	-	ID HUMAN SERVICES					FORM APPROVED
	5 FOR MEDICARE &	MEDICAID SERVICES	(X2) MULT		CONSTRUCTION		<u>/IB NO. 0938-0391</u> 3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` <i>′</i>			(74	COMPLETED
		345518	B. WING				С
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		09/08/2016
					5 BLAKE BOULEVARD		
INN AT QU	JAIL HAVEN VILLAGE			PIN	NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPR ASSESSMENTS	EHENSIVE	F 2	272			10/6/16
	a comprehensive, ac	duct initially and periodically curate, standardized nent of each resident's					
	A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;						
	Continence; Disease diagnosis an Dental and nutritional Skin conditions;	ing; and structural problems; id health conditions;					
	Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and Documentation of par						
		SUPPLIER REPRESENTATIVE'S SIGNATUF	35		TITLE		(X6) DATE

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.

09/30/2016

						<u>3-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	ſ
			A. DOILDIN	<u> </u>	с	
		345518	B. WING		09/08/201	6
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
	IAIL HAVEN VILLAGE			155 BLAKE BOULEVARD		
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPL D THE APPROPRIATE DA	(5) LETIO ATE
F 272	Continued From page	e 1	F 2	72		
		is not met as evidenced				
	by: Based on medical re	cord review and staff		The statements made or	n this Plan of	
	interview, the facility f	failed to completely assess		Correction are not an adr	mission to and do	
		prehensive assessment in		not constitute an agreem		
		tatus, mood, and pain for 2		alleged deficiencies. To r		
	#83). The findings in	nts (Residents #45 and		compliance with all Feder Regulations the facility ha		
	$\pi$ 00). The infullings in	ciudeu.		take the actions set forth		
	1. Resident #45 was	initially admitted to the		Correction. The Plan of		
	-	d readmitted on 5/30/16 with		constitutes the facility'□s	-	
		cluding a fracture of the		compliance such that all		
	dementia.	erus, anxiety disorder, and		deficiencies cited have be corrected by the date or o		
		ote dated 5/31/16 indicated ert and verbal with confusion		Corrective Action for Res On 9/26/16, Resident # 4		
	noted at times.			Minimum Data Set (MDS were reviewed by the MD	) assessments	
	Nursing progress not	es dated 6/1/16, 6/2/16, and		Consultant. Resident #4		
	6/3/16 indicated Resi	dent #45 was alert and		assessment was updated		
	oriented times three (	person, place, and time).		#83 s medical record ha		
	Nursing progress pot	es dated 6/3/16 and 6/4/16		due to discharge; therefo made. All identified issue		
		5 was alert and verbal with		and completed by 09/30/		
				Corrective Action for Res	idents Potentially	
		es dated 6/5/16 and 6/6/16		Affected		
		5 was alert with some		All residents have the po		
	known.	ble to make her needs		affected by this practice. Regional MDS Consultar		
				Registered Nurse (RN) N	•	
		inimum Data Set (MDS)		began auditing the most	current	
		6/16 indicated Resident #45		comprehensive MDS ass		
	-	e was usually understood		of the most current comp		
	C, the Cognitive Patte	nderstood others. Section		assessments were audite found to be out of compli	-	
		essed for Resident #45.		that resident interviews a		

Facility ID: 960236

If continuation sheet Page 2 of 43

	DF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	<b>`</b>		· · ·	PLETED
						С
		345518	B. WING		09	/08/2016
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COD	)E	
				155 BLAKE BOULEVARD		
	JAIL HAVEN VILLAGE			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 272	Continued From page	e 2	F 27	2		
	-	coded to indicate Resident		conducted and keyed into the	current	
		understood and the brief		MDS assessments on the As		
		status (questions C0200		Reference Date(ARD) or the		
	through C0500) was			the ARD, the Director of Nurs	ing (DON)	
				and/or the Licensed Practical	• •	
		ducted on 9/7/16 at 4:55 PM		MDS Support Nurse will revie	ew the	
	with the MDS Nurse a	and MDS Consultant. ission MDS dated 6/6/16 for		current MDS ARDs with the	1	
		viewed with the MDS Nurse		Interdisciplinary Team (IDT) of morning meeting, Monday thr	•	
		. Resident #45's medical		in order to ensure that the inter	•	
		n for the review period of the		completed timely.		
		ewed with the MDS Nurse				
	and MDS Consultant	. The MDS Nurse indicated		On 9/26/16 the Regional MDS	S Consultant	
	the previous social w	orker who no longer worked		conducted a direct re-educati	on with the	
	-	npleted this section of the		IDT team that included Socia		
		dent #45. The MDS Nurse		Director, Nurse Supervisors a		
	-	onsible for reviewing the		Managers, DON and Activitie		
	MDS assessments fo	•		who are responsible for cond resident interviews for mental		
	documentation contra	led the medical record		mood, pain and Customary R		
		indicated Resident #45 was		Re-education emphasized that		
		ood. She stated the brief		interviews must be attempted		
		status should have been		resident has a comatose hea		
	attempted with Resid	ent #45.		they are never / rarely unders	•	
				do not communicate in Englis		
		ducted with the Director of		is no available interpreter. The		
	- · ·	8/16 at 9:40 AM. She		interview exception are the C	•	
		ation was for residents to be essed in all areas of the		Routine as these can be cond resident s spouse or family r		
	MDS.			the resident is not able. On C		
				Regional MDS Consultant co		
	A follow up interview	was conducted with the		direct re-education with the S		
	MDS Nurse and MDS	S Consultant on 9/8/16 at		Services Director to ensure the		
		Consultant indicated that		conducting the interviews per		
		mental status was required		Assessment Instrument (RAI)		
	to be attempted even confusion.	if a resident had some		requirements and guidelines.		
				Systemic Changes		
	1b. The admission M			On 09/09/16, the MDS Coord		

Facility ID: 960236

If continuation sheet Page 3 of 43

	OF DEFICIENCIES	MEDICAID SERVICES		רוסי ד	E CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			1 Y /	IPLETED
			A. DOILDI	<u> </u>			С
		345518	B. WING			09	0/08/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				1	55 BLAKE BOULEVARD		
	JAIL HAVEN VILLAGE			Ρ	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 272	Continued From page	a 3	E	272			
1 212	1 0	ident #45 had clear speech,		212		atly	
		erstood and she sometimes			resigned her position. Facility is currer recruiting for an MDS Coordinator. In		
	-	ection D, the Mood section,			interim, The LPN MDS support nurse		
		ively assessed for Resident			assist, as appropriate, the MDS proce		
	#45. Questions D010	00 was coded to indicate			to support the Regional MDS Consulta	ant	
		rely/never understood and			so as to complete the facility MDS		
		erview (questions D0200			Assessments accurately and timely;		
	through D0300) was	not conducted.			further ensuring that resident scare		
	An interview was con	ducted on 9/7/16 at 4:55 PM			plans are accurate and that proper interventions are identified and		
	with the MDS Nurse				implemented to the care plans timely.		
		ission MDS dated 6/6/16 for					
		viewed with the MDS Nurse			Once a new MDS RN Coordinator is		
	and MDS Consultant	. Resident #45's medical			identified and hired, the Regional MDS	S	
	record documentation	n for the review period of the			Consultant will train new Coordinator	on	
		ewed with the MDS Nurse			accurately and comprehensively		
		. The MDS Nurse indicated			assessing residents in a face-to-face		
		orker who no longer worked			interview, conduct direct observation a		
		npleted this section of the			a thorough review of the medical reco		
		dent #45. The MDS Nurse			during any MDS assessment or look-to period so that accurate MDS coding is		
	MDS assessments for	onsible for reviewing the			maintained at all times. Direct focus v		
		led the medical record			include:	VIII	
	documentation contra						
		indicated Resident #45 was			Section C Mental Status (BIMS Intervi	ew):	
	rarely/never understo	ood. She stated the resident			Social Services Director will ensure th	-	
		nould have been attempted			all BIMS interviews are attempted and	l	
	with Resident #45.				questions (C0100 to C0500) are		
					accurately completed and coded base	ed	
		ducted with the DON on			upon a face-to-face interview with the		
	was for residents to b	the indicated her expectation			resident. The only times when the interview cannot be conducted for		
	assessed in all areas				residents that are comatose, never / ra	arelv	
					understood; or they do not talk,	arciy	
	A follow up interview	was conducted with the			understand or communicate in English	۱.	
		S Consultant on 9/8/16 at			Any contradictions noted in nursing		
		Consultant indicated that			documentation will be immediately		
		erview was required to be			resolved by the MDS Coordinator and	the	
		esident had some confusion.			DON to ensure accurate coding of sec		1

