PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
345518		B. WING _		,	10/04/2018		
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550 SS=D	CFR(s): 483.10(a)(1)(1)(1)(1)(2)(3)(4)(3)(4)(4)(1)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	Rights. tht to a dignified existence, of communication with and discrete services inside and cluding those specified in y must treat each resident ity and care for each and in an environment that the or enhancement of his or organizing each resident's ity must protect and the resident. cility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her in the facility and as a citizen	F 5	50		10/19/18	

10/19/2018

Electronically Signed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345518	B. WING			10/04/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	10/0 1/2010	
				155 BLAKE BOULEVARD			
INN AT QU	IAIL 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
_				DEFICIENCY)			
F 550	Continued From page	e 1	F 55	0			
	subpart.	rights as required under this is not met as evidenced					
	by:	n and staff interviews, the		The statements made on this l	Plan of		
		le privacy during insulin		Correction are not an admissio			
		abdomen for 1 of 2 residents		not constitute an agreement wi			
		dministration (Resident #1).		alleged deficiencies. To remain			
		,		compliance with all Federal and			
	Findings included:			Regulations the facility has take			
	J			take the actions set forth in this			
	Resident #1 was adm	nitted to the facility on		Correction. The Plan of Correction	ction		
	11/18/13 with the diag	gnosis of diabetes.		constitutes the facility's allegati	ion of		
				compliance such that all allege	ed		
	The resident 's care	plan dated 9/21/18 revealed		deficiencies cited have been or	r will be		
	goals and intervention	ns for diabetes mellitus with		corrected by the date or dates	indicated.		
	daily insulin and at ris	sk for complications.		F550			
				For the residents involved, corr			
		erly Minimum Data Set dated		action has been accomplished			
		resident had adequate		On date October 13, 2018, the			
		, and was understood and		Nursing spoke with Resident #			
		The cognition was severely		apologized to the resident and			
	impaired. The resider			/reaffirmed her right to be treat			
		ff for all activities of daily		respect and dignity. She assur			
	living except meals w	ere set up.		privacy during insulin administr			
	O 40/0/40 -+ 0-40			be accomplished going forward			
		m, an observation was done		October 13, 2018 Resident#1 r	•		
		ss of Nurse #2 administer		by saying "it is okay". Resident			
		ly (just below the skin) to		report to the Director of Nursing	•		
		domen. Nurse #2 had lifted		negative feelings during their d			
		p approximately 3 inches		Corrective action has been acc	•		
		lent 's elastic waistband of esident was sitting in her		on all residents with the potent			
	•	<u> </u>		affected by the alleged deficier	приасисе		
		ırtain was not pulled, and		by: On October 18, 2018 the Direct	etor of		
		The resident 's roommate		On October 18, 2018 the Direct			
		uld observe. The resident's		Nursing audited 100% of reside			
		room in her bed and looked		receiving scheduled insulin by	-		
	insulin administration	what was going on during		insulin administration practice, how privacy was maintained.			
		•	1	pas,as mamamou. /	,	1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345518	B. WING _			10/04/2018	
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BOULEVARD PINEHURST, NC 28374				
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE			
F 550	provide privacy for Readministering insulin required moving here injection site. Nurse pulled the privacy curadministration. On 10/3/18 at 4:30 proconducted with the Dishe expected staff to insulin administration.	m an interview was e #2 who stated he forgot to esident #1 before to her abdomen which clothing to expose the #2 stated he should have tain before insulin	F 5	noted were corrected at a results of the audit, see of One). Measures put in place or changes made to ensure deficient practice does not October 11, 2018, the End Nursing and Staff develor Coordinator (SDC) began training for all facility Reg (RN) and Licensed Prace Nurses(LPN), both fulltime on resident rights and primedical procedures (Exhaurses employed by the in-serviced by October 19 October 20, 2018, no not will be allowed to work ut has been completed. In a laminated sign was placed department of each media remind staff to provide prinjectable administration. The facility has implement Assurance Monitor: The Director of Nursing observation. She will audia administrations to assure rights /privacy are being the Residents' Right to Phassurance (QA) Monitor The monitor will be computative months and reported Quality of Life Team at the of Life Meeting. For any than 100% compliance, the extended an additional macorrective action will be in the Monthly Quality of Life Life Meeting.	exhibit (Exhibit r systematic the alleged of occur: Director of opment n an in- service gistered Nurses stical ne and part-time, ivacy during nibit Two). All facility were 9, 2018. As of rsing employee ntil the training addition, a the in the injectable ication cart to rivacy during that resident maintained, using rivacy Quality (Exhibit One). Deted weekly for the Monthly Qualit month with less the monitor will be month and mplemented by	g	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	' '	TE SURVEY MPLETED
