areas for general pest. -On 06/12/23, the comment on the service report included technician treated rooms 14, 19, 21, 22, 25, 26, 34, 35 and the laundry room for bedbugs, activity was found in rooms 26, 34, and 35. -On 06/23/23, the comment on the service report included kitchen and dining area was treated for general pest. -On 07/01/23, the comment on the service report included kitchen and dining area was treated for general pest. -On 08/23/23, the comment on the service report included rooms 32, 34, and 35 were treated for bed bugs, no activity was reported, kitchen, dining areas and apartments 1-8 were treated for general pest. -On 09/22/23, the comment on the service report included rooms 32, 24, and 35 were treated for bed bugs, kitchen, dining areas, and apartments 1-8 were treated for general pest. -On 10/02/23, the comment on the service report included rooms 21, 25, 34, and 50 were treated for bed bugs, no activity was reported, kitchen, dining areas and apartments 1-8 were treated for general pest. -On 11/02/23, the comment on the service report included rooms 3, 25, and 52 were treated for bed bugs, kitchen and dining areas and apartments 1-8 were treated for general pest. Telephone interview with a personal care aide (PCA) on 11/16/23 at 11:00am revealed:	D 079		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 6	D 079		

-Bed bugs had been a problem in the facility since she was hired in 2019 and had gotten worse.
-Staff were instructed to follow the protocol when bed bugs were seen in a resident's room.
-The protocol was to remove the bed linens, dry them to remove any bed bugs, and wash and dry the bed linens before placing them back on the mattress.
-The bed bugs were still in the mattress when clean or new bed linens were placed back on the bed and residents were still getting bitten.
-She saw a "hand full" of mattress covers or bed bags available to place on residents' mattresses to prevent bed bugs in the mattress.

Telephone interview with a second PCA on 11/16/23 at 9:42am revealed:
-The residents complained of seeing bed bugs in their rooms and being bitten all the time.
-She saw bed bugs in resident's rooms.
-She saw bed bug bites on residents and staff.
-She would notify the Executive Director (ED) and the Acting Resident Care Coordinator (RCC).
-They instructed staff to follow protocol, which was to take the bed linens off the beds, dry them to remove any bed bugs, wash and dry them before placing the bed linens back on the bed.
-There were still bed bugs in the mattresses.

Interview with a housekeeper on 11/15/23 at 10:40 am revealed:
-She was assigned to clean the residents' rooms.
-She had not seen any bed bugs.
-Residents had not reported to her about having bed bugs in their room.
-She was not aware if the facility was being treated for bed bugs.

Interview with a second housekeeper on 11/17/23

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 11/17/2023

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 079	Continued From page 7 at 10:00am revealed: -She was assigned to clean the residents' rooms. -She had not seen any signs of bed bugs in the rooms. -No one had reported to her about being bitten by bed bugs. -She had not been trained on how to handle the bed linen and clothing of residents who had bed bugs. Confidential interview with a staff person revealed: -She had observed bed bugs in some of the residents' beds. -Residents had reported being bitten by bed bugs. -She had reported seeing bed bugs and residents' reports of being bitten by bed bugs to the Acting RCC and the ED. -She were informed by the ED that the corporate office was not providing enough funding to treat the facility properly. Interview with the Acting RCC on 11/17/23 at 2:54pm revealed: -Bed bugs were present in the facility for a while. -A pest control company came out to the facility to treat the bed bugs, she did not know when or how often. -When residents saw bed bugs, they would report it to the Business Office Manager (BOM) who would report it to the ED. -Her overall concern was for the wellbeing of the residents and that the facility was being treated for bed bugs. Interview with the ED on 11/17/23 at 5:17pm revealed: -She was aware there was an on-going problem with bed bugs in the facility since she was hired	D 079		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 079	Continued From page 8	D 079		

over a year ago.
-The facility had a contract with a pest control company that came out once a month to treat those rooms where bed bugs had been sighted by residents or staff.
-Staff was trained on how to look for bed bugs.
-Staff were trained to inspect the furniture, bed linens, mattress, headboard, and bed frame for signs of bed bugs and blood stains.
-When bed bugs were reported, housekeeping was to strip the mattress of bed linens, vacuum the mattress, place the bed linens in a bag and take it to the laundry room to be placed in the dryer, washed, and dried and brought back to the room to be placed back on the bed.
-The PCAs would wash the bed linens.

Telephone interview with the Primary Care Provider (PCP) on 11/16/23 at 11:30am revealed:
-She was the facility's contracted PCP for the residents and came to the facility weekly.
-She saw a resident today (11/16/23) and he told her he slept in his recliner due to bed bugs in his bed.

A second telephone interview with the facility's PCP on 11/17/23 at 11:42am revealed:
-Bed bugs in the facility could bite residents and cause a rash and itching.
-Residents were at risk of a skin infection from excessive scratching from bed bug bites.
-Residents were at risk of open wounds that could become infected and could cause cellulitis (cellulitis is a common and potentially serious bacterial skin infection).
-If a resident developed cellulitis and it was not treated, the resident become septic.
-Bed bug activity in the facility could cause residents to have a difficult time sleeping due to the discomfort caused by itching from bed bug

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 079	Continued From page 9 bites. 2. Observation of a resident's room on the assisted living (AL) unit on 11/15/23 at 9:30am revealed a glue mouse trap on the floor behind a piece of furniture and a different kind of mouse trap behind another piece of furniture. Interview with the resident on 11/15/23 at 9:30am revealed: -There were mice that ran through the facility "all day long." -The facility placed the glue mouse trap behind the furniture near the exit door in his room. -He bought the other mouse trap that was behind another piece of furniture in his room. -The man from the pest control company recommended to the facility to have threshold strips at the bottom of doors to keep pests out. Observation of a second resident's room on the AL unit on 11/15/23 at 9:55am revealed: -There was one resident that resided in room 19. -There was a corner shelf in the bathroom with three shelves. -There was a large roll of industrial paper towels on the top shelf. -There were two mouse droppings on the top of the roll of the industrial paper towels. Interview with the second resident that resided in the room on 11/15/23 at 9:56am revealed the resident had seen mice in his room at least a few times a week. Interview with a third resident on 11/15/23 at 10:00am revealed the facility had a lot of problems with mice. Interview with a fourth resident on 11/15/23 at 10:15am revealed:	D 079		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 10	D 079		

-The facility had mice.
-He saw a mouse a couple of nights ago in his room.
-He thought pest control had placed glue traps in the facility.

Interview with a fifth resident 11/15/23 at 10:25am revealed:
-Mice ran around the facility every night.
-Everyone knew, including residents and staff, that there were mice in the facility.

Interview with a sixth resident on 11/15/23 at 10:45am revealed:
-The facility had mice.
-The last time he saw a mouse was last night.

Interview with a seventh resident that resided on the AL unit on 11/15/23 at 9:37am revealed:
-She had observed a mouse in her room several nights a week.
-She had reported concerns about the mouse to a medication aide (MA) a few weeks ago.
-The MA told her she would "handle it."

Interview with a eighth resident that resided on the AL unit on 11/16/23 at 8:35am revealed the mice at the facility were bad, she observed mice in her room almost every day.

Interview with a ninth resident on 11/17/23 at 9:09am revealed:
-He saw mice last night in his room.
-He saw mice at least two times a night.
-Management was aware of the mice in the building.

Interview with a tenth resident on 11/15/23 at 9:37am revealed:
-Mice ran around the halls every once in a while.

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 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 079	Continued From page 11	D 079		

-He saw mice in his room about two weeks ago.
-He had not informed staff about seeing the mice because he had caught a few mice and killed them and taken them outside.

