STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 3/20/23 through 3/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 67VX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/20/23 through 3/23/23. Event ID# 67VX11. The following intakes were investigated: NC00190426, NC00191603, NC00195393 and NC00196868 6 of the 14 complaint allegations resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		4/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/11/2023

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F 565	Continued From page 1 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to resolve repeat grievances related to dietary services which were reported in the Resident Council meetings for 7 out of 9 months reviewed (June 2022, July 2022, August 2022, October 2022, December 2022, January 2023, and February 2023). The findings included: Review of the Resident Council minutes dated 06/24/22 indicated a resident was concerned because her Sunday meal was not enough to help her with her blood sugar through the night. Residents discussed recent patterns of not being offered evening snack items. In addition, a resident stated her recent chicken entrée was blackened and burnt. Review of the Resident Council minutes dated 07/29/22 indicated one resident stated it	F 565	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F565 For the residents involved, corrective action has been accomplished by: On March 27, 2023, the Director of Nursing (DON) and Activity Director (AD) provided a grievance invention/ follow-up form to the resident council president (Exhibit 1). Corrective action has been accomplished on all residents with the potential to be	

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F 565	Continued From page 2 appeared that meat was being cooked ahead of time and sauce was being put on afterwards. Breakfast trays were occasionally missing items such as coffee and sugar. Another resident expressed concerns regarding the bread being hard. The Dietary Manager was present and discussed the concerns. Review of the Resident Council minutes dated 08/26/22 indicated residents stated at night there had been some "skim" on the top of the soup similar to when soup had been sitting out. Review of the Resident Council minutes dated 10/03/22 expressed concerns regarding the menu being difficult to understand because they did not know what some of the items were. A resident shared a concern regarding ordering fried eggs and she received scrambled. She was told only items on the menu were available. A grievance form dated 10/04/22 was completed on behalf of the Resident Council. The concern indicated the food and coffee were cold during breakfast and dinner. Review of the Resident Council minutes dated 10/28/22 expressed concerns regarding food being cold and residents were wondering if warming plates were being used. Review of the Resident Council minutes dated 12/30/22 expressed concerns with food not being consistently warm and the plate warmers did not seem to be as warm. The coffee was not hot. A resident expressed the desire for more "country food." Several residents would like more "meat and potato" type foods. There were concerns regarding missing utensils. The dessert that was	F 565	affected by the alleged deficient practice by: On March 27, 2023, the Director of Nursing (DON) audited 6 months of resident council minutes for unresolved issues that may rise to the level of a grievances. For results, please see exhibit (Exhibit 2). Any discrepancies noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 4, 2023, the Activity Director (AD), Director of Nursing (DON), Executive Director (ED) and the Director of Social Services were educated by the Nurse Consultant on the Grievance Policy and Procedure, Resident and Family Council Choice Form in addition the Resident Council Policy (Exhibit 3). The facility has implemented a quality assurance monitor: The Director of Nursing (DON) will complete a Resident Council Grievance Quality Assurance Audit Tool Monitor monthly times 3 months. The DON will evaluate all resident council minutes to ensure any unresolved complaints and addressed resolved. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. The meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be	

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F 565	Continued From page 3 offered on 12/30/22 did not taste good. Review of the Resident Council minutes dated 01/27/23 stated residents were receiving plastic utensils. They stated it was difficult to cut steak and meats with plastic utensils. Review of the Resident Council minutes dated 02/24/23 indicated vegetables were not tender and were difficult to cut with a knife. Residents felt like more attention needed to be paid to the tenderness of meats and vegetables. Observation of a Resident Council meeting was conducted on 03/21/23 at 2:00 PM with 4 alert and oriented members of the Resident Council revealed an issue with resolution of repeat grievances regarding multiple concerns regarding the dietary department. The residents reported having expressed concerns about the lack of variety on the menu; meat and vegetables being difficult to cut and chew; and the menus being difficult to understand. The President of the Resident Council (Resident #3) stated "many residents here have difficulty chewing the meat because it's so tough." She indicated the Dietary Manager has attended Resident Council meetings but she felt like concerns were not being addressed and resolved. Resident #17 indicated "we would like more variety in menu like having chicken salad, potato salad, or tuna salad." Resident #30 indicated when she went to pick items on the menu, she did not know what she was ordering because the names were confusing. Residents also stated the concern with food being cold had improved some, but not by much. The residents stated they had discussed their concerns with the dietary department several times during Resident Council meetings	F 565	extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	

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F 565	Continued From page 4 but felt like an appropriate resolution had not been made. An interview with the Activities Director on 03/22/23 at 8:55 AM revealed she met monthly with the Resident Council to discuss concerns. She stated for every grievance expressed in Resident Council meetings, she identified the type of grievance and then provided it to the relevant department head. The Dietary Manager was verbally made aware of the Resident Council's concerns regarding the dietary department. She stated the Social Worker completed the grievances. The Social Worker was interviewed on 03/22/23 at 1:06 PM. She stated the Activities Director informed her of Resident Council concerns and informed all the department heads depending on the type of concern. She stated she could not remember if she completed a grievance for every concern expressed in Resident Council. The Administrator was interviewed on 02/23/23 at 12:45 PM. She stated she was aware of Resident Council's repeat grievances regarding the dietary department and felt like the facility had addressed the concerns regarding the dietary department. She stated the menu had been changed due to Resident Council's request and she did not know why the Resident Council continued to express this concern. She stated she held a "Lunch with Admin" lunch monthly with the residents so they could express their concerns regarding anything they found important to them. She did not know why Resident Council kept bringing up previous concerns.	F 565		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment	F 584		4/11/23

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F 584	Continued From page 5 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 6 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident, Responsible Party (RP) and staff interviews, the facility failed to maintain a clean homelike environment for resident by failing to maintain side rail padding in good repair for 1 of 1 Residents (Resident #11) reviewed for homelike environment. The findings included: Resident #11 was admitted to the facility on 07/01/17 with diagnosis that included convulsions, generalized anxiety, obsessive-compulsive disorder, bipolar disorder, and vascular Dementia. A quarterly Minimum Data Set (MDS) assessment dated 02/01/23 revealed Resident #11 cognition was moderately impaired. She had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) that occurred 4-6 days during the look-back period and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that also occurred 4-6 days during the look-back period. Resident #11 ' s care plan last reviewed on 08/11/22 revealed the following focus areas. 1. Focus of very fragile skin with increased risk	F 584	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F584 For the residents involved the following corrective action has been accomplished by: On March 22 2023, the resident□s side rail padding was changed out by the maintenance department as soon as staff were alerted to the issue. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 27, 2023, the Director of Nursing (DON) audited 100% of current residents to ensure their padded side rails were in good repair. Any issues noted were corrected at that time. For results of the audit please see exhibit (Exhibit 4). Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur: The Focused Supervisor Room Round	

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F 584	Continued From page 7 for skin tears and Injuries. Interventions included: · Encourage good nutrition and hydration to keep skin well nourished. · Padded side rails to prevent injury. 2. Focus for use of 1/4, siderails to enable me to maintain as much independence with bed mobility as possible, with increased risk for complications including entrapment and injuries. Interventions included: · Padded side rails for comfort. On 03/20/23 at 10:28 AM an observation was conducted. Resident #11 was lying in bed with ¼ side rails up. The padding to the left side rail at the HOB had several pieces of thin black material peeling off and hanging from the padding. The pieces hanging down from the padding ranged from approximately 4 inches to a ½ inch in width and 3 inches to ½ inch in length. The Internal padding not exposed due to second layer of material covering it. On 03/21/23 at 4:41 PM an observation and interview were conducted with Resident #11 and her RP. Resident #11 and her RP stated they did not notice the "pleather" peeling from the bed rail padding. Resident #11 ' s RP further stated she did not believe Resident #11 would put the material in her mouth. She indicated the material hanging down did not represent a homelike atmosphere. On 03/22/23 at 10:00 AM an interview was conducted with the Maintenance Supervisor. He stated nursing would put a work order in when equipment and/or accessories needed to be repaired or replaced. He indicated that he had not received a work order ticket for room 306's side rail padding being in poor condition.	F 584	Audit form was amended to include checking the equipment to ensure each item is in good repair (Exhibit 5). On April 3, 2023, the DON educated all administrative staff on the amended Focused Supervisor Room Round Audit form and Resident Right Policy (Exhibit 6). The facility has implemented a Quality Assurance Monitor: The Director of Nursing will audit all padded side rails to ensure they are in good repair using the Side Rail Padding Audit Tool. The monitor will be completed weekly for three months and reported to the Monthly Quality of Life Team at the Monthly Quality of Life Meeting. For any month with less than 100% compliance, the monitor will be extended an additional month and corrective action will be implemented by the Monthly Quality of Life Team at that time. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist.	

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F 584	Continued From page 8 On 03/22/23 at 10:07 AM an interview was conducted with Nurse #3. She stated she works full time hours with the facility and always works the 300 hall. She further stated she did not realize or notice that the plastic/covering was peeling from Resident #11 ' s side rail pad. She also stated nursing staff were to create a work order when equipment or appliances need to be replaced or repaired. An interview with the Director of Nursing (DON) on 03/23/23 at 11:15 AM was conducted. She stated she expected nursing to fill out a work order if equipment and/or accessories needed to be repaired or replaced. She was unaware Resident #11 ' s siderail padding needed to be replaced.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		4/11/23

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F 623	Continued From page 9	F 623		