		345518	B. WING		1	0/04/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	Continued From page		F 550	time.		
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 64 ⁻	1		10/19/18
	resident's status. This REQUIREMENT by: Based on observatio interviews and record code the Minimum Da accurately in the area #33), cognition (Resident #23) and m This was for 4 of 13 s for MDS accuracy. The statement of the sta	t accurately reflect the is not met as evidenced ins, resident and staff review, the facility failed to ata Set (MDS) assessments is of dental status (Resident dent #6), diagnoses iedications (Resident #11). ampled residents reviewed ine findings included: admitted on 5/21/18 and Resident #33's admission		The statements made on this Plat Correction are not an admission to not constitute an agreement with alleged deficiencies. To remain in compliance with all Federal and Strangliance set forth in this Polaries of Correction. The Plan of Correction constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or worrected by the date or dates independent of the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates independent with the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates in the strangliance such that all alleged deficiencies cited have been or worrected by the date or dates in the strangliance such that all	to and do the State or will clan of on of	
	indicated she was conno behaviors. She was having no broken or lidentures, no missing likely cavity and no but Resident #33's quarte indicated she was conno behaviors. She was (dental status) as havifitting full or partial de	erly MDS dated 8/28/18 gnitive intact and exhibited as coded under section L ring no broken or loosely ntures, no missing natural kely cavity and no broken		F641 For the residents involved, correct action has been accomplished by On October 5, 2018 the Minimum Set Nurse reassessed Resident #completed and submitted a Signif Change Minimum Data Set. On October 9, 2018 the Social Set Director reassessed Resident #6 to assure that the resident's cognistatus is included and accurately on the resident's Minimum Data Set October 10, 2018 an accurate Min Data Set was submitted and access a modification of the admission M Data Set assessment.	r: Data 33 and ficant ervices in order itive coded Set. On nimum epted for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345518	B. WING _			10/	04/2018
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE		,	15	TREET ADDRESS, CITY, STATE, ZIP CODE 55 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	wheelchair in the hal and spoke to this sur several of her bottom wearing an upper ful In an interview on 10 #33 stated she had in front partial, but she confirmed wearing a the upper, full dentur She voiced no denta issues with eating. In an interview on 10 Nurse confirmed she status) of Resident #5/28/18 and her quant The MDS Nurse stat visualize Resident #3 stated the MDS date	sserved self-propelling her I. When Resident #33 smiled rveyor, observed was missing n, front teeth. She was	F	641	On date October 2, 2018, the Minimum Data Set Nurse reassessed Resident # in order to assure that 100% of resider active diagnosis are accurately coded of the resident's Minimum Data Set. On October 2, 2018 an accurate Minimum Data Set was completed and submitted for a modification of the last two quarter assessments since most recent entry to reflect the addition of Hyperlipidemia accurrent diagnosis. On date October 3, 2018 the Minimum Data Set Nurse reassessed Resident # in order to assure that 100% of resider medications are included and accurate coded on the resident's Minimum Data Set. On October 3 2018 an accurate Minimum Data Set was completed and accepted on October 4, 2018 for a modification of the last two quarterly assessments to include the administration of a diuretic during the assessment period.	t23 ht's on d rrly o s a t11 ht's	
	Administrator stated MDS be coded accurstatus of Resident #3 In an interview on 10 Assistant (NA) #1 state upper full dentures to on the bottom. NA #7 Resident #33 had a page 2. Resident # 23 was 11/22/17 with multiple hyperlipidemia.	it was her expectation the rately and reflect the dental 33. /3/18 at 9:39 AM, Nursing ated Resident #33 wore her to eat but had missing teeth a stated she was not aware if partial for the bottom. It is admitted to the facility on the diagnoses including			Corrective action has been accomplish on all residents with the potential to be affected by the alleged deficient practic by: On October 15, 2018 the facility Director of Nursing completed a 100 % audit of current residents' medical record review for dental status and verified that it was accurately coded on their most recent Minimum Data Set. For results, please see exhibit (Exhibit Three). Any discrepancies were corrected at that tir On October 12, 2018 the Director of Nursing completed a 100 % audit of all current residents' medical record review	ce or all w s	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345518	B. WING	·	1	10/04/2018	
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BOULEVARD PINEHURST, NC 28374	- '		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	Resident #23's physic Simvastatin (used to triglycerides) 40 milligmouth at bedtime for Review of the Septen Administration Record Resident #23 had recesses ment period. On 10/3/18 at 11:05 Anterviewed. She verreceived Simvastatin period but she had mor hyperlipidemia on assessment dated 8/On 10/3/18 at 11:05 Anterviewed. She verreceived Simvastatin period but she had mor hyperlipidemia on assessment dated 8/On 10/3/18 at 11:05 Anterviewed the MDS as accurately. 3. Resident # 11 was 10/6/17 with multiple mypertension. The quarterly MDS as not indicate that Residuretic during the assessment #11's physic chlorthalidone (an anterviewed and the second for the	cian's orders included treat high cholesterol and grams (mgs) 1 tablet by hyperlipidemia. Inber 2018 Medication d (MAR) revealed that revived Simvastatin during the served Simvastatin during the during the assessment issed to code the diagnosis the quarterly MDS 11/18. AM the Director of Nursing red. She stated that she seessments to be coded admitted to the facility on diagnoses including seessment dated 7/13/18 did dent #11 had received a	F 64	for cognitive status and verified to current cognitive status is accurate reflected on the Minimum Data Stresults, please see exhibit (Exhib Any changes noted were made attime. On October 12, 2018 the Director Nursing completed a 100 % audicurrent residents' medical record for active diagnosis of hyperlipide ensure the diagnosis was appropreflected on the Minimum Data Stresults, please see exhibit (Exhib Any changes required were completed a 100 % audicurrent residents' medical record for accurate reflection on the used diuretics on the most current Min Data Set. For results, please see (Exhibit Six). Any changes needed made at that time. Measures put into place or system changes made to ensure the alled deficient practice does not occur. On October 17, 2018, the Region Minimum Data Set/Quality Assur Consultant and Director of Nursicompleted an in-service training of the Minimum Data Set Vurse facility Social Services Director of accurately code: dental status, dicognition and medications on all Data Set. Education information taken directly from the Resident	ately Set. For Joit Four). At that or of At the or of all I review At the or of At		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345518 B. WING		1	0/04/2018		