Facility ID: 960236

If continuation sheet Page 4 of 43

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	I (VO) DATE	
	IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	
						C
	345518	B. WING			09/	08/2016
OVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AIL HAVEN VILLAGE						
SUMMARY ST						(X5)
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD B		COMPLETIC
Continued From page	e 4	F 2	72			
				C at all times.		
				Section D Mood: Social Services Dire	ctor	
she was usually unde	erstood and she sometimes			will ensure that all Mood Interview are		
				attempted and questions (D0100 to		
				-		
	•					
not conducted.	,			rarely understood; or they do not talk,		
				Any contradictions noted in nursing		
				-		
				<b>.</b>	lion	
	•			Section J Health Condition: MDS		
				•	ns	
•						
					L	
	-					
				-	not	
-					or	
	•			they do not talk, understand or		
	-			communicate in English. Direct		
				-		
					/	
	ent #40.					
An interview was con	ducted with the DON on				the	
				-		
was for residents to b	e comprehensively			J at all times.		
assessed in all areas	of the MDS.					
A fallow we interni				-		
-						
	AIL HAVEN VILLAGE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page 1c. The admission MI 6/6/16 indicated Resi she was usually under understood others. So Conditions section, we assessed for Resider coded to indicate Resi understood and the re- interview (questions and not conducted. An interview was con- with the MDS Nurse and Section J of the admining Resident #45 was revia and MDS Consultant. record documentation 6/6/16 MDS was revia and MDS Consultant. she completed Section Resident #45. She re- documentation contration Goumentation contration Goumentation contration and MDS Consultant. She completed Section Resident #45. She re- documentation contration and MDS Consultant. She completed Section Resident #45. She inter the resident pain assessment inter attempted with Resid An interview was con- 9/8/16 at 9:40 AM. Si- was for residents to b assessed in all areas A follow up interview	AL HAVEN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 1c. The admission MDS assessment dated 6/6/16 indicated Resident #45 had clear speech, she was usually understood and she sometimes understood others. Section J, the Health Conditions section, was not comprehensively assessed for Resident #45. Question J0200 was coded to indicate Resident #45 was rarely/never understood and the resident pain assessment interview (questions J0300 through J0600) was not conducted. An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section J of the admission MDS dated 6/6/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45's medical record documentation for the review period of the 6/6/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed Section J of the 6/6/16 MDS for Resident #45. She revealed the medical record documentation contradicted the coding of Question J0200 that indicated Resident #45 was rarely/never understood. She stated that she was unable to recall if she had attempted to complete the resident pain assessment interview with Resident #45. She indicated that according to the medical record documentation the resident pain assessment interview should have been attempted with Resident #45. An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS. A follow up interview was conducted with theMDS Nurse and MDS Consultant on 9/8/16 at 11:53	AIL HAVEN VILLAGE         ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           Continued From page 4         F 2           1c. The admission MDS assessment dated 6/6/16 indicated Resident #45 had clear speech, she was usually understood and she sometimes understood others. Section J, the Health Conditions section, was not comprehensively assessed for Resident #45. Question J0200 was coded to indicate Resident #45 was rarely/never understood and the resident pain assessment interview (questions J0300 through J0600) was not conducted.           An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section J of the admission MDS dated 6/6/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45's medical record documentation for the review period of the 6/6/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed Section J of the 6/6/16 MDS for Resident #45. She revealed the medical record documentation contradicted the coding of Question J0200 that indicated Resident #45 was rarely/never understood. She stated that she was unable to recall if she had attempted to complete the resident pain assessment interview with Resident #45. She indicated that according to the medical record documentation the resident pain assessment interview should have been attempted with Resident #45.           An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS.           A follow up interview was conducted with theMDS Nurse and MDS Consultant on 9/8/16 at 11:53	AIL HAVEN VILLAGE       ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 4       F 272         1c. The admission MDS assessment dated 6/6/16 indicated Resident #45 had clear speech, she was usually understood and she sometimes understood others. Section J, the Health Conditions section, was not comprehensively assessed for Resident #45. Question J0200 was coded to indicate Resident #45 was rarely/never understood and the resident pain assessment interview (questions J0300 through J0600) was not conducted.         An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section J of the admission MDS dated 6/6/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45's medical record documentation for the review period of the 6/6/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed Section J of the 6/6/16 MDS for Resident #45. She revealed the medical record documentation contradicted the coding of Question J0200 that indicated Resident #45 was rarely/never understood. She stated that she was unable to recall if she had attempted to complete the resident pain assessment interview with Resident #45. She indicated that according to the medical record documentation the resident pain assessment interview should have been attempted with Resident #45.         An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS.         A follow up interview was conducted with theMDS Nurse and MDS Consultant on 9/8/16 at 11:53	All HAVEN VILLAGE         155 BLAKE BOULEVARD PINEHURST, NC 23374           Isoummer to complete the medical record documentation contradicted the medical record documentation for the review with the MDS Nurse and MDS Consultant. The MDS Nurse and MDS Consultant. The MDS Nurse and MDS Consultant. Resident #45. She revealed the medical record documentation for the review period of the resident fields the medical record documentation for the review with the MDS Nurse and MDS Consultant. Resident #45. She revealed the medical record documentation for the review with the MDS Nurse and MDS Consultant. Resident #45. She indicated Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45. She indicated the acting of the resident file	AIL HAVEN VILLAGE         155 BLAKE BOULEVARD PINEHURST, NC 28374           Image: CARL DEFICIENCY WILL TO EXPLORE TO FORMATION)         D REACH DEFICIENCY WILL TO EXPLORE TO

If continuation sheet Page 5 of 43

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 345518 B. WING 09/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **155 BLAKE BOULEVARD** INN AT QUAIL HAVEN VILLAGE PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 272 | Continued From page 5 F 272 AM. The MDS Consultant indicated that the refresher courses for all employees resident pain assessment interview was required involved in this process will be to be attempted even if a resident had some re-educated by the Quality Assurance confusion. (QA) Team to verify that the change has been implemented. 2. Resident #83 was admitted to the facility on 5/16/16 with multiple diagnoses including a **Quality Assurance** fracture of the right hip, anxiety disorder, and The Regional MDS Consultant, the DON dementia. or the Executive Director will audit three resident MDS assessments for accuracy of section C, D and J per week and Nursing notes dated 5/17/16 and 5/20/16 indicated Resident #83 was alert, oriented to self, compliance documented on had some confusion, and was able to make some corresponding QA tools (Pain Interview, needs known to staff. Mood Interview, BIMS Interview). This will be done weekly for one month starting A physician progress note dated 5/20/16 indicated 9/23/16 then monthly for two months or Resident #83 had moderately impaired cognition. until resolved by Quality Assurance Committee. Reports will be presented to Nursing notes dated 5/21/16 and 5/22/16 the Executive Director or DON to ensure indicated Resident #83 was alert and oriented to corrective action initiated as appropriate. self. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA 2a. The admission Minimum Data Set (MDS) assessment dated 5/23/16 indicated Resident Meeting is attended by the DON, MDS #83 had clear speech, he was usually understood Coordinator, Support Nurse, Therapy, and he usually understood others. Section C, the Health Information Manager (HIM), Cognitive Patterns section, was not Dietary Manager and the Executive comprehensively assessed for Resident #83. Director. Question C0100 was coded to indicate Resident #83 was rarely/never understood and the brief interview for mental status (questions C0200 through C0500) was not conducted. An interview was conducted with the Director of Nursing (DON) on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 960236

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/20/2016 M APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	O. 0938-0391 E SURVEY PLETED
		345518	B. WING				C / <b>08/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE				55 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 272	Continued From page	96	F	272			
		ducted on 9/8/16 at 11:53					
		se and MDS Consultant.					
		reviewed with the MDS					
	Nurse and MDS Cons	sultant. Resident #83's					
		nentation for the review					
	•	MDS was reviewed with the Consultant. The MDS					
		revious social worker who					
	•	he facility had completed					
		3/16 MDS for Resident #83. d she was responsible for					
	reviewing the MDS as	-					
		curacy. She revealed the					
		nentation contradicted the					
		0100 that indicated Resident understood. She stated the					
		ntal status should have been					
	attempted with Reside						
		that the brief interview for					
	if a resident had some	uired to be attempted even					
	2b. The admission MI						
		sident #83 had clear speech,					
	he was usually unders understood others. S	stood and he usually ection D, the Mood section,					
		vely assessed for Resident					
		00 was coded to indicate					
		ely/never understood and					
	the resident mood into through D0300) was r	erview (questions D0200 not conducted.					
	An interview was con	ducted with the DON on					
		he indicated her expectation					
	was for residents to b						
	assessed in all areas						
	An interview was con	ducted on 9/8/16 at 11:53					

Facility ID: 960236

If continuation sheet Page 7 of 43

-		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 10/20/2016 APPROVED ). 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345518	B. WING					C 08/2016
NAME OF PROVIDER OF	R SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E	-	
				.	155 BLAKE BOULEVARD			
INN AT QUAIL HAVE					PINEHURST, NC 28374			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
AM with Section for Resi Nurse a medical period of MDS Nu Nurse ir no longe this sect The MD reviewin complet medical coding of #83 was resident attempte Consulta interview resident 2c. The 5/23/16 he was understa Condition assesse coded to understa interview not cono	D of the admi dent #83 was nd MDS Cons record docun f the 5/23/16 urse and MDS dicated the p er worked at the tion of the 5/2 S Nurse state of the MDS as eness and ac record docun of Question D s rarely/never mood intervise admission MI indicated Res usually under bod others. So ons section, w ed for Resider of dicate Res bod and the re v (questions J ducted. view was con t 9:40 AM. S residents to b ed in all areas	rse and MDS Consultant. Ission MDS dated 5/23/16 reviewed with the MDS sultant. Resident #83's nentation for the review MDS was reviewed with the consultant. The MDS revious social worker who he facility had completed 3/16 MDS for Resident #83. ed she was responsible for seessments for curacy. She revealed the nentation contradicted the D100 that indicated Resident understood. She stated the ew for should have been ent #83. The MDS that the resident mood d to be attempted even if a infusion. DS assessment dated sident #83 had clear speech, stood and he usually ection J, the Health as not comprehensively it #45. Question J0200 was sident #45 was rarely/never esident pain assessment 10300 through J0600) was	F	272				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED
						С
		345518	B. WING			9/08/2016
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODI	E	
INN AT QI	JAIL HAVEN VILLAGE			55 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 272	Continued From page	e 8	F 272			
F 278 SS=E	Section J of the admi Resident #83 was rev and MDS Consultant. record documentation 5/23/16 MDS was rev and MDS Consultant. she completed Sectio Resident #83. She re documentation contra Question J0200 that is rarely/never understo unable to recall if she the resident pain asse Resident #45. She in the medical record do pain assessment inter attempted with Resid Consultant indicated assessment interview attempted even if a re 483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status. A registered nurse mu assessment is completed	indicated Resident #83 was bod. She stated that she was a had attempted to complete essment interview with ndicated that according to bocumentation the resident rview should have been ent #83. The MDS that the resident pain was required to be esident had some confusion. SSMENT DINATION/CERTIFIED at accurately reflect the ust conduct or coordinate h the appropriate o professionals. ust sign and certify that the eted.	F 278			10/6/16

