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	HAL058010	A. BUILDING: _____ B. WING _____	R 10/10/2024

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 10/08/24 to 10/10/24.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F in a resident's room and shared resident bathrooms on the assisted living unit (AL) with temperatures of 122.3 degrees F to 132.8 degrees F. The findings are: Review of the facility's environmental health inspection report dated 09/09/24 revealed: -There was a total of 3.5 deductions. -There were 1.5 deductions for hot water that was to be maintained between 105 degrees F and 116 degrees F. -There was documentation hot water was 138 degrees Fahrenheit in a spa sink on the AL unit; there was no indication if the temperature was on	D 113		

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D 113	Continued From page 1 the 100 hall spa or the 200 hall spa. Observation of the spa room #1 on the 100 hall on 10/08/24 at 9:48am revealed there was no hot water caution sign posted. Observation of the hot water temperatures in spa room #1 on the 100 hall on 10/08/24 at 9:48am revealed: -The hot water temperature in the sink was 129.7 degrees F. -The hot water temperature in the tub was 131.4 degrees F. Observation of the spa room #2 on the 100 hall on 10/08/24 at 9:48am revealed there was a signed posted on the wall beside the mirror over the sink that read, "Caution. Hot Water" Observation of the hot water temperatures in spa room #2 on the 100 hall on 10/08/24 at 9:48am revealed: -The hot water temperature in the sink was 129.3 degrees F. -The hot water temperature in the shower was 128.8 degrees F. Observation of the hot water temperatures in a shared resident bathroom in room 34 on the 100 hall on 10/08/24 revealed the hot water in the sink was 122.3 degrees F. Interview with the resident in room 34 on 10/08/24 at 10:02am revealed: -The hot water got too hot. -He could adjust the temperature with the cold water, but it could scald a person if they were not careful. Observation of the spa room #1 on the 200 hall	D 113		

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on 10/08/24 at 9:20am revealed there was no hot water caution sign posted.

Observation of the hot water temperatures in spa room #1 on the 200 hall on 10/08/24 at 9:21am revealed:
-The hot water temperature in the sink was 130.8 degrees F.
-The hot water temperature in the bathtub was 132.8 degrees F.
-The hot water temperature in the shower was 130.0 degrees F.

Observation of the spa room #2 on the 200 hall on 10/08/24 at 9:27am revealed there was a hot water caution posted on the mirror above the sink.

Observation of the spa room #2 on the 200 hall on 10/08/24 at 9:28am revealed the hot water temperature in the sink was 130.0 degrees F.

Interview with Executive Director (ED) on 10/08/24 at 3:30pm revealed she had contacted a plumber earlier on 10/08/24 to adjust the mixing valve for the hot water, the plumber was able to decrease the water temperature.

Observation of the water thermometers calibrated by the Executive Director (ED) and surveyor on 10/08/24 at 3:57pm revealed:
-The ED and surveyor's water thermometers were placed in a cup of ice water.
-The ED's water thermometer temperature was calibrated at 30 degrees F.
-The surveyors water thermometer temperature was calibrated at 32 degrees F.

Observation of the re-check of water temperatures with the ED and surveyor on

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D 113	Continued From page 3 10/08/24 from 4:05pm to 4:24pm revealed: -The hot water temperature of the sink in spa room #1 on the 100 hall was 115.4 degrees F with the surveyor thermometer and 116.0 degrees F with the facility thermometer at 4:05pm. -The hot water temperature of the bathtub in spa room #1 on the 100 hall was 116.4 degrees F with the surveyor thermometer and 116.0 degrees F with the facility thermometer at 4:07pm. -The hot water temperature of the sink in the spa room #2 on the 100 hall was 115.0 degrees F with the surveyor thermometer and 115.0 degrees F with the facility thermometer at 4:10pm. -The hot water temperature of the shower in the spa room #2 on the 100 hall was 114.6 degrees F with the surveyor thermometer and 114.0 degrees F with the facility thermometer at 4:12pm. -The hot water temperature of the sink in resident room 35 on the 100 hall was 111.0 degrees F with the surveyor thermometer and 111.0 degrees F with the facility thermometer at 4:15pm. -The hot water temperature of the sink in spa room #1 on the 200 hall was 115.4 degrees F with the surveyor thermometer and 115.4 degrees F with the facility thermometer at 4:18pm. -The hot water temperature of the bathtub in spa room #1 on the 200 hall was 114.3 degrees F with the surveyor thermometer and 114.0 degrees F with the facility thermometer at 4:20pm. -The hot water temperature of the shower in spa room #1 on the 200 hall was 114 degrees F with the surveyor thermometer and 113.0 degrees F with the facility thermometer at 4:22pm. -The hot water temperature of the sink in spa room #2 on the 200 hall was 114.2 degrees F with the surveyor thermometer and 114.0 degrees F with the facility thermometer at 4:24pm. Review of the facility's hot water temperature weekly inspection log revealed:	D 113		

