

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

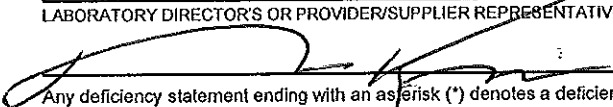
PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <i>AUG 09 2011</i>	(X3) DATE SURVEY COMPLETED 07/14/2011
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NAME OF PROVIDER OR SUPPLIER QUAIL HAVEN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BLVD PINEHURST, NC 28374
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F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of employee files and staff interview the facility failed to provide abuse and neglect training during initial orientation for 5 of 5 reviewed employee files. (Employee #1, 2, 3, 4, & 5)</p> <p>Findings include:</p> <p>The facility policy for preventing and detecting resident abuse, neglect and misappropriation of property prevention program revised 8/05 was reviewed. The section of the policy titled 'identification of potentially aggressive/abusive resident and prevention interventions' listed under interventions to avoid situations which might promote aggressive behavior or abuse was "Staff is education during orientation and at periodic in-services on resident rights, resident abuse, how to identify events or situations which might constitute abuse as well as how to report any behavior that they witness that they believe is abuse, neglect or misappropriation of property, without fear of reprisal."</p> <p>1. Employee #1 was hired as a nurse on 4/21/11. A review of the employee filed revealed orientation which included abuse and neglect training was on 4/26/11. Employee #1 started</p>	F 226	<p>Corrective Action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1. All new employees will receive training on facility policies and procedures regarding Mistreatment, Abuse, Neglect and Misappropriation of property before starting work in any Department.</p> <p>Corrective Action will be accomplished for those residents having potential to be affected by the deficient practice.</p> <p>Each new employees will be trained on:</p> <ol style="list-style-type: none"> 1. Definitions of abuse, neglect and misappropriation of resident's property. 2. Reporting requirements regarding allegations of abuse, without fear of reprisals from any other individual whether they are staff, management, residents or visitors. 3. Prevention and detection of abuse/neglect. 4. Appropriate interventions to use to when dealing with aggressive residents. 5. Recognition of and appropriate interventions for burnout, frustration and stress that could lead to reactions resulting in abusive situations. In-services are scheduled for 08/09/11 and 08/11/11. 	8/11/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 5 Aug 2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1 working on the floor with residents on 4/21/11.</p> <p>An interview with the Human Resource person on 7/14/11 at 8:43am revealed she does a small orientation with employees at the time of hire, however it does not include abuse and neglect training. The mini orientation includes orientation to work schedule, time clock and HIPA laws, "I do have the employees sign the form that they received training and information about resident rights." The HR staff stated "I used to do all the orientation at the time of hire which included abuse and neglect but it changed a awhile back." Orientation that includes the abuse and neglect training was scheduled for the 3rd Tuesday of every month.</p> <p>2. Employee #2 was hired as a nurses aide on 5/31/11. A review of the employee filed revealed orientation which included abuse and neglect training was on 6/12/11. Employee #2 started working on the floor with residents on 6/1/11.</p> <p>An interview with the Human Resource person on 7/14/11 at 8:43am revealed she does a small orientation with employees at the time of hire, however it does not include abuse and neglect training. The mini orientation includes orientation to work schedule, time clock and HIPA laws, "I do have the employees sign the form that they received training and information about resident rights." The HR staff stated "I used to do all the orientation at the time of hire which included abuse and neglect but it changed a awhile back." Orientation that includes the abuse and neglect training was scheduled for the 3rd Tuesday of every month.</p>	F 226	<p>Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <ol style="list-style-type: none"> 1. Abuse/Neglect Policy & Procedure was revised to include in Training Policy: All new employees will receive training on Abuse, Neglect, and Misappropriation of Resident Property before starting work in any Department. 07/28/11 (In Place) 2. All new employees will be given a copy of the Abuse/Neglect policy and will be required to sign a statement of receipt and understanding. 2. All current employees attend mandatory annual training on Abuse /Neglect and more often as determined by the facility and will be required to sign a statement of receipt and understanding. 3. This action will ensure that no employee hired at Quail Haven Village has a history of any abuse/neglect allegations by following policy and procedure that all prospective employees will undergo a background screening check for evidence of abuse allegations/convictions as required by law. 4. Social Services Director has sent E-mail to Ombudsman for Education In-service to be scheduled 08/04/11. 		