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and

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F 623	Continued From page 10	F 623		

telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with the

The statements made on this Plan of

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F 623	Continued From page 11 staff, the facility failed to notify the resident and or the responsible party (RP) in writing of the reason for the transfer/discharge to the hospital for 2 of 2 sampled residents reviewed for hospitalizations (Residents # 9 & # 43). Findings included: 1. Resident #9 was admitted to the facility on 11/1/22. Review of the nursing note dated 12/5/22 at 11:42 AM revealed that Resident #9 was sent to the emergency room (ER) due to a fall and was admitted. The resident was readmitted back to the facility on 12/13/22. Review of the nursing note dated 2/11/23 at 12:45 PM revealed that Resident #9 was sent to the emergency room (ER) due to a fall and was admitted. The resident was readmitted back to the facility on 2/16/23. Nurse #1 was interviewed on 3/21/23 at 12:01 PM. She stated that when a resident was transferred/discharged to the hospital, she notified the RP by calling her/him. Nurse #2 was interviewed on 3/21/23 at 12:03 PM. The Nurse stated that she notified the RP verbally when a resident was discharged to the hospital. The Admission Staff was interviewed on 3/21/23 at 12:10 PM. She stated that she was not responsible for notifying the RP in writing when a resident was discharged to the hospital. She added that she was not familiar of any form used by the facility to notify the RP when a resident	F 623	Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F623 For the residents involved, corrective action has been accomplished by: On April 5, 2023, the Business Office Manager (BOM) mailed the Notice of Discharge/ Transfer to the resident and or the responsible party (RP). Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On April 5, 2023, the Director of Nursing (DON) audited the last 30 days of discharges/ transferred residents and Notice of Discharge/ Transfer were sent to the resident and or RP at that time (Exhibit 7). On April 4, 2023, the Administrator educated the BOM, Social Worker and Admission Coordinator on the Transfer Notice policy (Exhibit 8). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 5, 2023, the Administrator added Transfer/ Discharge to the morning stand-up forms to ensure it is being discussed on a daily basis (Exhibit 9).	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 623	Continued From page 12 was discharged to the hospital. The Social Worker (SW) was interviewed on 3/21/23 at 3:30 PM. She stated that she notified the RP by calling her/him when a resident was discharged to the hospital. She reported that she had never sent a letter to the RP notifying them that a resident was sent to the hospital. She added that she was not familiar of any form used by the facility to notify the RP when a resident was discharged to the hospital. The Director of Nursing (DON) was interviewed on 3/21/23 at 3:31 PM. She stated that the facility had a form used to notify the resident and or the RP when a resident was discharged to the hospital. The form included the reason and the date the resident was discharged to the hospital. The DON reported that the SW and the Admission staff were responsible for completing and sending the form out to the resident and or RP. She verified that the SW and the Admission staff failed to complete the form for Resident #9 and therefore, the RP was not notified in writing when the resident was discharged to the hospital on 12/5/22 and 2/11/23. 2. Resident #43 was admitted to the facility on 02/21/23. A review of Resident #43's nurses notes, and transfer form revealed she was transferred to the hospital on 02/27/23 due to abdominal pain and was admitted. There was no documentation discovered in the resident ' s medical record of written notice of transfer provided to the resident and/or Responsible Party (RP) regarding the transfer. Resident #43 di not return to the facility. A 5-day Minimum Data Set (MDS) assessment	F 623	The facility has implemented a quality assurance monitor: The Administrator will complete a Transfer/ Discharge Quality Assurance Audit Tool monthly times four months. The Administrator will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. The meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	

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F 623	Continued From page 13	F 623		

dated 2/28/23 indicated Resident #43 was cognitively intact.

An interview was conducted on 03/21/23 at 12:03 PM with Nurse #2. She stated she notified the RP verbally by phone when the resident was discharged to the hospital.

The Admission Staff was interviewed on 3/21/23 at 12:10 PM. She stated that she was not responsible for notifying the RP in writing when a resident was discharged to the hospital. She added that she was not familiar of any form used by the facility to notify the RP when a resident was discharged to the hospital.

An interview was conducted on 03/21/23 at 03:01 PM with Nurse #1. She stated she notified the RP by phone regarding the change in condition and reason for the transfer. Charge Nurse #1 stated she was unaware of a written notification of transfer being provided to the RP and/or resident.

The Social Worker (SW) was interviewed on 3/21/23 at 3:30 PM. She stated that she notified the RP by calling her/him when a resident was discharged to the hospital. She reported that she had never sent a letter to the RP notifying them that a resident was sent to the hospital. She added that she was not familiar of any form used by the facility to notify the RP when a resident was discharged to the hospital.

The Director of Nursing (DON) was interviewed on 3/21/23 at 3:31 PM. She stated that the facility had a form used to notify the resident and or the RP when a resident was discharged to the hospital. The form included the reason and the date the resident was discharged to the hospital.

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F 623	Continued From page 14 The DON reported that the SW and the Admission staff were responsible for completing and sending the form out to the resident and or RP. She verified that the SW and the Admission staff failed to complete the form for Resident #43 and therefore, the RP was not notified in writing when the resident was discharged to the hospital on 02/27/23.	F 623		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Resident #25), hospice and prognosis (Resident #53) for 2 of 20 sampled residents whose MDS were reviewed. Findings included: 1. Resident #25 was admitted to the facility on 2/17/23 with diagnoses including bipolar disorder. Resident #25 had a physician's order dated 2/17/23 for Quetiapine Fumarate (an antipsychotic drug) 100 milligrams (mgs.) 1 tablet by mouth twice a day for bipolar disorder. Review of the February 2023 Medication Administration Records (MARs) revealed that Resident #25 had received Quetiapine Fumarate from February 17 through February 28, 2023.	F 641	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 For the residents involved, corrective action has been accomplished by: On March 23, 2023, the Minimum Data Set (MDS) for Resident # 53 was updated to reflect his Hospice designation, and life expectancy by the Minimum Data Set (MDS) Nurse. On March 27, 2023, the MDS Nurse corrected the MDS for Resident #25 to	4/11/23

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F 641	Continued From page 15 The admission Minimum Data Set (MDS) assessment dated 2/24/23 indicated that Resident #25 had received an antipsychotic medication daily during the assessment period. The antipsychotic medication review section indicated that Resident #25 did not receive an antipsychotic medication since admission/entry, reentry, or prior assessment. The MDS Nurse was interviewed on 3/22/23 at 9:20 AM. She reviewed the February 2023 MARs and the MDS assessment dated 2/24/23 and verified that Resident #25 had received an antipsychotic medication during the assessment period but missed to note that the resident had received an antipsychotic medication since admission/entry, reentry and or prior assessment. She added that it was an error. The Director of Nursing (DON) was interviewed on 3/23/23 at 11;20 AM. The DON stated that she expected the MDS assessment to be accurate. 2. Resident #53 was admitted to the facility on 10/26/21. Resident #53 had a physician's order dated 6/29/22 to refer to hospice services. Review of the hospice note revealed that the hospice care started on 6/30/22 for Resident #53. The significant change in status Minimum Data Set (MDS) assessment dated 7/1/22 did not indicate that Resident #53 was receiving hospice care. The assessment under prognosis also did	F 641	accurately reflect Antipsychotics received on a routine basis. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 24 and 29, 2023, the facility Administrator completed a 100 % audit of all current residents with Hospice Services and residents receiving antipsychotics to ensure accurate coding on their most current MDS. For results, please see exhibit (Exhibit 10). Any discrepancies noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On March 27, 2023, the DON completed an in-service training with the MDS nurse on accurately coding in the MDS. Education information was taken directly from the Resident Assessment Instrument (RAI). Specific education was provided on the following topics: Sections J1400, Sections O0100 and Sections N0450 in addition due the MDS Care Plan Coordinator policy specifically the process of accurately coding Minimum Data Set (Exhibit 11). The facility has implemented a quality assurance monitor: The Accurate Coding of MDS Audit Tool will be completed by the DON weekly for four weeks and monthly for three months: Accurate Coding of MDS Section J1400, Section O0100 and Section N0450 the MDS Coding Accuracy Audit Tool. The Director of Nursing will audit all	

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F 641	Continued From page 16 not indicate that Resident #53 had a condition or chronic disease that may result in a life expectancy of less than 6 months. The MDS Nurse was interviewed on 3/22/23 at 9:22 AM. She reviewed Resident #53's medical records and verified that the resident had started hospice services on 6/30/22. She also reported that the significant change in status MDS assessment was completed due to hospice care. The MDS Nurse reviewed the MDS assessment dated 7/1/22 and stated that it was an error, the hospice care and the prognosis should have been checked but were not. The Director of Nursing (DON) was interviewed on 3/23/23 at 11:20 AM. The DON stated that she expected the MDS assessment to be accurate.	F 641	residents□ receiving Hospice Services and resident receiving antipsychotics on their most recent MDS for accuracy in coding of hospice, life expectancy and antipsychotics. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time. The meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to shave a resident who needed extensive assistance or was dependent on the staff for activities of daily living (ADL) for 1 of 2 sampled residents reviewed for ADL (Resident #9). Findings included: Resident #9 was admitted to the facility on	F 677	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged	4/11/23

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F 677	Continued From page 17 11/1/22 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 2/7/23 indicated that Resident #9 had severe cognitive impairment, needed extensive assistance with personal hygiene and had no rejection of care. Review of Resident #9's care plan dated 2/7/23 was conducted. The care plan problems were "I have an activities of daily living (ADL) self-care performance deficit related to Alzheimer's dementia" and "I have potential to demonstrate physical behaviors related to dementia, hitting staff, refusing daily care and perineal care". The approaches included "I require staff assistance with grooming and personal hygiene. If I become resistant to care, report to nurse and attempt to determine possible cause and address, maintain safety, and approach me later" and "when I become agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later". Review of the Nurse's Aide (NA) behavior documentation revealed that Resident #9 did not exhibit rejection of care from March 13 through March 23, 2023. Resident #9 was observed on 3/20/23 at 11:07 AM in bed and at 3:59 PM up in wheelchair in front nurse's station. He was observed to be unshaven. His facial hair seemed approximately 3 days growth. Resident #9 was again observed on 3/21/23 at	F 677	deficiencies cited have been or will be corrected by the date or dates indicated. F677 For the residents involved, corrective action has been accomplished by: On March 24, 2023, the Nursing Supervisor assisted the aide in shaving the resident. On March 24, 2023, the Director of Nursing, provided one on one education on the Challenging Behavior Policy and Shaving Policy (Exhibit 12). Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 27, 2023, the Director of Nursing (DON) audited 100% of all current residents for facial hair who require extensive assistance or dependent on the staff for activities of daily living (ADL). For results of the audit, please see exhibit (Exhibit 13). Any issues noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 7, 2023, Staff Development Coordinator (SDC) completed an in-service training for all nurses and aides on Dealing with Challenging Behaviors and Shaving the Resident Policy (Exhibit 14). On April 3, 2023, the DON updated the Focused Supervisor Room Round Audit, that is due weekly by the administrative team, to reflect observing the resident for facial hair and reporting the results to the DON (Exhibit 15). On April 3, 2023, the DON educated the	

