DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	COM	E SURVEY PLETED
		345518	B. WING				C / 31/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	JAIL HAVEN VILLAGE			15	5 BLAKE BOULEVARD		
				PI	NEHURST, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000		8.73, Emergency t ID #43B311.	F	000			
F 578 SS=D	recertification and con conducted. There was allegations. All 5 alle unsubstantiated for in facility was found in c requirement CFR 483 Preparedness. See E	gations were sufficient evidence. The ompliance with the 3.73, Emergency vent ID #43B311. ntnue Trmnt;FormIte Adv Dir	F	578			11/19/19
	discontinue treatment	ht to request, refuse, and/or t, to participate in or refuse rimental research, and to e directive.					
	construed as the right the provision of medie	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or					
	requirements specifie subpart I (Advance D (i) These requirement inform and provide we residents concerning medical or surgical tre	is include provisions to ritten information to all adult the right to accept or refuse					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

11/19/2019

		ND HUMAN SERVICES			PRINTED: 12/03 FORM APPRO OMB NO. 0938-	OVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345518	B. WING		C 10/31/2019	Э
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	JAIL HAVEN VILLAGE			155 BLAKE BOULEVARD		
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLE	ETIO
F 578	Continued From page	e 1	F 57	o		
1 0/0			F 57	D		
		ritten description of the				
		nplement advance directives				
	and applicable State					
		nitted to contract with other s information but are still				
	legally responsible for					
	requirements of this					
	-	ual is incapacitated at the				
		d is unable to receive				
		ate whether or not he or she				
		ance directive, the facility				
		rective information to the				
		representative in accordance				
	with State Law.					
		relieved of its obligation to				
		on to the individual once he				
	or she is able to rece					
	Follow-up procedure	s must be in place to provide				
		e individual directly at the				
	appropriate time.	-				
	This REQUIREMEN	Γ is not met as evidenced				
	by:					
	Based on record rev	iew and staff interview, the		The statements made on this F	Plan of	
	facility failed to ensur	re that the resident's elected		Correction are not an admission	n to nor do	
	advance directive ma	atched with the physician's		they constitute an agreement w	vith the	
		c health record (EHR) and		alleged deficiencies. To remain		
	hard chart for 1 (Res	ident #24) of 1 sampled		compliance with all Federal and		
	resident reviewed for	advance directive.		Regulations the facility has take		
				take the actions set forth in this		
	Findings included:			Correction. The Plan of Correc		
				constitutes the facility's allegation		
		iginally admitted to the facility		compliance such that all alleged		
		discharged to the community		deficiencies cited have been or		
		lity's advance directive form		corrected by the date or dates i	ndicated.	
		vealed that the resident		F578		
	elected to be Full Co	de.		For the residents involved the for	-	
				corrective action has been acco	omplished	
		admitted to the facility on		by:		
	8/16/19 with multiple	diagnoses including		On October 29, 2019, the resid	ent's	

Facility ID: 960236

If continuation sheet Page 2 of 32

			0			<u>NO. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · · ·	TE SURVEY MPLETED	
			A. BUILDING	G			
		345518	B. WING			C	
	ROVIDER OR SUPPLIER	343310		STREET ADDRESS, CITY, STATE, ZIP CODE	1	0/31/2019	
	ROVIDER OR SUFFLIER			155 BLAKE BOULEVARD			
INN AT QU	JAIL HAVEN VILLAGE			PINEHURST, NC 28374			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETIO	
F 578	Continued From page	e 2	F 57	78			
		mur fracture. The admission		elected advanced directive was	corrected		
		ADS) assessment dated		by the Nursing Supervisor so that			
	8/23/19 indicated that			physician's order in the electron			
		npairment. The facility's		record (EHR) matched the hard			
		m signed by the power of		Corrective action has been acco			
		16/19 revealed that the		on all residents with the potentia			
	resident was a Do No	ot Resuscitate (DNR).		affected by the alleged deficient	practice		
	Desident #24/a EUDa			by:	an af		
		s and the hard chart were nt physician's order indicated		On October 30, 2019, the Direct Nursing (DON) audited 100% of			
		a Full code. The physician's		residents to ensure their elected			
		10/24/19 indicated that the		directive matched with the physi			
		The care plan dated 8/19/19		order in the EHR and the hard c			
	indicated that the res			issues noted were corrected at t	-		
				For results of the audit please se	ee exhibit		
		PM, the MDS Nurse was		(Exhibit One).			
		ified that Resident #24 had a		Measures put in place or system			
		full code and her care plan		changes made to ensure the all			
		is a DNR. The MDS Nurse		deficient practice does not occur			
		ike the resident was a Full		The Admission Audit form was a			
		ind was discharged to the ie was readmitted, her code		to include checking for the elect advance directive for all admissi			
		to a DNR. She indicated that		readmissions to ensure the physic			
		as readmitted, the code		order in the EHR and the hard c			
		een clarified by the admitting		match (Exhibit Two). On Novem			
	nurse.			2019, the DON educated all nur			
				fulltime and part time on the app			
		PM, Nurse #1, assigned to		use of the Admission Audit form			
		terviewed. The Nurse stated		advanced directive orders (Exhi			
	-	ed at the physician's order		The facility has implemented a C	Juality		
		e status in EHR or hard the nurses had a list of		Assurance Monitor:	in weakly		
		s in a clip board. Nurse #1		The Director of Nursing will beg observation. She will audit five			
		t #24 was a Full Code on the		new or readmitted residents usin			
	list. The Nurse furthe			Advance Directive Quality Assur	-		
		on, the admission staff		Monitor (Exhibit Four). The mor			
		e responsible party (RP) a		be completed weekly for three n			
	-	ective form to elect and to		and reported to the Monthly Qua			
		s code status. The form was		Team at the Monthly Quality of L	•		

Facility ID: 960236

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIDI I	ECONSTRUCTION	(X3) DATE	0. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	LETED
			-		С	
		345518	B. WING	10/31/2019		
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 578	Continued From page	e 3	F 578			
	was written based on	R and the physician's order the elected code status.		Meeting. For any month with less the 100% compliance, the monitor will be		
		he didn't know why the		extended an additional month and	d by	
	physician's order (Fu	DNR) did not match with the Il Code).		corrective action will be implemente the Monthly Quality of Life Team at		
	(DON) was interview staff to verify code sta ensure the physician EHR and hard copy r	AM, the Director of Nursing ed. The DON expected the atus on readmission and to order for code status in the natched with the code status		time.		
F 641 SS=D	elected by the reside Accuracy of Assessm CFR(s): 483.20(g)		F 641			11/19/19
	resident's status.	of Assessments. It accurately reflect the is not met as evidenced				
	interview, the facility Minimum Data Set (Mareas of hospice, life alarm (Resident #11) #32), and positioning	iew, observation, and staff failed to accurately code the ADS) assessments in the expectancy, and wander , pressure ulcer (Resident and mobility (Resident #26) reviewed. Findings included:		The statements made on this Plan Correction are not an admission to they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Stat Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction	nor do ne te will	
	4/8/19 with diagnoses dementia.			constitutes the facility's allegation or compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic	be	
	documented the resid was rarely understoo cognition was unable active diagnoses wer	rly MDS dated 8/6/19 dent had unclear speech and d or understands and his to be determined. The e non-Alzheimer's dementia, ignant melanoma of lower		F641 For the residents involved, correctiv action has been accomplished by: On October 30, 2019, the Minimum Set (MDS) for Resident # 11 was up	Data	