Interview with an eleventh resident on 11/15/23 at 9:46am revealed:
-The facility was filled with a lot of mice.
-Normally, he saw mice at night running from room to room.
-He had reported seeing mice to the Resident Care Coordinator (RCC) but was told nothing could be done about getting rid of the mice.

Interview with a twelfth resident on 11/15/23 at 10:16am revealed:
-She last saw a mouse about one week ago in the hallway.
-She informed staff about seeing the mouse and was told they would put a glue box down to catch the mouse.

Interview with the facility's contracted pest control representative on 11/16/23 at 12:10pm revealed:
-The company had provided pest control services to the facility for approximately three and a half years, including mice control.
-Mouse baits were prohibited from being used inside the building per facility policy.
-Mouse baits were placed around the building on the outside to prevent mice from entering the facility.
-Mouse baits on the outside of the building would not get rid of mice already inside the facility.
-Glue traps had been placed in some areas in the facility for mice control.
-It was recommended to the facility to place threshold strips underneath exit doors to act as a barrier to prevent pests from entering the facility.

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 11/17/2023

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 079	Continued From page 12 Review of the facility's contracted pest control monthly report revealed: -On 05/01/23, the comments on the service report included technician treated laundry room, kitchen, and dining room areas for general pest control. -On 06/12/23, the comment on the service report revealed there were no comments regarding rodent control. -On 06/23/23, the comment on the service report included kitchen and dining area was treated for general pest, glue boards were placed in main living room, kitchen and room 28 for rodent control. -On 07/01/23, the comment on the service report included kitchen and dining area was treated for general pest, glue boards were placed in main living room, kitchen and room 28 for rodent control. -On 08/23/23, the comment on the service report included kitchen, dining areas and apartments 1-8 were treated for general pest control. -On 09/22/23, the comment on the service report included kitchen, dining areas, and apartments 1-8 were treated for general pest, glue boards were placed for mice control. -On 10/02/23, the comment on the service report included kitchen, dining areas and apartments 1-8 were treated for general pest control. -On 11/02/23, the comment on the service report included kitchen and dining areas and apartments 1-8 were treated for general pest control, stations were placed for mice control (there was no indication as to where). Telephone interview with a family member on 11/15/23 at 3:40pm revealed: -The facility was full of mice. -A mouse was seen running down the hallway when they visited a family member in the facility.	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 11/17/2023

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 079	Continued From page 13	D 079		

-A resident told her that she was asleep in bed and woke up and found a mouse on her shoulder with droppings.
-She had reported it to the Executive Director (ED)

Interview with a Captain from the local fire department on 11/16/23 at 4:45pm revealed:
-The local fire department was at the facility on 11/06/23 after 12:00am in response to a fire.
-When he checked each residents room on the east wing of the AL unit, he observed mice droppings in each windowsill.
-When he entered one resident's room on the east wing of the AL unit, he observed a mouse that ran along the side of the room against the wall, ran over a resident's pair of shoes on the floor, and jumped on the resident's bed.

Telephone interview with a personal care aide (PCA) on 11/16/23 at 11:00am revealed she had seen mice in the facility.

Telephone interview with a medication aide (MA) on 11/17/23 at 9:29am revealed:
-There were a lot of mice at the facility; she saw them in the medication room, resident rooms, dresser drawers, closets and the hallways.
-Residents often complained about observing mice in the facility.
-Another MA found a mouse in the sharps container on the side of the medication cart in the medication room recently.
-She observed the MA bring the sharps container to a morning meeting and inform the ED that there was a mouse in the sharps container; the ED directed the MA to dispose of the mouse outside of the facility.
-She reported her observations of mice to the ED several times and informed the ED that there had

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 11/17/2023

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 079	Continued From page 14	D 079		

been several occasions when she opened a dresser drawer in a resident's room and a mouse jumped out of the drawer.

Interview with the ED on 11/17/23 at 5:17pm revealed:
-She was aware there were mice in the building.
-The facility was an "old" building located in the country.
-Mice glue traps had been placed in the facility.
-Mice baits had been placed around the building on the outside.
-Threshold strips had been placed underneath the front door of the facility and kitchen door leading to outside to keep pest out of the facility.

Telephone interview with the facility's primary care physician (PCP) on 11/17/23 at 11:42am revealed:
-She had observed mice in the facility on several occasions.
-She had informed a housekeeper, a PCA, and a MA on different occasions of her observations of mice in the facility.
-Residents were at risk of illnesses that could be transferred through the mice droppings, residents could have gastrointestinal problems.
-Residents were at risk of rat bite fever if they were bit by a mouse; rat bite fever could cause vomiting, muscle pain, and a fever.
-Residents were at risk of difficulties with sleep because mice were more active at night.
-Residents were at risk of increased anxiety from observations of mice.

3. Observation of a resident's cell phone on 11/15/23 at 9:30am revealed:
-There was a picture of a coiled snake on the floor near the baseboard and wall that had gotten in the facility

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 11/17/2023

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 079	Continued From page 15 -The snake was black and white and looked to be about 2 inches in diameter and 2 feet long. Interview with a resident on 11/15/23 at 9:30am revealed: -There was a snake in the building a couple of weeks ago. -He did not see the snake but was sent a picture of the snake by a staff person to his cell phone. -A resident killed the snake. Interview with a second resident on 11/17/23 at 9:09am revealed: -He was sitting in the hallway near the front entrance of the facility after dinner time, he heard a staff person running down the hall and yelling there was a snake down the hallway near the medication room. -He went down the hallway and killed the snake with a broom. -The snake was black and white and looked like a "chicken eating snake." -The resident illustrated with both hands the size of the snake which was estimated to be about an inch and a half in diameter and two and a half feet long. Telephone interview with a personal care aide (PCA) on 11/17/23 at 9:42am revealed: -There had been three snakes that had gotten in the facility since December 2022 that she was aware of. -A resident was moved out of the facility by the family when they heard about a snake being in the facility. -Nothing had been done to prevent snakes from getting into the facility. Interview with the Executive Director (ED) on 11/17/23 at 5:17pm revealed:	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 11/17/2023

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 079	Continued From page 16	D 079		

-She was made aware of a snake being in the facility several weeks ago through staff.
-She was not aware of there being three snakes in the facility since December 2022.
-The snake may have gotten in the facility through a nearby door that went out to the residents' designated smoking area that was constantly being opened.
-The facility had the grass cut and bushes/shrubbery cut back and cleared to prevent snakes being in that area.
-The facility's contracted pest control company did not provide treatment for snakes.

Telephone interview with the facility's primary care physician (PCP) on 11/17/23 at 11:42am revealed:
-She was told about a snake in the facility by a resident a few months ago.
-Snakes could be toxic to residents if there was a venomous snake in the facility.
-Residents could experience increased anxiety due to fear of snakes in their living environment.

4. Observation of front of the facility on 11/15/23 at 8:45am revealed:
-There was a front porch at the main entrance of the facility.
-There was a front porch to the right of the main entrance on the east wing of the Assisted Living (AL) unit.
-There was a front porch to the left of the main entrance on the west wing of the AL unit

Observation of the front porch at the main entrance of the facility on 11/17/23 at 4:48pm revealed:
-There were no cigarette receptacles on the porch or near the sidewalk.
-There was a flowerpot approximately 16 inches

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 11/17/2023

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 079	Continued From page 17	D 079		

in diameter on each side of the sidewalk of the landscaped area.
-There were cigarette butts in both flowerpots, on the ground to the right and left side of the front porch, and the front of the porch.