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Resident #11 had red the assessment period on 10/3/18 at 11:05 A interviewed. She ver received chlorthalidor period but she had munder medications or assessment dated 7/On 10/3/18 at 11:05 A (DON) was interviewed expected the MDS as accurately. 4. Resident #6 was a 6/28/18 with multiple vascular dementia. Resident #6's admiss 7/5/18 was reviewed. mental status (BIMs) long term memory was interviewed. The responsible for coding MDS assessment. S short and long term in	and Medication of (MAR) revealed that derived chlorthalidone during of. AM, the MDS Nurse was diffed that Resident #11 had the during the assessment dissed to code the diuretic of the quarterly MDS of the diving the assessment dissed to code the diving the diving the divingtion of the quarterly MDS of the divingtion of Nursing of the divingtion of Nursing of the divingtion of the diving	F 64		and specifically ding Minimum d a quality at a Set Coding per completed weeks and whibit Eight). audit five and Minimum ling of gnosis and all be reported at Team at the ing. For each compliance, any and be made by		
	interviewed. She sta	AM, the MDS Nurse was ted that she expected the taff for cognition if a resident e.					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345518	B. WING _			10/04/2018	
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	(DON) was interviewed expected the MDS as accurately.	e 7 AM the Director of Nursing ed. She stated that she ssessments to be coded w, Report Irregular, Act On	F 6			10/19/18	
F 756 SS=D	CFR(s): 483.45(c)(1) §483.45(c) Drug Reg §483.45(c)(1) The drumust be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's medical direct and these reports mu (i) Irregularities to the at facility's medical direct and these reports mu (i) Irregularities including that meets the condition of this section for (ii) Any irregularities in during this review mu separate, written report attending physician and director and director and director and the irregularity the (iii) The attending phyresident's medical rectiregularity has been action has been taken be no change in the rephysician should doct the resident's medical rectires and the irregularity medical rectiregularity has been action has been taken be no change in the rephysician should doct the resident's medical resident's medical rectires and the irregularity has been action has been taken be no change in the rephysician should doct the resident's medical rectires and the irregularity has been action has been taken be no change in the rephysician should doct the resident's medical rectires and the r	imen Review. Ig regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the ctor and director of nursing, st be acted upon. Ide, but are not limited to, any riteria set forth in paragraph an unnecessary drug. Noted by the pharmacist st be documented on a port that is sent to the not the facility's medical of nursing and lists, at a ant's name, the relevant drug, the pharmacist identified. Visician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in		756		10/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345518	B. WING _		10/04/2018	
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CO 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 OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE	
F 756	drug regimen review limited to, time frame the process and step when he or she iden requires urgent action. This REQUIREMEN by: Based on record rev. Consultant and staff Pharmacy Consultant address the long tern antibiotic without an sampled residents re (Residents # 6 & # 3 Findings included: 1. Resident #6 was a 6/28/18 with multiple vascular dementia. Data Set (MDS) asse indicated that Reside antibiotic drug during cognition was coded The physician's order reviewed. On 6/28//18 Resident #6 had an antibiotic drug) 50 m gastrostomy (G) tube infection (UTI) proph	d procedures for the monthly that include, but are not as for the different steps in as the pharmacist must take tifies an irregularity that in to protect the resident. This not met as evidenced view, and Pharmacy interview, the facility's at failed to identify and in use of prophylactic active infection for 2 of 2 eviewed on antibiotic therapy 5). admitted to the facility on diagnoses including The admission Minimum essment dated 7/5/18 and #6 had received an at the assessment period. Her as "not assessed". ars for Resident #6 were 8 (admission date), order for Nitrofurantoin (an illigrams (mgs) 1 capsule via a daily for urinary tract ylaxis. Is for Resident #6 were were no urinalysis nor urine	F	The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies. To rememoral compliance with all Federal Regulations the facility has to take the actions set forth in the Correction. The Plan of Correction. The Plan of Corrections in the facility's allege compliance such that all alleged deficiencies cited have been corrected by the date or date. For the residents involved, or action has been accomplish on October 12, 2018 the Mediscontinued Macrodantin for On October 15, 2018 the Mediscontinued Macrodantin for material forms. Corrective action has been as on all residents with the pote affected by the alleged deficiency: On October 15, 2018 the Direction of the correction of the state of the potential forms.	sion to and do with the ain in and State aken or will this Plan of rection gation of ged or will be es indicated. riew corrective ed by: edical Doctor or Resident #6. edical Doctor or Resident accomplished ential to be ient practice rector on esidents	
	culture reports noted	-		receiving antibiotics to ensurance stop dates. For	re that all had	

PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345518	345518 B. WING		10	0/04/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ININ AT O				155 BLAKE BOULEVARD			
INN AT QU	JAIL HAVEN VILLAGE			PINEHURST, NC 28374			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 756	Continued From page	e 9	F 75	56			
	The Medication Admi for June, July, Augus 2018 revealed that R	inistration Records (MARs) tt, September and October esident #6 had received		audit, please see exhibit (Exhi Any corrections needed were time.			
	2018 revealed that Resident #6 had received Nitrofurantoin as ordered. The drug regimen review (DRR) notes were reviewed. The notes revealed that the Pharmacy Consultant had conducted the monthly DRR on June 29, July 23, August 21 and September 20, 2018. The monthly DRR notes did not indicate that the Pharmacy Consultant had identified and addressed the prophylactic use of the antibiotic to the attending physician or the Director of Nursing (DON). On 10/2/18 at 4:23 PM, interview with the Physician was conducted. The Physician stated that he expected the Pharmacist to inform him of use of antibiotic without an active signs/symptoms of infection. On 10/3/18 at 1:46 PM, Pharmacy Consultant #1 was interviewed. She stated that the indication for the use of prophylactic antibiotic for Resident #6 was history of UTI. She further indicated that she normally addressed the use of prophylactic antibiotic to the attending physician or DON every 90 days. On 10/3/18 at 8:25 AM, the DON was interviewed. The DON stated that normally the facility didn't use antibiotic for UTI prophylaxis but in this case the family member of Resident #6 wanted the resident on antibiotic. 2. Resident #35 was admitted 8/30/18 a diagnosis of a history of Urinary Tract Infections (UTI).			Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On October 18, 2018 the Facility Consultant Pharmacist was re-educated on the proper procedure for managing prophylactic use of antibiotics and compliance with the Antibiotic Stewardship Program by Judy Jones Turnage, Doctor of Pharmacy, Board Certified Geriatric Pharmacist, American Society of Consult Pharmacy, Clinical Manager of Jones Professional Services, Inc (Exhibit Ten). Going forward, any resident noted with a prophylactic antibiotic will be flagged during review, referred to the Medical Doctor for further assessment. In addition, all prophylactic antibiotics will be given a stop and review date for a minimum of monthly.			