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D 113	Continued From page 4 -Four fixtures accessible to residents were inspected on the east and west halls, (100 and 200) halls on 08/20/24 with all temperatures documented as 110 degrees F for 4 spa rooms. -Five fixtures accessible to residents were inspected on the east and west halls, (100 and 200 halls) on 09/03/24 with documentation temperatures ranged from 111 degrees F to 114 degrees F including 4 spa rooms and the salon. Review of invoices from the facility's contracted plumber revealed: -There was an invoice dated 10/10/24 with documentation they received an emergency call from the facility on 10/09/24 because the hot water was too hot. -On 10/10/24, they found that the mixing valve was not working enough to bring the temperature down; A mixing valve was ordered and was expected to be delivered on 10/11/24 and it would be installed as soon as possible after it was delivered. -The previous invoices were dated 04/10/24,04/14/24 and 2 invoices were dated 06/24/24 with documentation the calls were for leaks and to replace a tankless water heater. Telephone interview with a regulator with environmental health inspector from the local health department on 10/10/24 at 10:50am revealed: -She completed a facility inspection at the facility on 09/09/24. -There was documentation that a spa sink on the AL unit was at 138 degrees F. -She reviewed the risks of hot water temperatures with the ED and the Business Office Manager (BOM). -She provided education to the ED and the BOM on the risks of severe burns due water	D 113		

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D 113	Continued From page 5 temperatures that were too high. Interview with maintenance staff on 10/10/24 at 8:12am revealed: -He only worked 3 days each week and was not always made aware of maintenance issues at the facility. -He found out from a plumber on 10/09/24 that the mixing valve for the hot water was faulty and a part was ordered. -The last hot water temperatures he had taken were on 09/11/24. -He never calibrated the thermometer he used to check water temperatures. Telephone interview with the facility's contracted primary care provider (PCP) on 10/10/24 at 10:36am revealed: -Increased water temperatures created a potential for burns ranging from redness to blisters depending on the severity of the burn. -Diabetic neuropathy and paralysis from a stroke could impact pain receptors in some people to not react to increased water temperatures. -As residents age, their ability to perceive how hot water temperatures can be decreased placing them at a risk of burns from water temperatures that are too hot. Interview with the Administrator on 10/08/24 at 12:02pm revealed: -The hot water temperatures were elevated when environmental health conducted their inspection on 09/09/24 and the home office sent someone to adjust the water temperature at that time. -She was not sure when the hot water temperatures were checked following the adjustment. -Maintenance staff checked random fixtures on a certain hall each week, so all halls were checked	D 113		

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D 113	Continued From page 6 monthly. -She last reviewed the hot water temperature log in August 2024. -She relied on the maintenance staff to let her know when there was a problem. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed: -First degree burns were burns that did not cause irreversible damage and second degree burns were a full thickness injury. -Hot water temperatures at 125.6 degrees F could cause first degree burns in 45 seconds and second degree burns in 1.5 minutes. -Hot water temperatures at 127.4 degrees F could cause first degree burns in 30 seconds and second degree burns in 60 seconds. -Hot water temperatures at 131 degrees F could cause first degree burns in 17 seconds and second degree burns in 30 seconds. _____ The facility failed to ensure hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees (F) on the assisted living (AL) unit which resulted in hot water temperatures from 122.3 degrees F to 132.8 degrees F at 9 of 11 fixtures accessible on AL unit, which placed the residents at risk of full thickness burns to the skin within seconds of exposure. 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 protection in accordance with G.S. 131D-34 on 10/08/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER	D 113		

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D 113	Continued From page 7 24, 2024.	D 113		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #4's current FL-2 dated 10/08/24 revealed: -Diagnoses included dementia, essential hypertension, hyperlipidemia, weakness and failure to thrive. -Her level of care was special care unit (SCU). Review of Resident #4's Resident Register revealed she was admitted to the facility on	D 234		