Facility ID: 960236

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/03/2019 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		345518	B. WING				C 10/31/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
INN AT QUAIL HAVEN VILLAGE				55 BLAKE BOULEVARD INEHURST, NC 28374				
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	answered "no," Sectia services" was coded wander alarm" was c There was a physicia hospice consult docu The care plan docum provided by outside p initiated on 4/29/19. On 10/31/19 at 11:15 conducted with the M that after review of th dated 8/6/19, the MD Section "O. 100 k hos human error and wou The Director of Nursi on 10/31/19 at 11:45 expected the MDS to 1b. Resident #11 was 4/8/19 with diagnoses dementia. The resident's quarte documented the resid was rarely understoo cognition was unable active diagnoses wer Parkinson's, and mal extremity. Section "J answered "no," Section	. 1400 life expectancy" was on "O. 100 k hospice "no," and Section "P. 200 e oded "no." n order dated 4/24/19 for mented for the resident. ented that hospice was orivate hospice services am an interview was IDS Coordinator who stated e resident's admission MDS S was incorrectly coded in spice services" which was ild be corrected. ng (DON) was interviewed am who stated that she be accurately coded. s admitted to the facility on s of Parkinson's and rly MDS dated 8/6/19 dent had unclear speech and d or understands and his to be determined. The e non-Alzheimer's dementia, ignant melanoma of lower . 1400 life expectancy" was on "O. 100 k hospice "no," and Section "P. 200 e	F	641	to reflect his wander alarm, Hospice designation, and life expectancy by th Minimum Data Set (MDS) Nurse. On October 30, 2019, the MDS Nurse corrected the MDS for Resident #32 the accurately reflect a pressure ulcer that was present on admission. On date October 30, 2019 the MDS N corrected the current MDS for Reside #26, to accurately reflect bilateral upp extremity contractures. Corrective action has been accomplis on all residents with the potential to be affected by the alleged deficient pract by: By November 18, 2019, the facility Director of Nursing completed a 100 audit of all current residents with Hos wander alerts, wounds and contractu to ensure accurate coding on their cu MDS. For results, please see exhibit (Exhibit Five). Any discrepancies not were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 15, 2019 the Regional Minimum Data Set/Quality Assurance Consultant completed an in- service training for MDS Nurse on how to accurately code hospice, life expecta wander alarms, pressure ulcers and contractures on the MDS. Education information was taken directly from th Resident Assessment Instrument (RA Education was provided on: Section P0200, Section O0100, Section M, an	e at Nurse ent ber shed e tice % pice, res rrent ed c c e ncy,		
	There was a physicia	n order dated 4/24/19 for			Section G0400 and specifically the process of accurately coding Minimum	n		

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/31/2019	
		345518	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QUAIL 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 SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 5	F 64	1		
		mented for the resident.		Data Set (Exhibit Six).		
	provided by outside p initiated on 4/29/19. On 10/31/19 at 11:15 conducted with the M that after review of th dated 8/6/19, the MD Section "J. 1400 life e human error and wou The Director of Nursii on 10/31/19 at 11:45 expected the MDS to 1c. Resident #11 was 4/8/19 with diagnoses dementia. The resident's quarte documented the resid was rarely understoo cognition was unable active diagnoses wer Parkinson's, and mali extremity. Section "J answered "no," Sectio services" was coded wander alarm" was co The resident had a pl guard order dated/pla each day, twice a day The resident's care p updated 6/27/19 at ris	IDS Coordinator who stated e resident's admission MDS S was incorrectly coded in expectancy" which was ald be corrected. Ing (DON) was interviewed am who stated that she be accurately coded. Is admitted to the facility on s of Parkinson's and Infly MDS dated 8/6/19 dent had unclear speech and d or understands and his to be determined. The re non-Alzheimer's dementia, ignant melanoma of lower 1. 1400 life expectancy" was on "O. 100 k hospice "no," and Section "P. 200 e oded "no."		The facility has implemented a quassurance monitor: The following QA Tools will be completed by the DON weekly fo weeks and monthly for three mor Accurate Coding of MDS Section MDS Coding Accuracy (Section F Audit Tool, Accurate Coding of Se M0300 (Ulcer Present upon Adm Audit Tool and Accurate MDS Co G0400 (Function al Limitation in F Motion) Audit Tool (Exhibit Seven Director of Nursing will audit five residents' most recent MDS for a in coding of hospice, life expectat wander alarms, pressure ulcers a contractures. The results will be monthly to the Quality of Life Tea Monthly Quality of Life Meeting. month with less than 100% comp the monitor will be extended. Any corrective action required will be the Quality of Life Team at that tir	r four ths: O0100, P-Alarms) ection ission) ding of Range of D. The current ccuracy ncy, and reported m at the For each liance, y made by	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) NAME OF PROVIDER OR SUPPLIER 345518 B. WING (X2) INN AT QUAIL HAVEN VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 155 BLAKE BOULEVARD INN AT QUAIL HAVEN VILLAGE PINEHURST, NC 28374 PINEHURST, NC 28374 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	DMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 10/31/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INN AT QUAIL HAVEN VILLAGE 155 BLAKE BOULEVARD PINEHURST, NC 28374 PINEHURST, NC 28374 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
INN AT QUAIL HAVEN VILLAGE 155 BLAKE BOULEVARD INN AT QUAIL HAVEN VILLAGE PINEHURST, NC 28374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE	
INN AT QUAIL HAVEN VILLAGE PINEHURST, NC 28374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
PINEHURST, NC 28374 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
DEFICIENCY)	B 475
F 641 Continued From page 6 F 641	
wander guard placement and check. The resident was receiving hospice services.	
Review of documentation for wander guard check/assessment in place and properly functioning twice a day for the past 60 days (from 9/1/19 to 10/29/19) was present signed by the Nursing Assistant.	
On 10/30/19 at 8:30 am an observation was done of the resident while sitting up in his bed and his wander guard was in place.	
On 10/31/19 at 11:15 am an interview was conducted with the MDS Coordinator who stated that after review of the resident's admission MDS dated 8/6/19, the MDS was incorrectly coded in Section "P. 200 e wander alarm" which was human error and would be corrected.	
The Director of Nursing (DON) was interviewed on 10/31/19 at 11:45 am who stated that she expected the MDS to be accurately coded.	
2. Resident #32 was admitted to the facility on 10/2/19 with diagnoses of displaced right femur fracture, fall, and pressure ulcer of the left buttocks stage 3.	
A review of the resident's admission Minimum Data Set dated 10/9/19 revealed the resident was admitted from the hospital on 10/2/19. The resident had minimal difficulty hearing and her cognition was intact. The active diagnoses were fracture and other trauma and pressure ulcer of the left buttock stage 3. The pressure ulcer was coded as not present on admission. The initial care plan dated 10/21/19 documented	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345518	B. WING			C 10/31/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	INN AT QUAIL 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 641	actual pressure ulcer. A physician order for initiated upon admissi A review of the reside administration record revealed documentati received pressure ulc was present on admis On 10/31/19 at 11:15 conducted with the M that after review of the dated 10/9/19, the MI Section "M. pressure which was human err The DON was intervie am who stated that sh accurately coded. 3. Resident # 26 was 6/28/18 with multiple dementia. The quarte (MDS) assessment da Resident #26 had imp on one side of upper Resident #26 had a p to apply upper extrem Resident #26's care p reviewed. One of the alteration in musculos contractures of bilater The physician progress	ns for at risk for fall and pressure ulcer care was ion dated 10/2/19. ent's treatment from 10/2/19 to 10/28/19 ion that the resident er care to her sacrum that ssion. am an interview was DS Coordinator who stated e resident's admission MDS DS was incorrectly coded in ulcer present on admission" or and would be corrected. ewed on 10/31/19 at 11:45 he expected the MDS to be admitted to the facility on diagnoses including erly Minimum Data Set ated 9/20/19 indicated that bairment in range of motion extremity. hysician order dated 9/24/18 hity splint at night.	F	641			
		ss note dated 10/15/19 ht #26's bilateral upper					