Observation of the front porch to the right of the main entrance on the east wing of the AL unit on 11/17/23 at 4:50pm revealed:
-There were no cigarette receptacles on the porch or near the sidewalk.
-There was a flowerpot approximately 16 inches in diameter on each side of the sidewalk of the landscaped area.
-There were 23 cigarette butts in the flowerpot to the left of the sidewalk.
-There were 43 cigarette butts in the flowerpot to the right of the sidewalk.
-There were numerous cigarette butts on the ground to the right and left side of the porch and the front of the porch.

Observation of the front porch to the left of the main entrance on the west wing of the AL unit on 11/17/23 at 4:52pm revealed:
-There were no cigarette receptacles on the porch or near the sidewalk.
-There was a flowerpot approximately 16 inches in diameter on each side of the sidewalk, at the front of the porch.
-One flowerpot had an empty 4 ounce styrofoam cup, three empty packs of cigarettes, and 38 cigarette butts.
-One pack of the empty cigarettes had two burnt holes at the top of the cigarette pack.
-A second flowerpot contained an empty paper medication cup and 52 cigarette butts.
-There were numerous cigarette butts on the ground to the right and left of the front porch, and on the ground in front of the porch.

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 11/17/2023

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 079	Continued From page 18 Observation of the front porch at the main entrance to the facility on 11/15/23 at 5:15pm revealed there was one resident smoking on the front porch; there were no cigarette receptacles available. Observation of the front porch at the main entrance to the facility on 11/16/23 at 2:00pm revealed there was one resident smoking on the front porch; there were no cigarette receptacles available. Telephone interview with a personal care aide (PCA) on 11/16/23 at 11:01am revealed: -Residents usually used the facility's designated smoking area across from the kitchen to smoke. -There was a gazebo in the designated smoking area with cigarette receptacles. -Residents usually smoked on one of the three front porches of the facility at night, because the lighting in the designated smoking area was not adequate at night. Telephone interview with a medication aide (MA) on 11/17/23 at 9:29am revealed: -Residents were expected to smoke in the facility's designated smoking area. -The designated smoking area was located across from the kitchen; there was an area outside that had a gazebo and cigarette receptacles. -Residents did not like to smoke in the designated smoking area because the lighting was not good at night. -She showed the Executive Director (ED) a while back that the designated smoking area had poor lighting at night and reported that residents were smoking at night on the front porches due to the poor lighting.	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 11/17/2023

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 079	Continued From page 19 Interview with the ED on 11/17/23 at 1:55pm revealed: -Residents were expected to smoke in the designated smoking area across from the kitchen where there were cigarette receptacles around the gazebo. -She had placed a sign on the inside of the front entrance door to the facility encouraging residents to not smoke anywhere at the front of the building. -She was aware that there were not any appropriate cigarette receptacles on the three front porches at the front of the facility. -Appropriate cigarette receptacles should have been provided for residents on the three front porches at the front of the facility to ensure their safety and the safety of others. -She was not aware that the lighting in the designated smoking area of the facility was not adequate. _____ The facility failed to provide a safe, clean, and hazard free environment for residents as evidenced by the presence of bed bugs, mice, a snake in the facility and failure to provide cigarette receptacles. The bed bugs could cause rashes, itching and bacterial skin infections from excessive scratching, and difficulty in sleeping due to anxiety and fear of sleeping in the bed. The continued persistent presence of mice and mice excrement caused anxiety, fear, and difficulty in sleeping and an increased risk of mice bites that could cause bacterial infections leading to vomiting, muscle pain and fever. The presence of snakes presented a risk of bites from a potentially venomous snake that could be toxic to residents. Not having receptacles for the proper disposal of cigarette butts posed a serious risk to the safety of residents and others. This	D 079		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 20 failure placed the residents at substantial risk for serious physical harm and constitutes an A2 Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 11/17/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 12/17/23. Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (A1 Violation).	D 079		
D 134	10A NCAC 13F .0407(a)(2) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (2) be able to implement all of the adult care home's accident, fire safety, and emergency procedures for the protection of the residents; This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interview and record review, the facility failed to evacuate 2 residents during an emergency which involved a brush and structural fire. The findings are: Review of the facility's Emergency/Accident Policy revealed:	D 134		

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 11/17/2023

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 134	Continued From page 21	D 134		

-An emergency was defined as any situation which arises suddenly and calls for prompt action.
-An accident was defined as an unexpected, unplanned event which may or may not cause injury.
-Staff were to remove residents from the immediate danger if possible.
-Staff were to evaluate the situation.
-Staff were to call, or ask someone to call, 911, if necessary.

Review of the facility's Fire Safety Policy revealed:
-A written fire evacuation plan with a diagram drawing in "Big print" would be posted in a central location on each floor in the facility.
-The facility should review the fire safety plan with each resident on admission.
-The facility should train staff to apply the fire safety plan.

Review of the facility's evaluation diagram plan revealed:
-The evacuation diagram did not include the written fire evaluation plan.
-The evacuation diagram was posted on each hall on assisted living and memory care unit.
-The evacuation diagram did not include written instructions where exit doors and fire extinguishers were located and the designated meeting area for residents and staff.

Review of a local fire department report dated 11/06/23 revealed there was a small fire on the front porch on the right side of the facility.

Interview with a resident on 11/15/23 at 4:47pm revealed:
-She heard staff yelling telling the residents to get out of the building.

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 11/17/2023

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 134	Continued From page 22	D 134		

-She smelled smoked.
-Staff had not knocked on her door and told her to evacuate the building because there was a fire.
-She left her room and went outside on the front middle porch.

Interview with a second resident on 11/16/23 at 9:45am revealed:
-She was asleep when a staff person knocked on her door "about" 2:00am in the morning and told her the building was on fire and to get up and go outside.
-She thought it was a fire drill at first.
-She got up and went outside on the front porch of the entrance of the building.
-She saw that the flame of fire was high up on the side of the other porch toward the end of the building on her left.
-She was "scared."
-She was told that resident started the fire with a cigarette butt accidentally.
-She was assigned a room to sleep in down the other hall away from the fire and did not come back to her room until about 12:15pm the next day.

Interview with a third resident on 11/16/23 at 9:09am revealed:
-He was asleep in bed the night of the fire.
-A staff person came to the door and knocked and said there was a fire.
-He was told to get up and go outside.
-There was smoke in the building.
-He went to the hallway of the entrance of the front of the building but did not go outside.
-Some residents went outside the front entrance of the building and were on the front middle porch.

Telephone interview with a personal care aide

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 11/17/2023

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 134	Continued From page 23 (PCA) on 11/16/23 at 11:01am revealed: -She worked third shift from 11:00pm to 7:00am on 11/06/23. -She and a medication aide (MA) went out the front entrance door to the facility on 11/06/23 after 12:00am to smoke a cigarette. -She observed the resident toss his cigarette into the bushes at the front of the porch on the east wing of the AL and go back inside. -She heard a popping sound like fireworks after the resident went back into the facility. -She observed a fire start in the bushes after she heard a popping sound and ran into the front entrance of the facility to get a pitcher of water to put the fire out. -When she took the pitcher of water to the front porch on the east wing of the AL unit, she saw flames at the top of the building. -She assisted with removing residents from the east wing of the AL unit outside. Telephone interview with a MA on 11/17/23 at 9:29am revealed: -Residents were not supposed to go outside any of the front entrances of the facility after 11:00pm. -She worked third shift from 11:00pm to 7:00am on 11/06/23. -She and a PCA from the AL unit went outside the front entrance to smoke after 12:00am on 11/06/23. -A second PCA that worked on the SCU on 11/06/23 came outside to smoke as well. -She and staff were in the grass across from the parking lot and she observed a resident come out the front exit door onto the porch on the east wing of the AL unit and light a cigarette. -She told the resident that he was not supposed to be outside smoking this late. -She observed the resident toss his cigarette into the bushes and go back into the facility.	D 134		