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		MEDICAID SERVICES			OMB NO. 0938-	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	<b>,</b>
					С	
		345518	B. WING		09/08/201	6
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
INN AT QU	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPL O THE APPROPRIATE DAT	ETIO
F 278	Continued From page	e 9	F 27	78		
	-	Medicaid, an individual who	,			
		ly certifies a material and				
		esident assessment is				
		ey penalty of not more than				
		essment; or an individual who ly causes another individual				
		ind false statement in a				
		is subject to a civil money				
	penalty of not more tl					
	assessment.					
	Clinical disagreemen material and false sta	t does not constitute a atement.				
	This REQUIREMEN	Γ is not met as evidenced				
	by:					
		ecord review, resident		The statements made o		
		nterview the facility failed to		Correction are not an ad		
	-	Minimum Data Set (MDS) eas of life expectancy		not constitute an agreem alleged deficiencies. To		
		aviors (Resident #45), falls		compliance with all Fede		
		sure ulcers (Resident #94),		Regulations the facility h		
		nts #62, #34, and #12),		take the actions set forth		
	<b>.</b> .	sidents #58 and #77), and		Correction. The Plan of		
		#12 and #18) for 8 of 13 The findings included:		constitutes the facility s compliance such that all		
		me infangs included.		deficiencies cited have b		
	1a. Resident #45 was	s initially admitted to the		corrected by the date or		
	facility on 3/17/16 and	d readmitted on 5/30/16 with				
	multiple diagnoses in	cluding heart failure.		Corrective Action for Res		
	A physician order det	tod 7/15/16 indicated		On 9/26/16, Resident #4		
	A physician order dat Resident #45 was ad			#12, #58, #77 and #18 M were reviewed by the MI		
				All identified issues were		
	The significant chang	ge Minimum Data Set (MDS)		correctly on the MDS As		
		ted Resident #45 was on		modifications and were of	-	
	hospice. Section J, t			09/28/16. For Resident		
	section, had not indic	cated Resident #45 had a life		Correction to Prior Comp	prenensive	

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TATEMENT C	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) F	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				OMPLETED
						С
		345518	B. WING			09/08/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
INN AT QU	AIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374		
		ATEMENT OF DEFICIENCIES	ID	-	N OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	COMPLETIO
F 278	Continued From page	e 10	F 27	78		
		nths or less (Question		Assessment was opene	ed for the IDT team	
	J1400).	(		to re-assesse and code		
				that had not been asse	•	
		ducted on 9/7/16 at 4:55 PM		These areas included;		
	with the MDS Nurse a			(BIMS), Mood, Pain inte		
	-	ficant change MDS dated #45 was reviewed with the		behaviors that had bee		
		Consultant. The MDS		appropriate coding of li prognosis and falls.	le expectancy	
		completed this section of the				
		ident #45. She revealed she		Corrective Action for Re	esident(s)	
	had coded question J	1400 incorrectly. She		Potentially Affected		
	indicated she was go			All residents have the p		
		cated Resident #45 had a life		affected by this practice		
	expectancy of six mo	ntns or less.		most current MDS of cu were re-assessed by th		
	An interview was con	ducted with the Director of		consultant and the RN	-	
		9:40 AM. She indicated her		for coding accuracy of		
		ne MDS to be completed		behaviors, falls, pressu	re ulcers,	
	accurately.			medications, range of r		
				diagnoses. Eight Com		
		s initially admitted to the		Assessments were aud		
	multiple diagnoses in	d readmitted on 5/30/16 with		were identified as non- corrected/modified by 1		
	anxiety.	cidding dementia and		and Nursing supervisor		
				audit of all residents wh	-	
		ote dated 7/16/16 indicated		in the last 6 months. Th		
	•	itated, non-compliant, and		any intervention that the		
	was trying to bite the	nurse.		initiated for each fall wa	•	
	The significant change	e MDS dated 7/22/16		reflected on the resider	$ts \square$ care plan.	
		e MDS dated 7/22/16 I5 had no behaviors during		On 9/26/16 the Regiona	al MDS Consultant	
		ack period (7/16/16 through		conducted a direct re-e		
	7/22/16).			Interdisciplinary Team (		
				included Social Service	s Director, Nurse	
		ducted on 9/7/16 at 4:55 PM		Supervisors and Unit M		
		and MDS Consultant. The		of Nursing (DON) and A		
		e 7/22/16 significant change		who are responsible for	-	
		5 was reviewed with the 6 Consultant. The medical		resident interviews for mood, pain and Custon		

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		MEDICAID SERVICES				<u>3 NO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	. ,	DATE SURVEY COMPLETED
		0.15540				С
		345518	B. WING			09/08/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		
NN AT QI	JAIL HAVEN VILLAGE			155 BLAKE BOULEVAR PINEHURST, NC 283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 278	Continued From page	e 11	F 2	28		
		n for the look back period of			nphasized that all	
		Resident #45 was reviewed			be attempted unless the	
		and MDS Consultant. The			omatose health condition;	
	MDS Nurse indicated	I she completed this section			rarely understood; or they	
	of the 7/22/16 MDS f	or Resident #45. She		do not communi	cate in English and there	
		ded the MDS incorrectly.			nterpreter. The only other	
		have missed the 7/16/16			ion are the Customary	
	-	ne completed the 7/22/16			e can be conducted with	
	MDS for Resident #4	5.			ise or family member if	
	An interview was con	ducted with the Director of			ot able. On 09-26-16, the Consultant conducted a	
		9:40 AM. She indicated her		-	on with the Social	
	-	he MDS to be completed			or to ensure that she is	
	accurately.	·			nterviews per RAI	
	1c. Resident #45 was	s initially admitted to the				
		d readmitted on 5/30/16 with				
		cluding a fracture of the		Systemic Chang		
	upper end of left hum	nerus and a history of falling.			e MDS Coordinator	
					sition. Facility is currently	
		#45's medical record from		•	MDS Coordinator. In the	
	-	16 revealed four falls since dated 6/6/16. These four			N MDS support nurse will priate, the MDS process	
		h minor injuries (7/1/16 and			egional MDS Consultant	
		nout injury (7/10/16 and			te the facility MDS	
	7/16/16).				curately and timely;	
				further ensuring	that resident □s care	
	The significant chang	e MDS dated 7/22/16			ate and that proper	
		45 had zero falls with no		interventions are		
		Ils with minor injury, and two			the care plans timely.	
	or more falls with ma	jor injury.			S RN Coordinator is	
	An interview was con	ducted on 9/7/16 at 4:55 PM			red, the Regional MDS rain new Coordinator on	
		and MDS Consultant. The		accurately and c		
		ange MDS for Resident #45			ents in a face-to-face	
	-	e MDS Nurse and MDS			ict direct observation and	
		dical record documentation			w of the medical record	
	of falls from 6/7/17 th	rough 7/22/16 for Resident		during any MDS	assessment or look-back	
	#45 was reviewed wi	th the MDS Nurse and MDS		neriod so that a	ccurate MDS coding is	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345518	B. WING			09/	C 08/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1:	55 BLAKE BOULEVARD			
INN AT QU	AIL HAVEN VILLAGE			Р	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 278	Resident #45. She re MDS incorrectly. She 7/22/16 MDS should I falls with major injury, injury, and two or mor An interview was com Nursing on 9/8/16 at 9 expectation was for th accurately. 2. Resident # 94 was 7/22/16 with multiple left upper limb. The a Set (MDS) assessme that Resident #94 had ulcers that were prese The hospital discharg was reviewed. The d that Resident #94 had sustained lacerations knees and right foot. The weekly wound as indicated that Residen ulcer. The assessme resident had an absco On 9/6/16 at 4:47 PM interviewed. She stat	S Nurse indicated she n of the 7/22/16 MDS for evealed she had coded the e indicated Resident #45's nave indicated she had zero two or more falls with minor re falls with no injury. ducted with the Director of 2:40 AM. She indicated her ne MDS to be completed admitted to the facility on diagnoses including cellulitis admission Minimum Data nt dated 7/29/16 indicated d 5 unstageable pressure ent on admission. e summary dated 7/22/16 ischarge summary indicated d a fall at home and to her left elbow, bilateral essesment dated 7/22/16 in indicated that the ess on her left elbow.	F	278	DEFICIENCY) maintained at all times. MDS Coordinator will ensure that questions relating to a resident s life expectancy, behaviors, falls, pressure ulcers, range of motion (or lack thereof cognition, dementia, pain measuremen and management, medication use (antipsychotic, diuretic, antibiotic, hypertension, anemia, etc.,) and days of administration of the medications accurately counted and coded based upon a face-to-face interview, direct observation and/or a thorough review of the medical record. If necessary, the resident Care Plan will be accurately updated within 24 hours of change in a noted health condition by the MDS Coordinator. The care plans should be updated daily and on as needed basis whenever a new intervention for any is is added for the resident. This information has been integrated in the standard orientation training for the MDS Coordinator and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Regional MDS Consultant will aud three resident MDS for accuracy in behaviors, falls, pressure ulcers,	it of sue ito		
		, Nurse #1 was interviewed. ent #94 has wounds on her			medications, range of motion, and diagnosis and compliance documented the MDS Coding Accuracy QA Tool. Th			

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	OMB NO. 0938-( (X3) DATE SURVEY COMPLETED
					C
		345518	B. WING		09/08/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
INN AT QU	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 278	Continued From page 13 elbow, knees and legs but were not pressure ulcers. The resident sustained the wounds from her fall at home. On 9/8/16 at 8:50 AM, the MDS Nurse was interviewed. The MDS Nurse indicated that the wound assessment indicated that the wounds on the resident's elbow, left and right knee and ankle were deep tissue injury and she interpreted that as pressure ulcer. On 9/8/16 at 11:50 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 3. Resident # 77 was admitted to the facility on 3/8/16 with multiple diagnoses including chronic lymphocytic leukemia. The admission MDS assessment dated 3/15/16 indicated that Resident #77 had no limitation in range of motion. The 14 day MDS assessment dated 3/22/16 indicated that Resident #77 had limitation in range of motion on both sides of the lower extremities.		F 278	will be done weekly until the new Coordinator has 1 month of 100 G compliance on the audit or until r by Quality Assurance Committee Reports will be presented to the R Director or DON to ensure correct action initiated as appropriate. Compliance will be monitored and ongoing auditing program review monthly QA Meeting. The month Meeting is attended by the DON, Coordinator, Support Nurse, The HIM, Dietary Manager and the Ex Director.	% esolved Executive tive d ed at the ly QA MDS rapy,
	The Physical Therapy 3/15-3/22/16 were re- that PT was working ambulation. The note resident had limitation on both lower extrem On 9/8/16 at 8:30 AM interviewed. The MDS resident had no limita	viewed. The notes indicated with the resident on es did not indicate that the n in range of motion (ROM)			