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F 677	Continued From page 18 9:30 AM in bed and at 1:50 PM up in wheelchair in his room. He was still unshaven. Nurse Aide (NA) # 1, assigned to Resident #9, was interviewed on 3/21/23 at 1:51 PM. She stated that Resident #9 was combative, and he had beaten a staff member last week. The NA verified that Resident #9 needed to be shaved. When asked if she had tried to shave the resident, she responded "no, I'm not here to get beaten up". Nurse #1 who was assigned to Resident #9 was interviewed on 3/21/23 at 1:56 PM. She stated that Resident #9 could be combative at times, but she was not notified that the resident was combative and had refused care today. The Restorative Aide (RA) was interviewed on 3/21/23 at 2:01 PM. She stated that Resident #9 could be combative at times but if you talk to him and explain what you're going to do, he will let you. The RA observed the resident and verified that the resident needed to be shaved. The RA was observed entering the resident's room and asked him if she could shave him and he agreed. The RA was observed shaving Resident #9 and he was cooperative. The Director of Nursing (DON) was interviewed on 3/23/23 at 11:20 AM. The DON expected the staff to provide care and if the resident was combative to leave and to try later.	F 677	administrative team on the amended Focused Supervisor Room Round Audits (Exhibit 16). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the ADL Shaving Audit Quality Assurance Tool weekly for four weeks and monthly for three months. The DON will evaluate 5 residents requiring extensive assistance or dependent on the staff for ADL□s. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		4/11/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 19 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the low air loss mattress was set according to the resident's weight for 3 of 4 residents reviewed for pressure ulcers (Resident #21, #32, and #34). The findings include: 1. Resident #21 was admitted to the facility on 11/23/20. Her diagnosis included Alzheimer ' s disease, dementia, contractures of the right and left thigh muscle, and unspecified viral infection characterized by skin and mucous membrane lesions. A review of the active physician orders included an order that read: low air loss mattress, check every shift for proper inflation, every day and night shift. Resident #21 ' s care plan revised on 11/08/22 included a focus for at risk for pressure ulcer development due to bowel and bladder incontinence, and decreased ability to assist with repositioning. The interventions included pressure	F 686	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F686 For the residents involved, corrective action has been accomplished by: On March 22, 2023, the Nursing Supervisor adjusted the air mattress setting to accurately reflect the resident□s current weight. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 27, 2023, the Director of Nursing audited 100% of all current	

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F 686	Continued From page 20 reducing, low air loss mattress on bed. A quarterly Minimum Data Set (MDS) assessment dated 01/27/23 indicated Resident #21 had severe cognitive impairment. She was at risk for Pressure Ulcers (PU) and did not have a pressure ulcer during this assessment lookback period. She had a pressure reducing device to the bed and was dependent on staff for bed mobility and all activities of daily living. The March 2023 Treatment Administration Record (TAR) revealed nursing staff had been documenting every day and night shift that the low air loss mattress was properly inflated. The order read: low air loss mattress, check every shift for proper inflation, every day and night shift. Resident #21's medical record included a weight of 81.0 pounds (lbs) on 03/06/23. On 03/20/23 at 10:23 AM Resident #21 ' s air mattress setting was observed, and the dial was set at 300 pounds (lbs). Pressure levels settings for the mattress ranged from 75 to 500 lbs. On 03/21/23 at 1:50 PM Resident #21 ' s air mattress setting was observed, and the dial was set at 300 pounds (lbs). Pressure levels for the mattress ranged from 75 to 500 lbs. An interview was conducted on 03/21/23 at 01:41 PM with the Wound Nurse. Observation of Resident #21 ' s air mattress setting on 350 pounds (lbs). The Wound Nurse indicated she would confirm Resident #21 ' s weight and correct the setting. The Wound Nurse stated that the floor nurses were responsible for checking if the air mattresses were functioning properly not to	F 686	residents currently using low air loss mattresses to ensure each mattress accurately reflected their current weight. For results of the audit, please see exhibit (Exhibit 17). Any issues noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On March 27, 2023, the Director of Nursing (DON) updated the Admission Checklist to ensure any resident using a low air loss mattress was properly inflated according to their weight (Exhibit 18). On April 7, 2023, Staff Development Coordinator (SDC) completed an in-service training for all nurses and aides on how to accurately set up a low air loss mattress according to the resident□s current weight (Exhibit 19). On April 3, 2023, the DON updated the Focused Supervisor Rounds to reflect air mattress setting (Exhibit 20). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Low Air Loss Mattress Quality Assurance Monitor weekly for four weeks and monthly for three months. The Director of Nursing will evaluate 5 residents with orders for a low air loss mattress to ensure each is properly inflated according to the resident□s current weight. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity	

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INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 686	Continued From page 21 see if the weight setting was correct. She indicated she did not know who was responsible for checking the weight setting and it should coincide with the resident ' s current weight. An interview was conducted on 03/21/23 at 04:15 PM with Nurse #1. She stated she only checked to see if air mattress lights were on and functioning properly. She stated she did not check the weight parameters. Nurse #1 verified she signed the Treatment Administration Record (TAR) on day shift 03/21/23. On 03/21/23 at 04:34 PM Resident #21 ' s air mattress setting was observed to be set at approximately 100lbs. The markings on the dial read 75 then 150, the knob was closer to the 75 lb mark. An interview was conducted on 03/21/23 at 01:55 PM with Maintenance Assistant #1. He indicated that he sets the air mattresses up when the order is received. He further indicated he was unaware the dial on the box was to be turned to coincide with the weight of the resident. An interview with the Director of Nursing (DON) on 03/23/23 at 11:15 AM. She stated the air mattress should have been set according to the resident ' s weight and monitored by nursing staff every shift. She was unaware the nursing staff did not know they were to check the inflation of the air mattresses. 2. Resident #32 was admitted to the facility on 06/14/21. Her diagnosis included Diabetes Mellitus and contractures of the right and left knees.	F 686	Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended one month. Any corrective action required will be made by the Quality of Life Team at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

A review of the active physician orders included an order for a low air loss mattress, check every shift for proper inflation, every day and night shift.

Resident #32's medical record included a weight of 112.8 pounds (lbs) on 03/06/23.

The March 2023 Treatment Administration Record (TAR) revealed nursing staff had been documenting every day and night shift that the low air loss mattress was properly inflated. The order read: low air loss mattress, check every shift for proper inflation, every day and night shift.

A quarterly Minimum Data Set (MDS) assessment dated 03/10/23 indicated Resident #32 had severe cognitive impairment. She was at risk for Pressure Ulcers and no pressure ulcers were coded on assessment. She had a pressure reducing device to the bed and was dependent on staff for bed mobility and all activities of daily living.

Resident #32 ' s care plan last revised on 03/15/23 included a focus for at risk for pressure ulcer development due to decreased ability to assist with repositioning. The interventions included low air loss mattress on bed, pressure reducing mattress on bed.

On 03/20/23 at 10:25 AM Resident #32 ' s air mattress setting was observed, and the dial was set at zero (0) pounds (lbs). Pressure levels for the mattress ranged from 0 lbs through 350 lbs.

An interview was conducted on 03/22/23 at 9:44 AM with Nurse #3. She stated she checks if air mattresses are functioning properly and if the weight is properly set during her shift. Nurse #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

verified she signed the Treatment Administration Record (TAR) on day shift 03/20/23. She indicated she did not remember what the setting was on at that time.

On 03/21/23 at 1:54 PM Resident #32 ' s air mattress setting was observed, and the dial was set at zero (0) pounds (lbs). Pressure levels for the mattress ranged from 0 lbs through 350 lbs.

An interview was conducted on 03/21/23 at 04:15 PM with Nurse #1. She stated she only checked to see if air mattress lights were on and functioning properly. She stated she did not check the weight parameters. Nurse #1 verified she signed the Treatment Administration Record (TAR) on day shift 03/21/23.

An interview was conducted on 03/21/23 at 01:41 PM with the Wound Nurse. The Wound Nurse stated that the floor nurses were responsible for checking if the air mattresses were functioning properly not to see if the weight setting was correct. She indicated she did not know who was responsible for checking the weight setting and it should coincide with the resident ' s current weight.

An observation with Nurse # 3 was conducted on 03/22/23 at 11:48 AM. Nurse #3 confirmed Resident #32 ' s air mattress setting was set at 0 pounds (lbs), and mattress was hard to the touch. Nurse #3 set Resident # 32 ' s air mattress to approximately 120 lbs. The markings on the dial read 80 then 120, the knob was closer to the 120 lb mark.

An interview was conducted on 03/21/23 at 01:55 PM with Maintenance Assistant #1. He indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24	F 686		

that he sets the air mattresses up when the order is received. He further indicated he was unaware the dial on the box was to be turned to coincide with the weight of the resident.

An interview with the Director of Nursing (DON) on 03/23/23 at 11:15 AM. She stated the air mattress should have been set according to the resident ' s weight and monitored by nursing staff every shift. She was unaware the nursing staff did not know they were to check the inflation of the air mattresses.
3. Resident #34 was admitted to the facility on 8/9/21 with diagnoses that included dementia.

Resident #34's active physician orders included an order dated 2/7/22 for a low air loss mattress. Check every shift for proper inflation.

A quarterly Minimum Data Set (MDS) assessment dated 1/12/23 indicated Resident #34 had severely impaired cognition and had no behaviors noted. She was coded with one Stage 2 pressure ulcer over a bony prominence and had a pressure relieving device to the bed.

A review of Resident #34's active care plan, last reviewed 1/16/23, included the following focus areas:
- I am incontinent of bladder with increased risk for skin breakdown and infections. One of the interventions was a low loss air mattress.
- I currently have a pressure ulcer to my sacrum and am at risk for development of additional pressure ulcers due to decreased ability to reposition and incontinence. The interventions included a pressure reducing, low air loss mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 686	Continued From page 25	F 686		

Resident #34's weight on 3/15/23 was 110.4 pounds (lbs.).

A review of Resident #34's medical record revealed from 1/1/23 to 3/22/23 she received wound care every day to the sacral pressure ulcer.

The March 2023 Treatment Administration Record (TAR) revealed the nursing staff had been checking for proper inflation of the low air loss mattress to Resident #34's bed every shift (twice a day) and initialed the TAR.