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 11/17/2023

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 134	Continued From page 24 -She heard popping sounds and observed a fire start in the bushes fast. -She directed one PCA to call 911 and get water, she told other staff to help her evacuate residents from the east wing of the AL unit to the front parking lot. Interview with a Captain from the local fire department on 11/16/23 at 4:45pm revealed: -The local fire department was at the facility on 11/06/23 after 12:00am in response to a fire. -After arriving at the facility, he asked a staff member if all residents had been accounted for and evacuated from the east wing of the AL unit. -The staff member told him all residents had been accounted for and evacuated. -The local fire department policy was to trust but to verify; even when staff informed him that all residents had been accounted for and evacuated, he was still responsible for verifying that all residents had been evacuated. -He searched each room on the east wing of the AL unit and found two residents in their rooms. -The two residents were in separate rooms; he directed the two residents to evacuate the building and they independently exited the building at the front entrance of the facility. Interview with a second PCA on 11/17/23 at 4:26pm revealed: -She had received training on evacuation and fire drills. -She was to ensure all residents were out of the building during a fire. -Residents were to be accounted for once out of the building. -If a resident was not accounted for, staff were to team up and search for any missing residents. -Residents were to wait on the porch during an evacuation.	D 134		

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 11/17/2023

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 134	Continued From page 25 -She was not aware of any other specific designated area for residents to wait during an evacuation. -There was not a designated area where the residents and staff were to meet. Interview with a third PCA on 11/17/23 at 4:37pm revealed: -She had received some training on evacuation. -She was trained to get all of the residents out of the building when she heard the fire alarm. -Residents were escorted outside to the grassy area in front of the building. -A head count of all residents were to be completed by calling their names from a roster or identifying resident by matching their names and faces. -Staff were to search for unaccounted residents by double checking the inside of the facility. -Residents who lived on the assisted living halls were to meet in front of the building. -Residents who lived on the memory care unit were to meet on the unit's front porch or on the side of the building. Interview with a Cook on 11/17/23 at 4:31pm revealed she had not received any training on evacuation or fire drills. Interview with a medication aide (MA) on 11/17/23 at 4:22pm revealed: -She received training on the evacuation and fire drill policy about one month ago. -Residents were not to be left inside of the building. -The ambulatory residents were to be escorted out of the building and the non-ambulatory residents were to be assisted outside of the building. -There was not a designated area where the	D 134		

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 11/17/2023

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 134	Continued From page 26 residents and staff were to meet during an evacuation. Interview with the Executive Director (ED) on 11/17/23 at 5:17pm revealed: -There was a fire which started when a resident tossed a lit cigarette into a bush on 11/06/23 around 12:00am hour. -She thought all residents were evacuated from the assisted living (AL) east wing to the outside of the building. -The AL residents were to meet outside in front of the building on the lawn. -She had not gone to check the rooms on the east wing of the AL when she arrived to the facility. -Residents left inside of the building during a fire were at risk smoke inhalation or being burned by the fire -Staff were expected to check all residents' rooms where the fire started by going into each room to ensure all residents were out of their rooms and escorted outside of the building. _____ The failure of the facility to evacuate all residents during a brush and structural fire and leaving behind two residents who were found still in the building by the local fire department resulted in substantial risk of death or serious physical harm to two residents and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/17/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 16, 2023.	D 134		

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 11/17/2023

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D 270	Continued From page 27	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who improperly discarded a cigarette on the porch of the facility resulting in a fire on the grounds of the porch which extended to the roof of the facility, causing residents from one wing of the facility to be evacuated for safety. The findings are: Review of the facility's use of tobacco policy revealed: -The facility was a smoke free facility. -Residents who smoked would be requested to use designated smoking areas. -Residents who were found to be unsafe with smoking materials would not be allowed to keep the smoking materials in their possession. -The facility reserved the right to confiscate all smoking materials and to discharge the resident if the resident failed to adhere to the tobacco policy. Review of Resident #3's current FL-2 dated	D 270		

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D 270	Continued From page 28 03/02/23 revealed: -Diagnosis included paranoid schizophrenia. -The resident was ambulatory. -There was no documentation of the resident's orientation status. Review of Resident #3's Resident Register revealed the resident was admitted to the Assisted Living (AL) unit on 05/13/20. Review of Resident #3's current care plan dated 03/02/23 revealed: -The resident liked to walk outside the facility and to surrounding areas of the facility. -The resident was oriented but was forgetful and needed reminders. -The resident required supervision with eating, toileting, bathing, and dressing. -The resident required limited assistance with grooming. Review of a supervised smoking policy for Resident #3 revealed: -Resident #3 and the Executive Director (ED) signed a supervised smoking policy on 01/23/23. -The resident signed that he understood that the supervised smoking policy was for his safety, and he would abide by the smoking policy plan. -The resident signed that he understood that violation of this plan could lead to being discharged from the facility. -The facility was a smoke free environment; smoking was not allowed in the facility. -Smoking was allowed in the designated smoking areas only. -The facility reserved the right to confiscate all smoking material if a resident failed to abide by the smoking policies to ensure fire safety for themselves and other residents. -If a resident was unsafe with smoking,	D 270		

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D 270	Continued From page 29	D 270		

supervised smoking would be permitted in three hour intervals.
-Smoking times started at 6:30am and ended at 11:30pm for 15 minute increments.
-Facility staff would supervise the resident during smoking times and maintain all smoking materials.
-Residents would be given one cigarette at a time and the cigarette should be lit by staff.

Review of a progress note for Resident #3 dated 11/06/23 revealed:
-The ED documented that Resident #3 was outside on the front porch of the east wing of the AL unit smoking a cigarette.
-The resident threw the cigarette into a bush beside the porch and the bush caught on fire.
-The ED spoke with the resident and the resident stated that he tried to put the cigarette out and thought he had put the cigarette out before throwing it away.
-The fire started accidentally and there was no harm to residents.

Review of a 15 minute supervision documentation for Resident #3 revealed staff documented observation of the resident every 15 minutes from 3:15am to 11:00am on 11/06/23.

Observation of the gazebo outside area of the facility on 11/17/23 at 9:34am revealed:
-Resident #3 was in the gazebo area smoking without staff supervision.
-Resident #3 flicked off a lit cigarette into the grass area.
-There were two makeshift smoking receptacle cans placed on a table in the gazebo area.