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CENTER STATEMENT ( AND PLAN OF NAME OF PI	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345518	A. BUILDING	E CONSTRUCTION		FORM OMB NO (X3) DATE COMPI	LETED
	JAIL HAVEN VILLAGE		-	PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	she expected the MD accurate. 4. Resident #62 was 8/11/16. Cumulative of Depression, Sexually disorder and Dementi disturbance. An Admission Minimu 8/20/16 indicated Res and long term memor severely impaired in or administered during th back period was docu antidepressant and 7 Antipsychotic medicat Physician admission of reviewed and an order (antipsychotic medicat mouth daily. A review of the Medic (MAR) for the look-bas 8/14/168/20/16 reve Seroquel 12.5 milligrat was not coded on the On 9/8/16 at 7:48AM, with the MDS Nurse. copy of the MAR for F the medications admi look back period and information. The MDS #62's MAR and stated	ed. The DON stated that S assessments to be admitted to the facility diagnoses included: inappropriate conduct a without behavioral m Data Set (MDS) dated ident #62 had short term y impairment and was cognition. Medications to 7 day assessment look imented as follows: 7 anticoagulant. ion was documented as "0" orders dated 8/11/16 was r was noted for Seroquel tion) 12.5 milligrams by ation Administration Record ck period from aled Resident #62 received ims on 8/14/16. Seroquel	F 278				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345518	B. WING				C /08/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
INN AT QU	JAIL HAVEN VILLAGE				155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 278	Continued From page	9 15	F	278	3		
	conducted with the D	9AM, an interview was irector of Nursing. She the MDS to be accurate.					
	6/13/16. Cumulative Dementia, Lumbar sp and sciatica (compres back and with pain ra	admitted to the facility diagnoses included: bine stenosis with back pain ssion of nerves in the lower diating down the leg) and ebrovascular accident (CVA).					
	6/20/16 indicated Res impaired in cognition.	Im Data Set (MDS) dated sident #58 was moderately No impairment in functional motion was indicated for the nities.					
	#58 was cognitively in	6/27/16 indicated Resident ntact. Limitation in range of both lower extremities.					
	with the MDS Nurse. two areas when she will f a resident had trout the resident as having motion. Also, a diagr	, an interview was conducted She stated she looked at was coding range of motion. ble walking, she would code g limitation in range of nosis such as stroke would functional limitation in range					
	conducted with the R stated she was familia had worked with her of She stated Resident a limitation in her range She said Resident #5	AM, an interview was ehabilitation director. She ar with Resident #58 and during her stay at the facility. #58 had no functional e of motion of all extremities. 58 had a lot of back pain one of the limiting factors in					

Facility ID: 960236

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	-	D HUMAN SERVICES				INTED: 10/20/2016 FORM APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		IB NO. 0938-0391 DATE SURVEY COMPLETED
		345518	B. WING			C 09/08/2016
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, Z	IP CODE	
INN AT QU	JAIL HAVEN VILLAGE			55 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 278	her discharge to the h On 9/08/2016 8:36:03 re- interviewed. She at the question regard motion wrong and the walking, it would be c stated she coded the On 9/08/2016 at 11:44 conducted with the Di stated she expected t 6. Resident #34 was 11/18/13. Cumulative Dementia and Hypert An Annual MDS dated #34 was cognitively ir administered during th back period was doct antidepressant and 7 Physician orders were order for HCTZ (hydro milligrams by mouth 0 A review of the Medic (MAR) for the look ba 4/8/16 revealed HCTZ 4/2/16, 4/4/16, 4/6/16 On 09/08/2016 at 9:00 conducted with the M reviewed Resident #3 the MDS for medication	by but had improved prior to hospital. A AM, the MDS Nurse was stated she had been looking ling functional range of hught if they had difficulty oded as limitation. She section incorrectly. AAM, an interview was rector of Nursing. She he MDS to be accurate. admitted to the facility e diagnoses included: ension. A 4/8/16 indicated Resident thact. Medications he 7 day assessment look imented as follows: 7 diuretic. e reviewed and revealed an bochloriazidea diuretic) 12.5 QOD (every other day). ation Administration Record ck period of 4/2/16 through Z was administered on , and 4/8/16 (4 days). DAM, an interview was DS Nurse who stated she 4's MAR when she coded ons. She reviewed the MAR	F 278		ENCY)	
	4/2/16, 4/4/16, 4/6/16 On 09/08/2016 at 9:0 conducted with the M reviewed Resident #3	, and 4/8/16 (4 days). DAM, an interview was DS Nurse who stated she 4's MAR when she coded ons. She reviewed the MAR #34 received diuretic				

Facility ID: 960236

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 10/20/2016 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	LETED
		345518	B. WING		_	( 09/0	C 08/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
INN AT QU	IAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374	i.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	conducted with the Di stated she expected t 7a. Resident #12 was readmitted 5/31/16 an including hypertension Tract Infection (UTI). The 8/26/16 Quarterly was reviewed and rev coded as occurring fo look back period (8/20 The Medication Admir Physician Orders for 8 reviewed and reveale Keflex (an antibiotic) f during the look back p antibiotic) for UTI prop during the look back p	9AM, an interview was rector of Nursing. She he MDS to be accurate. s admitted 11/10/15 and last ad had multiple diagnoses in and history of Urinary Minimum Data Set (MDS) realed antibiotic use was r 3 of the 7 days during the D/16 - 8/26/16). histration Record (MAR) and B/20/16 - 8/26/16 were d Resident #12 received for cellulitis for 3 of 7 days period and Nitrofurantoin (an ohylaxis for 7 of 7 days period.	F 278		DEFICIENCY)		
	Resident #12 had ord Nitrofurantoin on an o had it for 7 of 7 days o She acknowledged th coded and should hav opposed to 3 of 7 day	ed she was aware that ers for and was taking ingoing basis and that she during the look back period. at the MDS was incorrectly ve indicated 7 of 7 days as s.					
	was interviewed. She MDS had been incorre	A the Director of Nursing e acknowledged that the ectly coded for antibiotic nat her expectation was that curate.					

Facility ID: 960236

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 10/20/2016 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345518	B. WING		_	( 09/0	C 08/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
INN AT QU	IAIL HAVEN VILLAGE			155 BLAKE BOULEVARD			
				PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	9 18	F 27	8			
	last readmitted 5/31/1 diagnoses including h Urinary Tract Infection The 8/26/16 Quarterly was reviewed for activ hypertension was not diagnoses for Residen The Medication Admin Physician Orders for 8 reviewed and reveale coreg for hypertension period. On 9/8/16 at 9:28 AM interviewed. She indi #12 was prescribed a hypertension during th hypertension should t one of the resident ' s 8/26/16 MDS. On 9/8/16 at 11:15 AN was interviewed. She MDS had been incorr diagnoses, as hyperte included, and that her MDS would be accura	ypertension and history of (UTI). Minimum Data Set (MDS) ve diagnoses and revealed listed as an active nt #12. histration Record (MAR) and 3/20/16 - 8/26/16 were d Resident #12 received in during this look back the MDS Nurse was cated that since Resident nd received a medication for he look back period and that herefore have been listed as active diagnoses on the M the Director of Nursing e acknowledged that the ectly coded for active ension should have been rexpectation was that the					
	multiple diagnoses inc The 6/23/16 Quarterly was reviewed for activ						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/20/2016 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345518	B. WING _				C 08/2016
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	AIL HAVEN VILLAGE				5 BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	9 19	F 2	278			
	Physician orders for 6 reviewed and reveale	nistration Record (MAR) and 6/17/16 - 6/23/16 were d Resident #18 received nemia during this look back					
	interviewed. She ack #18 was prescribed a anemia during the loo anemia should therefo	If the MDS Nurse was nowledged that Resident nd received a medication for k back period and that ore have been listed as one tive diagnoses on the 6/23/6					
F 280 SS=D	was interviewed. She MDS had been inaccu should have been incl expectation was that t 483.20(d)(3), 483.10(	the MDS would be accurate.	F 2	280			10/6/16
		vise found to be ne laws of the State, to g care and treatment or					
	within 7 days after the comprehensive assess interdisciplinary team, physician, a registered for the resident, and c disciplines as determinand, to the extent prace	e plan must be developed e completion of the ssment; prepared by an , that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, cticable, the participation of lent's family or the resident's					

Facility ID: 960236

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		MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	<b>i i</b> <i>i</i>	SURVEY
	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDI	ING _			
							С
		345518	B. WING			09	/08/2016
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
	JAIL HAVEN VILLAGE			1	55 BLAKE BOULEVARD		
				P	PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO DATE
F 280	Continued From page	e 20	F:	280			
		and periodically reviewed					
		n of qualified persons after					
	each assessment.						
	This REQUIREMENT	is not met as evidenced					
	by:						
	-	iew and staff interview the			The statements made on this Plan of		
	facility failed to revise	e care plans after falls for 2			Correction are not an admission to and	d do	
		ents #45 and #83) reviewed			not constitute an agreement with the		
	for falls. The findings	-			alleged deficiencies. To remain in		
					compliance with all Federal and State		
	1. Resident #45 was	initially admitted to the			Regulations the facility has taken or wi	ill	
	facility on 3/17/16 and	d readmitted on 5/30/16 with			take the actions set forth in this Plan o	f	
	multiple diagnoses in	cluding a fracture of the			Correction. The Plan of Correction		
	upper end of left hum	erus, hip fracture, anxiety			constitutes the facility 's allegation of		
	disorder, and dement	tia.			compliance such that all alleged		
					deficiencies cited have been or will be		
	The Risk Assessmen	t dated 5/30/16 indicated			corrected by the date or dates indicate	ed.	
	Resident #45 had a f	all within the last month and					
	a fall within the last 2	to 6 months. Resident #45			Corrective Action for Resident(s) Affect	ted	
		hairfast (ability to walk was			On 9/26/16, Resident #45, and #83 MI	DS	
	-	on-existent), mobility was			assessments and Care Plans were		
		ccasional slight changes in			reviewed by the MDS consultant.		
		sition, but unable to make			Resident #45 s Care Plan was update		
		t changes independently),			to include new interventions. Resident		
	-	ntly stand, and exhibited a			#83 s medical record had been closed		
	loss of balance while	standing.			due to discharge; therefore, no change		
					made. All identified issues were correct	cted	
	The plan of care for F				and completed by 09/30/16.		
		16, included the focus area					
		isk for further falls. The risk			Corrective Action for Resident(s)		
	factors indicated wer				Potentially Affected		
		e, history of falls, pain, poor			All residents have the potential to be		
		id a history of anemia. The			affected by this practice. On 09/26/16		
		on 5/30/16 included:			09/27/16, 100% of current residents w	ere	
	⊢ncourage me to	o call for assistance prior to			re-assessed by the DON, RN Clinical		1