				The facility has implemented a assurance monitor: The Director of Nursing will converge prophylactic Use of Antibiotics Assurance Monitor weekly for and monthly for three months Eleven). The Director of Nursi evaluate all residents with antipensure an appropriate stop data appropriate documentation from Medical Provider and consulting specialist. The results will be monthly to the Quality of Life Monthly Quality of Life Meeting	emplete the signal Quality four weeks (Exhibit and will abiotics to te and will am Primary and greported feam at the		

Facility ID: 960236

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345518	B. WING _			0/04/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 155 BLAKE BOULEVARD PINEHURST, NC 28374	•	3.0 1.201.0
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From pag		F 7			
	orders dated 8/30/18	#35's admission Physician included an order for tic) 100 milligram (mg) e time a day for UTI		month with less than 100% the monitor will be extende corrective action required view the Quality of Life Team at	d. Any vill be made by	
	had a history of UTI's	plan dated 8/30/18 read she s and an intervention odantin for prophylaxis				
	Review of the electronic and written medical record revealed no evidence of a Urinalysis to diagnose the presence of a UTI for Resident #35 from 8/30/18 to present. Review of Resident #35's admission History and Physical (H&P) completed by the Physician dated 8/31/18 read she had a history of UTIs but the H&P did not include Macrodantin as one of Resident #35's prescribed medications.					
	AM read Resident #3	n note dated 9/4/18 at 8:31 85 was being treated for a plan to finish the Macrodantin				
	AM read Resident #3	n note dated 9/11/18 at 8:41 55 was finishing up treatment experiencing no fevers, chills discomfort.				
	PM read a medicatio Resident #35 was co	mpleted with vital signs eviewed, consults reviewed, ges reviewed. The ated there was a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345518 B. WING			10/04/2018		
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COL 155 BLAKE BOULEVARD PINEHURST, NC 28374)E	
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 756	Review of two Pharm dated 9/21/18 did not Macrodantin for UTI pan active infection with In an interview on 10/Director of Nursing (Difacility's Infection Cornesident #35 was add Macrodantin daily for never been discontinuthere was no evidence Urinalysis to rule out to In an interview on 10/Physician stated it was Consultant Pharmacis	acy Recommendations include the use of prevention in the absence of the no stop date. 218 at 11:20 AM, the process of the large and the large	F 7	56		
	who was admitted wit antibiotic (Macrodanti active infection. In a telephone intervice Consultant Pharmacis completed the medication 9/20/18. She state prescribed the Macrodanother facility. Consultant Pharmacy recomment for the Physician to act Physician reviewed a orders for Resident #35 to the Macrodantin was on the Physician to act Physician reviewed a orders for Resident #35 to the Macrodantin immediately.	h prescribed a prescribed n) in the absence of an ew on 10/3/18 at 1:30 PM, at #1 confirmed she ation review for Resident #5 d Resident #5 was dantin on admission from altant Pharmacist #1 stated ad a history of UTIs, the ner "radar" to make a dation after "a few months" ddress. She stated since the nd signed the admission 35, she would not address ediately. She also no recommendation about				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345518	B. WING			10/	04/2018
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	stated it was her experience Pharmacist would have recommendation for the Resident #35's antibid UTI in the absence of	3/18 at 3:07 PM, the DON ectation the Consultant ve completed a he Physician to address otic for the prevention of a fan infection.		756			10/10/19
F 757 SS=D	CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug unnecessary drugs. A drug when used- §483.45(d)(1) In exce duplicate drug therap §483.45(d)(2) For exc §483.45(d)(3) Withou use; or §483.45(d)(5) In the p consequences which reduced or discontinu §483.45(d)(6) Any co	cary Drugs-General. regimen must be free from An unnecessary drug is any ressive dose (including y); or ressive duration; or t adequate monitoring; or t adequate indications for its resence of adverse indicate the dose should be	F	757			10/19/18
	by: Based on record revi facility administered a presence of active inf adequate indication for	ew and staff interview, the an antibiotic without the fection and without an or use for 2 of 2 sampled an antibiotic therapy (Resident			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State	do	

PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345518	B. WING _			10/	04/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 .0,		
				155 BL	AKE BOULEVARD			
INN AT QU	IAIL HAVEN VILLAGE			PINE	IURST, NC 28374			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
TAG REGULATORY OR LSC IDENTIFYING		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
F 757	Continued From page	e 13	F 7	57				
	#6 & #35).				egulations the facility has taken or vice the actions set forth in this Plan			
	Findings included:			Co	prrection. The Plan of Correction nstitutes the facility's allegation of	.		
	1. Resident #6 was a	dmitted to the facility on			mpliance such that all alleged			
	6/28/18 with multiple		I .	ficiencies cited have been or will be				
	Data Set (MDS) asse				rrected by the date or dates indicat	ed.		