On 3/20/23 at 9:55 AM, Resident #34 was observed sitting up in a wheelchair at her bedside. The low air loss mattress machine was set at 225 lbs. per weight setting. The machine had settings of 75 lbs., 150 lbs., 175 lbs., 225 lbs., 300 lbs., 375 lbs., 450 lbs., and 500 lbs. and indicated to set according to the resident's weight per pounds. The low air loss mattress machine had directions to set according to the resident's weight.

On 3/21/23 at 9:07 AM, Resident #34 was observed sitting upright in the bed. The low air loss mattress machine was set at 225 lbs.

An interview occurred with Nurse #2 on 3/21/23 at 11:07 AM. She stated she checked the functionality of the pressure reducing mattresses, making sure the connections were good, the light was on, and the mattress was inflated. Nurse #2 was unaware who set the weight on the pressure reducing mattress machine.

An observation was made with the Wound Nurse on 3/21/23 at 3:21 PM, of Resident #34's low air

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 686	Continued From page 26 loss mattress machine, confirming it was set at 225 lbs. and adjusted to the correct weight setting. The Wound Nurse stated the nursing staff checked the functioning of the air mattresses each shift ensuring the connections were secured and the mattress was inflated. She was unable to explain why Resident #34's mattress was set at 225 lbs. The Wound Nurse was unaware who was responsible for the weight setting on the pressure reducing mattress machine. On 3/21/23 at 11:46 AM, an interview occurred with Maintenance Assistant #1. He explained he put the pressure reducing mattresses on the beds when the order was received. He ensured the connections were tight, the machine was operating correctly and thought the mattress automatically set the weight of the resident once they laid on it. He was unaware the dial on the machine was to be turned to coincide with the resident's weight. The Physician Assistant (PA) was interviewed on 3/22/23 at 9:38 AM and indicated the air mattresses should be set according to the resident's weight if so indicated. On 3/23/23 at 10:00 AM, an interview was held with the Administrator and Director of Nursing, they stated they expected the low air loss mattress machine to be set according to the resident's weight as stated on the machine but felt it could also be set according to resident's preference for firmness or softness.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 27 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the Physician Assistant (PA) and staff, the facility failed to provide supervision and effective interventions to prevent repeated falls to a resident who was assessed as high risk for falls for 1 of 5 sampled residents reviewed for accidents (Resident #9). On 12/5/22, Resident # 9 sustained an acute mildly displaced fracture of the right subtrochanteric femoral neck from a fall and underwent open reduction and internal fixation (ORIF) of the right periprosthetic femur fracture and revision of the right hip arthroplasty (a surgical procedure to replace damaged joint with an artificial joint) on 12/6/22. On 2/11/23, Resident #9 continued to fall and sustained a mild displacement of the previous subtrochanteric fracture of the right femur. Findings included: Resident #9 was originally admitted to the facility on 11/1/22 with multiple diagnosis including Alzheimer's disease and hemiarthroplasty (procedure used to replace part of the hip with a prosthesis) of the right hip (9/2/22). Resident #9 had fall risk assessments on 11/1/22, 12/13/22 and 2/16/23. The fall risk model used by the facility indicated that a score of 5 or greater indicated high risk for falls. Resident #9 had a	F 689	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F689 For the residents involved, corrective action has been accomplished by: At the time of the survey, the resident□s Actual Fall Care Plan was reassessed by the Regional Nurse Consultant. Any recommendations were initiated at that time. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 24,2023, the Administrator educated the Director of Nursing on the following policies: Fall Management and Falls Prevention (Exhibit 21). On March 27, 2023, the Administrator audited 1 month of current resident falls to	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 689	Continued From page 28 score of 8 on each assessment, which made him a high risk for falls. The admission Minimum Data Set (MDS) assessment dated 11/8/22 indicated that Resident #9 had severe cognitive impairment, needed extensive assistance with 2 plus persons assist with transfers and ambulation in room/corridor did not occur during the assessment period. The assessment further indicated that the resident had falls since admission or prior assessment. Resident #9's care plan that was initiated on 11/8/22 revealed a problem of "I have had an actual fall with risk for further falls due to poor balance and unsteady gait". The goal was "my risk for future falls will be minimized through current interventions". The approaches included " anticipate my needs as much as possible, colored tape to call bell, grip strips to bilateral sides of bed (added 1/20/23), keep my call light in my reach, reinforce safety reminders frequently (added 12/2/22), staff to frequently assess resident's brief to ensure he is clean and promote comfort, staff to provide diversional activities as tolerated for resident when restlessness is noted (added 12/6/22), staff to ensure resident placement in the middle of the bed as tolerated to prevent resident from rolling out while sleeping (added 3/10/23). The quarterly MDS assessment dated 2/7/23 indicated that Resident #9 had severe cognitive impairment, needed limited assistance with 2 or more persons physical assist with transfers and ambulation in room/corridor did not occur during the assessment period. The assessment further indicated that the resident had falls since	F 689	ensure each fall had an appropriate intervention. For results, please see exhibit (Exhibit 22). Any discrepancies noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 7, 2023, the Staff Development Coordinator (SDC) educated 100% of nurses and aides on the following policies: Fall Management and Falls Prevention (Exhibit 23). The facility has implemented a quality assurance monitor: The Director of Nursing (DON) will complete a Fall Prevention & Intervention Quality Assurance Audit Tool Monitor weekly x 4 and monthly x3. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. The meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

admission or prior assessment.

Review of the incident reports and the nurse's notes revealed that Resident #9 had 7 falls since admission to the facility. The dates of the falls were:
11/4/22 at 3:35 PM - Resident #9 was found on the floor in the resident's room in front of his wheelchair by the Therapist. Resident was assessed with no injury noted. It appeared that the resident was attempting to get up from his wheelchair unassisted. A colored tape was placed on the resident's call bell to visually remind the resident to call for assistance when needed.
11/5/22 at 7:30 PM - A visitor informed the nurse that Resident #9 was attempting to get out of bed. When the nurse arrived, the resident was observed sliding from his bed to the floor. Resident was assessed with no injury noted. The resident was noted to have a soiled brief, incontinent care was provided. The staff were educated to frequently assess resident's brief to ensure he was clean and dry to promote comfort.
12/2/22 at 12:50 AM - During rounds, the Nurse Aide (NA) heard Resident #9 making noises and noted him on the floor beside his bed. The resident stated, "I was trying to get the floor". When assessed, no injury was noted. The staff were educated to reinforce safety reminders with the resident frequently.
12/5/22 at 11:42 AM - The NA informed the nurse that Resident #9 was on the floor at the nurse's station and the wheelchair was behind him. When assessed, he had an abrasion to his right forehead with a small amount of blood noted. He complained of severe pain in his right hip. He stated, "I was getting up to go home and fell." The staff reported that that they were assisting other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

residents at the time of the fall. The staff were educated to provide diversional activities as tolerated for the resident when restlessness was noted. The resident was sent to the emergency room (ER) for evaluation and was diagnosed with an acute, closed mildly displaced fracture of the right subtrochanteric femoral neck.
1/20/23 at 4:05 AM - Resident #9 was noted yelling in his room and was found on the floor at bedside on his knees. He stated, "I slid out of bed". When assessed, there was no injury noted. Grip strips were placed on bilateral side of bed to assist in the prevention of resident slipping.
2/11/23 at 12:32 PM - The Nurse and NAs were working on the hallway when a loud thump was heard, and Resident #9 cried out. The resident was noted on the floor next to the nurse's station. It appeared that he hit his head and he was grimacing. He was noted to have a scraped knee. The resident stated, "I was trying to go home". Resident was trying to ambulate without assistance at the time of the fall. The resident was sent to ER for evaluation. Therapy to evaluate and treat when he returns. Review of the hospital discharge summary dated 2/16/23 revealed that Resident #9 sustained a mild displacement of the previous subtrochanteric fracture of the right femur.
3/10/23 at 1:15 AM - During rounds, the NA found Resident #9 on the floor beside his bed sleeping. When assessed, there was no injury noted. It appeared that the resident rolled from the bed while sleeping. The staff were educated to ensure resident placement in the middle of the bed as tolerated to prevent resident from rolling out while sleeping.

Resident #9 was observed on 3/20/23 at 11:07 AM up in wheelchair in his room snoozing and at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

3:59 PM, he was observed in his wheelchair at the nurse's station. There were no staff members observed at the nurse's station at this time. The bed was in a low position, and he had grip strips on the floor. His call light was noted to have a colored tape on it.

Nurse #2 was interviewed on 3/21/23 at 2:55 PM. She stated that the resident was confused and was at a high risk of falling. The Nurse reported that the resident tried to get up wanting to go home. She reported that on 2/11/23, the NAs were in the resident's rooms, and she was at the medication cart. She heard a thump and observed the resident on the floor at the nurse's station. She indicated that she could not always be with him, he could use a sitter for more supervision. The Nurse stated that the resident had complained of his hip hurting after the 2/11/23 fall, and he was sent to the ER and was diagnosed with mild displacement of the subtrochanteric right femur fracture.

The PA was interviewed on 3/22/23 at 9:45 AM. The PA reported that Resident #9 was very demented and was a high risk for falls. He stated that Resident #9 needed close supervision and a place where he could roll his wheelchair around like in the memory unit.