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D 234	Continued From page 8 04/14/21 from her residence.. Review of Resident #4's record for a tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test administered on 03/19/21 to the left forearm and read as negative on 03/22/21. -There was no documentation of a second TB skin test for Resident #4. Documentation of a second TB skin test for Resident #4 was requested on 10/09/24 at 9:54am and not provided. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Interview with the Special Care Unit Coordinator (SCUC) on 10/10/24 at 8:42am revealed: -She or the Executive Director (ED) were responsible to make sure each resident had a two-step TB skin test. -She had been the SCUC since October 2023. -She and the ED performed chart audits for the residents. -Chart audits include making sure the residents' FL2s, care plans, quarterly reviews, physicians order sheet, and resident contact information were up to date. Interview with the Business Office Manager (BOM) on 10/10/24 at 2:33pm revealed: -She was not responsible for tracking TB skin tests for the residents. -If she was given a copy of a residents' TB skin test, she kept them on file. -She did not have a copy of a second TB skin test for Resident #4.	D 234		

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D 234	Continued From page 9 Interview with the ED on 10/10/24 at 2:03pm revealed: -It was a combined effort of the care managers, herself and the BOM to make sure the residents had a two-step TB skin test. -The BOM kept a copy of the residents' TB skin test on file and a copy was kept in the residents' record. -She and the SCUC performed chart audits at least quarterly. -Chart audits included reviewing for new orders, referrals and follow-up appointments, lab work, pharmacy review and recommendations, making sure care plans and physicians orders, standing orders, and diet orders were up to date. -She only reviewed TB skin tests for new admissions. -She did not review established residents' records for TB skin because she assumed that was a one-time task completed upon admission to the facility. -She was not the ED when Resident #4 was admitted to the facility. -She was ultimately responsible to make sure each resident had a two-step TB skin test. -She was not sure why Resident #4 did not have a second TB skin test when she was admitted to the facility.	D 234		
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	D 358		

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D 358	Continued From page 10 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#5, #6) observed during the medication pass including errors with a rapid-acting insulin used to treat diabetes (#5) and a medication for arthritic pain (#6) and for 1 of 5 sampled residents (#5) pertaining to a medication used to treat high blood pressure. The findings are: Review of the facility's undated medication administration policy revealed: -Medications, prescriptions and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Documentation will be provided for each dose of medication by the staff who prepared the medications for administration. -Documentation will be provided by staff who administered the medications and performed the treatments to the residents on the facility's electronic medication administration record (eMAR). -Staff will provide documentation on the eMAR after observing the resident taking the medication and before administration to another resident. -The eMAR will include the resident's name, the name of the medication and/or treatment to be performed, strength, dosage or quantity of the medication, instructions for administering the medication or performing the treatment, date and time of administration, or date and time when treatment was performed, the name and initials of	D 358		

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the person administering the medication or performing the treatment.
-Omissions and refusals of medications or treatments and the reason for omissions will be documented on the eMAR.

Review of a Medication Administration Training and employee sign-in sheet provided by the facility dated 08/09/24 revealed:
-Insulin administration; typically, one unit of insulin drops the blood glucose by approximately 50mg/dl, this drop in blood sugar can range from 30-100mg/dl or more, depending on individual insulin sensitivities and other circumstances.
-Rapid acting insulin should be given within 15-30 minutes of meals.
-Right Documentation; signing off the eMAR when medication is administered, must be done immediately after medication is administered, if a resident refused or was not available, this should be documented, and the provider should be notified.
-Six rights of medication administration, right patient, right medication, right route, right time, right dose and right documentation.

1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 33 opportunities during the 8:00am and 11:30am medication pass on 10/08/24 and the 8:00am medication pass on 10/09/24.

a. Review of Resident #5's current FL-2 dated 01/04/24 revealed:
-Diagnoses included vascular dementia, anxiety disorder, type II diabetes mellitus, and hypertension.
-Her level of care was Special Care Unit (SCU).

Review of Resident #5's Resident Register

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revealed an admission date of 01/11/23.

Review of Resident #5's physicians orders dated 06/27/24 revealed:
-There was an order to check finger stick blood sugar (FSBS) before meals and at bedtime.
-There was an order for Novolog Flexpen (Novolog is a rapid-acting insulin used to treat elevated blood sugar) 100units/ml, inject 11 units three times a day with meals (prime pen with 2 units prior to each use).