		nt #6 had received an			'57			
	cognition was coded	assessment period. Her		- 1	or the residents involved, corrective tion has been accomplished by:			
	cognition was coded	as 110t assessed .			n October 12, 2018 the Medical Do	ctor		
	The physician's order	rs for Resident #6 were		I .	scontinued Macrodantin for Resider			
		8 (admission date), Resident			October 15, 2018 the Medical Doo			
		litrofurantoin (an antibiotic)			scontinued Macrodantin for Resider	nt		
	(G) tube daily for urin	I capsule via gastrostomy ary tract infection (UTI)		#3				
	prophylaxis.			on	prrective action has been accomplise all residents with the potential to b	e		
	_	for Resident #6 were			ected by the alleged deficient pract	iice		
	culture reports noted.	vere no urinalysis nor urine		by	: n October 15, 2018 the Director on			
	culture reports noted.			- 1	ursing audited all current residents			
	The Medication Admi	nistration Records (MARs)		- 1	ceiving antibiotics to ensure that all	had		
		t, September and October			propriate stop dates. Please see			
		esident #6 had received		- 1	hibit for results (Exhibit Nine). Any			
	Nitrofurantoin as orde				rrections needed were made at tha ne.	it		
		M, Pharmacy Consultant #1						
		e stated that the indication			easures put into place or systemation	3		
		actic antibiotic for Resident			anges made to ensure the alleged			
	#6 was history of UTI	•			ficient practice does not occur: n October 12, 2018 the Staff			
	On 10/3/18 at 8:25 A	M, the DON was			evelopment Coordinator began			
		N stated that normally the			servicing all nurses, part-time and			
		biotic for UTI prophylaxis but			Itime, on the expectation of following	ıg		
	in this case the family			e Antibiotic Stewardship Program,	-			
	#6 on antibiotic. The			ecifically ensuring all antibiotic orde				
	#6 had no active infe	ction.		ha	ve a stop date and that the patient	is		

Facility ID: 960236

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345518	B. WING		1	0/04/2018	
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 757	Continued From page 14 2. Resident #35 was admitted 8/30/18 a diagnosis of a history of Urinary Tract Infections (UTI). Review of Resident #35's admission Physician orders dated 8/30/18 included an order for Macrodantin (antibiotic) 100 milligram (mg) capsule by mouth one time a day for UTI prevention. Resident #35's care plan dated 8/30/18 read she had a history of UTI's and an intervention included taking Macrodantin for prophylaxis (prevention). Review of the electronic and written medical record revealed no evidence of a Urinalysis to diagnose the presence of a UTI for Resident #35 from 8/30/18 to present. Review of the electronic and written medical record revealed Resident #35 has remained afebrile since admission with her temperature ranges from 97.0 to 98.8 degrees Fahrenheit.		F 757	experiencing an active infection Twelve). The in-service was of by October 19, 2018 at which it nurses must be in-serviced privivorking. Going forward, in the an active infection, the nurse in request of the doctor a consult specialty physician to ensure the long-term use of the antibiotic appropriate and provide frequences reassessment as ordered by the physician. The facility has implemented an assurance monitor: The Director of Nursing will consume the prophylactic Use of Antibiotics and monthly for three months of Eleven). The Director of Nursing evaluate all residents with antilensure an appropriate stop data appropriate documentation from Medical Provider and consulting the service was a service with antilensure and consulting the service was a service with antilensure and consulting the service was a service with antilensure and consulting the service was a service was a service with antilensure and appropriate documentation from the service was a service was	completed time all or to absence of nust from a hat the is ent ne quality omplete the Quality four weeks (Exhibit ng will biotics to te and m Primary		
	record revealed Res Macrodantin 100 mg a day for UTI preven Review of Resident a Physical (H&P) comp 8/31/18 read she had H&P did not include Resident #35's preso Review of the nursin	capsule by mouth one time tion from 8/30/18 to present. #35's admission History and pleted by the Physician dated d a history of UTIs but the Macrodantin as one of cribed medications. g notes from 8/30/18 to documentation regarding the		specialist. The results will be a monthly to the Quality of Life T Monthly Quality of Life Meeting month with less than 100% cot the monitor will be extended. A corrective action required will the Quality of Life Team at that	eam at the g. For each mpliance, Any pe made by		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345518	B. WING _		1	0/04/2018
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP (155 BLAKE BOULEVARD PINEHURST, NC 28374	CODE	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From pag	e 15	F 7	757		
	Resident #35 remain	ed on Macrodantin for a UTI.				
	AM read Resident #3	n note dated 9/4/18 at 8:31 5 was being treated for a blan to finish the Macrodantin				
	AM read Resident #3	n note dated 9/11/18 at 8:41 5 was finishing up treatment experiencing no fevers, chills discomfort.				
	PM read a medicatio Resident #35 was co	mpleted with vital signs eviewed, consults reviewed, ges reviewed. The ated there was a				
	dated 9/21/18 did no Macrodantin for UTI an active infection wi	prevention in the absence of the no stop date.				
	Director of Nursing (I was admitted with or daily for UTI preventi discontinued. The DO	/218 at 11:20 AM, the DON) stated Resident #35 ders for the Macrodantin on and it had never been DN confirmed there was no ent #35 had a Urinalysis to e of a UTI.				