Facility ID: 960236

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				FOR	M APPROVED 0. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		(X3) DATE SURVEY COMPLETED C	
	345518	B. WING			/31/2019
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
INN AT QUAIL HAVEN VILLAGE			155 BLAKE BOULEVARD PINEHURST, NC 28374		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
extremities had claw I On 10/29/19 at 8:35 A PM, Resident #26 wa hands were noted to I On 10/31/19 at 9:05 A interviewed. The MD Resident #26's bilater She stated that the qu was coded incorrectly correction to the MDS range of motion to bo On 10/31/19 at 11:45 (DON) was interviewe she expected the MD accurately. Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inti includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac- the resident and the r An explanation must	hands with braces in place. AM and on 10/30/19 at 4:30 s observed. Her bilateral be contracted. AM, the MDS Nurse was S Nurse verified that ral hands were contracted. Jarterly MDS dated 9/20/19 and she would make a b to reflect the limitation in th upper extremities. AM, the Director of Nursing ed. The DON stated that S assessments to be coded I Revision (i)-(iii) ensive Care Plans brehensive care plan must I days after completion of ssessment. rerdisciplinary team, that ited to				11/19/19
	S FOR MEDICARE & DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR I Continued From page extremities had claw I On 10/29/19 at 8:35 A PM, Resident #26 wa hands were noted to I On 10/31/19 at 9:05 A interviewed. The MD Resident #26's bilater She stated that the qu was coded incorrectly correction to the MDS range of motion to bo On 10/31/19 at 11:45 (DON) was interviewed she expected the MD accurately. Care Plan Timing and CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac- the resident and the r An explanation must	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345518 ROVIDER OR SUPPLIER JAIL HAVEN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 extremities had claw hands with braces in place. On 10/29/19 at 8:35 AM and on 10/30/19 at 4:30 PM, Resident #26 was observed. Her bilateral hands were noted to be contracted. On 10/31/19 at 9:05 AM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #26's bilateral hands were contracted. On 10/31/19 at 9:05 AM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #26's bilateral hands were contracted. On 10/31/19 at 9:05 AM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #26's bilateral hands were contracted. On 10/31/19 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B)	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A BUILDIN 345518 B. WING_ ROVIDER OR SUPPLIER JALL HAVEN VILLAGE JAIL HAVEN VILLAGE D (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 8 F 6 extremities had claw hands with braces in place. D On 10/29/19 at 8:35 AM and on 10/30/19 at 4:30 PM, Resident #26 was observed. Her bilateral hands were noted to be contracted. On 10/31/19 at 9:05 AM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #26's bilateral hands were contracted. She stated that the quarterly MDS dated 9/20/19 was coded incorrectly and she would make a correction to the MDS to reflect the limitation in range of motion to both upper extremities. On 10/31/19 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b)(2) A comprehensive care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Drevared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C)	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIERICLIA (P2) MULTIPLE CONSTRUCTION A BUILDING	MENT OF HEALTH AND HUMAN SERVICES OMB N SFOR MEDICARE & MEDICALD SERVICES OMB N preservices and the service of the service o

Facility ID: 960236

If continuation sheet Page 9 of 32

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/03/20 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 10/31/2019	
		345518					
NAME OF P	ROVIDER OR SUPPLIER	•		SI	IREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QUAIL HAVEN VILLAGE				55 BLAKE BOULEVARD INEHURST, NC 28374			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 657	not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and of assessments. This REQUIREMENT by: Based on record rev interview, the facility care plans in the area (Resident #12), infect discharge planning (F sampled residents. The findings included 1. Resident #12 was 7/20/18 and most rec with diagnoses that in history of falling. The quarterly Minimu assessment dated 8/ #12 's cognition was required the extensiv mobility, transfers, loo personal hygiene. Re on her feet, she utilizand she was frequen bowel. She was code without injury. Resident #12 's care	 bresentative is determined c development of the e staff or professionals in ined by the resident's needs are resident. ised by the interdisciplinary symmetry including both the quarterly review T is not met as evidenced iew, observation, and staff failed to review and revise as of fall risk interventions tions (Resident #19), and Resident #19) for 2 of 14 d: admitted to the facility on tently readmitted on 12/20/18 included dementia and a 	F	657	The statements made on this Plar Correction are not an admission to they constitute an agreement with alleged deficiencies. To remain in compliance with all Federal and St Regulations the facility has taken of take the actions set forth in this Pla Correction. The Plan of Correction constitutes the facility s allegation compliance such that all alleged deficiencies cited have been or wil corrected by the date or dates indie F657 For the residents involved, correcti action has been accomplished by: On October 29, 2019, the MDS Nu corrected the care plan for Resider to accurately reflect current fall risk interventions. On October 30, 2019, the MDS Nu corrected the care plan for Resider to accurately reflect infections and discharge planning. Corrective action has been accomp on all residents with the potential to	nor do the ate or will an of of I be cated. ve urse nt #12 c urse nt #19 plished	

Facility ID: 960236

If continuation sheet Page 10 of 32

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIPI	E CONSTRUCTION	(X3) DA	TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	MPLETED	
						с	
		345518	B. WING		1	0/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC	DE		
	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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 657	Continued From page	e 10	F 65	7			
		luded, in part, removal of		affected by the alleged defic	ient practice		
		BSC). This intervention was		by:			
	initiated on 8/6/19 an	d was active as of 10/29/19.		On November 13, 2019, the			
				Nursing audited the care pla			
		conducted of Resident #12 '		current residents for accurat	-		
	observed next to her	t 3:46 PM. A BSC was		planning in the resident⊡s c interventions and infection c			
		bed.		precautions). For results of	•		
	An interview was con	ducted with Nursina		please see exhibit (Exhibit E			
		10/29/19 at 3:47 PM. She		issues noted were corrected			
	stated that Resident #	#12 had a BSC in place as a		Measures put into place or s	systematic		
	fall risk intervention.			changes made to ensure the	-		
		ducted with the Director of		deficient practice does not o			
		ducted with the Director of /29/19 at 3:48 PM. She		On November 15, 2019, the Minimum Data Set/Quality A			
	· ·	ent #12 had a BSC in place		Consultant completed an in			
		ion. She reported that they		training for the MDS Nurse of			
	had a trial removal of	the BSC for a short period		accurately care plan risk inte	erventions,		
		educed Resident #12 ' s		infections and discharge pla	nning. (Exhibit		
		ed this was an effective		Nine).			
		s put back in place. The		The facility has implemented			
		recall when the intervention ack into place, but she		The facility has implemented assurance monitor:	a quality		
		g after it was removed		The Director of Nursing will	complete the		
	(8/6/19).	J		Care Plan Update and Revis			
				Assurance Monitor weekly for	or four weeks		
		ducted with the MDS Nurse		and monthly for three month			
		PM. The care plan related		Ten). The Director of Nursing			
		12 was reviewed with the realed the intervention of the		the care plans of three curre			
		should have been revised		to ensure accuracy with fall discharge planning and infe			
	when the BSC was p			results will be reported mont			
		·		Quality of Life Team at the M	•		
	-	was conducted with the		of Life Meeting. For each m	onth with less		
		11:45 AM. She indicated		than 100% compliance, the			
	-	re plans to be reviewed and		extended. Any corrective ac			
	revised to reflect the	current status of the		will be made by the Quality of	of Life Team at		
	resident.			that time.			