Interview with Resident #3 on 11/15/23 at 10:45am revealed:

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D 270	Continued From page 30 -He went out to the front porch on the east wing of the AL unit on 11/06/23 by himself to smoke sometime after midnight. -There was not any staff with him when he went out to smoke. -He smoked his cigarette and thought he put the cigarette out with his foot on the grass. -He went back inside to the couch in the living room at the front porch east wing door. -A staff person came to tell him that the east wing front porch was on fire and residents needed to evacuate the building. -He was directed to evacuate the building at the front entrance of the facility. Interview with Resident #3 on 11/17/23 at 9:34am revealed: -On the night of the fire the door alarm was not turned on when he went outside to smoke. -He did not remember the day of the fire but knew it was late at night. -He was outside smoking alone on the front porch of the east wing of the assisted living (AL) unit for about 15 minutes. -He did not seen or heard staff until someone yelled for him to go back inside of the facility. -Staff were standing in the front of the building when they yelled for him to go back inside of the facility. -He did not go back inside of the facility and was outside when the fire started. -Staff did not supervise him when he would go outside to smoke. -He was allowed to keep up with his own cigarettes and lighter. Observation of Resident #3 on 11/17/23 at 10:00am revealed: -The resident was sitting in the lobby of the AL unit.	D 270		

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D 270	Continued From page 31 -The resident had a lighter in his left hand. Interview with Resident #3 on 11/17/23 at 10:00am revealed: -He kept his own lighter and cigarettes. -He was not supervised when he went outside to smoke. -He usually smoked outside near the gazebo during the day. -He preferred to sleep on a couch in the living room on the east wing of the AL unit. -He went outside at night to smoke on the front porch of the east wing of the AL unit. Telephone interview with a PCA on 11/16/23 at 11:01am revealed: -She worked third shift from 11:00pm to 7:00am on 11/06/23. -She and a MA went out the front entrance door to the facility on 11/06/23 after 12:00am to smoke a cigarette. -She and the MA noticed Resident #3 was on the front porch of the east wing of the AL unit smoking a cigarette. -Sometimes when staff reminded the resident that he needed to smoke in the designated smoking area, the resident would get upset and walk away from staff. -She and the MA did not want to upset the resident, so they waited for the resident to finish his cigarette. -She observed the resident toss his cigarette into the bushes at the front of the porch on the east wing of the AL and go back inside. -She heard a popping sound like fireworks after the resident went back into the facility. -She observed a fire start in the bushes after she heard a popping sound and ran into the front entrance of the facility to get a pitcher of water to put the fire out.	D 270		

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D 270	Continued From page 32 -When she took the pitcher of water to the front porch on the east wing of the AL unit, she saw flames at the top of the building and observed Resident #3 laying on the couch in the living room at the exit door for the front porch on the east wing of the AL unit. -The resident liked to sleep on one of the couches in the living room area that had an exit door to the front porch on the east wind of the AL unit. -Prior to the fire, she thought Resident #3 was on the couch in the living room by the front porch on the east wing of the AL unit, she was not aware that the resident was outside smoking until she and the MA observed him when they went out the front entrance to smoke. -Resident #3 had required increased supervision in the past, but she did not think he had ever had supervision with his smoking. -When the resident needed increased supervision, the MA on duty would inform her of the increased supervision. -Increased supervision checks were usually 15 or 30 minutes, staff had to document on a form the date, time, and location of the resident when he was on increased supervision checks. -The resident had been on increased supervision in the past because he would leave the facility and not sign out. -He walked away from the facility often to go to local stores. -She had observed him at local stores near the facility when she was on her way to work but knew that staff were not allowed to transport residents in their personal vehicles. -Sometimes she would stop when she saw the resident and encourage him to return to the facility. -She would encourage him to stay at the facility, but she knew they were not able to physically	D 270		

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D 270	Continued From page 33	D 270		

restrain him to prevent him from leaving the facility.
-Resident #3 had always had his own cigarettes and lighter and was allowed to smoke when he wanted to.
-Residents were not supposed to go outside of the facility after 11:00pm, however Resident #3 often went outside after 11:00pm to smoke.
-When she saw Resident #3 go outside to smoke in the past, she would encourage him to come back in the facility; but she realized she could not force him to come back into the facility.

Telephone interview with a second PCA 11/16/23 at 3:18pm revealed:
-She worked third shift on the Special Care Unit (SCU) on 11/06/23.
-She went to the front porch to smoke a cigarette after 12:30am and there was a PCA and MA from the AL unit already on the front porch smoking.
-She observed Resident #3 on the front porch of the east wing of the AL unit smoking.
-The MA told the resident that he needed to go back inside.
-She observed the resident toss his cigarette onto the ground and go back inside.
-She then observed a bush catch on fire and heard popping sounds.
-The MA directed her to call 911 and for other staff to help evacuate residents on the east wing of the AL out of the facility.
-When the fire department arrived, the fire on the front porch of the east wing of the AL was up to the roof.
-She observed the east wing of the AL unit become smokey.
-Resident #3 usually smoked outside in the designated smoking area at the gazebo, but at night he smoked outside on the front porch of the east wing of the AL unit.

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D 270	Continued From page 34 -Resident #3 kept his cigarettes and lighter with him and was not supervised when he smoked. -The resident was known to obtain cigarettes from other residents. -Resident #3 was placed on increased supervision when he left the facility and returned intoxicated. -She thought the last time the resident was placed on increased supervision was a few months ago. -She had to complete a 15 or 30 minute supervision checklist which included documentation of the date, time, and location of the resident. -The increased supervision checklist was in the medication room. Interview with a resident that resided on the east wing of the AL unit on 11/15/23 at 9:37am revealed: -She was asleep when the fire occurred on the front porch on the east wing of the AL unit. -She heard a noise and noticed her door was open, she usually closed her door at night. -She looked out her door and saw smoke in the hallway. -She asked a medication aide (MA) that was on the hall what happening; the MA told her that there was a fire in the building and residents needed to clear out of the building. -She told the MA that her roommate was still asleep in the bed and the MA helped explain to her roommate that there was a fire in the facility and the residents needed to evacuate. Interview with a second resident that resided on the east wing of the AL unit on 11/16/23 at 8:35am revealed: -She usually went to bed between 12:00am and 12:30am.	D 270		

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D 270	Continued From page 35	D 270		

-She lived on the east wing of the AL near Resident #3.
-She observed Resident #3 smoke by himself outside on the front porch on the east wing of the AL during the day and at night.
-On 11/06/23 after midnight a personal care aide (PCA) or MA woke her up to notify her that there was a fire in the facility, and she needed to evacuate.
-When she got to the front door of the facility, she walked in the parking lot toward the grass across from the front entrance.
-She thought the facility was conducting a fire drill.
-She observed flames above the roof of the front porch of the east wing of the AL.

Telephone interview with a MA on 11/17/23 at 9:29am revealed:
-Residents were not supposed to go outside any of the front entrances of the facility after 11:00pm.
-She worked third shift from 11:00pm to 7:00am on 11/06/23.
-She and a PCA from the AL unit went outside the front entrance to smoke after 12:00am on 11/06/23.
-A second PCA that worked on the SCU on 11/06/23 came outside to smoke as well.
-She and staff were in the grass across from the parking lot and she observed Resident #3 come out the front exit door onto the porch on the east wing of the AL unit and light a cigarette.
-She told the resident that he was not supposed to be outside smoking this late.
-She observed the resident toss his cigarette into the bushes and go back into the facility.
-She heard popping sounds and observed a fire start in the bushes fast.
-She directed one PCA to call 911 and get water, she told other staff to help her evacuate residents