Facility ID: 960236

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 10/20/20 APPROVE . 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY LETED
		345518	B. WING		09/0	; )8/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
INN AT QI	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 280	transfers. - Encourage me to not wearing shoes. - Have [Physical T needed. - Keep frequently - Keep my call ligh - Make sure that I appropriately. - Observe me for p medications that may and report to nurse if balance. - Provide activities strength building whe activities if bedbound - [Physical Therap and mobility. - Reinforce safety The admission Minim assessment dated 6/4 had significant cognit extensive assistance living. She was indic the last month prior to within the last 2 to 6 r The Care Area Assess MDS indicated Resid falls due to her confut was indicated no safe frequent observations to attempt to get out of she had difficulty mai	b wear non slip socks when Therapy] evaluate me as used objects in my reach. In in my reach. have non-slip shoes that fit possible side effects from offect my gait and balance I have change in my gait or a that promote exercise and there possible. Provide 1:1 by consultation] for strength reminders frequently. Num Data Set (MDS) 6/16 indicated Resident #45 ive impairment and required with all activities of daily ated to have had a fall within to admission as well as a fall months prior to admission. Assement (CAA) for the 6/6/16 ent #45 remained at risk for sion and restlessness. She lependent on staff for	F 24	<ul> <li>Supervisor, and RN Supervisor, Plan accuracy and to ensure interventions were identified appropriately documented or Plans. Sixty three Care Plan audited; 28 were found out o were modified by 10/04/16.</li> <li>On 9/26/16 the Regional MD conducted a direct re-educat Interdisciplinary Team (IDT) fincluded Social Services Dires Supervisors and Unit Manag of Nursing (DON) and Activiti who would be responsible for resident Care Plans and ens said Care Plans are approprie each and every time new interdetermined at the daily morn each Monday through Friday inter-disciplinary team. Said will be transferred to the resident Date of Supervisors behavic communication, life expectar motion (or lack thereof), behavis assistance that may enhanced resident S quality of life or p incidents based upon an inci in condition or direct observation Systemic Changes On 09/09/16, the MDS Coord resigned her position. Faciliti recruiting for an MDS Coordi interim, The LPN MDS support assist, as appropriate, the M</li> </ul>	e that proper and n said Care ns were of compliance S Consultant tion with the team that ector, Nurse ers, Director is Director r updating the uring that iately updated erventions are ing meetings with the interventions dent S Care meeting. vention for iors, ncy, range of aviors, ADL e a revent further dent, change ation.	

Facility ID: 960236

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
						С
		345518	B. WING		09	9/08/2016
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE,	ZIP CODE	
				155 BLAKE BOULEVARD		
	JAIL HAVEN VILLAGE			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE ) TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 280	Continued From page	N 99	Г оо			
1 200	· · · · · · · · · · · · · · · · ·		F 28			
	antianxiety medication	ns, and didretics.		so as to complete the f Assessments accurate	•	
	A nursing progress pr	ote dated 7/1/6 indicated		further ensuring that re		
		of her bed and sustained a		plans are accurate and		
	skin tear to her left ar	m and a bruise to her		interventions are identi		
	forehead. The fall in	vestigation report dated		implemented to the car	re plans timely.	
	7/4/16 indicated staff	continued to keep Resident		Once a new MDS RN	Coordinator is	
		st position and continued		identified and hired, the	-	
	-	ing of Resident #45. There		Consultant will train ne		
		tions added to Resident #45		accurately and compre	•	
	's care plan.			assessing residents in		
		ate dated 7/10/16 indicated		interview, conduct dire a thorough review of th		
		ote dated 7/10/16 indicated of her bed. No injury was		during any MDS asses		
		vestigation report dated		period so that accurate		
		sident #45 was unable to		maintained at all times	•	
		ion. Staff were reminded to			-	
		bed in the lowest position		The MDS Coordinator	or DON will ensure	
	and to provide freque	nt safety checks. Resident		that Care Plans are ap	propriately updated	
	#45's care plan was ι	updated with the		each and every time no	ew interventions are	
	-	ate my needs as much as		determined at the daily		
	possible" on 7/11/16.			each Monday through		
	A			inter-disciplinary team.		
		ote dated 7/15/16 indicated		will be transferred to th		
	two skin tears to her r	of her bed and sustained		Plan within 24 hours of This would include any	-	
		ated 7/16/16 indicated staff		falls, pressure ulcers, t		
		sident #45's bed in the		communication, life ex		
		rovided frequent monitoring.		motion (or lack thereof		
	There were no new ir			assistance that may er		
	Resident #45's care p	blan.		resident⊡s quality of lif		
				incidents based upon a	-	
		ote dated 7/16/16 indicated		in condition or direct of	bservation.	
		of her bed. No injury was		This information book	oon intograted into	
		vestigation report dated		This information has be		
		ventative measures included device the second		the standard orientatio Coordinator and in the		
	-	plan was updated with the		refresher courses for a	-	
	intervention, "Winged			will be reviewed by the		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345518 NAME OF PROVIDER OR SUPPLIER INN AT QUAIL HAVEN VILLAGE			. ,	STF	CONSTRUCTION REET ADDRESS, CITY, STATE, ZIP CODE 5 BLAKE BOULEVARD NEHURST, NC 28374	FORM OMB NC (X3) DATE COMP	0: 10/20/2016 1 APPROVED 0: 0938-0391 SURVEY LETED C 08/2016
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 280	reminders for bounda bed" on 7/26/16. A nursing progress no Resident #45 fell out of were sustained. Resi her non-slip socks. S educated on the use of investigation report da Resident #45's chair of from her room, staff of monitoring, and her b were no new interven #45's care plan. A nursing progress no Resident #45 fell out of sustained. The fall im provided. As of 9/6/1 added to Resident #4 An interview was conto on 9/7/16 at 4:55 PM. completed the care pl revised interventions. responsible for adding who were fall risks an actual falls. The MDS were reviewed during that occurred every M stated the Director of Supervisor, and herse The MDS Nurse state were discussed in that responsible for adding care plan. The medic	ries, define parameters of the dated 8/25/16 indicated of her chair. No injuries dent #45 was not wearing that were indicated to be of non-slip socks. The fall ated 8/28/16 indicated was going to be removed ontinued with frequent ed in the low position. There tions added to Resident the dated 9/2/16 indicated of her bed. No injuries were vestigation report was not 6 no new interventions were 5's care plan. ducted with the MDS Nurse She indicated she ans and reviewed and She stated she was g interventions for residents d/or who had sustained S Nurse indicated that falls the daily morning meeting londay through Friday. She Nursing (DON), Nursing elf attended the meeting. ed that new interventions for it meeting and she was g the interventions to the cal record and fall for Resident #45's 6 falls the MDS Nurse. She	F 28	30	Process to verify that the change has been sustained. Quality Assurance The DON will audit three residents□ medical records for accuracy of the residents□ Care Plans per week and compliance documented on the Care F & Falls Interventions QA Tool. This will done weekly for one month then month for two months or until resolved by Qua Assurance Committee. Reports will be presented to the Executive Director or DON to ensure corrective action initiate as appropriate. Compliance will be monitored and ongoing auditing progra reviewed at the monthly QA Meeting. monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurs Therapy, HIM, Dietary Manager and th Executive Director.	l be hly ality ed m The e,	

Facility ID: 960236

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345518	B. WING				C 1 <b>08/2016</b>
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE				155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			ЗE	(X5) COMPLETION DATE		
F 280	mentioned in the fall i Resident #45 that she plan. These intervent #45's bed being in the frequent monitoring b stated she should have to the care plan the d She additionally indice developing new intervent for Resident #45 as the retain safety information "I just didn't know what On 9/7/16 the following to Resident #45's care - Check for possib with repeated falls. - Check on me free call bell. - Please keep me restlessness. - Bed low An interview was cone 9/8/16 at 9:30 AM. The a daily morning meet through Friday. She s Supervisor, Assistant (ADON), MDS Nurse, meeting. She indicate falls were reviewed and completed. The DON meeting was to review interventions, and/or of She stated that new in to existing intervention the meeting were exp plan of care by the Mil	nvestigation reports for e had not added to the care titions included Resident e lowest position and y staff. The MDS Nurse ve added these interventions ay they were discussed. ated she had difficulty ventions that were effective he resident was not able to ion. The MDS Nurse stated, at to do for [Resident #45]". Ing intervention were initiated e plan for falls: ility of [urinary tract infection] quently as I forget to use my clean and dry to lower my ducted with the DON on he DON indicated there was ng held each Monday stated the Nursing	F	280			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 10/20/2016 1 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345518	B. WING			( 09/	C 08/2016
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE	•••	
			1	55 BLAKE BOULEVARD			
INN AT QU	IAIL HAVEN VILLAGE		P	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 280	had not served its pur became aware of inter to care plans as of 9/7 facility was already we added care plan inter- care plan for falls as of 2. Resident #83 was a 5/16/16 with multiple of hip fracture, history of A nursing note dated a #83 was found lying of yelling for help. No in investigation report in room was moved closs and resident was edu using his call bell. The plan of care for R initiated date of 5/16/7 of an actual fall with ri factors indicated were psychoactive drug use comprehension, fall ri The interventions initia - Anticipate my new - Encourage me to standing up. - Encourage me to ambulating. - Encourage me to not wearing shoes. - Have [Physical T	re plan then the meeting pose. She revealed she rventions not being added 7/16. She indicated the orking on this and have ventions to Resident #45's of yesterday (9/7/16). admitted to the facility on diagnoses that included a falling, and dementia. 5/16/16 indicated Resident in the floor of his room juries were noted. The fall dicated Resident #83's ter to the nursing station cated on the importance of tesident #83, with an 16, included the focus area sk for further falls. The risk e an unsteady gait, e, poor communication and sk, poor safety awareness. ated on 5/16/16 included: eds as much as possible. i call for assistance prior to i lock my brakes before i use my walker when i wear non-slip socks when herapy] evaluate me as	F 280				
	- Have [Physical T	herapy] evaluate me as tly used objects in my					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345518	B. WING				C 108/2016
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
INN AT QU	JAIL HAVEN VILLAGE				155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	<ul> <li>Keep my call ligh</li> <li>Make sure that I fit appropriately.</li> <li>Monitor/documer [physician] for [signs a bruises, change in me of confusion, sleepine posture, agitation.</li> <li>Observe me for p medications that may and report to nurse if balance.</li> <li>Pharmacy [consu- medications.</li> <li>Provide activities strength building whe on one] activities if be</li> <li>The admission Minim assessment dated 5/2 #83 had significant co- indicated to require ex- mobility, transfers, toi hygiene. He was add requiring limited assiss and off the unit. Resi balance, he was only assistance, and had a range of motion on or extremities. He was i with a fracture within admission and one fa admission.</li> </ul>	used objects in my reach. t in my reach. have non-slip shoes on that nt/report PRN x 72 hours to and symptoms of] pain, ental status, with new onset ess, inability to maintain possible side effects from affect my gait and balance I have change in my gait or ultation] to evaluate that promote exercise and re possible. Provided [one edbound. um Data Set (MDS) 23/16 indicated Resident ognitive impairment. He was ktensive assistance with bed leting, dressing, and litionally indicated as stance with locomotion on dent #83 had impaired able to stabilize with staff a functional limitation in he side of his lower ndicated to have had 1 fall	F	280			