		/2/18 at 2:15 PM, Nurse #1 exhibited no symptoms of a				
	In an interview on 10 Physician stated it wa	/3/18 at 9:21 AM, the as his practice to wait for a				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345518	B. WING		1	0/04/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 155 BLAKE BOULEVARD PINEHURST, NC 28374	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 757	specify the organism resident had increased tract infection sympto increased pulse the rempirically while awaresults. In an interview on 10 Assistant (NA) #1 stated she had not of UTI when caring for In a telephone intervice Consultant Pharmacic completed the medical on 9/20/18. She stated prescribed the Macrodantin was on pharmacy recomment for the Physician to a Physician reviewed a orders for Resident #35 had Macrodantin immorphismed she made the Macrodantin 9/20. In an interview on 10 stated it was her experiment of the physician reviewed and the Macrodantin 9/20. In an interview on 10 stated it was her experiment of the physician reviewed and the Macrodantin 9/20. In an interview on 10 stated it was her experiment of the physician receive and a UTI in the absence of the province of the physician review on 10 stated it was her experiment of the physician receive and a UTI in the absence of the physician review on 10 stated it was her experiment of the physician review on 10 stated it was her experiment.	efore prescribing an noce a Urinalysis would not to treat. He stated if a sed and/or significant urinary oms such as fever or resident would be treated aiting the urine culture /3/18 at 9:39 AM, Nursing ated Resident #35 could let needs to be changed. NA #1 observed any evidence of a Resident #35. where on 10/3/18 at 1:30 PM, ast #1 confirmed she ation review for Resident #5 and Resident #5 was obtain on admission from sultant Pharmacist #1 stated and a history of UTIs, the her "radar" to make a modation after "a few months" and signed the admission signed the admission signed the admission after "Sed also no recommendation about	F 75			10/19/18	
SS=D	CFR(s): 483.45(c)(3)						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345518	B. WING		10/04/2018	
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 758	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreheresident, the facility in \$483.45(e)(1) Reside psychotropic drugs at unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral intervention contraindicated, in and drugs; §483.45(e)(3) Reside psychotropic drugs punless that medication diagnosed specific coin the clinical record; §483.45(e)(4) PRN of are limited to 14 days §483.45(e)(5), if the aprescribing practition appropriate for the Plant in the procession of the pro	ppic Drugs. hotropic drug is any drug that a associated with mental vior. These drugs include, drugs in the following ensive assessment of a must ensure that ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic and ons, unless clinically in effort to discontinue these drugs are for the discontinue these drugs in is necessary to treat a diagnosed and documented ons, unless clinically in effort to discontinue these drugs are for the discontinue these drugs are for psychotropic dr	F 754			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345518	B. WING		10/04/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BOULEVARD PINEHURST, NC 28374	,
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 758	indicate the duration §483.45(e)(5) PRN of drugs are limited to renewed unless the prescribing practition the appropriateness. This REQUIREMEN' by: Based on record reviacility failed to transcorrect dose of antid for 1 of 5 sampled reunnecessary medicates. Findings included: Resident #11 was ac 10/6/17 with multiple depressive disorder. Resident #11 had a for Zoloft (antidepressive disorder.) Resident #11 had a for Zoloft (antidepressive disorder.) On 8/21/18, the Phaconducted a drug regrecommended a graffor Zoloft. On 8/23/18, the Physique of the recoming Zoloft 75 mgs by monther reassess.	ent's medical record and for the PRN order. orders for anti-psychotic 14 days and cannot be attending physician or her evaluates the resident for of that medication. T is not met as evidenced or iew and staff interview, the cribe and to administer the epressant drug as ordered sidents reviewed for tions (Resident #11). Imitted to the facility on diagnoses including major cian's orders were reviewed. Soctor's order dated 11/5/17 is ant drug) 125 millligrams or for depression. Imacy Consultant had gimen review (DRR) and had dual dose reduction (GDR) sician had responded and mendation and ordered uth daily for 30 days and	F 7	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 State Regulations the facility has taken of take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indice the resident # 11, the anti-depress order was corrected to reflect the recommendation of the Pharmacist subsequent order of the Medical Decorrective action has been accomponed all residents with the potential to affected by the alleged deficient proby: On October 19, 2018 the Director of the Medical Decorrective action has been accomponed to the probability.	and do ne ate or will an of of be cated. ve sant t and octor. blished b be actice
		t, September and October ministration Records (MARS)		Nursing audited all Pharmacy Recommendations for the precedir	ng

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345518	B. WING		10/04/2018
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	revealed that Resider Zoloft 125 mgs by more of the commendations from the commendation from the comm	outh daily. M, the Director of Nursing ed. The DON stated that in making sure the m the Pharmacy Consultant e indicated that after the to the recommendation, she had to write the order. The lathat after the physician formmendation to reduce the 1/23/18, the form went all records for filing and has missed. AM the Director of Nursing ed. She stated that she an's order to be transcribed hedication to be	F 758	month for accurate completion, includ transcription of Medical Doctor orders (Exhibit Thirteen). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On October 18, 2018 the Director of Nursing re-educated the Health Information Manager on the process on the up-loading Pharmacy Consultation prior to being signed off by the Medical Doctor or Physician's Assistant and a nurse as being completed (Exhibit Fourteen). Going forward, the Health Information Manager will only upload both the nurse and the Medical Doctor Physician's Assistant have initialed, noting the consultation has been acknowledged and any changes warranted have been made. In additing the Director of Nursing will compare the completed Pharmacy Consultant Recommendations to the master Pharmacy Report to ensure each one been addressed and completed prior is sending to the Health Information Manager for uploading. The facility has implemented a quality assurance monitor: The Director of Nursing will complete Unnecessary Psychotropic Medication Quality Assurance Monitor weekly for weeks and monthly for three months (Exhibit Fifteen). The Director of Nursi will review each Pharmacy Recommendation to ensure the recommendation is addressed and an	of install once on the ins

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345518	B. WING	B. WING		10/04/2018	