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F 226	<p>Continued From page 2</p> <p>3. Employee #3 was hired as a nurses aide on 2/28/11. A review of the employee filed revealed orientation which included abuse and neglect training was on 3/17/11. Employee #3 started working on the floor with residents on 2/28/11.</p> <p>An interview with the Human Resource person on 7/14/11 at 8:43am revealed she does a small orientation with employees at the time of hire, however it does not include abuse and neglect training. The mini orientation includes orientation to work schedule, time clock and HIPA laws, "I do have the employees sign the form that they received training and information about resident rights." The HR staff stated "I used to do all the orientation at the time of hire which included abuse and neglect but it changed a awhile back." Orientation that includes the abuse and neglect training was scheduled for the 3rd Tuesday of every month.</p> <p>4. Employee #4 was hired as a nurses aide on 2/28/11. A review of the employee filed revealed orientation which included abuse and neglect training was on 3/15/11. Employee #4 started working on the floor with residents on 3/3/11.</p> <p>An interview with the Human Resource person on 7/14/11 at 8:43am revealed she does a small orientation with employees at the time of hire, however it does not include abuse and neglect training. The mini orientation includes orientation to work schedule, time clock and HIPA laws, "I do have the employees sign the form that they received training and information about resident rights." The HR staff stated "I used to do all the orientation at the time of hire which included abuse and neglect but it changed a awhile back."</p>	F 226	<p>The facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The Human Resource Director will monitor all new employee files to ensure that the employee received training on Abuse/Neglect, Misappropriation of Property prior to starting work. Perform audits to verify that each new employee file has receipt of Abuse & Neglect Acknowledgment Form initially & annually. Audit tool in place. 08/04/11</p> <p>The PoC is integrated into the quality assurance system of the facility. The Human Resource Director audits will be integrated into the QA system . Monitoring will include the # of new employees hired for each month to verify that abuse and neglect training occurred and was in place before the employee went to work on the floor. Audits will also include those employees who received Abuse/Neglect training during annual orientation to verify that they received a copy of the abuse policy and that they have signed a statement of receipt and understanding.</p>		

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F 226	Continued From page 3 Orientation that includes the abuse and neglect training was scheduled for the 3rd Tuesday of every month. 5. Employee #5 was hired as a nurse on 1/5/11. A review of the employee filed revealed orientation which included abuse and neglect training was on 1/18/11. Employee #5 started working on the floor with residents on 1/10/11. An interview with the Human Resource person on 7/14/11 at 8:43am revealed she does a small orientation with employees at the time of hire, however it does not include abuse and neglect training. The mini orientation includes orientation to work schedule, time clock and HIPA laws, "I do have the employees sign the form that they received training and information about resident rights." The HR staff stated "I used to do all the orientation at the time of hire which included abuse and neglect but it changed a awhile back." Orientation that includes the abuse and neglect training was scheduled for the 3rd Tuesday of every month.	F 226	The plan must be implemented and the corrective actions evaluated for its effectiveness. The Human Resource Director will report monthly audit findings to Quality Assurance Coordinator who will review audits and forward findings to the Quality Assurance and Assessment committee on a quarterly basis. Corrective action will be completed. In-services are scheduled for Abuse & Neglect Training for all staff on 08/09/11 and 08/11/11.		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412	Corrective Action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 4 Approval & consent for to participate in Oral Care Program obtained from Responsible Party for Resident # 4 on 07/28/11. Dental Appointment is scheduled with Dr. Alexander on 08/05/11.	8/11/11	