Review of a subsequent physician's order for Resident #5 dated 08/29/24 revealed to decrease the scheduled Novolog to 9 units three times a day with meals.

Observation of the 12:00pm medication pass on 10/08/24 revealed:
-The medication aide performed a FSBS on Resident #5 and her blood sugar was 190 at 11:29am.
-The MA placed a needle on the Novolog Kwikpen and dialed the dose to 2 units and performed a 2-unit air shot.
-The MA then dialed the Novolog Kwikpen to 9 units and injected Novolog into the resident's left upper arm at 11:34am and withdrew the needle after 6 seconds.
-The resident was not offered a snack.

Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS before meals and at bedtime, scheduled for 7:00am, 11:30am, 5:00pm and 8:00pm.
-The resident's blood sugar ranged from 91 to 319 from 10/01/24 to 10/08/24.
-There was an entry for Novolog Flexpen

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100mg/100 unit/ml, inject 9 units three times a day with meals, scheduled at 7:30am, 12:00pm, and 5:30pm.
-Novolog Flexpen 100units/ml, 9 units was documented as administered at 7:30am on on 10/01/24 through 10/08/24, at 12:00pm on 10/01/24 through 10/08/24 and at 5:30pm on 10/01/24 through 10/07/24.

Interview with Resident #5 on 10/08/24 at 11:40am revealed:
-The facility had a scheduled outing for lunch today and she was attending.
-They were scheduled to leave at 11:30am but the transporter was running behind.
-She was not sure where they were going for the lunch outing.
-Her blood sugar usually ran high and very rarely ran low.
-She could tell if her blood sugar ran low by feeling like she needed to lay down.
-She denied feeling like she needed to lie down.

Observation of the SCU on 10/08/24 from 11:51am to 12:01pm revealed:
-Resident #5 was with two other SCU residents and a staff waiting to be picked up for the lunch outing.
-The lunch meal was brought in for the SCU residents except for the residents that were attending the lunch outing.
-Resident #5 was not offered or given a snack.

Interview with the MA on 10/08/24 at 12:01pm revealed:
-If a medication was ordered to be given with a meal, it should be administered within 30 minutes of the meal.
-Rapid-acting insulin should be administered within 30 minutes of a meal to prevent the blood

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sugar from dropping too low.
-Snacks were only offered to the residents during the scheduled snack times of 10:00am and 2:00pm for day shift in the SCU.
-She was not sure when the residents attending the lunch outing were leaving for lunch or how far they were going.
-It did not occur to her to offer Resident #5 a snack since her lunch was delayed due to the outing.
-At 12:06pm, she asked one of the personal care aides (PCAs) to obtain a snack from the kitchen for Resident #5 after being prompted by the surveyor.

Observations revealed Resident #5 was provided with a package of 2 oatmeal cookies at 12:09pm and left the SCU, escorted by a staff member for the lunch outing at 12:19pm and the transport van for the outing remained in the facility parking lot at 12:30pm.

Interview with the Special Care Unit Coordinator (SCUC) on 10/10/24 at 10:13am revealed:
-Medications ordered to be given with meals should be administered within 30 minutes of the meal.
-Fast acting insulin should not be given too soon prior to a meal, to prevent the blood sugar from dropping too low.
-Fast-acting insulin should be administered within 30 minutes of a meal.
-If insulin was administered and a meal was delayed, then a snack should be offered.

Interview with the Executive Director (ED) on 10/10/24 at 2:30pm revealed:
-Rapid-acting insulin should be administered within 15 to 30 minutes of a meal.
-Ideally Resident #5 should have received her

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insulin just prior to leaving for the lunch outing as these are usually local but this outing was about 40 minutes away and they were late leaving.
-Resident #5 should have been given a sandwich or a snack of some kind after the Novolog was administered.
-There was not a process in place for insulin administration when the residents went out for meal outings.

Interview with Resident #5's primary care provider (PCP) on 10/10/24 at 10:37am revealed:
-She prescribed Novolog for Resident #5 for diabetes.
-Ideally, Novolog should be administered within 30 minutes of a meal.
-If Novolog was administered too far in advance of a meal, Resident #5's blood sugar could drop too low.
-A mild drop in blood sugar could cause fatigue, lethargy and altered mental status.
-A severe drop in blood sugar could cause unresponsiveness, coma or ultimately death.
-If rapid-acting insulin was administered and there was a delay in the meal being served, then a snack should be offered.

b. Review of Resident #6's current FL-2 dated 02/29/24 revealed diagnoses included hypertension, gout and edema of the lower extremities.