	ROVIDER OR SUPPLIER		•	15	TREET ADDRESS, CITY, STATE, ZIP CODE 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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 20	F	758	order changes are transcribed correctly. The results will be reported monthly to Quality of Life Team at the Monthly Qua of Life Meeting. For each month with lethan 100% compliance, the monitor will extended. Any corrective action require will be made by the Quality of Life Tear that time.	the ality ess I be ed	
F 881 SS=D	- I - I - I - I - I - I - I - I - I - I		on at	881			10/19/18
	follow their Antibiotic evidenced by the use the presence of active adequate indication for residents reviewed or (Residents #6 & #35) Findings included: The facility's Antibiotic dated November 201 program read in part tools for fighting and processes the series of	nterview, the facility failed to Stewardship program as of an antibiotic drug without e infection and without or use for 2 of 2 sampled n antibiotic therapy . c Stewardship program 7 was reviewed. The "Antibiotics are powerful			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or wil take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F881 For the residents involved, corrective	II :	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED		
		345518	345518 B. WING				10/04/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
DD 47 01				15	55 BLAKE BOULEVARD			
INN AT QU	JAIL HAVEN VILLAGE			Р	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 881	Continued From pag	e 21	F 8	881				
	resulted in an alarming increase in antibiotic -resistant infection and a subsequent need to rely on broad -spectrum antibiotic that might be more toxic and expensive. In addition to the development of antibiotic resistance, antibiotic use is associated with an increased risk of Clostridium difficile infection and adverse drug reaction. Since antibiotics are frequently over and inappropriately prescribed, a concerted effort to decrease or eliminate inappropriate use can make a big impact on resident safety and the reduction of adverse events. Antibiotic stewardship consists of coordinated interventions aimed at treating infections while promoting appropriate antibiotic use". The program further revealed "it is the policy of this facility to maintain an Antibiotic Stewardship Program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use".				action has been accomplished by: On October 12, 2018 the Medical Doc discontinued Macrodantin for Residen: On October 15, 2018 the Medical Doc discontinued Macrodantin for Residen: #35. Corrective action has been accomplish on all residents with the potential to be affected by the alleged deficient practi- by: On October 15, 2018 the Director on Nursing audited all current residents receiving antibiotics to ensure that all I appropriate stop dates and appropriate indications for use. For results, please the exhibit (Exhibit Nine). Any correction needed were made at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur:	t #6. tor t ned ce nad e see ons		
	6/28/18 with multiple vascular dementia. Data Set (MDS) asset indicated that Reside antibiotic during the acognition was coded The physician's order reviewed. On 6/28//1 #6 had an order for Marug) 50 milligrams (gastrostomy (G) tube infection (UTI) prophysical properties of the control of	The admission Minimum essment dated 7/5/18 ent #6 had received an assessment period. Her as "not assessed". rs for Resident #6 were 8 (admission date), Resident Nitrofurantoin (an antibiotic mgs) 1 capsule via e daily for urinary tract			deficient practice does not occur: On October 18, 2018 the Facility Consultant Pharmacist was re-educate on the proper procedure for managing prophylactic use of antibiotics and compliance with the Antibiotic Stewardship Program by Judy Jones Turnage, Doctor of Pharmacy, Board Certified Geriatric Pharmacist, America Society of Consult Pharmacy, Clinical Manager of Jones Professional Servic Inc (Exhibit Ten). Going forward, any resident noted with a prophylactic antibiotic will be flagged during review referred to the Medical Doctor for furth assessment. In addition, all prophylac antibiotics will be given a stop and rev date for a minimum of monthly.	an es, , er :tic		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345518	B. WING _		10)/04/2018	
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI 155 BLAKE BOULEVARD PINEHURST, NC 28374	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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) COMPLETION DATE	
F 881	Culture reports noted The Medication Adm for June, July, Augu 2018 revealed that F Nitrofurantoin as ord On 10/3/18 at 1:46 F was interviewed. Sh for the use of prophy #6 was history of UT On 10/3/18 at 8:25 A interviewed. The DO had no active infectithe indication for the Resident #6 was UT request. The DON refacility's Antibiotic Sh followed. 2. Resident #35 was diagnosis of a histor (UTI). Review of Resident orders dated 8/30/18 Macrodantin (antibio capsule by mouth or prevention. Resident #35's care had a history of UTI' included taking Mac (prevention).	were no urinalysis nor urine d. Ininistration Records (MARs) st, September and October Resident #6 had received lered. PM, Pharmacy Consultant #1 ne stated that the indication vlactic antibiotic for Resident TI. AM, the DON was DN verified that Resident #6 on. She also indicated that use of the antibiotic for TI prophylaxis and per family evealed that she expected the rewardship program be	F	On October 12, 2018 the State Development Coordinator be in-servicing all nurses, part-tifulltime, on the expectation of the Antibiotic Stewardship Prespecifically ensuring all antibe have a stop date and that the experiencing an active infect Twelve). In the absence of a infection, the nurse must required doctor a consult from a spector ensure the longtime use of antibiotic is appropriate and preassessment as ordered by physician. The in-service was by October 19, 2018 at which nurses must be in-serviced providing. The facility has implemented assurance monitor: The Director of Nursing will be prophylactic Use of Antibiotic Assurance Monitor weekly for and monthly for three monthsteleven). The Director of Nursevaluate all residents with an ensure an appropriate stop of appropriate documentation from Medical Provider and consultable specialist. The results will be monthly to the Quality of Life Monthly Quality of Life Meetimonth with less than 100% of the monitor will be extended. Corrective action required will the Quality of Life Team at the consultable of the monitor will be extended.	egan ime and of following rogram, viotic orders e patient is tion (Exhibit an active quest of the vialty physician of the provide of the s completed the s completed that all prior to the season of the complete the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345518	B. WING _			10/04/2018	
	ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE	•	,	STREET ADDRESS, CITY, STATE, ZIP COD 155 BLAKE BOULEVARD PINEHURST, NC 28374	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 881	diagnose the present from 8/30/18 to present electron record revealed Resent afebrile since admissionages from 97.0 to record revealed Resent electron electron record revealed Resent electron el	evidence of a Urinalysis to ce of a UTI for Resident #35 ent. Donic and written medical ident #35 has remained sion with her temperature 98.8 degrees Fahrenheit. Donic and written medical ident #35 received ident #35 received ident #35 received ident #35 received ident #36 received ident #37 received identification #36 received identification #37 rec	F	381			
	AM read Resident #	an note dated 9/11/18 at 8:41 35 was finishing up treatment experiencing no fevers, chills discomfort.					