Facility ID: 960236

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			F	NTED: 10/20/2016 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345518	B. WING			C 09/08/2016
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	
			1	55 BLAKE BOULEVARD		
	JAIL HAVEN VILLAGE		P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	intervention of keepin nurses' station while Staff were indicated to monitoring while Resi There were no new in Resident #83's care p An interview was come on 9/7/16 at 4:55 PM. completed the care pl revised interventions. responsible for adding who were fall risks an actual falls. The MD were reviewed during that occurred every M stated the Director of Supervisor, and herse The MDS Nurse state falls were discussed i responsible for adding care plan. An interview was come 9/8/16 at 9:30 AM. Th a daily morning meeti through Friday. She s Supervisor, Assistant (ADON), MDS Nurse, meeting. She indicate falls were reviewed an completed. The DON meeting was to review interventions, and/or n She stated that new in to existing intervention the meeting were exp plan of care by the MI	g Resident #83 near the he was up in wheelchair. o provide frequent dent #83 was in his room. terventions added to lan. ducted with the MDS Nurse She indicated she ans and reviewed and She stated she was g interventions for residents d/or who had sustained S Nurse indicated that falls the daily morning meeting londay through Friday. She Nursing (DON), Nursing elf attended the meeting. d that new interventions for n that meeting and she was g the interventions to the ducted with the DON on he DON indicated there was ng held each Monday stated the Nursing	F 280			

Facility ID: 960236

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	D: 10/20/2016 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345518	B. WING		-		C 08/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 280 F 323 SS=D	had not served its pur became aware of inter to care plans as of 9/7 A follow up interview of DON on 9/8/16 at 11:0 medical record and car reviewed with the DO new care plan interve Resident #83's fall on 483.25(h) FREE OF A HAZARDS/SUPERVIS The facility must ensur environment remains as is possible; and ear	re plan then the meeting pose. She revealed she rventions not being added 7/16. was conducted with the 00 AM. Resident #83 ' s are plan for falls was N. She confirmed that no ntions were added after 6/14/16. ACCIDENT SION/DEVICES are that the resident as free of accident hazards	F 2				10/6/16
	by: Based on medical req interview the facility fa interventions and ens place were followed to a resident who sustain 7/15/16, 7/16/16, 8/25 timeframe (Resident # reviewed for falls. Th Resident #45 was init on 3/17/16 and readm multiple diagnoses ind	ailed to implement effective ure the interventions in p reduce the risk of falls for ned 6 falls (7/1/16, 7/10/16, 5/16, 9/2/16) in a 64 day #45) for 1 of 3 residents e findings included: ially admitted to the facility		The statements ma Correction are not a not constitute an ag alleged deficiencies compliance with all Regulations the faci take the actions set Correction. The Pla constitutes the facili compliance such the deficiencies cited ha corrected by the dat	an admission to and greement with the s. To remain in Federal and State ility has taken or will forth in this Plan of an of Correction ity'□s allegation of at all alleged ave been or will be	1	

Facility ID: 960236

If continuation sheet Page 29 of 43

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345518 B. WING 09/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **155 BLAKE BOULEVARD** INN AT QUAIL HAVEN VILLAGE PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 29 F 323 disorder, and dementia. Corrective Action for Resident Affected On 9/26/16, In reference to resident #45, The Risk Assessment dated 5/30/16 indicated MDS assessments and Care Plans were Resident #45 had a fall within the last month and reviewed by the Regional MDS consultant. Resident #45 s Care Plan was updated a fall within the last 2 to 6 months. Resident #45 was indicated to be chairfast (ability to walk was to include new interventions on each severely limited or non-existent), mobility was documented fall. All identified issues were very limited (made occasional slight changes in corrected and completed by 09/30/16. body or extremity position, but unable to make frequent or significant changes independently), Corrective Action for Resident Potentially unable to independently stand, and exhibited a Affected loss of balance while standing. All residents have the potential to be affected by this practice. On 09/26/2016 The plan of care for Resident #45, with an through 09/29/2016, a 6 month look back initiated date of 5/30/16, included the focus area review was completed of current residents of an actual fall with risk for further falls. The risk falls and reviewed by the Director of factors indicated were an unsteady gait, Nursing and RN Clinical Supervisors for psychoactive drug use, history of falls, pain, poor Care Plan accuracy to ensure that proper safety awareness, and a history of anemia. The interventions were identified and interventions initiated on 5/30/16 included: appropriately documented on all residents Encourage me to call for assistance prior to Care Plans. transfers. Results of the audit: Resident Care Plans Encourage me to wear non slip socks when not wearing shoes. that were noted unsatisfactory was 28 out Have [Physical Therapy] evaluate me as of 63 documented falls were identified. All the modifications were completed by the needed. Keep frequently used objects in my reach. Regional MDS Consultant, DON and RN Keep my call light in my reach. Clinical Supervisors by 10/04/16. Make sure that I have non-slip shoes that fit appropriately. On 09/27/16, the RN Nurse Consultant Observe me for possible side effects from conducted an in-service with the IDT [IDT medications that may affect my gait and balance consists of the DON. MDS Coordinator. and report to nurse if I have change in my gait or Therapy, RN Supervisors, Activities and balance. Dietary) on appropriate fall interventions Provide activities that promote exercise and to assist with Care Planning. Such strength building where possible. Provide 1:1 interventions may include, but may not be activities if bedbound. limited to: Therapy to screen for gait, [Physical Therapy consultation] for strength safety, cognition, environmental and mobility. evaluation and need for assistive devices;

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 960236

If continuation sheet Page 30 of 43

		MEDICAID SERVICES				3 NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	,	DATE SURVEY
						С
		345518	B. WING		_	09/08/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	
INN AT OL	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD		
				PINEHURST, NC 28374	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 323	Continued From page	e 30	F 32	3		
		reminders frequently.			uct medication review	
		- ··· · <b>/</b> ·		-	ctions, and potential	
	The admission Minim			adverse effects; M		
		6/16 indicated Resident #45		-	ns, new diagnoses,	
		ive impairment and required with all activities of daily			. When a patient has a view the incident report	
		ated to have had a fall within			propriate interventions	
		o admission as well as a fall			ot cause, history of the	
		months prior to admission.		resident and natur		
				interventions listed	l above may be	
		sment (CAA) for the 6/6/16		appropriate for the		
		ent #45 remained at risk for			ot be identified, the IDT	
		sion and restlessness. She		further evaluation.	medical provider for	
	was indicated to be d mobility and transfers					
	-	ety awareness and needed		Systemic Changes	3	
		s by staff. She was indicated			RN Clinical Supervisor,	
	to attempt to get out	of bed without assistance,		will ensure that ne	w fall interventions that	
		ntaining sitting balance, and		are determined at		
	-	e during transfers. Resident		•	nday through Friday	
	#45 was on antidepre			· ·	s will be reviewed on	
	antianxiety medicatio	ns, and diuretics.		Monday mornings) inter-disciplinary te		
	A nursing progress n	ote dated 7/1/6 indicated			hen transferred to the	
		of her bed and sustained a			an within 24 hours of	
	skin tear to her left ar	m and a bruise to her			e interventions are	
		vestigation report dated			Care Plan, the DON	
		continued to keep Resident			Supervisor will make	
		st position and continued			of resident, with access	
		ring of Resident #45. There ntions added to Resident		to Care Plan and v	interventions have	
	#45's care plan.	מטוים מעובע נו הבשוולוונ		been implemented		
		ote dated 7/10/16 indicated		Quality Assurance		
		of her bed. No injury was			Clinical Consultant will	
		vestigation report dated sident #45 was unable to			nt Care Plans per week	
		ion. Staff were reminded to		-	nterventions have been emented for each fall.	
	-	bed in the lowest position			e documented on the	

Facility ID: 960236

STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED
	CONNECTION	IDENTITIOATION NUMBER.	A. BUILDING			C
		345518	B. WING			08/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 31	F 323	3		
<ul> <li>F 323 Continued From page 31 <ul> <li>and to provide frequent safety checks. Resi</li> <li>#45's care plan was updated with the intervention, "Anticipate my needs as much possible" on 7/11/16.</li> </ul> </li> <li>A nursing progress note dated 7/15/16 indicated two skin tears to her right arm. The fall investigation report dated 7/16/16 indicated continued to keep Resident #45's bed in the lowest position and provided frequent monitor. There were no new interventions added to Resident #45's care plan.</li> <li>A nursing progress note dated 7/16/16 indicated 7/25/16 indicated preventative measures income a winged mattress and bed in the lowest position and provided frequent monitor. There were no new interventions added to Resident #45's care plan.</li> </ul>		updated with the ate my needs as much as ote dated 7/15/16 indicated of her bed and sustained right arm. The fall ated 7/16/16 indicated staff esident #45's bed in the rovided frequent monitoring. Interventions added to oblan. ote dated 7/16/16 indicated of her bed. No injury was investigation report dated ventative measures included ad bed in the lowest position. oblan was updated with the I mattress to provide		Weekly QA Monitor Tool; thus val the accuracy of the Care Plan. Th done weekly until for one month a bi-weekly for two months or until by Quality Assurance Committee Reports will be presented to the E Director or DON to ensure correct action initiated as appropriate. Compliance will be monitored and ongoing auditing program review monthly QA Meeting. The monthl Meeting is attended by the DON, Coordinator, Support Nurse, Their HIM, Dietary Manager and the Ex Director.	nis will be and then resolved Executive tive d ed at the y QA MDS rapy,	
	Resident #45 fell out were sustained. Resident enon-slip socks. Se educated on the use investigation report de Resident #45's chain from her room, staff of monitoring, and her be were no new interven #45's care plan.	ote dated 8/25/16 indicated of her chair. No injuries ident #45 was not wearing Staff were indicated to be of non-slip socks. The fall ated 8/28/16 indicated was going to be removed continued with frequent hed in the low position. There nations added to Resident				