Review of Resident #6's physician's order dated 07/16/24 revealed diclofenac gel 1%, 1 Gm was to be applied to the right hand twice a day. (Diclofenac gel 1% is a medication used to relieve pain.)

Observation of the 8:00am medication administration pass on 10/08/24 from 8:27am to

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D 358	Continued From page 16 8:00am revealed: -The medication aide (MA) administered 18 tablets my mouth at 8:37 and 1 intranasal spray at 8:45am to Resident #6. -Diclofenac gel 1% was not administered to Resident #6. Review of Resident #6's electronic medication administration record for October 2024 revealed: -There was a computerized entry for diclofenac gel 1%, 1 Gm to be administered to the right hand twice a day and scheduled for 8:00am and 8:00pm. -There was documentation diclofenac gel 1%, 1 Gm was administered at 8:00am on 10/08/24. Observation of medications on hand for Resident #6 on 10/08/24 at 11:25am revealed diclofenac gel 1% was available for administration. Interview with Resident #6 on 10/08/24 at 12:20pm revealed: -He received diclofenac for pain related to arthritis. -His pain level was currently a 1-2. -Diclofenac was not applied to his hand that morning but it was administered the previous evening. Interview with the MA on 10/08/24 at 11:25am revealed: -She did not administer diclofenac gel 1% to Resident #6 that morning because the MA on the previous shift reported to her that it had already been administered. -The previous MA told her the reason the diclofenac gel was administered was because Resident #6 complained that his hand was hurting.	D 358		

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D 358	Continued From page 17 Second interview with the MA on 10/09/24 at 2:15pm revealed: -She did not observe diclofenac gel 1% to be administered to Resident #6 on 10/08/24 by the MA on the previous shift so she could not be sure the medication was actually administered. -She documented the administration of the diclofenac gel 1% at 8:00am on 10/08/24 when she was documenting the administration of the other medications scheduled for 8:00am because she was used to administering the medication to Resident #6. Telephone interview with a second MA on 10/10/24 at 8:45am revealed: -She left duty just after 7:00am on 10/08/24 when the oncoming MA relieved her. -Resident #6 was scheduled to receive diclofenac gel 1% at 8:00am which was administered by the day shift staff. -She did not administer diclofenac gel 1% to Resident #6 on 10/08/24. Telephone interview with Resident #6's primary care provider (PCP) on 10/10/24 at 10:36am revealed: -Resident #6 was prescribed diclofenac gel for arthritis pain in his hands. -Resident #6 could experience pain and stiffness in his hands if the medication was not administered as ordered. Interview with the Administrator on 10/10/24 at 1:48pm revealed medications should be administered as prescribed to effectively treat the condition it was prescribed for. 2. Review of Resident #5's current FL-2 dated 01/04/24 revealed: -Diagnoses included vascular dementia, anxiety	D 358		

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D 358	Continued From page 18 disorder, type II diabetes mellitus, and hypertension. -Her level of care was Special Care Unit (SCU). Review of Resident #5's Resident Register revealed an admission date of 01/11/23. Review of Resident #5's signed physicians order sheet dated 06/27/24 revealed an order for carvedilol 6.25mg (carvedilol is used to treat high blood pressure) take one tablet every 12 hours for hypertension. Review of a signed Physician's Consultation Report dated 08/29/24 revealed an order to increase Resident #5's carvedilol from 6.25mg to 12.5mg twice per day. Review of Resident #5's August 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Carvedilol 6.25mg take one tablet every 12 hours for hypertension, scheduled at 8:00am and 8:00pm. -Carvedilol 6.25mg was documented as administered at 8:00am on 08/01/24 through 08/07/24. -Carvedilol 6.25mg was documented as not administered at 8:00am on 08/08/24 with the exception documented as "patient refused medication". -Carvedilol 6.25mg was documented as administered at 8:00am on 08/09/24 through 08/29/24. -Carvedilol 6.25mg was documented as administered at 8:00pm on 08/01/24 through 08/29/24. -There was an entry for Carvedilol 12.5mg, take one tablet twice a day with an order date of 08/29/24.	D 358		