The Director of Nursing (DON) was interviewed on 3/22/23 at 12:10 PM. She stated that Resident #9 was demented and was a high risk for falls. She reported that she was responsible for the falls, she reviewed the incident reports and she put interventions in place to prevent further falls. She also reported that incident reports were reviewed and discussed daily during the interdisciplinary team (IDT) meeting and identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 689	Continued From page 32 the root cause of the falls. She stated that the resident has the right to fall, and the facility does not offer one on one supervision. Nurse #3 was interviewed on 3/22/23 at 1:22 PM. The nurse reported that Resident #9 was demented and was at a high risk for falls. He was trying to get out of bed or wheelchair unassisted. On 12/5/22, he was trying to get out of bed, he was placed in wheelchair and was taken to the nurse's station. He was found by the NA on the floor beside his wheelchair. He had an abrasion to his right forehead that was bleeding. He complained of severe pain in his right hip. He was sent to the ER for evaluation and was diagnosed with a fracture. When asked what could help the resident from falling, the Nurse stated that "keeping him busy and occupied would help". The DON was again interviewed on 3/23/23 at 11:20 AM. The DON verified that Resident #9 was assessed as high risk for falls. She stated that she was responsible for the falls, and she had put interventions after each fall for Resident #9. The DON also stated that the resident has the right to fall and one on one supervision was not offered at the facility.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 692	Continued From page 33 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Registered Dietitian (RD) and Physician Assistant (PA) interviews and record review, the facility failed to identify a significant weight loss for Resident #17. This was for 1 of 2 residents reviewed for nutrition. The findings included: Resident #17 was admitted on 11/18/22 with diagnoses of aspiration pneumonia, dysphagia and dementia. Resident #17's admission Physician orders dated 11/18/22 included the following: *Regular diet soft and bite sized texture with liquids of thin consistency *Weekly weights x four weeks then monthly and as needed (prn). Resident #17's electronic medical record (EMR) read her admission weight of 131.6 lbs. on 11/21/22. Resident #17's diet orders were changed on	F 692	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F692 For the residents involved, corrective action has been accomplished by: On March 22, 2023, the resident was re-weighed to accurately reflect the resident□s current weight. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 27, 2023, the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 692	Continued From page 34 11/21/22 to easy to chew texture and fluids of mildly thickened consistence. There was no documentation in the EMR as to why her diet order was changed. Review of a Speech Therapy evaluation only dated 11/28/22 indicated a recommendation of a fiberoptic endoscopic evaluation of swallowing (FEES)study and supervision for all oral intake. A FEES study was to determine how well Resident #17 was able to swallow. Review of a Dietitian Nutritional Assessment dated 12/1/22 read Resident #17's weight was 131.6 lbs. The assessment read to continue the regular easy to chew diet with mildly thicken liquids and her average oral intake was between 50-75%. There were no new nutritional recommendations. Resident #17's EMR read she weighed 125.2 lbs. on 12/2/22. There was no documented evidence of weekly weights as ordered for the week ending 12/10/22 or the week ending 12/17/22. Review of the FEES test dated 12/9/22 read no change in diet or liquid consistency but recommended Resident #17 to sit upright with all intake for at least 20-30 minutes. There were no new Physician orders based on the results of her FEES study. Resident #17's EMR read she weighed 123.8 lbs. on 1/4/23, a 5.93% weight loss since admission. Review of Resident #17's nutritional care plan initiated 11/21/22 and revised on 1/4/23 read she had a potential for a problem with her nutrition due to difficulty chewing and swallowing, eating	F 692	Nursing (DON) audited 100% of all current residents for ordered weekly weights and monthly weights to assess for weight loss and or weight gain. In addition, on March 31, 2023, the DON audited to ensure each weight task is fired in the Point of Care (POC) charting for the aides. Firing this task will ensure each weight is transcribed into Point Click Care (PCC). For results of the audit, please see exhibit (Exhibit 24). Any issues noted were corrected at that time. On April 5, 2023, the DON educated the Support Nurse on the weight policy and the importance of tasking weekly weights on admission in the POC (Exhibit 25). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On March 27, 2023, the DON created a Weekly and Monthly Weight Loss/ Gain Audit (Exhibit 26). The Admission Check List was updated to include weekly weights in the POC (Exhibit 27). On April 7, 2023, Staff Development Coordinator (SDC) completed an in-service training for all nurses and aides on the weight policy and the revised Admission Check List which includes the weight task. (Exhibit 28). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Weekly and Monthly Weight Loss/ Gain Quality Assurance Monitor weekly to access for weight loss and or weight gain for four weeks and monthly for three months. The results will be reported monthly to the Quality of Life Team at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 692	Continued From page 35 too fast and not completely chewing her food. Interventions included encouraging Resident #17 to slow down eating, take time to chew food her completely. Review of the Speech Therapy re-screen on Resident #17 dated 1/5/23 following the FEES study. There was no skilled justification for speech therapy due to the time since the onset of her dysphagia and her baseline cognitive impairment, but it was recommended restorative dining for safety. There was a Physician order dated 1/5/23 for mighty shakes (dietary supplement) three times per day. There was no documentation in the EMR as to the reason Resident #17 was placed on the supplement. Review of Resident #17's care plan included a new focus dated 1/6/23 for restorative dining for safe swallowing strategies. Review of Resident #17's January 2023 food intake ranged from zero to 100% with the monthly average of 50%. There was no documented evidence that the facility obtained Resident #17's weight for the month of February 2023. Resident #17's quarterly Minimum Data Set (MDS) dated 2/25/23 indicated she had severe cognitive Impairment, required extensive assistance with eating, intact skin and her weight of 123 lbs. The MDS nurse was interviewed on 3/22/23 at 1:30 PM. She stated she used the weight in the	F 692	Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for one month. Any corrective action required will be made by the Quality of Life Team at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 692	Continued From page 36	F 692		

EMR for 1/4/23 when completing Resident #17's MDS dated 2/25/23.

Review of Resident #17's February 2023 food intake ranged from zero to 100% with 25% or less documented intake for all meals and supplements on 2/4/23, 2/10/23, 2/13/23, 2/14/23, 2/17/23, 2/18/23, 2/19/23, 2/22/23, 2/23/23 and 2/25/23.

There next documented evidence of a weight obtained on Resident #17 was on 3/15/23 when she weighed 119.2 lbs. which was a 9.42% weight loss in 4 months.

A lunch meal observation was completed on 3/20/23 at 1:02 PM of the lunch meal in the dining area designated for restorative dining and there were several episodes of Resident #17 coughing during the meal. There were 10 residents observed with 2 aides at one table feeding/assisting the residents at that table. The table where Resident #17 sat did not have any staff present observing her eat, drink or swallow. It appeared that she ate approximately 50% and she drank all of her dietary supplement.

The EMR included a Dietary Review completed by the DM on 3/15/23. The review was modified on 3/21/23. The original Dietary Review dated 3/15/23 did not include any documentation in the following areas:

*supplement orders
*swallowing issues
*relevant conditions and diagnosis
*feeding assistance/meal location
*patient preferences
*dietary summary

The revised Dietary Review dated 3/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 692	Continued From page 37	F 692		

included the following documentation:
*supplement orders-nutritional shake and multivitamin
*swallowing issues-coughing or choke during meals or when swallowing medications
*relevant conditions and diagnosis-Vitamin D deficiency and dysphagia
*feeding assistance/meal location-supervised eating
*patient preferences-see tray card
*dietary summary-patient is on a regular diet with soft and bite sized textures, intake is 50/75%,
Vitamin D, dysphagia, supplemented with nutritional shake and multivitamin

The DM was interviewed on 3/22/23 at 8:55 AM. He validated he completed the Dietary Review dated 3/15/23 but he locked the review in the EMR on 3/21/23 when he noticed he had not done it. He stated the facility held a weekly weight meeting which he attended. He stated the weekly weight meetings were held every Thursday and if the RD was unable to attend, he would communicate any identified concerns with her. He stated he did not recall if Resident #17 was discussed in last week meeting, but the support nurse would know.

The support nurse was interviewed on 3/22/23 at 9:43 AM. She confirmed she had oversight of resident weights. She recalled Resident #17 triggered on the EMR dashboard as have loss weight last week. She stated it was discussed that there was no February weight recorded in the EMR, and she was going to investigate why the RA did not enter a February weight. The support nurse stated she forgot to follow up with the RA about the missing weight and the RD was unable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 38	F 692		

to attend with weight meeting Thursday. She stated she planned to let the RD know if the February weight showed continued weight loss, but she forgot to pursue anything about Resident #17's weight loss or missing February weight.

An observation was completed on 3/21/23 at 8:23 AM. Resident #17 was sitting up in her bed feeding herself. There was no staff in her room to observe or encourage her. She ate approximately 25% and drank only a few slips of her dietary supplement. There were no observed coughing episodes.

Another observation was completed on 3/21/23 at 12:25 PM of the lunch meal in the dining area designated for restorative dining. There were 2 aides at one table feeding/assisting the residents at that table. There was 2 observed occasions of Resident #17 coughing during the meal. She ate approximately 25% and she only took a few slips of her dietary supplement.

The restorative aide (RA) was interviewed on 3/21/23 at 12:30 PM. She stated Resident #17 would only eat small amounts and she often coughed with her liquids. She stated Resident #17 was only in restorative dining for lunch and for other meals, she ate in her room. She stated staff did not sit with Resident #17 while she ate her lunch but rather she was to intervene as needed for her swallowing difficulty with coughing. The RA stated the MDS was over the restorative program.

The MDS Nurse was interviewed on 3/22/23 at 2:54 PM. She confirmed she was over the RA who obtained the weights as ordered. She stated she informed the RA if any resident was ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 39	F 692		

a weight other than monthly. The MDS Nurse confirmed the RA was often pulled to the floor. She stated she was not a part of the weekly weight meetings and only updated the care plans from the email she would receive from the DON. The MDS Nurse stated Resident #17 was in restorative dining for closer observation while eating.

An interview was completed on 3/22/23 at 3:40 PM with nursing assistant (NA) #3. She stated Resident #17 ate breakfast in bed with the head of her bed raised to prevent choking, ate lunch in restorative dining area and ate dinner in her room usually sitting up in her wheelchair. NA #3 stated Resident #17 was a picky eater, often coughed while eating but she was able to clear her throat in order swallow. She said Resident #17 was a poor eater and ate around 25% of her breakfast and dinner.

The Director of Nursing (DON) was interviewed on 3/22/22 at 8:35 AM. She confirmed there was a weekly weight meeting held every Thursday but stated she did not attend the meetings. She stated the treatment nurse, restorative aide, the Staff Development Coordinator, the DM and the support nurse all attended the meeting. She stated the support nurse had oversight of the weight meetings and resident weights. The DON stated the DM communicated with the RD if she was not able to attend the meeting. She stated after the meetings, any changes she emailed the MDS Nurse to update the care plans. The DON stated she was unaware of the significant weight loss.

The RA was interviewed again on 3/22/23 at 1:25 PM. She stated she had been doing restorative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 40	F 692		

nursing a few months and she was responsible for monthly, weekly weights and restorative dining. The RA stated there were occasions where she was pulled to work the floor and the aides would have to get their own weights for any residents that required it. She stated she entered the weights into the EMR and that she nor the MDS Nurse were part of the weekly weight meetings. The RA provided Resident #17's February 2023 weight she had documented on her undated written February weight list, but she stated she must have forgotten to enter it into the EMR. She stated the support nurse or anyone else requested Resident #17's February weight so she was unaware that it was not in the EMR until surveyor requested it. The February 2023 weight was 118.6 lbs. with was a 9.88% weight loss in 3 months. The he RA monthly were normally obtained the first week of every month.