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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 SURVEY COMPLETED	
		345518	B. WING			C 10/31/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
INN AT QUAIL 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)	ECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 657	 2. Resident #19 was a 8/16/19 with diagnose and heart failure. The admission Minim assessment dated 8/2 #19 's cognition was 2a. A physician 's order f 8/22/19 indicated conshingles for 7 days. To 6 8/29/19. A physician 's order f 8/22/19 indicated Valamedication) 1 gram (g shingles for 7 days. To 6 8/30/19. A review of Resident and Medication Admin from 8/29/19 through #19 was removed from completed his antivira had no further episod contact isolation. An interview was contact isolation for was reviewed with the facus area shingles for a first and Medication Admin from 8/29/19 through #19 was removed from completed his antivira had no further episod contact isolation. 	admitted to the facility on es that included dementia um Data Set (MDS) 23/19 indicated Resident severely impaired. der for Resident #19 dated tact precautions due to This order had an end date for Resident #19 dated acyclovir HCI (antiviral gm) three times daily for This order had an end date #19 ' s care plan indicated tact isolation related to on 8/29/19 and continued to ea as of 10/29/19. #19 ' s physician ' s orders histration Records (MARs) 10/29/19 indicated Resident m contact precautions and al medication on 8/29/19. He es of shingles requiring ducted with the MDS Nurse PM. The care plan related r shingles for Resident #19 e MDS Nurse. She revealed	F	657			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) PROVIDERSUPPLIERQUA IDENTIFICATION NUMBER: (X) MUTTPLE CONSTRUCTION A. BUILDING (X) DATE SUPPLICE C (X) DATE SUPPLICE C (X) DATE SUPPLICE (X) DATE SUPPLICE<		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/03/2019 APPROVED). 0938-0391
10/31/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE. INN AT QUALL HAVEN VILLAGE STREET ADDRESS, CITY, STATE, ZP CODE. IPSE INK SUMMARY STATEMENT OF DEFICIENCIES IPSERVENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PL PREFIX PREFIX CACH CORRECTION AND THE PRECEDED BY FULL CO F 657 Continued From page 12 TAG PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CO J 10/31/2 An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. F 657 F 0.57 S at a grad of therapy was 9/9/19 completed by the Director of Nursing (DON) indicated Resident #19 's last day of therapy was 9/9/19 and he was staying at the facility for long term care. A review of Resident #19 's care plan, initiated on 8/29/19, indicated the focus area of a planned discharge to the community once his current treatment plan was completed. This focus area conducted to be active as of 10/29/19. An interview was conducted with the MDS Nurse. She revealed that this focus area should have be nervised with Resident. She stated that she missed this charge and she probably would 've realized if when his quarterly				. ,			COMP	LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INN AT QUAIL HAVEN VILLAGE ISTREET ADDRESS, CITY, STATE, ZIP CODE (C4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (REQUIDENTERINM UNST BE PRECEDED BY FULL REQUIDENT ON USCIDENTEVING INFORMATION) ID PREFIX F 657 Continued From page 12 that this was an error. F 657 An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. F 657 2b. A nursing note dated 9/9/19 completed by the Director of Nursing (DON) indicated Resident #19 's last day of therapy was 9/19/19 and he was staying at the facility for long term care. A review of Resident #19 's care plan, initiated on 8/29/19, indicated the focus area of planned discharge to the community once his current treatment plan was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to planned discharge to the community for Resident #19 was reviewed with the MDS Nurse. She revealed that this focus area stread biol have been revised with Resident #19 converted from a short term stay to a long-term resident. She stated that she missed this change and she probably would 've realized it when his quarterly			345518	B. WING		_		
INN AT QUAL HAVEN VILLAGE PINEHURST, NC 28374 Mai D PRETRY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORDERCTIVE ATION SHOLD BE (EACH ORDERCTIVE ATION SHOLD BE REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETRY TAG PROVIDER'S PLAN OF CORRECTIVE (EACH ORDERCTIVE ATION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO F 657 Continued From page 12 that this was an error. F 657 F 657 An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. F 657 2b. A nursing note dated 9/9/19 completed by the Director of Nursing (DON) indicated Resident #19 's last day of therapy was 9/9/19 and he was staying at the facility for long term care. A review of Resident #19 's care plan, initiated on 8/29/19, indicated the focus area of a planned discharge to the community once his current treatment plan was completed. This focus area conducted to be active as of 10/29/19. An interview was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to planned discharge to the community for Resident #19 was reviewed with the MDS Nurse. She revealed that this focus area should have been revised when Resident #19 converted from a short term stay to a long-term resident. She stated that she missed this change and she probably would 've realized it when his quarterly	NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
(M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO F 657 Continued From page 12 that this was an error. F 657 F 657 An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. F 657 2b. A nursing note dated 9/9/19 completed by the Director of Nursing (DON) indicated Resident #19 's last day of therapy was 9/9/19 and he was staying at the facility for long term care. A review of Resident #19 's care plan, initiated on 8/29/19, indicated the focus area of a planned discharge to the community once his current treatment plan was completed. This focus area conducted to be active as of 10/29/19. An interview was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to planed discharge to the community for Resident #19 was reviewed with the MDS Nurse. She revealed that this focus area should have been revised when Resident #19 converted from a short term stay to a long-term resident. She stated that she missed this change and she probably woud' 've realized it when his quarterly	INN AT QU	JAIL HAVEN VILLAGE						
 that this was an error. An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. 2b. A nursing note dated 9/9/19 completed by the Director of Nursing (DON) indicated Resident #19 's last day of therapy was 9/9/19 and he was staying at the facility for long term care. A review of Resident #19 's care plan, initiated on 8/29/19, indicated the focus area of a planned discharge to the community once his current treatment plan was completed. This focus area conducted to be active as of 10/29/19. An interview was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to planned discharge to the community for Resident #19 was reviewed with the MDS Nurse. She revealed that this focus area should have been revised when Resident #19 converted from a short term stay to a long-term resident. She stated that she missed this change and she probably would 've realized it when his quarterly 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
		Continued From page that this was an error. An interview was com Nursing on 10/31/19 a that she expected car revised to reflect the o resident. 2b. A nursing note da Director of Nursing (D 's last day of therapy staying at the facility f A review of Resident a 8/29/19, indicated the discharge to the com treatment plan was co conducted to be activ An interview was com on 10/30/19 at 12:09 to planned discharge Resident #19 was rev She revealed that this been revised when Re a short term stay to a stated that she misse probably would ' ve re	 a 12 ducted with the Director of at 11:45 AM. She indicated re plans to be reviewed and current status of the ted 9/9/19 completed by the DON) indicated Resident #19 was 9/9/19 and he was for long term care. #19 's care plan, initiated on a focus area of a planned munity once his current completed. This focus area e as of 10/29/19. ducted with the MDS Nurse PM. The care plan related to the community for viewed with the MDS Nurse. a focus area should have esident #19 converted from long-term resident. She d this change and she ealized it when his quarterly 					
2019. An interview was conducted with the DON on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident.		2019. An interview was con 10/31/19 at 11:45 AM expected care plans t to reflect the current s Respiratory/Tracheos	ducted with the DON on . She indicated that she o be reviewed and revised status of the resident.	F 695				11/19/19

Facility ID: 960236

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345518	B. WING		1	C 0/31/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO)DE	
				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 695	§ 483.25(i) Respirator tracheostomy care and The facility must ensu- needs respiratory care care and tracheal suc- care, consistent with practice, the compreh- care plan, the resider and 483.65 of this suf- This REQUIREMENT by: Based on record revi- interview, and staff in provide nasal saline s- residents (Resident # care. The findings included Resident #37 was add 5/23/16 and most rec- with diagnoses that in disease, and chronic The quarterly Minimu assessment dated 4/ #37 had short term and problems and severel She had no behaviors A Physician 's Assista- indicated Resident #37 request related to a w green mucus. The p treatment plan include spray for Resident #33 A hard copy physician	ry care, including id tracheal suctioning. Irre that a resident who e, including tracheostomy tioning, is provided such professional standards of tensive person-centered tts' goals and preferences, opart. is not met as evidenced ew, Physician' s Assistant terview, the facility failed to spray as ordered for 1 of 1 37) reviewed for respiratory : mitted to the facility on ently readmitted on 1/7/19 icluded dementia, heart kidney disease. m Data Set (MDS) 16/19 indicated Resident nd long-term memory y impaired decision making. and no rejection of care. ant (PA) note dated 7/15/19 F was seen at staff ' s ret productive cough and hysician indicated his ed, in part, nasal saline	F 6	The statements made on the Correction are not an admission they constitute an agreement alleged deficiencies. To remission compliance with all Federal Regulations the facility has take the actions set forth in Correction. The Plan of Con- constitutes the facility's allege compliance such that all alled deficiencies cited have been corrected by the date or dat F695 For the residents involved, of action has been accomplish At the time of the survey, the ordered was completed for the corrective action has been on all residents with the pote affected by the alleged defice by: On November 18, 2019 the Nursing audited all current ri- medication compliance usin Administered Med Pass Las Hour Report. The report was	ssion to nor do nt with the nain in and State taken or will this Plan of rrection gation of eged n or will be es indicated. corrective red by: e nasal saline Resident #37. accomplished ential to be cient practice Director on residents for g the Not st Twenty-Four	