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	S FOR MEDICARE &					0. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY PLETED	
		345518	B. WING			C / <b>08/2016</b>	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
NN AT QL	JAIL HAVEN VILLAGE			I55 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From page	e 32	F 323				
		6 no new interventions were					
	An interview was conducted with the MDS Nurse on 9/7/16 at 4:55 PM. She indicated she						
	revised interventions.	lans and reviewed and She stated she was g interventions for residents					
	who were fall risks ar	nd/or who had sustained S Nurse indicated that falls					
	that occurred every N	) the daily morning meeting /onday through Friday. She Nursing (DON), Nursing					
	Supervisor, and herse	elf attended the meeting.					
	responsible for addin	in that meeting and she was g the interventions to the					
	care plan. The medic investigation reports were reviewed with th	for Resident #45's 6 falls					
	revealed there were						
	plan. These interver	e had not added to the care ntions included Resident					
		y staff. The MDS Nurse ve added these interventions					
	to the care plan the d She additionally indic	ay they were discussed. ated she had difficulty					
	for Resident #45 as to retain safety informat	ventions that were effective he resident was not able to ion. The MDS Nurse stated, at to do for [Resident #45]".					
		ng intervention were initiated					
	to Resident #45's car	e plan for falls: ility of [urinary tract infection]					

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	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			
		345518	B. WING			C
	ROVIDER OR SUPPLIER	040010		REET ADDRESS, CITY, STATE, ZIP CODE		/08/2016
				5 BLAKE BOULEVARD	-	
INN AT QU	JAIL HAVEN VILLAGE			NEHURST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLETIO
F 323	Continued From page	e 33	F 323			
1 020	call bell		1 020			
		clean and dry to lower my				
	restlessness	, ,				
	- Bed low					
	A					
		ducted with the DON on the DON indicated there was				
		ing held each Monday				
	through Friday. She	5				
	Supervisor, Assistant					
		, and herself attended the				
		ed this meeting was where				
		nd investigations were				
	-	N reported the purpose of the				
	-	w interventions, develop revise interventions for falls.				
		nterventions and/or revisions				
		ins that were discussed in				
		pected to be added to the				
	plan of care by the M	DS Nurse the same day.				
		he interventions were not				
		re plan then the meeting				
	· · ·	rpose. She revealed she				
		erventions not being added 7/16. She indicated the				
	•	orking on this and have				
		ventions to Resident #45's				
	care plan for falls as					
F 356	483.30(e) POSTED N		F 356			10/6/16
SS=C	INFORMATION					
		t the following information on				
	a daily basis:					
	o Facility name.					
	o The current date.	nd the actual hours worked				
	l o The local number al	nu me actual nours worked				
	by the following categ	nories of licensed and				

Facility ID: 960236

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 10/20/2016 MAPPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345518	B. WING					C 08/2016
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP (	CODE		
INN AT QU	JAIL HAVEN VILLAGE		155 BLAKE BOULEVARD PINEHURST, NC 28374					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
F 356	resident care per shift - Registered nurse - Licensed practic vocational nurses (as - Certified nurse a o Resident census. The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors. The facility must, upo make nurse staffing d for review at a cost no standard. The facility must main staffing data for a min required by State law. This REQUIREMENT by: Based on record revi interview, the facility f staffing information th accurate and on a dai each shift for 2 of 2 dai included: On 9/6/16 at 8:30 AM facility was conducted staffing information po On 9/7/16 at 12:30 PM	<ul> <li>al nurses or licensed defined under State law).</li> <li>ides.</li> <li>the nurse staffing data daily basis at the beginning ust be posted as follows: format.</li> <li>e readily accessible to</li> <li>n oral or written request, ata available to the public of to exceed the community</li> <li>thain the posted daily nurse imum of 18 months, or as , whichever is greater.</li> <li>is not met as evidenced</li> <li>ew, observation and ailed to post the nurse at was complete and ly basis at the beginning of ays observation. Findings</li> <li>and 4:30 PM, tour of the t. There was no nurse</li> </ul>	F3		The statements made on Correction are not an adm not constitute an agreeme alleged deficiencies. To re compliance with all Federa Regulations the facility has take the actions set forth in Correction. The Plan of C constitutes the facility' s a compliance such that all a deficiencies cited have be corrected by the date or data	ission to and nt with the main in al and State s taken or wi n this Plan of orrection allegation of lleged en or will be	 -	

Facility ID: 960236

If continuation sheet Page 35 of 43

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345518 B. WING 09/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **155 BLAKE BOULEVARD** INN AT QUAIL HAVEN VILLAGE PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 356 Continued From page 35 F 356 station 1 dated 9/6/16. The posting had 4 **Corrective Action** Registered Nurses (RNs) listed on 7A-7P shift. On 9/9/16, all licensed nursing staff were The information for 7P-7A was blank. in-serviced on properly completing the Nurse Staffing Information Sheet for every On 9/7/16 at 3:32 PM, Nurse #2 was interviewed. shift each day. This Nurse Staffing Nurse #2 stated that it was the responsibility of Information is posted at each Nurse s the nurse to complete the nurse staffing Station at the start of each shift by the information daily and to post it. The nurse Nursing Supervisor. The Nursing Staffing indicated that he normally completed the form Sheet is clear, in readable format and before he left at 7 PM. He added that he was the posted in a prominent place readily one who completed the form for 9/6/16 and he accessible to residents and visitors. The would complete the 9/7/16 before the end of his facility will maintain the posted daily nurse shift and post it. The nurse acknowledged that staffing data for a minimum of 18 months the 7 P-7A shift nurse did not complete the as required by state law. information on the form for 9/6/16. Nurse #2 further stated that the 4 RNs were the Director of Nursing (DON), MDS Nurse, Assistant DON and Systemic Changes the RN supervisor. On 09/09/16, all licensed nursing staff were in-serviced on properly completing the Nurse Staffing Information Sheet for On 9/7/16 at 12:35 and 3:45 PM, a nurse staffing every shift each day and then posted at information was observed posted on station 2 each Nurse s Station at the start of each dated 9/7/16. The posting had 4 RNs and 3 shift. In-service for current licensed staff Licensed Practical Nurses (LPNs) listed. was completed on 09-16-16 by the Director of Nursing. Any new licensed On 9/7/16 at 3:45 PM, Nurse #3 was interviewed. staff will be in-serviced during orientation Nurse #3 stated that she completed the form and on the proper completion and posting of the 4 RNs were the DON, MDS Nurse, ADON Nurse Staffing Information Sheet. and RN supervisor and the 3 LPNS were Nurse #2, Nurse #3 and Nurse #4 who was on her first day orientation. **Quality Assurance** The Director of Nursing, Executive On 9/7/16 at 11:50 AM, the DON was interviewed. Director and/or RN Clinical Supervisors The DON stated that the nurses worked 12 hour will verify that the accurate Nurse Staffing shift. The day shift nurse was responsible for Information is posted each day at the completing the nurse staffing information for beginning of each shift including weekends. This will be completed three 7A-7P and the night shift nurse was responsible for the 7P-7A. The DON indicated that the form times a week for one month then weekly should be completed at the start of the shift. The for one month or until resolved by Quality

FORM CMS-2567(02-99) Previous Versions Obsolete

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345518	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	040010		STREET ADDRESS, CITY, STATE, ZIP CODE	09/08/2016
				155 BLAKE BOULEVARD	
INN AT QU	JAIL HAVEN VILLAGE			PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 356		e 36 at DON, MDS Nurse and	F 35	6 Assurance Committee. The ongoi	na
	Nurse #4 should not I	be counted on the nurse ne DON stated that she		monitoring will be completed by th Director of Nursing and the RN CI	ne
		taffing information to be		Team. Reports will be presented to	
	complete, accurate an at the start of the shift	nd posted on the daily basis t		Executive Director or DON to ensu corrective action initiated as appro	
				Compliance will be monitored and	
				ongoing auditing program reviewe	ed at the
				monthly QA Meeting. The monthl	
				Meeting is attended by the DON, I Coordinator, Support Nurse, There	
				HIM, Dietary Manager and the Ex	
				Director.	
F 371	483.35(i) FOOD PRC STORE/PREPARE/S		F 37	1	10/6/16
SS=E	STURE/PREPARE/S	ERVE - SANITARY			
	The facility must -				
		sources approved or			
	authorities; and	ry by Federal, State or local			
		stribute and serve food			
	under sanitary condition				
		is not met as evidenced			
	by: Based on observatio	n, staff interview and		The statements mane on this Pla	n of
	document review the	facility failed to label and		Correction are not an admission to	o and do
		red foods from freezer and		not constitute an agreement with t	the
		ods from refrigerator, and oducts at 41 degrees F		alleged deficiencies. To remain in compliance with all Federal and S	tate
		. The findings included:		Regulations the facility has taken	
	1. Review of the facili	ty precedure number B006		take the actions set forth in this Pl	an of
		brage Procedures", revised		Correction. The Plan of Correction	
	1/14 revealed "Remo	ve from storage any items		constitutes the facility'□s allegatio	