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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D 270	Continued From page 36 from the east wing of the AL unit to the front parking lot. -Resident #3 kept his own cigarettes and lighter and was allowed to smoke without supervision. -The ED would notify staff when the resident required increased supervision. -When a resident was on increased supervision, staff had to complete a 15 or 30 minute checklist documenting the date, time, and location of the resident. -When she observed Resident #3 leave the facility, she would encourage him to stay at the facility. -Resident #3 had a history of becoming intoxicated when he left the facility and went to local stores. -It had been a few months since the resident had returned to the facility intoxicated. -The resident was last on increased supervision after the fire on 11/06/23. -The resident was on 15 minute checks until 11:00am on 11/06/23. Review of a local fire department report dated 11/06/23 revealed: -When the fire department arrived at the facility, they found a small fire on the front porch on the right side of the facility. -The heat source that caused the fire was a hot or smoldering object. -The area of the fire was first ignited from organic materials. -The cause of the ignition of the fire was unintentional. -Human factors contributing to the ignition of the fire were an unattended person. -Factors contributing to the ignition of the fire were outside, an open fire for debris or waste disposal.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 37 Interview with a Captain from the local fire department on 11/16/23 at 4:45pm revealed: -The local fire department was at the facility on 11/06/23 after 12:00am in response to a fire. -There were numerous cigarette butts on the ground in front of the porch on the east wing of the AL unit. -The cigarette butts could have been smoldering for quite some time before the fire ignited. -The fire was in the bushes at the porch on the east wing of the AL unit and reached the roof of the facility. Observation of the front porch to the right of the main entrance on the east wing of the AL unit on 11/17/23 at 4:50pm revealed: -There were no cigarette receptacles on the porch or near the sidewalk. -There were portions of vinyl siding missing from a portion of the porch roof. -There was an area under the left portion of the roof of the porch that was exposed; there was not vinyl siding and construction beams could be seen into the roof. -There were two charred bushes to the left of the porch. -There was a flowerpot approximately 16 inches in diameter on each side of the sidewalk with numerous cigarette butts in both flowerpots. -There were numerous cigarette butts on the ground in front of the porch and alongside the sidewalk. of the landscaped area. Telephone interview with Resident #3's primary care physician (PCP) on 11/16/23 at 11:35am revealed: -Resident #3 had a diagnosis of paranoid schizophrenia, which caused him to become agitated at times.	D 270		

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D 270	Continued From page 38 -She was not aware that there was a fire at the facility until a resident told her earlier this morning when she was at the facility. -The ED, Resident Care Coordinator (RCC), or MA should have notified her that Resident #3 was smoking late at night unsupervised, and a fire started outside the facility. -She would have ordered the resident to be placed on 15 minute checks for 72 hours to ensure appropriate supervision. -Resident #3 should have a smoking assessment completed to determine whether he should continue to smoke without supervision. -Resident #3 had a history of walking to local stores and returning to the facility intoxicated. -She was not aware that the resident needed supervision when he smoked at the facility. Telephone interview with Resident #3's PCP on 11/17/23 at 11:42am revealed: -Resident #3 had a chronic behavior of leaving the facility and returning to the facility intoxicated. -The ED could also implement increased supervision for the residents as needed. -If the ED implemented increased supervision for Resident #3, she expected to be notified. -Resident #3 needed a smoking assessment to determine if he was safe to smoke without supervision and to keep his own lighter and cigarettes. Interview with the ED on 11/15/23 at 9:20am revealed: -Resident #3 threw a cigarette outside on the porch on the east wing of the AL and a bush caught fire on 11/06/23 around 12:30am -Staff were with the resident when he was outside smoking a cigarette on 11/06/23 around 12:30am. -Smoke got into the building on the east wing of the AL unit.	D 270		

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
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 270	Continued From page 39 -She received a call from a MA on 11/06/23 at approximately 12:30am informing her about the fire. -When she arrived at the facility the fire had been extinguished by the local fire department. -The fire department relocated residents from the east wing of the AL unit to the west wing of the AL unit. -Staff encouraged residents to smoke in the designated smoking area of the facility where there was a gazebo. -Resident #3 was placed on a supervised smoking contract on 01/23/23 for about a month when he was caught smoking in the facility. -Resident #3 was on a supervised smoking contract for approximately one month. -Resident #3 did not require supervision for smoking and did not have scheduled smoking times. -Resident #3 was placed on 15 minutes supervision checks after the fire until 11:00am on 11/06/23. -The PCAs and MAs were responsible for completing supervision checks whenever a resident was placed on increased supervision. -Residents on the AL unit were allowed to smoke independently, keep their cigarettes and their own lighter if they were not on a supervised smoking contract. Interview with the ED on 11/17/23 at 1:55pm revealed: -When she arrived at the facility on 11/06/23 after a MA notified her by phone of a fire at the facility, she contacted the corporate on call manager. -She updated the corporate on call manager about the fire and was instructed to place Resident #3 on increased supervision with 15 minute checks until 11:00am on 11/06/23. -The resident was not placed on continued	D 270		

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 11/17/2023

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 270	Continued From page 40 supervision for smoking because the cause of the fire was accidental; the resident did not intentionally cause the fire that occurred on 11/06/23. -A smoking assessment was not completed on Resident #3 after the fire because the resident had not been deemed an unsafe smoker. _____ The facility failed to provide supervision for Resident #3 who had a history of smoking cigarettes in the facility, wandering from the facility and consuming alcohol who regularly smoked outside on a porch at the facility unsupervised, did not properly dispose of his cigarette which caused a brush and structural fire at the facility, resulting in the local fire department having to extinguish the fire and evacuate residents from a wing of the unit. The resident was permitted to smoke without supervision and possess smoking materials after starting the fire at the facility. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2023.	D 270		
D 327	10A NCAC 13F .0906 (f-3) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services Visting (3) A signout register shall be maintained for	D 327		

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 11/17/2023

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

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D 327	Continued From page 41 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 reviews and interviews, the facility failed to maintain an accurate sign-out and sign-in register for 1 of 5 residents sampled (#3) who left the facility alone with no indications of location and return time. The findings are: Review of Resident #3's current FL-2 dated 03/02/23 revealed: -Diagnoses included paranoid schizophrenia and history of alcohol abuse. -The resident was ambulatory. -There was no documentation of the resident's orientation status. Review of Resident #3's Resident Register revealed the resident was admitted to the Assisted Living (AL) unit on 05/13/20. Review of Resident #3's current care plan dated 03/02/23 revealed: -The resident liked to walk outside the facility and to surrounding areas of the facility. -The resident was oriented but was forgetful and needed reminders. Review of the facility sign in/out log revealed: -Resident #3 signed out of the facility on 10/24/23 at 3:50pm, desitnation was "self" with an estimated time back at 10:00pm.	D 327		

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

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D 327	Continued From page 42 -Resident #3 did not sign back into the facility on 10/24/23. -Resident #3 signed out of the facility on 10/28/23 at 6:00pm, designation was walk with an estimated time back at 8:30pm. -Resident #3 did not sign back into the facility on 10/28/23. -Resident #3 signed out of the facility on 10/31/23 at 1:15pm, designation was walk and estimated time back was not documented. -Resident #3 did not sign back into the facility on 10/31/23. Review of a facility care note for Resident #3 revealed: -A care plan meeting was held with the resident's legal guardian, the Executive Director (ED), a medication aide (MA), the Business Office Manager (BOM), and the resident on 10/04/23. -The resident was educated and encouraged to sign out and sign back into the facility. Review of a mental health provider visit note dated 10/09/23 revealed: -Resident #3 had a history of alcohol abuse. -Staff reported that the resident would leave the facility and "get drunk." -The mental health provider completed a counseling session on the harm of drinking alcohol and coping strategies to reduce drinking alcohol. Telephone interview with a personal care aide (PCA) on 11/16/23 at 11:01am revealed: -Resident #3 was supposed to sign out and sign back in when he left the facility so staff knew where he was and when he would return. -The resident had a habit of walking to local stores and forgot to sign out and sign back into the facility.	D 327		

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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

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D 327	Continued From page 43	D 327		

-She had observed him at local stores near the facility when she was on her way to work.
-Sometimes when the resident returned to the facility, he smelled like alcohol.

Telephone interview with a MA on 11/17/23 at 9:29am revealed:
-Resident #3 was known to leave the facility and loiter at local businesses.
-The resident was supposed to sign out with a time and destination; he was also supposed to sign back in when he returned to the facility.
-The resident did not always sign out or sign back in when he returned to the facility.