Facility ID: 960236

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVI		
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	i .	
		345518	B. WING		C 10/31/2019		
NAME OF P	ROVIDER OR SUPPLIER				15		
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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) IPLETION DATE	
F 695	Continued From page	e 14	F 695	5			
	 #37. An electronic physicial entered by Nurse #2 is 5 times daily for coug #37. This was once a copy order written by A review of the July 2 Administration Record corresponding MAR r information related to nasal saline spray (NS - 7/16/19 at 04:00 PM NSS - 7/16/19 at 08:00 PM NSS - 7/17/19 at 12:00 AM administered NSS - 7/17/19 at 12:00 PM administered NSS; 1: arrival" - 7/17/19 at 04:00 PM administered NSS; 4: and awaiting arrival" 	019 Medication d (MAR) and the notes revealed the following the administration of the SS) for Resident #37: I: Nurse #2 administered I: Nurse #6 administered I: Nurse #6 administered I: Nurse #3 had not I: Nurse #3 had not 18 PM note: "awaiting		identify any missed administrat Please see exhibit for results (I Eleven). Any issues noted were that time. Measures put into place or sys changes made to ensure the a deficient practice does not occ On October 30, 2019 the Staff Development Coordinator bega in-servicing all nurses and med aides, part-time and fulltime, on expectation of following physic and how to document any issu Twelve). All nurses, fulltime ar and all medication aides were The facility has implemented a assurance monitor: The Director of Nursing will co Missed Medication Quality Ass Monitor weekly for four weeks monthly for three months (Exhi Thirteen). The Director of Nurs evaluate three residents to ens medication administration is co results will be reported monthly Quality of Life Team at the Mor of Life Meeting. For each mon than 100% compliance, the mo	Exhibit e correct at tematic lleged ur: an dication n the ian orders es (Exhibit nd part time in-serviced. quality mplete the urance and bit ing will sure orrect. The v to the nthly Quality th with less		
	not received from p - 7/18/19 at 08:00 AM NSS - 7/18/19 at 12:00 PM	17/19 at 11:57 PM note: " harmacy yet" I: Nurse #2 administered I: Nurse #2 had not 27 PM note: "arriving lacy"		will be made by the Quality of I that time.	_ife Team at		

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345518	B. WING				C 31/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				1	155 BLAKE BOULEVARD		
	JAIL HAVEN VILLAGE			F	PINEHURST, 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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	administered NSS; 4: orderwill receive fro - 7/18/19 at 08:00 PM NSS - 7/19/19 at 12:00 AM 04:00 PM, 08:00 PM: - 7/20/19 at 12:00 AM 04:00 PM, 08:00 PM: - 7/21/19 at 12:00 AM administered A PA note dated 7/19, was seen at staff 's r she had coughed up. review of the record s not been getting all of ordered on 7/15/19. S NSS. The resident w upper respiratory con recommended comple An interview was con Nursing (DON) on 10, 2019 MAR and the co related to Resident #2 with the DON. The D stock medication that be ordered from the p that Nurse #2 was ne entered the electronic probably had not real medication. The DON probably the case wit Nurse #3 and Nurse # NSS was on order fro stated that she believ contracted nurse, had	23 PM note: "on m pharmacy tomorrow" I: Nurse #5 administered I, 08:00 AM, 12:00 PM, NSS administered I, 08:00 AM, 12:00 PM, NSS administered I, 08:00 AM, 12:00 PM: NSS (19 indicated Resident #37 equest about green phlegm The PA revealed that howed Resident #37 had i her medications that were She was not receiving her as noted to continue to have	F	695			

Facility ID: 960236

If continuation sheet Page 16 of 32

	-	D HUMAN SERVICES					FORM): 12/03/2019 I APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		(X3) DATE COMP	LETED
		345518	B. WING				(10/:	C 31/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE				55 BLAKE BOULEVARD			
				P	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	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page had the NSS for admi		F	695				
	10/31/19 at 11:10 AM s order entry sheet da the PA that indicated I days was reviewed wi order dated 7/15/19 c indicated NSS 5 times reviewed with Nurse # transcription error on the facility at that time electronic medical rec that indicated Nurse # NSS on 7/16/19 at 4:0 AM was reviewed. Th notes that indicated N administered the NSS 4:00 PM as she was w the pharmacy were re she believed the 7/16 at 8:00 AM were error had not known the NS so she thought it was pharmacy and had no A phone interview was on 10/30/19 at 3:55 P recall any information NSS order from July 2 knew that NSS was n and had not needed to pharmacy. She was o notes indicated the NS was awaiting its arriva A phone interview was on 10/30/19 at 3:58 P	cords system. The MAR 22 had administered the 20 PM and 7/18/19 at 8:00 be MAR and corresponding lurse #2 had not 35 on 7/18/19 at 12:00 PM or waiting for it to arrive from eviewed. Nurse #2 revealed 719 at 4:00 PM and 7/1819 rs. She explained that she 36 was a stock medication, being delivered from the at arrived at the facility yet. 36 s conducted with Nurse #3 37 M. Nurse #3 was unable to related to Resident #37 ' s 2019. She stated that she ormally a stock medication o be ordered from the unable to explain why her SS was ordered and she al. s conducted with Nurse #4						

Facility ID: 960236

If continuation sheet Page 17 of 32

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMF	E SURVEY PLETED
		345518	B. WING				C /31/2019
NAME OF P	ROVIDER OR SUPPLIER	L		Ś	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	8:00 PM and then that administered on 7/18, "not received from the reviewed with Nurse as she believed the 7/17 administration of the L error. A phone interview was on 10/30/19 at 4:00 P recall any information NSS order from July 2 taking a resident 's N An interview was con 10/31/19 at 9:10 AM. order entry sheet date NSS 4 times a day fo electronic order dated Nurse #2 that indicated days was reviewed. believed this was a ha by Nurse #2. The 7/1 the NSS was not adm reviewed. He stated there were missed do #37 when he reviewe that this had no negat Resident #37. The P the nurses to transcrift to administer medication A follow up interview of DON on 10/31/19 at 2 indicated that she exp transcribe physician ' administer medication	Resident #37 on 7/17/19 at at the NSS was not /19 at 12:00 AM as it was e pharmacy yet" were #4. Nurse #4 stated that /19 at 8:00 PM NSS was documented in s conducted with Nurse #6 PM. Nurse #6 was unable to or related to Resident #37 ' s 2019. She denied ever ISS home with her. ducted with the PA on The hard copy physician ' s ed 7/15/19 that indicated r 5 days was reviewed. The d 7/15/19 completed by ed NSS 5 times a day for 5 The PA reported that he armless transcription error 19/19 PA note that indicated hinistered as ordered was that he had noticed that bases of the NSS for Resident d her record. He reported tive consequences for A indicated that he expected be his orders correctly and tions as ordered. was conducted with the 11:45 AM. The DON bected the nurses to	F	695			

Facility ID: 960236

If continuation sheet Page 18 of 32

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345518	B. WING				31/2019
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				1	155 BLAKE BOULEVARD		
	NIL HAVEN VILLAGE PINEHURST, NC 28374				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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
TAG	Posted Nurse Staffing CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g)(1) Data re- must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must pospecified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readabh (B) In a prominent pla residents and visitors §483.35(g)(3) Public a	a Information (4) ffing Information. equirements. The facility ig information on a daily and the actual hours worked pries of licensed and aff directly responsible for t: a. I nurses or licensed defined under State law). des. g requirements. best the nurse staffing data in (g)(1) of this section on a inning of each shift. ed as follows: e format. ice readily accessible to access to posted nurse cility must, upon oral or		732	DEFICIENCY)	ATE	DATE
	available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater.	for review at a cost not to y standard.					