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F 412	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to follow-up on and provide annual dental exams of a resident with several missing and/or chipped teeth for 1 of 1 sampled resident with dental problems. (Resident #4).</p> <p>Findings included:</p> <p>Resident #4 was admitted to the facility on 8/22/09 with diagnoses which included: dementia, failure to thrive, congestive heart failure with dysfunction, hypertension; and, gout.</p> <p>A review of the clinical records documented Resident #4's last dental exam provided by the facility was on 11/6/09. The results of the exam revealed the resident had generalized cervical decay with many anterior teeth broken and/or chipped. However, the "Dental Progress Notes" dated 11/18/09 indicated the resident's family refused treatment for the resident because there was no money in the resident's trust for the necessary dental treatment.</p> <p>The review of Resident #4's clinical records revealed the resident was a Medicaid recipient. There was no documentation in the resident's records to indicate the facility followed-up with the family or the Dentist concerning the findings of the dental exam on 11/6/09; or that the resident had a dental exam since 11/6/09.</p> <p>A review of the Physician's Telephone Order</p>	F 412	<p>Corrective Action will be accomplished for those residents having potential to be affected by the deficient practice.</p> <ol style="list-style-type: none"> All facility residents will have an annual oral assessment provided by a Licensed Dentist as part of routine dental services. Any resident in need of emergency dental services will be assisted by the facility to have this service provided within 24 hours. <p>Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur: The facility has established the following plan to ensure that all residents will have an annual Dental Consult provided by a Licensed Dentist..</p> <ol style="list-style-type: none"> All Current Census residents have been audited for Annual Dental Services. Completed 07/22/11. RN Clinical Supervisor Quarterly/Annual Assessment Tracking List has been up-dated and will be utilized to identify residents need for their Annual Dental Consult. Completed 08/04/11. If a significant Change of Condition has occurred, the resident's dental needs will be assessed by the RN @ that time to ensure that the resident has had their 		

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F 412	<p>Continued From page 5</p> <p>dated 3/23/11 indicated Resident #4's mechanical soft diet was discontinued due to the resident's request, and the resident was to receive a pureed diet.</p> <p>The review of the quarterly MDS (Minimum Data Set) dated 4/13/11, indicated Resident #4's cognition was severely impaired. The MDS also documented that the resident received a therapeutic diet; but, did not indicate whether the resident had any oral or dental problems.</p> <p>During an observation on 7/11/11 at 3:28pm, Resident #4 was observed in her bed, smiling. The resident had three small, decaying front top teeth.</p> <p>During a second observation, accompanied by the ADON (Assistant Director of Nursing) on 7/13/11 at 8:35am, Resident #4 was observed in her bed smiling with missing and chipped front upper teeth. The resident stated that she had no mouth or tooth pain.</p> <p>During an interview on 7/13/11 at 8:40am, the ADON stated that Resident #4 was alert but not always oriented; and, the resident had not shown any signs of mouth pain and the resident's weight had remained stable. The ADON revealed that she and Nursing Supervisor #1 were responsible for setting up initial Dental Referrals for new residents. After the initial referral, the Dentist's office would contact her (ADON) to set up each resident's exam (the dental office would send the ADON a list of residents to be seen with the scheduled times). If/when ADON was informed of a resident's complaint of mouth/gum/tooth pain, the resident and/or the resident's Power of</p>	F 412	<p>Annual Dental Consult or is in need of one. An appointment will be made to resident's dentist of choice or facility contracted Dentist be will be offered to the Resident/POA or Responsible Party for acceptance or decline.</p> <p>Consent/Declination of Facility contracted dental services will be filed in Medical Record. Resident/POA or Responsible Party declination of any dental services will be re-evaluated on an annual basis following the above plan.</p> <p>4. Any resident in need of emergency dental services will have services provided within 24-Hours. RN Clinical Supervisor will contact resident's dentist of choice to notify of the need for emergency dental services. For those residents who have consented for the facility contracted dentist to provide services; The RN Clinical Supervisor will notify the contracting dentist that the resident is in need of emergency dental services.</p> <p>5. All licensed and non-licensed nursing staff members will have education on the prompt reporting of the resident's need to be seen by the dentist for lost, broken or damaged dentures and the prompt reporting of any resident needing to be seen for emergency dental services.</p>		