Interview with Resident #3 on 11/17/23 at 10:00am revealed:
-He usually signed out and signed back in when he left the facility.
-He enjoyed walking outside and to local stores.
-He usually walked to the store when he was out of cigarettes.

Interview with a resident on 11/16/23 at 8:35am revealed Resident #3 liked to walk to local stores and would not return to the facility until after supper at times.

Telephone interview with Resident #3's primary care physician (PCP) on 11/16/23 at 11:35am revealed:
-Resident #3 had a diagnosis of paranoid schizophrenia, which caused him to become agitated at times.
-Resident #3 had a history of walking to local stores and returning to the facility intoxicated.
-Resident #3 was expected to sign out and sign back in when he returned to the facility, so staff were aware of his whereabouts.

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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 327	Continued From page 44 Interview with the ED on 11/17/23 at 5:17pm revealed: -She had provided counseling to Resident #3 about her expectation to sign out and sign in when he left the facility. -The resident was aware that he needed to document the time he left, the location of where he planned to go and the time he expected to return. -Staff needed to be aware of where the resident was located to ensure his safety. Attempted telephone interview with Resident #3's mental health provider on 11/17/23 at 12:13pm was unsuccessful.	D 327		
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 Based on observations, record reviews, and interviews, the facility failed to provide the care and services to ensure Resident Rights were maintained related to bed bugs and mice being in the facility. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 122 beds including 72 beds for the	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 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 45 assisted living (AL) unit and 50 beds for a special care unit (SCU). Review of the facility's census reports provided on 11/15/23 revealed: -The facility's in-house census was 57 residents. -There were 34 residents residing in the AL side of the facility. -There were 23 residents residing in the SCU. 1. Observation of a resident's room on the AL unit on 11/15/23 at 9:30am revealed: -The resident was sitting in a recliner. -Bed linens had been taken off the bed and placed on a nearby chair in the room leaving the mattress exposed. -There were dead bed bugs, which were reddish in color, wingless, and the shape of an apple seed, and bed bug carcasses, excrement, and dried blood on the mattress. -There was a mattress bag that looked new and had not been taken out of the plastic bag that was lying on the nightstand. Interview with the resident that resided on the AL unit on 11/15/23 at 9:30am revealed: -He removed the bed linens and placed them on a nearby chair because the mattress had bed bugs. -He told management about the bed bugs in his room. -He had been sleeping in his recliner for about a month because he was anxious about sleeping in the bed due to the bed bugs. -Sometimes he had "smashed" the bed bugs with his finger when he saw them, and blood came out. -The facility bought him a bed cover/bag for the mattress, but it had not been put on yet. -He would prefer and be more comfortable	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 46	D 338		

sleeping in his bed if there were no bed bugs.
-The facility did not have a Resident Council anymore where residents could voice their concerns.

Observation of a second resident's room on the AL unit on 11/15/23 at 10:05am revealed:
-There were red pinpoint spots, scratches and scabbed areas on a resident's arms and legs consistent with bed bug bites and where the resident might have been scratching.
-Bed linens had been taken off her bed.

Interview with the second resident that resided on the AL unit on 11/15/23 at 10:05am revealed:
-The facility had bed bugs.
-She last saw a bed bug yesterday.
-She had been bitten by bed bugs, which caused excessive itching and scratching.
-She showed the surveyor areas on her legs and arms where she had been bitten by bed bugs that cause her to constantly scratch the areas.
-Her sheets had been taken off her bed today and and washed almost every day because of bed bugs.
-Sometimes the facility would take their clothes out of the closet and wash them or threw them away.

Interview with a third resident that resided on the AL unit on 11/15/23 at 10:15am revealed:
-This facilty had on-going problems with bed bugs.
-A family member had bought her some new clothes and a new pillow, and the facility threw them away without her knowledge due to bed bugs.
-She was very upset.

Interview with a fourth resident that resided in

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 338	Continued From page 47	D 338		

room #26 on the AL unit on 11/15/23 at 9:37am revealed:
-She had bed bug bites on her right shoulder and on her lower back several weeks ago.
-She had difficulty sleeping at night due to the itching.

Interview with a fifth resident on 11/15/23 at 4:47pm revealed:
-She had issues with bugs crawling on her.
-She slept in her chair to keep the bugs from crawling on her.
-She reported the bugs crawling on her to the Business Office Manager (BOM) and was told the bugs would fall off of her and die.

Telephone interview with a personal care aide (PCA) on 11/16/23 at 9:42am revealed:
-The residents complained of seeing bed bugs in their rooms and being bitten all the time.
-She had seen bed bugs in resident's rooms.
-She had seen bed bug bites on residents and staff.
-She would notify the Executive Director (ED) and the Acting Resident Care Coordinator (RCC).

Confidential interview with a staff person revealed:
-She had observed bed bugs in some of the residents' beds.
-Residents had reported being bitten by bed bugs.
-She had reported seeing bed bugs and residents' reports of being bitten by bed bugs to the Acting RCC and the ED.
-She was informed by the ED that the corporate office was not providing enough funding to treat the facility properly.

Interview with the Acting RCC on the AL unit

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 11/17/2023

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 338	Continued From page 48	D 338		

11/17/23 at 2:54pm revealed:
-Bed bugs had been seen in the facility for a while.
-When residents saw bed bugs, they would report it to the Business Office Manager (BOM) who would report it to the ED.
-She had not seen bed bug bites on any resident.
-She had not seen bed bugs crawling on any resident or staff.
-She was not aware of a resident sleeping in his recliner due to not wanting to sleep in his bed because of bed bugs on his mattress until now.
-Her overall concern was for the wellbeing of the residents and that the facility was being treated for bed bugs.

Interview with the ED on 11/17/23 at 5:17pm revealed:
-She was aware there was an on-going problem with bed bugs in the facility since she was hired over a year ago.
-She was not aware a resident was sleeping in his recliner due to bed bugs being in his bed until now, she thought it was his preference.
-She had not received any reports of residents being bitten by bed bugs.

Telephone interview with the Primary Care Provider (PCP) on 11/16/23 at 11:30am revealed:
-She was the facility's contracted PCP for the residents and came to the facility weekly.
-She saw a resident today (11/16/23) and he told her he slept in his recliner due to bed bugs in his bed.

A second telephone interview with the facility's PCP on 11/17/23 at 11:42am revealed:
-Bed bugs in the facility could bite residents and cause a rash and itching.
-Bed bug activity in the facility could cause

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 338	Continued From page 49	D 338		

residents to have a difficult time sleeping due to the discomfort caused by itching from bed bug bites.

2. Observation of a resident's room on the assisted living (AL) unit on 11/15/23 at 9:30am revealed a glue mouse trap on the floor behind a piece of furniture and a different kind of mouse trap behind another piece of furniture.

Telephone interview with a family member on 11/15/23 at 3:40pm revealed:
-The facility was full of mice.
-A mouse was seen running down the hallway when they visited a family member in the facility.
-A resident told her that she was asleep in bed and woke up and found a mouse on her shoulder with droppings.

Interview with the Executive Director (ED) on 11/17/23 at 5:17pm revealed:
-She was aware there were mice in the building.
-The facility was an "old" building in the country.
-Mice glue traps had been placed in the facility.
-Mice baits had been placed around the building on the outside.

Telephone interview with the facility's primary care physician (PCP) on 11/17/23 at 11:42am revealed:
-She had observed mice in the facility on several occasions.
-She had informed a housekeeper, a PCA, and a MA on different occasions of her observations of mice in the facility.
-Residents were at risk of difficulties with sleep because mice were more active at night.
-Residents were at risk of increased anxiety from observations of mice.