Facility ID: 960236

If continuation sheet Page 19 of 32

		ND HUMAN SERVICES			FORM AF OMB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345518	B. WING		C 10/31/2	2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
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 PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE CC E APPROPRIATE	(X5) DMPLETIOI DATE
F 732	Continued From page	e 19	F	732		
	interview, the facility f number and the actual the Registered Nurse Practical Nurse (LPN resident care and fail- information daily in a accessible to residen observed. Findings included: On 10/28/19 at 4:30 F 10/30/19 at 10:10 AW the daily nurse staffing posted at the nurse's The nurse staffing inf name of the facility, th number and actual ho unlicensed nursing st form did not include t actual hours worked p On 10/31/19 at 8:15 / assigned on 500/600 Nurse stated that the 500/600 hall, was resposting the nurse staffing information form did r and the actual hours On 10/31/19 at 8:20 / 300/400 hall, was inter nurse staffing informat hall (500/600 hall) an) directly responsible for the ed to post the nurse staffing prominent place readily ts and visitors for 4 of 4 days PM, 10/29/19 at 3:10 PM, 1 and 10/31/19 at 8:10 AM, ng information was observed station of the 500/600 hall. formation form included the he census, the actual ours worked per shift of the taff (nursing assistant). The he total number and the per shift of the RN and LPN. AM, Nurse #2, nurse hall, was interviewed. The morning shift nurse on sponsible for completing and ffing information daily.		The statements made on the Correction are not an admission they constitute an agreement alleged deficiencies. To rema- compliance with all Federal and Regulations the facility has to take the actions set forth in the Correction. The Plan of Correction. The Plan of Correction is the facility's allege compliance such that all aller deficiencies cited have been corrected by the date or date F732 For the residents involved, control action has been accomplished On November 15, 2019, the began using a new form that specifically Registered Nurse Licensed Practical Nurse (LFF (Exhibit Fourteen). Corrective action has been at on all residents with the pote affected by the alleged defice by: The new Daily Nursing Staff will begin being posted with results on November 19, 207 November 18, 2019, the Direc Nursing posted at all three videsignated entrances the nei the Daily Nursing Staffing Po- located with the survey result notification will remain posted minimum of one week.	sion to nor do it with the ain in and State aken or will his Plan of rection vation of ged or will be es indicated. orrective ed by: nursing staff treflects e (RN) and PN) hours accomplished ential to be ient practice ing Posting the survey 19. On ector on isitor ew location of osting which is lts. This	

Facility ID: 960236

If continuation sheet Page 20 of 32

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			
		345518	345518 B. WING			, 31/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	IAIL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 732	Continued From page	20	F 732			
	that residents and far 300/400 hall had no a staffing information. On 10/31/19 at 11:40 (DON) was interviewed nurse staffing informat form and she would of ensure the regulation and actual hours word followed. The DON for past, the nurse staffin on each hall, howeve information, complete match, so it was decir hall. The DON stated entrance/exit doors a	AM, the Director of Nursing ed. The DON stated that the ation form was a corporate sheck with the corporate to regarding the total number ked for the RN and LPN was urther indicated that in the ng information was posted		Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 18, 2019, the Staff Development Coordinator educated nurses, fulltime and part time and th Scheduler on the proper completion new Posted Nurse Staffing Informatiand where to post the form daily (ExFifteen). The facility has implemented a qualitassurance monitor: The Director of Nursing will complete Daily Nursing Staffing Sheet Quality Assurance Monitor weekly for four wand monthly for three months (Exhibits Sixteen). The results will be report monthly to the Quality of Life Team a Monthly Quality of Life Meeting. For month with less than 100% compliar the monitor will be extended. Any corrective action required will be ma	all e of the on hibit ty e the veeks bit ed at the reach nce, de by	
F 812 SS=E	CFR(s): 483.60(i)(1)(F 812	the Quality of Life Team at that time.		11/19/19
	§483.60(i) Food safet The facility must -	y requirements.				
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State				

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			0.00		OMB NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· /	E SURVEY IPLETED
			A. BUILDI	NG			
		345518	B. WING			C	
		545516	D. WING _			10/31/2019	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QU	JAIL HAVEN VILLAGE	ILLAGE 155 BLAKE BOULEVARD					
	1			P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 21	F	312			
		ompliance with applicable					
	safe growing and foo						
		es not preclude residents					
		is not procured by the facility.					
	§483.60(i)(2) - Store,	prepare, distribute and					
	serve food in accorda	ance with professional					
	standards for food se	-					
		I is not met as evidenced					
1	by:						
		on, and staff interview, the			The statements made on this Plan of		
	-	rd expired food items in 2 of			Correction are not an admission to nor	do	
	2 reach-in refrigerato refrigerator. Findings				they constitute an agreement with the alleged deficiencies. To remain in		
					compliance with all Federal and State		
	On 10/28/19 at 9:40 a	am an initial tour of the			Regulations the facility has taken or wi	ill	
		ed with the Dietary Manager			take the actions set forth in this Plan of		
		servation of the walk-in			Correction. The Plan of Correction		
	refrigerator revealed	there was a large plastic			constitutes the facility's allegation of		
	container (approxima	tely a gallon) with plastic			compliance such that all alleged		
	wrap semi-adhered tl				deficiencies cited have been or will be		
	vegetables and an ex				corrected by the date or dates indicate	ed.	
	10/27/19. The reach						
	was observed and th			F812			
		nd sliced turkey in a plastic					
		i items (approximately a			For the residents involved, corrective		
	pound each) had an (c container were several cut			action has been accomplished by: On October 29, 2019, the expired food		
		rting to turn brown/wilted and			items were discarded by the Food Service		
		ed) in a metal container with			Director.		
	plastic wrap cover an						
		10/22/19. In the metal door			Corrective action has been accomplish	ned	
		was a large plastic container			on all residents with the potential to be	:	
		on) with plastic wrap cover			affected by the alleged deficient practic	ce	
	-	ng with an expiration tag			by:		
		Dietary manager was			On October 29, 2019, the Food Service		
		d identified each food item			Director audited all refrigerators to ens	ure	
	as expired.				that no other expired food items were		
					present. For results, please see the		1

Facility ID: 960236

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	S FOR MEDICARE &	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>		COMPLETED
		345518	B. WING		C 10/31/2019
iame of Pi	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NN AT QL	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
F 812	On 10/28/19 at 9:55 a and commented that discarded after 4 day vegetables in the wal expired and would be observation of the two DM stated she would expired food items du The Administrator wa 11:40 am and informe food items identified of with the DM. The Ad	am the DM was interviewed cooked vegetables would be ys. DM stated the cooked k-in refrigerator were a discarded. After the o reach in refrigerators, the discard all the identified uring observation. s interviewed on 10/31/19 at ed regarding the expired on 10/28/19 and interview ministrator stated she staff to discard expired food	F 81	 exhibit (Exhibit Seventeen). Any issundet noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 19, 2019, the Food Set Director educated all fulltime and part dietary staff on how to properly label and when to discard the food (Exhibit Eighteen). The facility has implemented a quality assurance monitor: The Food Service Director will compthe QA Label and Dating Inspection Report Quality Assurance Monitor we for four weeks and monthly for three months (Exhibit Nineteen). The Food Service Director will inspect all refrigerated storage for proper labelir and expired foods. The results will b reported monthly to the Quality of Life Meeting. For each month with less th 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Teamate the Monthly Quality of Life Teamate Service Action required for the Calify the C	c rvice t time food t v lete ekly g e e e an
F 842 SS=B	Resident Records - Io CFR(s): 483.20(f)(5),	dentifiable Information 483.70(i)(1)-(5)	F 84	that time. 12	11/19/19
	 (i) A facility may not not resident-identifiable to (ii) The facility may represent the facility may represent the facility may represent the factor of the fa	lease information that is			