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D 358	Continued From page 19 -Carvedilol 12.5mg was documented administered at 8:00am and 8:00pm on 08/30/24 and 08/31/24. Review of Resident #5's September 2024 eMAR revealed: -There was an entry for Carvedilol 12.5mg, take one tablet twice per day scheduled at 8:00am and 8:00pm. -Carvedilol 12.5mg was documented as administered at 8:00am on 09/01/24 through 09/08/24. -Carvedilol 12.5mg was documented as not administered at 8:00am on 09/09/24, 09/10/24, and 09/11/24 with the exception documented as "refill requested". -Carvedilol 12.5mg was documented as administered at 8:00am on 09/12/24 and 09/13/24. -Carvedilol 12.5mg was documented as not administered at 8:00am on 09/14/24 and 09/15/24 with the exception documented as "refill requested". -Carvedilol 12.5mg was documented as not administered at 8:00am on 09/16/24 with the exception documented as "patient refused medication". -Carvedilol 12.5mg was documented as not administered at 8:00am on 09/17/24 with the exception documented as "refill requested". -Carvedilol 12.5mg was documented as administered at 8:00am on 09/18/24. -Carvedilol 12.5mg was documented as not administered at 8:00am on 09/19/24 with the exception documented as "patient refused medication". -Carvedilol 12.5mg was documented as not administered at 8:00am on 09/20/24 with the exception documented as "refill requested". -Carvedilol 12.5mg was documented as	D 358		

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D 358	Continued From page 20 administered at 8:00pm on 09/01/24 through 09/30/24. Telephone interview with a representative from the facility's contracted pharmacy provider on 10/09/24 at 2:20pm revealed: -An order was received on 08/29/24 for Resident #5 to increase carvedilol from 6.25mg twice daily to 12.5mg twice a day. -Carvedilol 12.5mg was dispensed for Resident #5 on 08/29/24 for a quantity of 14 tablets for a 7-day supply to take 1 tablet twice per day. -Carvedilol 12.5mg was dispensed for Resident #5 on 8/30/24 for a quantity of 56 tablets for a 28-day supply to take one tablet twice per day to start on 09/05/24. -A carvedilol 12.5mg refill was requested for Resident #5 from the facility on 09/25/24 through the eMAR system and quantity of 12 tablets for a 6-day supply to take twice per day was sent on 09/27/24. -Carvedilol 12.5mg was dispense for Resident #5 on 09/30/24 for a quantity of 56 tablets for a 28-day supply to take twice per day to start on 10/03/24. Observation of Resident #5's medication on hand on 10/09/24 at 2:11pm revealed: -There were 2 bubble cards of carvedilol 12.5mg tablets, dispensed on 10/03/24 for a quantity of 56 tablets. -The first bubble card had 15 carvedilol 12.5mg tablets remaining, to take one tablet twice per day. -The second bubble card had 28 carvedilol 12.5mg tablets remaining, to take one tablet twice per day. Interview with the medication aide (MA) on 10/10/24 at 9:35am revealed:	D 358		

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D 358	Continued From page 21 -The MAs could request refills for the residents electronically through the eMAR system. -The facility automatically received batch-filled medications from the facility's contracted pharmacy every 28 days. -Medications were to be re-ordered for the residents, when there was about 5 days remaining on the medication card. -She did not have a medication card for Resident #5's carvedilol 12.5mg in part of September 2024. -She requested a carvedilol 12.5mg refill for Resident #5 in September 2024 when she could not locate it on the medication cart. -If medication refills were requested from the pharmacy before 2:00pm, they were delivered on the night shift and the night shift MA placed the medication on the medication cart, if the request was after 2:00pm, it would be the next day before it arrived. -If the medication did not arrive by the next day, she contacted the pharmacy by phone about the refill. -She thought she contacted the pharmacy around 11:00am on the first day that she could not find carvedilol 12.5mg on the medication cart for Resident #5. -She waited about 2 days for Resident #5's carvedilol 12.5mg refill and called the pharmacy and the pharmacy did not answer. -If she had trouble getting a medication refill for a resident, she usually notified the Special Care Unit Coordinator (SCUC), but she did not notify the SCUC about not having Carvedilol 12.5mg available for Resident #5 and was not sure why she had not notified the SCUC. -She could not explain why Resident #5's carvedilol 12.5mg was available for the 8:00pm dose for the month of September 2024 or why it was available at 8:00am on 09/11/24 and 09/12/24.	D 358		