Event ID: FE8311

Facility ID: 960236

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					OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345518	B. WING		09/08/2016
NAME OF P	ROVIDER OR SUPPLIER		- I - I	STREET ADDRESS, CITY, STATE, ZIP CODE	05/00/2010
				155 BLAKE BOULEVARD	
INN AT QU	JAIL HAVEN VILLAGE			PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE
F 371	Continued From page	27	F 07		
1 571	Continued From page		F 37		
	for which the expiration	•		compliance such that all alleged deficiencies cited have been or w	ill be
		policy "Sanitation and Food s" (undated) revaled "Food		corrected by the date or dated ind	
		kaging should be lables			
	wrapped and dated".			Corrective Action for Area Affected	d:
				On 9/6/2016, State Surveyor note	d facility
	On 9/6/16 at 8:00 AM	I the walk in freezer located		failed to label, date and discard ex	kpired
		as observed with Chef #1.		food items in the refrigerator. On	
		l items were observed in the		9/6/2016, all items that were not la	
	freezer:			dated or had expired in the walk-i	
	1 bog turkov outloto	everined 8/8/6		and freezer were immediately disc	carded.
	1 bag turkey cutlets 1 bag stuffed peppers	-		Systemic Changes	
	1 bag mushroom grav			On 09/07/16, the Director of Dieta	rv
		implingsexpired 8/16/16		Services in-serviced dietary staff	
	(also unlabeled)			proper labeling and dating of item	
	1 bag chicken and du	Implingsexpired 8/14/16		well as the appropriate shelf life o	f food
	1 bag salmon patties			products that are received, stored	
	1 bag salmon patties			prepared. The Director of Dietary	
	1 bag stuffed pepper	-		Services will also conduct a forma	
	1 bag tuna-expired 4/			mandatory Communication Health	
	1 bag asparagus sou			Training (CHAT training) with dieta	
	1 bag mushroom sou	pexpired 5/7/16 ken soupexpired 8/10/16		members on 09/28/16 that will ad Morrison⊡s guidelines and policie	
				procedures for proper food and st	
	In addition the followi	ng unlabeled and/or undated		items.	
	items were observed	-			
				Packaged food label information r	nust
	-	rapped in cellophane,		include:	
	unlabeled and undate			The common name of the food; o	r, absent
		cakes-opened and undated		a common name, an adequately	
	(ice crystals in the ba 1 bag with 8 frozen b			descriptive identity statement. Items will be labeled with a Date I	n date
	crystals in the bag)	ושכעונש עוועמובע (ונש		for all items, boxed or unboxed, ir	
				refrigerator, freezer or dry storage	
	On 9.6.16 at 8:20 AM	I the walk in refrigerator was		Prepared items, i.e., glasses of te	
		1. The following items were		etc., will have a Use By label date	
		heir discard by date but not		adhered to the side of glass/cup.	
	yet discarded:			cups of dressing, poured from large	ner

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	OMB (X3) [	DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	8	Ć	OMPLETED
						С
		345518	B. WING			09/08/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				155 BLAKE BOULEVARD		
	JAIL HAVEN VILLAGE			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 371	Continued From page	e 38	F 37	1		
				bottle, will have Use By lab	el date	
1	9 pieces Boston crea	m pie dated as prepared on		adhered to top of serving c		
		ation/use by date of 9/3/16		boxes of desserts will have		
		prepared on 8/31/16 with an		on top of box; any sliced de	•	
	expired/use by date of			Use By label on cellophane		
	2 pieces of chocolate	e cake dated as prepared on		Any item that does not have	e a Date In,	
	8/31/16 with an expire	ed/use by date of 9/4/16		Use By, manufacturer⊡s ex	kpiration, or	
				other allowable food label t	•	
		1 interview with Chef #1		identifies a date opened, ar		
		ary staff were expected to		use by will immediately be		
		lates and discard expired		expired and thusly discarde	ed.	
		r use by date and that no				
	one staff member wa	s responsible.		Quality Assurance:		
				The Director of Dietary Ser		
		M the Dietary Manager was		Chef will audit on alternatin	-	
		cated that his staff had told		reach-in, walk-in refrigerato		
		d food items in the freezer		to ensure that all items are		
		en removed but he had not		labeled with a Date In, a m		
		lesserts in the refrigerator		expiration date and/or a Us	•	
	-	se by date. He said he		three times per week with p		
	-	or these items still being in		weekend audits and compli		
		erator could have had to do		documented on the Food S		
		was one of the issues he had		Sanitation Audit. This will b		
		solve but that he had not		and documented 3 times per		
	been in his position v	ery long.		weeks; then one time per w		
	On 9/8/16 at 12:30 D	M the Administrator was		weeks; then bi-weekly for 2 until resolved by the Quality		
		ed that she expected expired		Committee. Reports will be		
		d and food items to be		weekly to the Executive Dir		
	properly labeled and			to ensure corrective action		
				appropriate. Compliance w		
	2. Review of the facili	ity procedure number B006,		monitored and ongoing auc		
		orage Procedures" revised		reviewed at the monthly QA	• •	
	1/14 revealed "Milk w	•		monthly QA Meeting is atte		
		ceipt. A with all refrigerated		DON, MDS Coordinator, Su		
		s must be maintained at 41		Therapy, HIM, Dietary Man		
	(degrees) F (Fahrenh			Executive Director.	-	
	On 9/7/16 at 11:15 A	M Chef #1 was observed to				

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						OMB NC	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345518		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			С		
		345516				09/	08/2016
IAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
NN AT QU	JAIL HAVEN VILLAGE				BLAKE BOULEVARD IEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	IOULD BE COMPLET	
F 371	Continued From page	20	Г 27	74			
1 371	Continued From page		F 37		Or and the Article for Area Affected		
		nometer to measure the			Corrective Action for Area Affected:		
		le serving carton of milk n in refrigerator located			On 9/6/2016, State Surveyor observed that dairy products specifically milk did		
	directly behind the ste			maintain a proper temperature below 4			
	that was available to			degrees. Milk products were immediat			
	during the lunch servi			placed in ice bath to bring below requir			
	temperature of the mi			41 degrees. Upon re-inspection, milk			
	(Fahrenheit). The ter		1	maintained a temperature of below 41			
	refrigerator, according			degrees. Any milk product that was			
	indicator display outside the refrigerator, was 43				above the minimum 41 degrees was		
	degrees F at this time. The temperature reading			i	immediately discarded.		
	on the thermometer inside the refrigerator was not observed. Chef #1 then measured the						
				Systemic Changes: On 9/6/2016, the Director of Dietary			
	-	ore single serving cartons of gistered 44 degrees F. A			Services in-serviced the dietary staff		
	-	cartons of milk was then			ad-hoc on the importance of proper		
		r chiller across the room			temperatures for all food products, but		
	(not observed) and C	hef #1 measured the			specifically milk products. As of 09-06		
	temperature of one of			all milk products are placed in an ice b			
	registered 42 degrees	s F. The Dietary Manager			before meal service to insure proper		
		rprised it did not register a			temperature is reached before placeme	ent	
		cause the chiller it was			on meal trays. Temperatures are then		
		emperature reading of 32			randomly checked once meal carts left		
		ik had been delivered		'	dietary department.		
		in that chiller since then. acknowledged the reach in			On 09/07/16, the Dietary Services Dire	otor	
		e steam table was exposed			conducted a formalized in-service for a		
		am table and was being			dietary staff on proper temperature saf		
		that was where most of the			zones and approximate thresholds for		
		being put on the lunch trays,			diary, produce, protein, hot held, and c	old	
		and iced tea, were being			held items. Dietary staff were also train		
	stored for use.				on completing the temperature monitor	-	
					sheets each day to ensure temperature	Э	
		M the Administrator was			safety zones are maintained on all of		
		d that she expected milk			products, inclusive of checking and	- 6	
	products to be mainta				documenting the internal temperature	IC	
	temperatures under 4	H uegrees F.			our walk-in and reach-in coolers. The Director of Dietary Services will also he	Nd	
					DIRECTOL OF DIRECTLY SELVICES WILL SISO UC	אנ	1

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CENTER STATEMENT	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	FORM OMB NC (X3) DATE	0: 10/20/2016 MAPPROVED 0: 0938-0391 SURVEY LETED
							c
		345518	B. WING			09/	08/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE				55 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 371 F 520 SS=E	COMMITTEE-MEMBI QUARTERLY/PLANS A facility must maintal assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to	ERS/MEET in a quality assessment and consisting of the director of hysician designated by the other members of the		520	DEFICIENCY) with dietary staff members on 9/28/201 Quality Assurance: The Director of Dining Services or Sou Chef will randomly audit the reach-in, walk-in and tray line service ice bath container to ensure that proper milk temperatures are achieved and maintained. This will be completed and documented 3 times per week for 6 weeks; then one time per week for 7 weeks; then one time per week for 8 weeks; then bi-weekly for 2 months or until resolved by the Quality Assurance Committee. Reports will be presented weekly to the Executive Director or DO to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing progra reviewed at the monthly QA Meeting. monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse Therapy, HIM, Dietary Manager and th Executive Director.	s d N m The e,	10/6/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345518		(X2) MULTIPL	OMB NO. 0938-039			
		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		B. WING	09/08/2016			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QUAIL HAVEN VILLAGE						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 520	develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such correquirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observation interview, the facility's Assurance (QAA) corr implemented procedu interventions that the following the 10/1/15 was for a recited defice assessment accuracy was cited again on the survey of 9/8/16. The two federal surveys o the facility 's inability Quality Assessment a The findings included This tag is cross refer F278 - Assessment A record review, resider interview the facility fa	ents appropriate plans of ified quality deficiencies. ary may not require rds of such committee h disclosure is related to the ommittee with the ection. y the committee to identify ficiencies will not be used as ' is not met as evidenced n, record review and staff s Quality Assessment and nmittee failed to maintain ires and monitor these committee put into place recertification survey. This ciency in the area of (F278). This deficiency e current recertification e continued failure during f record show a pattern of to sustain an effective and Assurance program. renced to: ccuracy: Based on medical nt interview, and staff ailed to accurately code the IDS) assessment in the	F 520	The statements made on this plan correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and star regulations the facility has taken or take the actions set forth in this plac correction. The plan of correction constitutes the facility' a sallegation compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. Corrective Action for Resident Affer Resident #45- Behaviors and falls; Resident #45- Behaviors and falls;	and do ie te will n of of be cted ident s; otions; MDS rrected	

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С
		345518	B. WING			09/08/2016
NAME OF P	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NN AT QI	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		IOULD BE COMPLETIC	
F 520	Continued From page	e 42	F 52			
	REGULATORY OR LSC IDENTIFYING INFORMATION)			Corrective Action for Resident Por Affected All residents have the potential to affected by this practice. See oth of corrections cited for F278. On 09/29/2016, the QA Nurse Co in-serviced the Administrator and of Nursing. Topics included: The continue all plan of correction qui assurance monitors until full com is sustained for 3 months. Once sustained for 3 months the surve will be completed quarterly until a next survey cycle to ensure comp on the next survey. This information has been integra the standard orientation training a required in-service refresher cou all employees and will be reviewe Quality Assurance Process to ve the change has been sustained. Quality Assurance The QA Nurse Consultant will mo issue using the QA Survey Tool. Assurance Audit tools identified i plan of correction will be reviewe to ensure that corrective action ir appropriate. Compliance will be r and ongoing auditing program re the monthly QA Meeting. The m Meeting is attended by the DON, Nurse, MDS Coordinator, Unit M Support Nurse, Therapy, HIM, Di Manager and the Administrator.	o be er plans onsultant Director need to ality pliance y monitor after the bliance ated into and in the rses for ed by the rify that onitor this Quality n this d monthly itiated as monitored viewed at onthly QA Wound anager,	

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