Facility ID: 960236

If continuation sheet Page 23 of 32

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL			ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/03/2019 APPROVED). 0938-0391
JA45518 B. WING 10/31/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 155 BLAKE BOULEVARP PINEHURST, NC 28374 155 BLAKE BOULEVARP PINEHURST, NC 28374 (%1)D PRETIX TAG EAVE DEPTISENT OF DEFICIENCIES (EAVE DEPTISENT MOLECTION SHOLLD BE RECOLUTION OR LGC DENTIFYING INFORMATION) D PROVIDER CARCORRECTIVE ACTION SHOLLD BE CRCH CORRECTIVE ACTION SHOLD BE CRCH CORRECTIVE (I) Readily accessible; and (I) Systematically organized S483.7001(2) The facility must keep confidential al information contained in the rescident representative where permitted by applicable law	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			COMP	LETED
NAME OF PROVIDER OR SUPPLER STREET ADDRESS OF IV, STATE, ZP CODE INN AT QUAL HAVEN VILLAGE ISB BLAKE BOULEWARD PINEHURST, NC 28374 (V4) ID PYEERX TAG SUMMARY STAELENT OF DEFICIENCIES REPUZATORY OR USD THE PRECEDED BY PULL REPUZATORY OR USD THE PRECEDED BY PULL REPUZATORY OR USD DEINTFINING INFORMATION) PREFX PREVIDERS PLAN OF CORRECTION CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY CONTINUED THE PRECEDED BY PULL REPUZATORY OR USD DEINTFINING INFORMATION) PREFX PREVIDENCIES TO THE APPROPRIATE DEFICIENCY CONTINUED THE PREVIDENCIES OF THE APPROPRIATE DEFICIENCY CONTINUED THE PREVIDENCIES OF THE APPROPRIATE DEFICIENCY CONTINUED CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY F 842 F 842 CONTINUED TO THE APPROPRIATE DEFICIENCY F 842 F 842 F 842 G CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY F 842			345518	B. WING				
INNATOUAL HAVEN VILLAGE PINEHURST, NC 28374 (A) ID PHEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORFCENCY MUST BERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ORFCENTWE ATTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID OUTPONT DEFICIENCY F 842 Continued From page 23 except to the extent the facility itself is permitted to do so. F 842 F 842 § 483.70(i) Medical records. § 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are. (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized F 843 § 483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is is. (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health car operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or aftery as permitted	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPIL DEFICIENCY) F 842 Continued From page 23 except to the extent the facility itself is permitted to do so. F 842 F 842 §483.70(i) Medical records. §483.70(i) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; F 842 (iii) Recally accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident representative where permitted by applicable law; (ii) Required by Law; If in the resident representative where permitted by applicable law; (iii) Required by Law; If in Required by Law; (iii) Required by Law; (iii) Required by Law; (iii) Required by Law; (iii) Required and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, organ donation purposes, research purposes, organ donation Ability Accurately do cavert a serious threat to health or safety as permitted	INN AT QU	JAIL HAVEN VILLAGE				l		
except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B		(X5) COMPLETION DATE
§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842	except to the extent the to do so. §483.70(i) Medical real §483.70(i)(1) In accomprofessional standard must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically orgen §483.70(i)(2) The faci- all information contain regardless of the form- records, except when (i) To the individual, or- representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitted with 45 CFR 164.506 (iv) For public health and an eglect, or domestic was activities, judicial and law enforcement purp purposes, research purp medical examiners, fu- a serious threat to head by and in compliance §483.70(i)(3) The faci- record information ag- unauthorized use. §483.70(i)(4) Medical	he facility itself is permitted cords. dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, nor storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, noses, organ donation urposes, or to coroners, ineral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or	F 84	2			

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		ND HUMAN SERVICES			FORM APPRO OMB NO. 0938-0	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345518			(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED C 10/31/2019		
		B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
INN AT QUAIL 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETI	
F 842	Continued From page	e 24	F 84	2		
	1.0	required by State law; or		-		
		le date of discharge when				
	there is no requireme	-				
	(iii) For a minor, 3 yea legal age under State	ars after a resident reaches e law.				
		edical record must contain- ion to identify the resident;				
		sident's assessments;				
		ive plan of care and services				
	provided;					
	•	y preadmission screening				
	and resident review e	evaluations and				
	determinations condu					
		e's, and other licensed				
	professional's progre					
		logy and other diagnostic				
		equired under §483.50. Γ is not met as evidenced				
	by:					
		iew and staff interview, the		The statements made on this P	lan of	
		complete and accurate		Correction are not an admission	to and do	
		Residents #8, #19, and #37		not constitute an agreement with		
	for 3 of 14 sampled r	esidents.		alleged deficiencies. To remain i		
	The findings included	l:		compliance with all Federal and Regulations the facility has take	n or will	
	1 Resident #10 was	admitted to the facility on		take the actions set forth in this Correction. The Plan of Correct		
		es that included dementia		constitutes the facility's allegatio		
	and heart failure.			compliance such that all alleged		
	The admission Minim	num Data Set (MDS)		deficiencies cited have been or		
		23/19 indicated Resident		corrected by the date or dates in		
	#19' s cognition was	severely impaired.				
				F842		
		for Resident #19 dated			-4:	
		ntact precautions due to		For the residents involved, corre	CLIVE	
					N/:	
		This order had an end date		action has been accomplished b 1. On November 14, 2019, the	-	

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						B NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				
			A. BUILDING					
		345518	B. WING					
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TE. ZIP CODE	10/31/2019		
			155 BLAKE BOULEVARD					
INN AT QUAIL 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETIC DATE		
F 842	Continued From page	25	Гол	2				
1 042			F 84		dant #10 to raflact			
		for Resident #19 dated acyclovir HCI (antiviral		Correction for Resid accurate Contact P				
		gm) three times daily for			14, 2019, the Director			
		This order had an end date			Health Status Note to			
	of 8/30/19.				t #37 did not receive			
				nasal saline as orde	ered on July 17th and			
		#19 ' s physician ' s orders		18th and that the pr	• • •			
		nistration Records (MARs)		aware and no new				
		10/29/19 indicated Resident			19, 2019, the Director			
		m contact precautions and		of Nursing made a				
		al medication on 8/29/19. He les of shingles requiring		contacted the Resp	Dr. Alexander's office			
	contact isolation.	les of simgles requiring		Resident # 8 and he	•			
				recommended extra				
	Nursing notes dated	8/30/19 through 9/8/19			9, 2019, the Director			
	•	#2, Nurse #5, Nurse #7,		of Nursing made a				
		#9 inaccurately indicated		note to reflect that t	he MD and PA notes			
		contact precautions for			arding his Lasix were			
	shingles and was rec	eiving antiviral medication.		incorrect and should				
	An intonviow was con	ducted with Nurse #9 on		the morning and 20	der of Lasix 40mg in			
		1. The inaccurate notes that			ing at 2pm daily.			
	indicated Resident #1							
		les and was receiving		Corrective action ha	as been accomplished			
		fter the contact precautions		on all residents with				
		on had been discontinued		-	ged deficient practice			
		lurse #9. She confirmed the		by:				
		e. She indicated that the			2019, the Director on			
	-	like a template and she and		Nursing audited all				
		d to revise the section of the ontact precautions, shingles,		medication adminis	tration records, sician progress notes,			
	and antiviral medicati				ntal consultant reports			
				for the past fourteer				
	A phone interview wa	is conducted with Nurse #7			or results, please see			
	-	AM. The inaccurate notes		the exhibit (Exhibit				
	that indicated Reside	nt #19 was on contact		corrections needed				
	-	les and was receiving		time.				
		fter the contact precautions						
	and antiviral medicati	on had been discontinued		Measures put into p	place or systematic			