Review of Resident #17's March 1 to March 22, 2023, food intake ranged from zero to 100% with 25% or less documented intake for all meals and supplements on 3/14/23, 3/17/23, and 3/21/23 with the average of 50%.

Review of the EMR included a weight of 120 lbs. obtained 3/22/23 for Resident #17.

Review of a Dietitian nutritional Review dated 3/22/23 completed by the RD read as follows: Referral for review request related to 3% weight loss-not significant with Resident #17's weight on 3/22/23 was 120 lbs. Nutritional supplements were ordered on 1/5/23. Current oral intake was 54.7% in last 13 days, no skin issues and recommended dietary to reevaluate Resident #17's food preferences and offer snacks in addition to regular meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 692	Continued From page 41 A telephone interview was completed on 3/23/23 at 9:43 AM with the RD. She stated she started at the facility in February 2023 and attended the weekly weight meeting remotely. She also stated if there were any concerns that came up prior to the next meeting, the DM would email or call her the let her know. She stated she had not received any request to reassess Resident #17 until 3/22/23. She stated she was not able to attend the weight meeting held last Thursday. She stated there was no documented weight in the EMR for the month of February 2023 so Resident #17 was weighed yesterday. When the February weight of 118.6 lbs. was provided to the RD by the surveyor, she stated in relation to Resident #17's admission weight of 131.6, that it was a significant weight loss and had she known the weight in February 2023, should have added another supplement or other recommendations. A telephone interview was completed with the PA on 3/23/23 at 10:00 AM. He stated he was not aware of the significant weight loss on Resident #17. He stated he would assess Resident #17 the following day to see what other interventions could be implemented to address her weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 42 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and Physician Assistant (PA) interviews and record review, the facility failed to change the oxygen tubing weekly as ordered and failed to obtain oxygen saturation parameters for an order to titrate oxygen as tolerated. This was for 1 (Resident #250) 1 residents reviewed for respiratory care. The finding included: Resident #250 was admitted on 3/10/23 with diagnoses of respiratory failure and Congestive Heart Failure (CHF). Review of Resident #250's admission orders dated 3/10/23 included the following orders related to his oxygen usage: - Oxygen at 3 L/M continuous via nasal cannula - Change oxygen tubing every week on Sunday nights - Titrate oxygen as tolerated His admission Minimum Data Set was in progress and indicated he was cognitively intact. Review of Resident #250's oxygen care initiated on 3/10/23 read that he required continuous oxygen therapy due to CHF and ineffective gas exchange. Interventions included oxygen at 3 liters per minute (L/M-a measurement of the velocity in which oxygen flows to the resident) continuously and an intervention dated 3/13/23 to titrate oxygen as tolerated. Review of Resident #250's Medication Administration Record (MAR) for March 2023 indicated Nurse #4 initialed she changed	F 695	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F695 For the residents involved, corrective action has been accomplished by: At the time of the survey, oxygen tubing was changed for the resident. And parameters were obtained for the oxygen titration orders. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 28, 2023, the Director on Nursing (DON) audited all current residents for oxygen titration orders and each order that did not have parameters the DON obtained orders. Also, on March 28, 2023, the DON audited 100% of residents requiring oxygen to ensure each of the tubing was changed per Physician□s order. Please see exhibit for results (Exhibit 29). Any issues noted were correct at that time. Measures put into place or systematic changes made to ensure the alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 43 Resident #250's oxygen tubing on 3/19/23. An interview and observation was completed on 3/20/23 at 10:41 AM. Resident #250 stated he did not use oxygen at home but was discharged from the hospital with the oxygen. He stated he wore the oxygen all the time since being admitted to the facility. Observation of the oxygen concentrator revealed it running at the ordered rate of 2.5 L/M. Observation of his oxygen tubing had a label dated 3/13/23. Observation of Resident #250's oxygen tubing on 3/21/23 at 9:25 AM still had a label indicating last changed on 3/13/23. The oxygen was running at 2 L/M. Observation of Resident #250's oxygen tubing on 3/22/23 at 9:40 AM had a label indicating last changed on 3/13/23. The oxygen was running at 2.5 L/M. A telephone interview was completed on 3/22/23 at 11:49 AM with Nurse #5. She confirmed she worked night shift on 3/19/23 and initialed off that she changed Resident #250's tubing. She stated she got distracted with something else and forgot to actually replace Resident #250's oxygen tubing and she should not have initialed off that she completed it until she actually replaced the old tubing. An interview was conducted on 3/22/23 at 9:30 AM with Nurse #2. She stated Resident #250's oxygen was ordered for 3 L/M but there was also orders to titrate his oxygen as tolerated. She stated it was her understanding that therapy was titrating Residents #250's his oxygen to see if he could be discharged home without it.	F 695	deficient practice does not occur: On April 7, 2023, the Staff Development Coordinator (SDC) completed education on the Oxygen Policy with all nurses and medication aides, part-time and fulltime, on the expectation of following physician orders (Exhibit 30). On April 7, 2023, one on one education provided to the nurse that was noted in the 2567 on the Oxygen Administration Policy by the SDC (Exhibit 31). The facility has implemented a quality assurance monitor: The Director of Nursing will use the Oxygen Tubing and Titration Order Quality Assurance Audit Tool to ensure that all titration orders have parameters. In addition, to following physician orders related to tubing changing. The monitor will be completed weekly for four weeks and monthly for three months. And the DON will audit 5 residents weekly for four weeks and monthly for three months to ensure the oxygen tubing was changed per Physician□s order and each titration order includes parameters. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 44 An interview was completed with the Therapy Director on 3/22/23 at 1015 AM. She stated titrating a resident's oxygen rate was not a therapy function but rather was done by the nursing staff with titration parameters ordered by the Physician. An interview was completed on 3/22/23 at 3:20 PM with the Director of Nursing (DON). She reviewed March 2023 MAR and noted Nurse #5 initialed that she changed the oxygen tubing but was not aware that Nurse #5 forgot to change his oxygen tubing. The DON agreed there should be a Physician order indicating Resident #250's oxygen saturation parameters in order to titrate Resident #250's continuous oxygen. A telephone interview was completed on 3/23/23 at 10:00 AM with the PA. He stated in order to titrate a resident off of continuous oxygen, there needed to be parameters for the resident's oxygen saturation to ensure the resident tolerated the decrease in the oxygen flow rate. He stated for a resident without the diagnosis of Chronic Obstructive Pulmonary Disease, the oxygen saturation percent should be maintained at 92% or above. Review of Resident #250's oxygen saturation rate in his electronic medical record never dropped below 92% with the average of 97%.	F 695	100% compliance, the monitor will be extended one month. Any corrective action required will be made by the Quality of Life Team at that time.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 697	Continued From page 45 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and resident, staff and Physician interviews, the facility failed to assess for level of pain and treat a resident with complaints of pain during wound care (Resident #21). This was for 1 of 4 residents reviewed for wound care. The findings included: Resident #21 was admitted to the facility on 11/23/20. Her diagnosis included Alzheimer ' s disease, dementia, contractures of the right and left thigh muscle, and unspecified viral infection characterized by skin and mucous membrane lesions. Resident #21 ' s care plan reviewed on 11/08/22 included the following: 1. I have recurrent bullous skin disease to my chest and left buttock. · Give anti-pruritic medication as ordered by MD. Monitor/document side effects and effectiveness. · Monitor skin bullous skin disease for increased spread or signs of infection. · Seek medical attention if skin becomes bloody or infected. 2. I have episodes of displaying the following inappropriate behaviors: refusing care, yelling out, especially during bathing. · Approach in a calm manner. · Explain all procedures to me before starting and allow me adequate time to adjust to changes.	F 697	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F697 For the residents involved, corrective action has been accomplished by: On March 22, 2023, antilytic mediation was ordered prior to dressing changes as needed to assist with anxiety related to wound care. On March 24, 2023, resident was reviewed by the provider. New orders were obtained for pain management prior to dressing changes as needed. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 31, 2023, the Director of Nursing (DON) audited 100% of current residents with wounds to ensure pain medication orders are in place. For results, please see exhibit (Exhibit 32). Any discrepancies noted were corrected at that time.	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 46 A quarterly Minimum Data Set (MDS) assessment dated 01/27/23 revealed Resident #21 had severe cognitive impairment and displayed no behaviors. She required extensive assistance of one person for bed mobility. The MDS indicated pain was present occasionally and was rated a 04 out of 10 for severity. As needed pain medication was given for reports of pain. She was coded for the application of dressings with ointments and/or medications to skin. A review of the active physician orders from February 2023 through March 2023 revealed Resident #21 was not ordered anything for pain on a routine basis. She did however have an order for acetaminophen 325 Milligrams (MG), give 1 tablet by mouth every 6 hours as needed for Pain/fever. Documentation on Resident #21 ' s March 2023 Medication Administration Record (MAR) indicated acetaminophen 325mg, 1 tablet by mouth was administered on 03/04/23 with a 07 out of 10 for severity pain rating, 03/19/23 with a 08 out of 10 for severity, and 03/21/23 at 3:00 PM, post wound care, with effective results. There was an order for Doxycycline Monohydrate Capsule 100 MG, give 1 capsule by mouth two times a day for wound infection for 14 Days started on 03/20/23. An order that read pain assessment every shift, ask patient if they are in pain according to a 0-10 scale. Pain level documented for March 2023 ranged from 0-2 out of 10 for severity pain rating. Review of Resident #21 ' s Treatment Administration Record (TAR) and the active physician orders from February 2023 through March 2023 were completed. An order with a	F 697	On April 5, 2023, the Wound Care Nurse was educated by the Director of Nursing (DON) on pain management related to wound care (Exhibit 33). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: Facility Medical Director contacted related to pain assessment orders prior to dressing changes. The Director of Nursing (DON) will complete a Wound Pain Management Assessment Quality Assurance Audit Tool to ensure each dressing change order has a pain assessment included in addition to pain management medications as needed. On April 7, 2023, the SDC education 100% of nurses on General Treatment Guidelines Policy (Exhibit 34). The facility has implemented a quality assurance monitor: The Director of Nursing (DON) will complete a Wound Pain Management Assessment Quality Assurance Monitor weekly times 4 weeks then monthly times 3 months. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. The meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended 1 month. Any corrective action required will be made by the Quality of Life Team at that time	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 697	Continued From page 47	F 697		

start date of 03/13/2023 and a discontinue date of 03/17/2023 to please paint chest wound area or back side of abdominal pad with Vaseline (petroleum-based ointment) to prevent sticking, current abdominal pad needs to be well saturated to remove. An order with a start date of 03/18/2023 that read ALERT: Cleanse chest wound with normal saline, apply Medi honey cover with 4x4 dressing every day shift. Being followed by Physician Assistant (PA) PLEASE DO NOT CHANGE TREATMENT.