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D 358	Continued From page 22 Interview with the SCUC on 10/10/24 at 9:51am revealed: -The residents' medications were batch filled by the facility's contracted pharmacy every 28 days except for eye-drops, ear drops, creams, topical's, inhalers and as needed medications. -Medications could be requested electronically, via fax or phone call by the MAs. -Medications requested before 2:00pm came to the facility that night and were placed on the medication cart by the night shift MA, medications requested after 2:00pm came the following day. -If the requested medication did not arrive the next day, the MAs were to call the pharmacy about the refill or notify her and she would call the pharmacy. -She was not aware Resident #5 did not receive her morning carvedilol 12.5mg on nine occasions in September 2024. -If a resident had extra stock of medication on the medication cart, the extra medication card was turned backward in the resident's drawer of the medication cart until the first card was used. -She should have been notified by the MA when the Resident #5 missed her first dose of carvedilol 12.5mg and when the carvedilol 12.5mg could not be found on the cart. -She was not sure why Resident #5's carvedilol 12.5mg was available for all the 8:00pm doses and not for all the 8:00am doses in September 2024. -She could not explain why carvedilol 12.5mg was documented as not available for Resident #5 in September 2024 when the pharmacy's dispensing records indicated carvedilol 12.5mg was supplied for Resident #5. -It was possible the MA overlooked the carvedilol 12.5mg medication card on the medication cart. -Medication cart audits were performed monthly	D 358		

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by herself or one of the other lead MAs.
-Medication cart audits included, checking for expired or discontinued medications, and making sure medications were available for administration,
-The eMARs were compared to the medications on the medication cart during the monthly medication cart audit.
-The eMARs were reviewed for gaps and missed doses of medication.
-She thought the last medication cart audit was last week, and it was an oversight that the omissions for Resident #5's carvedilol were not identified in September 2024.
-She should have been notified when the MA could not locate the carvedilol 12.5mg for Resident #5.
-Resident #5's primary care provider should have been notified when Resident #5 missed the first dose of carvedilol 12.5mg.
-She expected the residents to receive their medications as ordered.

Interview with the Executive Director (ED) on 10/10/24 at 2:03pm revealed:
-The MAs were responsible for requesting medication refills for the residents.
-Medication refills were requested electronically, by fax, or phone.
-The residents' medication should be requested at least three days in advance to prevent being without.
-If a requested medication was not received by the next day, the MA contacted the pharmacy via telephone to see what the problem was.
-Most of the residents' medications were automatically batch-filed every 28 days.
-The MA should have notified the SCUC when the carvedilol 12.5mg was not available for Resident #5.

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D 358	Continued From page 24 -Resident #5's primary care physician (PCP) should have been notified after the first missed dose of carvedilol 12.5mg. -She could not explain why Resident #5's carvedilol 12.5mg was documented as available for all the 8:00pm doses but not for all the 8:00am doses in September 2024. -She could not explain why carvedilol 12.5mg was documented as not available for Resident #5 in September 2024 when the pharmacy's dispensing records indicated carvedilol 12.5mg was supplied for Resident #5. Interview with Resident #5's PCP on 10/10/24 at 10:37am revealed: -She prescribed carvedilol for Resident #5 for hypertension. -She increased Resident #5's carvedilol from 6.25mg to 12.5mg twice a day in late August 2024 because her blood pressure was elevated. -She had not been notified that Resident #5 had missed nine doses of carvedilol 12.5mg in September 2024. -The missed doses of carvedilol could cause Resident #5's blood pressure to be elevated. -Mildly elevated blood pressure could cause headaches and dizziness. -Severely elevated blood pressure could possibly result in stroke and/or brain hemorrhage. -She expected to be notified after two missed doses of the carvedilol. -She expected Resident #5's medications to be administered as ordered.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 25 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 4 residents (#6) observed during the medication pass related to a medication used to control pain (#6). The findings are: Review of Resident #6's current FL-2 dated 02/29/24 revealed diagnoses included hypertension, gout and edema of the lower extremities. Review of Resident #6's physician's order dated 07/16/24 revealed diclofenac gel 1%, 1 Gm was to be applied to the right hand twice a day.	D 367		