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F 412	<p>Continued From page 6</p> <p>Attorney (POA) would be asked if the resident wanted to be examined by the Dentist. The ADON indicated that she would notify the dentist's office who would make an emergency visit. The ADON revealed that she was unaware Resident #4 had not been seen by the Dentist since 2009; and, unaware that the resident's POA had instructed the Dentist's office not to do any treatment due to lack of financial means. The ADON stated that if she had been made aware, she would have followed-up with the POA concerning the resident's eligibility for dentures as a Medicaid recipient.</p> <p>During an interview on 7/13/11 at 10:26am, NA#1 (Nursing Assistant) confirmed that Resident #4 had missing several frontal upper and lower teeth. The three frontal upper teeth were narrow and appeared decaying due to the gray/brown coloring around edges. NA#1 stated that the resident did not complain of mouth/gum/teeth pain, or showed any signs of mouth pain.</p>	F 412	<p>The facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. Monitoring will include : Week-end Clinical Supervisor will review resident charts monthly to validate that Annual Dental Consult has been completed or is due to be completed. Audit tool is in place 08/04/11. Weekend RN Clinical Supervisor will be instructed on Audit Tool usage 08/06/11.</p> <p>The PoC is integrated into the quality assurance system of the facility.</p> <p>1. <u>Weekend-Clinical Supervisor will report monthly audit findings to Quality Assurance Coordinator who will forward findings to the Quality Assurance and Assessment committee on a quarterly basis.</u></p> <p>Corrective action will be completed. In-services are scheduled for 08/09/11 and 08/11/11 with Licensed and Non-Licensed Staff on Dental Services.</p>		

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K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: library and men and womens bathroom in breakroom require two motion of hand to open door.	K 038	K 038 - The door handles in the Main Entrance clubhouse bathrooms and library area were replaced 9/8/11 with single motion handles. These new locks allow for a single action when exiting a room that the door handle is locked. Completed. No other doors were found to have two motions of the hand to exit a locked room. The Maintenance Director will review with the campus QA Committee the actions taken at the next quarterly QA meeting.	9/18/11
K 045 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: egress illumination was observed in library and would leave the patient in darkness.	K 045	K 045 - The facility will install a 24 hour light that will be on the facility generator in the Main Entrance clubhouse library. This light will not be able to be turned off by staff and will illuminate the library 24 hours a day. Completion by 9/18/11. No other areas of lighting concern were identified. The Maintenance Director will review with the campus QA Committee the actions taken at the next quarterly QA meeting.	9/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Executive Director* (X6) DATE *9/9/11*

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K 045	Continued From page 1	K 045		
K 061 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: could not check tamper alarm on backflow valve(would not turn).	K 061	K061 – The facility employed professional service to review the backflow valve, the service was able to turn the backflow valve and certify the proper function of the valve. Completed 9/8/11. There were no other issues with the system. The Maintenance Director will review with the campus QA Committee the actions taken at the next quarterly QA meeting.	9/18/11
K 062 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: facility could not provide documentation	K 062	K062 – The facility employed a professional service to complete a 5 year flush test of the sprinkler system. The system flush was completed on 9/8/11. The system was working properly and no other issues were identified. Completed 9/8/11. The Maintenance Director will review with the QA Committee the actions taken at the next quarterly QA Meeting.	9/18/11

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346518	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2011
NAME OF PROVIDER OR SUPPLIER QUAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 166 BLAKE BLVD PINEHURST, NC 28374	
(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) COMPLETION DATE
K 062	Continued From page 2 on 5 year flush test of sprinkler system.	K 062		
K 076 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: empty bottles mix in with full oxygen cylinders(300 hall oxygen room). 42 CFR 483.70(a)	K 076	K076 – During the Life Safety inspection a Maintenance employee misunderstood the correct storage location of M6 O2 bottles. At the time of the inspection the M6 bottles were placed in the improper location by the employee. At the time of the inspection the bottles were then removed and properly stored. The Maintenance employee was in-serviced on proper O2 bottle storage. The Maintenance Director will rein-service all staff on proper O2 bottle storage. And at annual staff in-services the Maintenance Director will review with all employees proper O2 storage. Completion 9/18/11. No other O2 bottle storage issues were identified. The Maintenance Director will review with the campus QA Committee the actions taken at the next quarterly QA meeting.	9/18/11