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 50 The facility failed to provide the care and services to ensure Resident Rights were maintained related to bed bugs and mice being in the facility. Residents suffered from anxiety and lack of sleep as evidenced by sleeping in chairs in their rooms instead of their beds due to the fear of being bitten by bed bugs causing itching and scratching, the inconvenience of bed linens being constantly stripped off their beds and washed due to bed bugs, and personal clothing items being thrown away. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 11/17/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 01/01/24 .	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: Based on record reviews, and interviews, the facility failed to ensure the administration of a medication used to control high blood as ordered for 1 of 5 (#2) sampled residents.	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 11/17/2023

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 358	Continued From page 51 The findings are: Review of Resident #2's current FL-2 dated 10/05/23 revealed diagnosis included diabetes mellitus type 2. Review of Resident #2's Resident Register revealed an admission date of 09/22/23. Review of Resident #2's physician order dated 10/19/23 revealed an order for Humalog Insulin Kwik Pen 100/ml, give four additional units subcutaneous with scheduled dose at mealtimes if fingerstick blood sugar (FSBS) was equal to or greater than 350. (Humalog is a medication used to control high blood sugar). Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Insulin Kwik Pen 100/ml, give 4 additional units subcutaneous with scheduled dose as mealtimes if the FSBS is equal to or greater than 350 to be administered at 8:00am, 12:00pm, and 5:00pm. -There was documentation Humalog Insulin, four units were administered on 10/23/23 at 5:00pm for a FSBS of 329, 10/26/23 at 5:00pm for a FSBS of 314, 10/29/23 at 5:00pm for a FSBS of 279, and 10/30/23 at 8:00am for a FSBS on 279. -The additional four units of Humalog were administered four times in October 2023 when it should not have been per the ordered parameters because the FSBSs were less than 350. Review of Resident #2's November 2023 eMAR revealed: -There was an entry for Humalog Insulin Kwik Pen 100/ml, give 4 additional units subcutaneous	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 11/17/2023

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 358	Continued From page 52	D 358		

with scheduled dose as mealtimes if the FSBS is equal to or greater than 350 to be administered at 8:00am, 12:00pm, and 5:00pm.
-There was documentation Humalog four units were administered on 11/02/23 at 12:00pm for a FSBS of 329, 11/04/23 at 8:00am for a FSBS of 330, 11/05/23 at 12:00pm for a FSBS of 173, 11/06/23 at 12:00pm for a FSBS of 212, and 11/07/23 at 12:00pm for a FSBS of 278.
-The additional four units of Humalog insulin were administered five times in November 2023 when it should not have been per the ordered parameter because the FSBSs were less than 350.

Interview with the medication aide (MA) on 11/17/23 at 6:06pm revealed:
-She was aware of the order to give four additional units of Humalog insulin in addition to the scheduled order for Resident #2 if the FSBS was equal to or greater than 350.
-She administered Resident #2's medications.
-She probably was moving fast and clicked off on the eMAR that she administered the insulin by mistake when it was not administered.
-She needed to be more careful when documenting on the eMAR.

Interview with the Acting Resident Care Coordinator (RCC) on 11/17/23 at 2:54pm revealed:
-The MAs had been trained in the administration of insulin and following parameters.
-The FSBS parameters should be followed for the additional four units of insulin for Resident #2 as ordered.

Interview with the Executive Director (ED) on 11/17/23 at 1:55pm revealed:
-She was aware of Resident #2's FSBS running

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	HAL058010	A. BUILDING: _____ B. WING _____	R 11/17/2023

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 358	Continued From page 53 high. -The MAs understood the ordered parameters because they followed the order to administer the additional 4 units of the insulin if the resident's FSBS was more than 350 most of the time. -She was not sure why the ordered parameters were not followed. Telephone interview with Resident #2's Primary Care Provider (PCP) on 11/17/23 at 11:42am revealed: -Resident's #2's FSBS had been running high and she ordered the additional four units of Humalog insulin to stabilize and control the resident's high blood sugar. -Her concern with the administration of more insulin than ordered per the parameter would be the risk of the FSBS dropping too low. -The resident had a minimal risk of the FSBS dropping too low due to the additional four units being administered because her blood sugar tended to run high.	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 to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION	D 366		

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D 366	Continued From page 54 Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#5) was observed taking medication as evidenced by a controlled medication to treat anxiety being found in a nightstand drawer in a resident's room. The findings are: Review of Resident #5's current FL-2 dated 08/15/23 revealed: -Diagnoses included major neurocognitive disorder and mood disorder. -The resident's level of care was Assisted Living (AL). -There was no documentation of the resident's orientation. -There was an order for Lorazepam 1mg; take one tablet two times a day (Lorazepam is controlled substance used to treat anxiety). Review of Resident #5's facility record revealed the resident did not have a self-administration order for the Lorazepam. Observation of Resident #5's room on 11/15/23 at 10:05am revealed: -Resident #5 was sitting in his wheelchair beside his nightstand. -There was a three drawer nightstand by the resident's bed. -The second drawer of the nightstand had five white round tablets with an imprint of U33 on one side of the tablet. -The five white round tablets were scattered in the drawer. Interview with Resident #5 on 11/15/23 at 10:06am revealed:	D 366		

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D 366	Continued From page 55 -The medication aide (MA) left his medications in a cup on his nightstand some mornings. -He took his medication each day and did not remember how the pills got into his nightstand. Observation of Resident #5's medications on hand on 11/15/23 at 10:28am revealed: -There was a bubble packet that contained white round tablets with an imprint of U33 on one side of the tablet with a pharmacy label that identified the medication as Lorazepam. -There was a bubble packet of Lorazepam with a pharmacy label and instructions to administer one tablet twice a day. -There were 31 doses remaining in the bubble packet that was dispensed on 10/31/23. Interview with a MA on 11/15/23 at 10:31am revealed: -She stayed with a resident and observed residents take their medication when she administered medications to ensure they received their medications as ordered. -When she administered medications to a resident, she compared the electronic medication administration record (eMAR) with the medication order three times. -Medications should not be in Resident #5's nightstand drawer because he did not have an order to self-administer medications. -Residents in the facility were at risk of finding the medication in the resident's nightstand and taking the medication which could cause an adverse reaction and possibly make them sick. Telephone interview with Resident #5's primary care physician (PCP) on 11/16/23 at 11:35am revealed: -Resident #5 did not have an order to self administer medications.	D 366		

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D 366	Continued From page 56 -Resident #5 should not have medications in his nightstand drawer. -She expected MAs to observe residents take their medications and to document when medications were administered in the eMAR system. -Resident #5 and other residents were at risk of taking medication that was in the resident's nightstand drawer. -Medications should not be accessible to residents in the facility because the medication could cause harm to a resident if they took medication that was not prescribed for them. Interview with the Executive Director (ED) on 11/15/23 at 10:55am revealed: -MAs were expected to observe residents take their medications. -Resident #5 should not have medications in his nightstand drawer. -Other residents were at risk of taking the medication from his nightstand drawer, which could cause harm to a resident that was not prescribed the medication. _____ The facility failed to ensure medication aides observed a resident take their prescribed medications. A resident had five tablets in his nightstand drawer that were a controlled substance used to treat anxiety. The facility medication aides (MAs) failure to observe the resident take his medication placed Resident #5 at risk of not receiving his medication as ordered and placed other residents at the facility at risk of taking the medication. This failure was detrimental to the health and safety of Resident #5 and other residents who resided at the facility and constitutes a Type B Violation. _____ The facility provided a plan of protection in	D 366		

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D 366	Continued From page 57 accordance with G.S. 131 D-34 on 11/15/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 1, 2024.	D 366		