	PM read a medication Resident #35 was contact the second read a medication read a me	cy note dated 9/20/18 at 9:53 on regimen review for ompleted with vital signs eviewed, consults reviewed,					

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345518	B. WING		10/04/2018	
NAME OF PROVIDER OR SUPPLIER INN AT QUAIL HAVEN VILLAGE			155 BLAKE BOULEVARD	10/04/2010	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
and medication chair Pharmacy note indice recommendation material Review of two Pharmacy and the 9/21/18 did not Macrodantin for UTI an active infection with In an interview on 10 Director of Nursing (facility's Infection Consultant Harmacy Resident #35 was an Macrodantin daily for never been disconting there was no evident Urinalysis to rule out In an interview on 10 stated Resident #35 UTI. In an interview on 10 Physician stated it was admitted was admitted wantibiotic (Macrodantic Macrodantic (Macrodantic In a second interview Physician stated it warring culture result to antibiotic for a UTI second interview on 10 Physician stated it warring culture result to antibiotic for a UTI second interview antib	inges reviewed. The cated there was a add to the Physician. macy Recommendations of include the use of prevention in the absence of with no stop date. 0/218 at 11:20 AM, the (DON) stated she was the control Preventionist and dmitted with orders for the or UTI prevention and it had nued. The DON confirmed for that Resident #35 had a at the presence of a UTI. 0/2/18 at 2:15 PM, Nurse #1 is exhibited no symptoms of a 0/2/18 at 4:23 PM, the was his expectation that the cist would have completed a endation for Resident #35 with prescribed a prescribed intin) in the absence of an or 10/3/18 at 9:21 AM, the was his practice to wait for a perfore prescribing an since a Urinalysis would not	F 88	1		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From pag and medication chan Pharmacy note indic recommendation ma Review of two Pharm dated 9/21/18 did no Macrodantin for UTI an active infection w In an interview on 10 Director of Nursing of facility's Infection Co Resident #35 was a Macrodantin daily for never been discontin there was no evider Urinalysis to rule ou In an interview on 10 stated Resident #35 UTI. In an interview on 11 Physician stated it w Consultant Pharmac Pharmacy Recomm who was admitted w antibiotic (Macrodar active infection. In a second interview Physician stated it w urine culture result to antibiotic for a UTI se	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 and medication changes reviewed. The Pharmacy note indicated there was a recommendation made to the Physician. Review of two Pharmacy Recommendations dated 9/21/18 did not include the use of Macrodantin for UTI prevention in the absence of an active infection with no stop date. In an interview on 10/218 at 11:20 AM, the Director of Nursing (DON) stated she was the facility's Infection Control Preventionist and Resident #35 was admitted with orders for the Macrodantin daily for UTI prevention and it had never been discontinued. The DON confirmed there was no evidence that Resident #35 had a Urinalysis to rule out the presence of a UTI. In an interview on 10/2/18 at 2:15 PM, Nurse #1 stated Resident #35 exhibited no symptoms of a UTI. In an interview on 10/2/18 at 4:23 PM, the Physician stated it was his expectation that the Consultant Pharmacist would have completed a Pharmacy Recommendation for Resident #35 who was admitted with prescribed a prescribed antibiotic (Macrodantin) in the absence of an active infection. In a second interview on 10/3/18 at 9:21 AM, the Physician stated it was his practice to wait for a urine culture result before prescribing an antibiotic for a UTI since a Urinalysis would not	A BUILDING 345518 B. WING BOVIDER OR SUPPLIER JAIL HAVEN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 and medication changes reviewed. The Pharmacy note indicated there was a recommendation made to the Physician. Review of two Pharmacy Recommendations dated 9/21/18 did not include the use of Macrodantin for UTI prevention in the absence of an active infection with no stop date. In an interview on 10/218 at 11:20 AM, the Director of Nursing (DON) stated she was the facility's Infection Control Preventionist and Resident #35 was admitted with orders for the Macrodantin daily for UTI prevention and it had never been discontinued. The DON confirmed there was no evidence that Resident #35 had a Urinalysis to rule out the presence of a UTI. In an interview on 10/2/18 at 2:15 PM, Nurse #1 stated Resident #35 exhibited no symptoms of a UTI. In an interview on 10/2/18 at 4:23 PM, the Physician stated it was his expectation that the Consultant Pharmacist would have completed a Pharmacy Recommendation for Resident #35 who was admitted with prescribed a prescribed antibiotic (Macrodantin) in the absence of an active infection. In a second interview on 10/3/18 at 9:21 AM, the Physician stated it was his practice to wait for a urine culture result before prescribing an antibiotic for a UTI since a Urinalysis would not	ROYNDER OR SUPPLIER JAIL HAVEN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 24 and medication changes reviewed. The Pharmacy note indicated there was a recommendation made to the Physician. Review of two Pharmacy Recommendations dated 9/21/18 did not include the use of Macrodantin for UTI prevention in the absence of an active infection Control Preventionist and Resident #35 was admitted with orders for the Macrodantin daily for UTI prevention and it had never been discontinued. The DON confirmed there was no evidence that Resident #35 had a Urinalysis to rule out the presence of a UTI. In an interview on 10/2/18 at 2:15 PM, Nurse #1 stated Resident #35 exhibited no symptoms of a UTI. In an interview on 10/2/18 at 4:23 PM, the Physician stated it was his expectation that the Consultant Pharmacy Recommendation for Resident #35 who was admitted with prescribed a prescribed antibiotic (Macrodantin) in the absence of an active infection. In a second interview on 10/3/18 at 9:21 AM, the Physician stated it was his practice to wait for a urine culture result before prescribing an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345518	B. WING		10/04/2018	
NAME OF PROVIDER OR SUPPLIER INN AT QUAIL HAVEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BOULEVARD PINEHURST, NC 28374		1 1010-1120-10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 881	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F 88	.1		
	the Physician if it wa	of preventive antibiotics with as not already done by the Pharmacist stated the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345518	B. WING		1	10/04/2018	
NAME OF PROVIDER OR SUPPLIER INN AT QUAIL HAVEN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CO 155 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 881	for Resident #35 on I obviously ordered he UTI prevention. She quarterly Antibiotic Strommittee quarterly. In an interview on 10 stated it was her exp Stewardship program	he medications prescribed her admission and he or to be on the antibiotic for confirmed she attended the tewardship Review 1/3/18 at 3:07 PM, the DON ectation the Antibiotic in be followed, and Resident d an antibiotic in the absence	F	881			