The nursing progress notes from 09/14/23 to 03/22/23 were reviewed and indicated Resident #21 had no episodes of refusals of wound care.

The Physician Assistant (PA) notes for Resident #21 from 2/27/23 to 03/22/23 were reviewed. A note dated 02/27/2023 that upon assessment Resident #21 had a large chest wound, skin excoriation like thermal or chemical burn. Most likely from extremely adhesive bandages. A note dated 03/10/23 stating follow-up to evaluate ongoing large superficial chest epidermal injury. Instructions given to apply very light coating of Vaseline (petroleum-based lubricant) to wound/abdominal pad, prefer painting abdominal pad and then applying. Porosity of abdominal pad is causing issues with proteins leaking out to heal and being dried by abdominal pad to the point of sticking/gluing to wound surface so that removal damages healing portions.

A note dated 03/17/23 included instructions given to apply very light coating of Vaseline to wound/abdominal pad, prefer painting abdominal pad and then applying. Issue with overly aggressive adhesive bandages being applied which is sticking/gluing to wound surface so that

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 697	Continued From page 48	F 697		

removal damages healing portions, and tears new skin.

On 03/21/23 at 1:41 PM wound care observation was completed with the Wound Nurse. The Social Worker (SW) assisted with the dressing change by holding Resident #21 ' s hands and talking to her in a calm voice. The Wound Nurse started to remove the old dressing andResident #21 was observed pushing the Wound Nurses hands away and yelling out "it hurts, stop". At that time the Wound Nurse was asked if she gave pain medication before the wound care to Resident #21 and she stated yes that she had given her something for pain prior to the dressing change. The Wound Nurse stopped touching the area and Resident #21 stopped yelling. After a brief 30 second to 1 minute pause the Wound Nurse then saturated the old bandage with normal saline to aid in an easier removal. Resident #21 started moaning and yelling when the Wound Nurse removed the old dressing and she stated, "I ' ll be done in just a minute". During the removal of dressing a piece of skin approximately 1-1.5 inches was observed coming off with old bandage. Resident #21 was yelling out continuously while the dressing was being removed and the wound was being cleaned and then was observed Medi honey was applied to a new abdominal pad and then placed on top of chest wound. Wound care lasted approximately 10 minutes total. Review of Medication Administration Record (MAR) revealed that no pain medication was administered prior to the dressing change.

An interview was conducted on 03/22/23 at 9:44 AM with the Wound Nurse. She stated she did not administer pain medication prior to wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 697	Continued From page 49	F 697		

care on Resident #21 on 03/21/23 like she had previously stated. She then stated she administered the pain medication after the dressing change was completed on 03/21/23. She did not stop yesterday when the resident asked her because she thought by saturating the dressing and taking breaks the resident would be able to tolerate the dressing change better. The Wound Nurse explained the floor nurses normallyperformed wound care on Resident #21. She indicated that she was familiar with Resident #21 but had not asked other staff if the resident voiced or showed signs/symptoms of pain when her dressing was changed.

An interview was conducted on 03/21/23 at 2:00 PM with the Social Worker (SW). She stated Resident #21 yells out at times when her treatment was being performed, during incontinence care, and during bathing. She further stated at times she comes in and attempts to distract her and comfort her.

An interview was conducted on 03/21/23 at 4:15 PM with Nurse #1. She stated she did not give Resident #21 pain medication prior to her dressing change on 03/21/23. Nurse #1 did not perform wound care on Resident #21 on 03/21/23 but she was her nurse. She also stated Resident #21 would sometimes verbalize pain according to the 0-10 severity pain scale and other times she would evaluate her pain by looking at non-verbal signs such as facial grimacing and/or moaning. She further stated Resident #21 would often yell out during incontinent care and showers.

An interview was conducted on 03/21/23 at 3:48 PM with Resident #21. She stated the area to her chest hurts when her dressing was changed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 50	F 697		

A phone interview was conducted on 03/21/23 at 3:55 PM with Nurse #5. He stated he does the treatments on Resident #21 ' s chest wound when he works day shift. Nurse #5 worked on March 15th, 16th, 18th, and 19th and confirmed he completed the treatment. He also stated he always medicated her prior to the dressing change because the treatment was very painful to her. Resident #21 was able to verbalize pain according to the 0-10 severity pain scale but other times he would assess her nonverbal behaviors. He stated the acetaminophen helped but she still had pain when the dressing was changed. He further stated Resident #21 would moan or yell out at times during the dressing change, but she did not ask him to stop. When she would moan or yell, he would pause and give breaks which helped her with pain. He would saturate the dressing prior to removing it and explained what he was doing prior to doing it, which helped for easy removal. Nurse #5 stated he did administer acetaminophen on March 15th, 16th, and 18th but he forgot to sign the Medication Administration Record (MAR).

An interview was conducted on 03/22/23 at 9:52 AM with Physician Assistant (PA) related to Resident #21 ' s chest wound. He stated Resident #21 should receive pain medication prior to the dressing change to her chest because the area was very painful. He also stated he told nursing to administer the pain medication prior to the dressing change but he had not written an order to do so. He then stated if the acetaminophen was administered prior to the dressing change but was ineffective he would expect to be notified. He further stated she had acetaminophen ordered for pain, but he would add a different

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 697	Continued From page 51 pain medication to her orders to be administered prior to wound changes. An interview with the Director of Nursing (DON) on 03/23/23 at 11:15 AM. She indicated she was unaware Resident #21 was in pain during her dressing change and that she was not given pain medication prior to the dressing change. She also indicated if a resident had a painful wound change, she would expect pain medication to be given 30 minutes prior to the wound care. She further indicated if a resident exhibited pain during the treatment the nurse should stop and administer pain medication and return later to complete the wound care.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 732	Continued From page 52 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the daily nurse staffing data in a prominent location readily accessible to all residents and visitors for 4 of 4 days (3/20/23 through 3/23/23). The findings included: During an initial tour of the facility on 3/20/23 at 9:45 AM, the surveyor was unable to locate the posted staffing data. On 3/20/23 at 9:47 AM, Nurse #2 working at nursing station #2 for 500/600 hall directed the surveyor to nursing station #1 on the 300/400 hall to the posting located on the wall. Observations were completed on 3/21/23 at 10:07 AM, 3/22/23 at 12:48 PM and 3/23/23 at 10:30 AM revealed the staff posting data was only visible at the nursing station #1 for the 300/400 hall.	F 732	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F732 For the residents involved, corrective action has been accomplished by: On March 23, 2023 the Staff posting was relocated to a location that the surveyors believe is a more prominent location by the Social Worker office. Corrective action has been accomplished on all residents with the potential to be	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 53 The Director of Nursing (DON) was interviewed on 3/22/23 at 11:20 AM. She stated the residents and visitors would be able to see the staffing data posting at nursing station #1 for the 300/400 hall since it was near the therapy room. She offered no explanation as to why the staffing data was not posted visually for the residents and visitors on 500/600 hall.	F 732	affected by the alleged deficient practice by: The Staffing Posting was moved along with the survey notebook to a location that is in a more prominent area. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On March 27, 2023, the Administrator educated the Director of Nursing regarding the Posted Staff Posting Guidelines Policy (Exhibit 35). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Daily Nursing Staffing Sheet Quality Assurance Monitor weekly for four weeks and monthly for three months. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 54 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to date leftover food in 1 of 2 walk-in refrigerators; failed to maintain a clean kitchen floor; failed to store clean and dirty knives separately; and failed to thaw meat in sanitary conditions to prevent the potential for cross contamination. The failures had the potential to affect food served to residents. The findings included: 1. An initial observation of 1 of 2 walk-in coolers on 03/20/23 at 9:38 AM revealed an open, undated package of parmesan cheese. During an interview with the Dietary Manager (DM) on 03/20/23 at 9:39 AM, he stated the parmesan cheese was probably opened during the weekend and it should have been dated when it was opened. 2. An initial observation of the kitchen floor on	F 812	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F812 For the residents involved, corrective action has been accomplished by: No residents were affected by the alleged deficient practice. On March 20, 2023, the parmesan cheese was disregarded by the Director of Dining Services. On March 20, 2023, the bottom of the sink was cleared and cleaned of food debris	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 812	Continued From page 55 03/20/23 at 9:45 AM revealed there were crumbs in various sizes across the entire kitchen floor including under and behind appliances. Another observation of the kitchen floor on 03/20/23 at 2:10 PM revealed very small to nickel sized crumbs across the entire kitchen floor including under and behind appliances. An additional observation on 03/21/23 at 8:30 AM revealed crumbs of various sizes throughout the kitchen including the prep area and tray line area. Crumbs were also observed under and behind appliances. An observation and interview with the DM on 03/22/23 at 10:45 AM revealed there were crumbs throughout the entire kitchen including under and behind appliances. He stated it was his expectation that the floors needed to be clean to ensure pest infestations do not occur. He stated the Utility Worker was responsible for cleaning the kitchen floor. The Utility Worker was interviewed on 03/22/23 at 10:50 AM which revealed he swept and mopped every day. He stated the floors were old and it's difficult to get them clean. He stated he had swept and scrubbed the floors during the survey. 3. An observation of the 1-compartment sink in the prep area on 03/20/23 at 2:10 PM revealed a large package of ground turkey meat three-forth submerged in an 8-quart plastic container thawing under cool running water in a clogged sink with food debris. Additionally, on the shelf attached to the 1-compartment sink there were clean knives stored in a dishwasher basket and dirty knives were observed to be stored outside	F 812	and the knives were disinfected. On March 23, 2023, the Director of Dining Services (DM) assisted with cleaning the crumbs from various locations throughout the kitchen including the floor. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 20, 2023, the walk-in coolers were audited to ensure each item is labeled and dated. In additional to the food safety and sanitation checklist was completed (Exhibit 36). On March 23, 2023, the Director of Dining Services (DM) audited cleaning for crumbs from various locations including the floor. On April 5, 2023, the Maintenance Director serviced the sink for clogs, any issues were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 5, 2023, the Systems Director educated 100% of kitchen staff on the importance of kitchen sanitation and prevention of cross contamination (Exhibit 37). On April 5, 2023, the Dietary Manager was educated on how to place a work order for equipment that is not functioning properly (Exhibit 38). The facility has implemented a quality assurance monitor: The Director of Dining Services or Designee will complete the Kitchen QA Audit Tool to ensure compliance with labeling and dating of food, floor	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 812	Continued From page 56 and touching the basket. During the observation on 03/20/23 at 2:10 the DM acknowledged the food particles in the sink. He stated the building was old and had issues with sink draining. He stated the ground turkey should not have been thawing in a clogged sink with food particles. Additionally, the clean knives were stored at the sink because "that's the safest place for them." He stated the facility did have a magnetic knife holder; however, the knives fall off it. He further stated the dirty knives and clean knives were stored together because they were all going to get cleaned at the same time. An interview with the Administrator on 03/22/23 at 2:14 PM revealed she expected food to be label and dated when opened, kitchen floors should be kept clean, meat should be thawed properly to avoid potential contamination, and clean and dirty dishes should be kept separate.	F 812	cleanliness and sink free of clogs. This audit will be completed weekly x 4 weeks, then monthly x3 months. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting The Dietary Manager (DM) will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. The meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information 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	F 842		4/11/23