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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 367	Continued From page 26 Observation of the 8:00am medication administration pass on 10/08/24 from 8:27am to 8:00am revealed diclofenac gel 1% was not administered to Resident #6. Review of Resident #6's electronic medication administration record for October 2024 revealed: -There was a computerized entry for diclofenac gel 1%, 1 Gm to be administered to the right hand twice a day and scheduled for 8:00am and 8:00pm. -There was documentation diclofenac gel 1%, 1 Gm was administered at 8:00am on 10/08/24. Observation of medications on hand for Resident #6 on 10/08/24 at 11:25am revealed diclofenac gel 1% was available for administration. Interview with Resident #6 on 10/08/24 at 12:20pm revealed: -He received diclofenac for pain related to arthritis. -His pain level was currently a 1-2. -Diclofenac was not applied to his hand that morning but it was administered the previous evening. Interview with the medication aide (MA) on 10/08/24 at 11:25am revealed: -She did not administer diclofenac gel 1% to Resident #6 that morning because the MA on the previous shift reported to her that it had already been administered. -The previous MA told her the reason the diclofenac gel was administered was because Resident #6 complained that his hand was hurting. Second interview with the MA on 10/09/24 at 2:15pm revealed:	D 367		

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D 367	Continued From page 27 -She did not observe diclofenac gel 1% to be administered to Resident #6 on 10/08/24 by the MA on the previous shift so she could not be sure the medication was actually administered. -She documented the administration of the diclofenac gel 1% at 8:00am on 10/08/24 when she was documenting the administration of the other medications scheduled for 8:00am because she was used to administering the medication to Resident #6. Telephone with a second MA on 10/10/24 at 8:45am revealed: -She left duty just after 7:00am on 10/08/24 when the oncoming MA relieved her. -Resident #6 was scheduled to receive diclofenac gel 1% at 8:00am which was administered by the day shift staff. -She did not administer diclofenac gel 1% to Resident #6 on 10/08/24. Telephone interview with Resident #6's primary care provider (PCP) on 10/10/24 at 10:36am revealed the eMAR needed to accurately reflect medication administration because she may increase dosage or change a medication based on whether or not the medication was administered. Interview with the Administrator on 10/10/24 at 1:48pm revealed: -Providers reviewed the eMAR when making decisions about a resident's treatment. -Providers needed to know if a medication is administered or not administered especially when comparing medications with laboratory results.	D 367		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit	D 463		

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D 463	Continued From page 28 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled residents (#4) residing in the Special Care Unit (SCU) had a pre-admission screening for appropriate placement. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 122 residents with a Special Care Unit (SCU) capacity of 50 residents. Review of the facility's census on 10/08/24 revealed there were 15 residents in the SCU.	D 463		

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D 463	Continued From page 29 Review of Resident #4's current FL-2 dated 10/08/24 revealed: -Diagnoses included dementia, essential hypertension, hyperlipidemia, weakness and failure to thrive. -Her level of care was SCU. Review of Resident #4's Resident Register revealed an admission date of 04/14/21. Documentation of a pre-screening assessment for Resident #4 was requested on 10/09/24 at 9:54am and not provided. Interview with the Special Care Unit Coordinator (SCUC) on 10/10/24 at 8:42am revealed: -She had been in the role of the SCUC since October 2023. -The Executive Director (ED) was responsible to make sure the SCU residents had a pre-screening assessment. Interview with the Business Office Manager (BOM) on 10/10/24 at 2:33pm revealed: -She was not responsible for tracking pre-admission screenings for the SCU residents. -If she was given a copy of the residents' pre-admission screening, she kept them on file. -She did not have a copy of a pre-admission screening for Resident #4. Interview with the ED on 10/10/24 at 2:03pm revealed: -It was her responsibility to review all admission paperwork, which included the pre-admission screening for the residents to ensure they were appropriate for admission to the facility's SCU. -The BOM kept a copy of the residents' pre-admission screening on file and a copy was	D 463		

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D 463	Continued From page 30 kept in the residents' record. -She and the SCUC performed chart audits at least quarterly. -Chart audits included reviewing for new orders, referrals and follow-up appointments, lab work, pharmacy review and recommendations, making sure care plans, physicians orders, standing orders, and diet orders were up to date. -She only reviewed pre-admission screening for new admissions. -She did not review established SCU residents' records for pre-admission screening because she assumed that was a one-time task completed upon admission to the facility. -She was not the ED when Resident #4 was admitted to the facility's SCU. -In the past, the facility had a Marketer that completed the pre-admission screening for residents seeking admission to the SCU. -She was ultimately responsible to make sure each SCU resident had a pre-admission screening. -She was not sure why Resident #4 did not have a pre-admission screening on file when she was admitted to the facility's SCU.	D 463		