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		MEDICAID SERVICES				NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345518	B. WING		C 10/31/2019			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
INN AT QUAIL 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE		
F 842	TAGREGULATORY OR LSC IDENTIFYING INFORMATION)F 842Continued From page 26 were reviewed with Nurse #7. She confirmed the notes were inaccurate. She explained that the previous notes were able to be copied and used as a template and they were supposed to revise any areas that had changed from the previous note. She stated that not revising the notes was an error.A phone interview was conducted with Nurse #5 on 10/30/19 at 11:44 AM. The inaccurate notes that indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication for he contact precautions and antiviral medication had been discontinued were reviewed with Nurse #5. She confirmed the notes were inaccurate. She explained that the previous notes were able to be copied and used as a template and they were supposed to revise any areas that had changed from the previous note. She stated that not revising the notes was an error.A phone interview was conducted with Nurse #5 notes were inaccurate. She explained that the previous notes were able to be copied and used as a template and they were supposed to revise any areas that had changed from the previous note. She stated that not revising the notes was an error.A phone interview was conducted with Nurse #8 on 10/30/19 at 11:02 AM. The inaccurate notes that indicated Resident #19 was on contact		F 84	 changes made to ensure the adeficient practice does not occo On November 15-19, 2019, the Development Coordinator and Nursing educated all nurses, fit part time and the MD and PA of proper documentation of Conta Precautions, Medication Admin follow up of consultations and of physician documentation (E Twenty-one). The facility has implemented at assurance monitor: The Director of Nursing will con Accurate Documentation Qual Assurance Monitor weekly for and monthly for three months Twenty-two). The Director of N evaluate five residents to ensure documentation nursing, MD ar and proper documentation of of follow up. The results will be monthly to the Quality of Life T Monthly Quality of Life Meeting month with less than 100% con 	ur: e Staff Director of ulltime and on the act nistration, monitoring xhibit quality quality four weeks (Exhibit ursing will re proper ad PA notes consultant reported eam at the g. For each			
	antiviral medication a and antiviral medicati were reviewed with N the contact precaution had been discontinue inaccurate. A phone interview wa on 10/30/19 at 11:09 that indicated Reside precautions for shing antiviral medication a	les and was receiving fter the contact precautions on had been discontinued lurse #8. She stated that if ns and antiviral medication ed then these notes were as conducted with Nurse #2 AM. The inaccurate notes nt #19 was on contact les and was receiving fter the contact precautions on had been discontinued		the monitor will be extended. corrective action required will the Quality of Life Team at that	Any be made by			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345518	B. WING				C /31/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
INN AT QU	JAIL HAVEN VILLAGE				155 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 842	 were reviewed with N the contact precaution had been discontinue inaccurate. She report the electronic medica An interview was con Nursing on 10/31/19 at that she expected the accurate and to be reany changes with the treatment regimen. 2. Resident #37 was a 5/23/16 and most rec with diagnoses that in disease, and chronic The quarterly Minimu assessment dated 4/7 #37 had short term an problems and severel An electronic physicia entered by Nurse #21 5 times daily for coug #37. A review of the July 2 Administration Record corresponding MAR r information related to nasal saline spray (Na - 7/16/19 at 04:00 PM NSS - 7/16/19 at 08:00 PM NSS 	 and antiviral medication and antiviral medication of then these notes were orted she was still learning I records system. ducted with the Director of at 11:45 AM. She indicated e nursing notes to be vised as needed to reflect resident and/or their admitted to the facility on ently readmitted on 1/7/19 neluded dementia, heart kidney disease. m Data Set (MDS) 16/19 indicated Resident nd long-term memory ly impaired decision making. an 's order dated 7/15/19 indicated nasal saline spray h for 5 days for Resident 019 Medication 	F	842	2			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/03/2019 APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345518	B. WING					C 31/2019	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
INN AT QL	INN AT QUAIL HAVEN VILLAGE			1	155 BLAKE BOULEVARD				
				F	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE	
F 842	Continued From page NSS - 7/17/19 at 08:00 AM administered NSS - 7/17/19 at 12:00 PM administered NSS; 1: arrival" - 7/17/19 at 04:00 PM administered NSS; 4: and awaiting arrival" - 7/17/19 at 04:00 PM NSS - 7/18/19 at 12:00 AM administered NSS; 7/ not received from pl - 7/18/19 at 12:00 PM administered NSS; 2: tomorrow from pharm - 7/18/19 at 12:00 PM administered NSS; 4: will receive from pharm - 7/18/19 at 04:00 PM administered NSS; 4: will receive from pharm - 7/18/19 at 11:10 AM Nurse #2 had adminis at 4:00 PM and 7/18/7 The MAR and corresp Nurse #2 had not adm 7/18/19 at 12:00 PM of waiting for it to arrive reviewed. Nurse #2 r 7/16/19 at 4:00 PM ar errors. She explained NSS was a stock med	2 28 2: Nurse #3 had not 1: Nurse #3 had not 18 PM note: "awaiting 1: Nurse #3 had not 34 PM note: "Ordered 1: Nurse #4 administered 1: Nurse #4 had not 17/19 at 11:57 PM note: " harmacy yet" 1: Nurse #2 had not 27 PM note: "arriving harmacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 23 PM note: "on order armacy tomorrow 1: Nurse #2 had not 2: Nurse #2		842	DEFICIENCY)				
	7/16/19 at 4:00 PM ar errors. She explained NSS was a stock med was being delivered fi	nd 7/18/19 at 8:00 AM were d that she had not known the dication, so she thought it rom the pharmacy and had							

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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:	`,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345518	B. WING				C /31/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
INN AT QUAIL 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)		EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH				(X5) COMPLETION DATE	
F 842	A phone interview wa on 10/30/19 at 3:58 P corresponding notes f administered NSS to 8:00 PM and then tha administered on 7/18/ "not received from the reviewed with Nurse at she believed the 7/17 administration of the f error. An interview was com- Nursing on 10/31/19 at that she expected the 3. Resident #8 was at 7/16/15 and most rec- with diagnoses that in Disease and heart fai Data Set (MDS) asse indicated Resident #8 impaired. He was ass cavity or broken natur administered diuretic during the MDS revier 3a. A dental consultant 5/14/19 indicated extr for 3 of Resident #8 to be spoken with rela extractions. A review of the medic through 10/30/19 rever	s conducted with Nurse #4 M. The MAR and that indicated Nurse #4 had Resident #37 on 7/17/19 at it the NSS was not /19 at 12:00 AM as it was e pharmacy yet" were #4. Nurse #4 stated that /19 at 8:00 PM NSS was documented in ducted with the Director of at 11:45 AM. She indicated MAR to be accurate. dmitted to the facility on ently readmitted on 7/25/16 focuded Alzheimer 's lure. The annual Minimum ssment dated 8/3/19 8's cognition was severely sessed with obvious or likely ral teeth. Resident #8 was medication on 7 of 7 days w period. tion progress note dated actions were recommended s teeth. The dental provider 8's family member needed ated to the recommended ated to the recommended	F	842				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED	
		345518	B. WING			C 10/31/2019		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
INN AT QU	INN AT QUAIL HAVEN VILLAGE				I55 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ON SHOULD BE HE APPROPRIATE		
F 842	An interview was com Nursing (DON) on 10, 5/14/19 dental consul was reviewed with the to look into this furthe information. An email exchange fm provider on 10/30/19 up information on the for Resident #8. A re provider to the DON of indicated Resident #8 extractions at that tim would be in November approval. An interview was com Nursing on 10/31/19 a that she expected info consultation recomment the resident 's medic 3b. A physician 's ord Resident #8 indicated 40 milligrams (mg) in the evening. A review of the physic Medication Administra December 2018 throu Resident #8 's Lasix remained an active or A review of Physician 12/21/18, 2/6/19, 3/20 5/28/19, 6/18/19, 6/25 indicated that Resident	ducted with the Director of /30/19 at 9:45 AM. The tation note for Resident #8 e DON. She stated she had r to provide more om the DON to the dental at 9:55 AM requested follow 5/14/19 dental consultation turn email from the dental on 10/30/19 at 10:22 AM 3's family had declined the e and the next dental visit er 2019 pending the family 's ducted with the Director of at 11:45 AM. She indicated ormation related to dental endations to be included in al record. der dated 11/8/17 for I Lasix (diuretic medication) the morning and 20 mg in cian 's order summaries and ation Records (MARs) from ugh October 2019 indicated order initiated 11/8/17	F	842				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/03/2019 MAPPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		345518	B. WING				C 10/31/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE			
INN AT QU	JAIL HAVEN VILLAGE				55 BLAKE BOULEVARD INEHURST, NC 28374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE	
TAG F 842	Continued From page morning and 20 mg in A physician note date indicated Resident #8 day rather than the or and 20 mg in the even An interview was cond 10/31/19 at 9:10 AM. and 1 inaccurate phys 2018 through August reviewed with the PA. notes pulled forward I unable to edit the note new note. He explain in one note it was like if the error was not ide explained the physicia as a template as well caused an error in the stated that ideally, he notes to be accurate. An interview was cond Nursing on 10/31/19 a that she expected the be accurate and to be	e 31 a the evening. d 8/21/19 inaccurately 8 was on Lasix 20 mg per rdered 40 mg in the morning ning. ducted with the PA on The 9 inaccurate PA notes sician note from December 2019 for Resident #8 were The PA revealed that his ike a template and he was e without creating an entirely ned that if there was an error by repeated in several notes	F	842					

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