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 57	F 842		

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, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§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-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 842	Continued From page 58 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of wound care (Resident #34) and weights (Resident #17 and Resident #41). This was for 3 of 13 resident records reviewed. The findings included: 1. Resident #34 was admitted to the facility on 8/9/21 with diagnoses that included dementia. A quarterly Minimum Data Set (MDS) assessment dated 1/12/23 indicated Resident #34 had severe cognitive impairment, displayed no behaviors or rejection of care, and was coded with one stage 2 pressure ulcer over a bony prominence. A review of Resident #34's active physician orders included an order dated 1/17/23, to cleanse the sacrum with normal saline, pat dry, apply skin prep, calcium alginate (a dressing that absorbs wound fluid) with Medihoney (an antibacterial gel) to the wound bed and cover with a dry dressing every day.	F 842	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F842 For the residents involved, corrective action has been accomplished by: At the time of the survey, weights were obtained for the residents. At the time of the survey, the Wound Nurse assessed the resident with the missing treatment documentation. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 27, 2023, the Director of Nursing (DON) audited all 100% of	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 842	Continued From page 59 The January 2023, February 2023 and March 2023 Treatment Administration Records (TARs) were reviewed and revealed the sacral wound care had not been documented as completed or refused by the resident on 1/20/23, 1/25/23, 1/29/23, 2/11/23, 2/25/23, 2/26/23, 3/2/23 and 3/7/23. Review of the nursing progress notes from 1/17/23 to 3/22/23 did not reveal any refusals of wound care by Resident #34. On 3/21/23 at 11:05 AM, an interview occurred with Nurse #1, who was assigned to care for Resident #34 on the day shift of 1/25/23, 2/25/23 and 2/26/23. She reviewed the TARs showing no initial as completing the wound care or refusal by Resident #34 and stated that she completed the wound care as ordered but got busy and forgot to sign the treatments off as completed. Nurse #2 was interviewed on 3/21/23 at 11:10 AM. She was assigned to care for Resident #34 on the day shift of 1/20/23, 1/29/23, 2/11/23 and 3/7/23. Nurse #2 reviewed the TARs showing no initials as completing the wound care or refusal by Resident #34 and stated she had completed the wound care as ordered but had forgotten to sign the TAR. The Director of Nursing was interviewed on 3/23/23 at 10:00 AM and indicated it was her expectation for the nursing staff to complete wound care as ordered as well as to document that it was completed or refused by the resident. 2. Resident #17 was admitted on 11/18/22. There was no documented evidence that the	F 842	current residents for wound treatment compliance using the Not Administered Med Pass in the Last Twenty-Four Hour Report. The report is used to identify any missed administrations of treatments. Please see exhibit for results (Exhibit 39). Any issues noted were correct at that time. On March 27, 2023, the DON audited 100% of all current residents requiring weekly weights and or monthly weights for weight loss and or weight gain (Exhibit 40). On March 31, 2023, the DON audited to ensure each weight task is fired in the Point of Care (POC) charting for the aides. Firing this task will ensure each weight is transcribed into Point Click Care (PCC). For results of the audit, please see exhibit (Exhibit 41). Any issues noted were corrected at that time. On April 5, 2023, the Support Nurse was educated one on one with tasking weekly weights to the Point of Care Charting (POC). Please see exhibit for results (Exhibit 42). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 7, 2023, the Staff Development Coordinator (SDC) completed education with all nurses and medication aides, part-time and fulltime, on the expectation of following physician orders in addition to the Weight Policy and Medication/ Treatment Administration records (Exhibit 43). The facility has implemented a quality assurance monitor:	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 842	Continued From page 60 facility obtained Resident #17's weight for the month of February 2023. The support nurse was interviewed on 3/22/23 at 9:43 AM. She confirmed she had oversight of the resident weights. She recalled Resident #17 triggered on the Electronic Medical Record (EMR) dashboard as having lost weight last week. She stated it was discussed that there was no February weight, and she was going to investigate why the Restorative Aide (RA) did not enter a February weight into the EMR. The RA was interviewed on 3/22/23 at 1:25 PM. She stated she obtained and entered the weights into the EMR and provided Resident #17's February weight of 118.6 lbs. she had documented on her undated handwritten February weight list, but she must have forgot to enter it into the EMR. The Director of Nursing (DON) was interviewed on 3/22/22 at 8:35 AM. She reviewed the EMR for Resident #17 and stated she was not aware there were missing February weight on Resident #17's in the EMR. A telephone interview was completed on 3/23/23 at 10:00 AM with the Physician Assistant (PA). He stated it was important to have accurate and complete weights in the EMR to rule out and intervene weight loses or gains. 3. Resident #41 was admitted on 12/16/22. Review of Resident #41's admission orders dated 12/16/22 included an order for weekly weights for four weeks.	F 842	The Director of Nursing will complete the Weight Loss/ Gain Quality Assurance Audit and Missed Treatment Quality Assurance Monitor weekly for four weeks and monthly for three months. The Director of Nursing will evaluate three residents to ensure treatment administration and accurate weights are correct. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 61	F 842		

Review of Resident #41's electronic medical record (EMR) include her weight of 214 pounds (lbs.) on 12/16/22. This was the only documented weight in the EMR for Resident #41.

Review of the admission Minimum Data Set dated 12/23/23 indicated Resident #41 was cognitively intact with her admission weight of 214 lbs.

Review of Resident #41's medication administration record (MAR) for December 2022 did not include documented evidence of her weight on 12/16/22 but rather on 12/23/22. There was no weekly weight due on 12/30/22 or 1/6/23.

Review of Resident #41's MAR and EMR did not include evidence of a monthly weight for February or March 2023 as of 3/20/23. There was new newly documented weight dated 3/20/23 of 214 lbs. in the EMR.

The Restorative Aide (RA) was interviewed on 3/22/23 at 1:25 PM. She stated she obtained and entered the weights into the EMR for all the residents. She did not provide evidence of Resident #41's weight for January or February 2023.

An interview was completed on 3/22/23 at 3:25 PM with Nurse #1. She confirmed she documented the weight of 214 lbs. for Resident #41 in the EMR dated 3/20/23. She stated someone asked her yesterday told her to obtain her weight, but she just used the weight of 214 lbs.in the EMR. Nurse #1 confirmed there was no other weight in the computer other than her admission weight of 214 lbs. on 12/16/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 62 The Director of Nursing (DON) was interviewed on 3/22/22 at 8:35 AM. She stated she was not aware there were missing weights in Resident #41's EMR and not aware the documented weight on 3/20/23 was inaccurate. Review of the EMR on 3/23/23 indicated a weight of 217.4 lbs. had been entered for 2/8/23 and 216 lbs. on 3/8/23. A telephone interview was completed on 3/23/23 at 10:00 AM with the Physician Assistant (PA). He stated it was important to have accurate and complete weights in the EMR to rule out and intervene weight loses or gains.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 63	F 867		

information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 64	F 867		

of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 65 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, Physician Assistant, residents and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following a focused infection control and complaint survey completed on 10/5/20. This was for two deficiencies that were cited in the areas of Respiratory Care and Infection Control. In addition, four additional deficiencies were cited during the annual recertification and complaint survey on 8/25/21 in the areas of Resident/Family Group and Response, Accuracy of Assessments, Treatment/Services to Prevent/Heal Pressure Ulcers and Resident Records. The duplicate citations during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F695- Based on observations, resident, staff,	F 867	This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. F867 For the residents involved, corrective action has been accomplished by: There was no resident adversely affected by this practice. Interventions put in place include the following: a. Infection Control at the time of the survey, the aides were educated on disinfecting the multiuse medical equipment between residents (Exhibit 44) b. Respiratory Care at the time of the survey, oxygen tubing was changed. And parameters were obtained for the oxygen titration orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 867	Continued From page 66 and Physician Assistant (PA) interviews and record review, the facility failed to change the oxygen tubing weekly as ordered and failed to obtain oxygen saturation parameters for an order to titrate oxygen as tolerated. This was for 1 (Resident #250) 1 residents reviewed for respiratory care. The finding included: During the facility's focused infection control and complaint survey of 10/5/20, the facility failed to initiate the physician ' s treatment plan for incentive spirometry (device utilized for breathing exercises) for 1 of 3 residents reviewed for respiratory care. In an interview with the Administrator and Director of Nursing on 3/23/23 at 10:00 AM, they indicated the oxygen concentrators could be bumped, adjusted by the resident or if the nurse was looking over the machine rather than at eye level could cause the oxygen setting to not be the ordered rate. 2. F880- Based on record review, observations and staff interview the facility failed to disinfect multi use medical equipment between residents for 1 of 1 Nursing Assistant (NA) observed for infection control practices. (NA #4) During the facility's focused infection control and complaint survey of 10/5/20, the facility failed to implement the Centers for Disease Control (CDC) guidelines and the facility's COVID-19 Preparation and Response policy in the facility's COVID positive unit in 4 of 4 residents reviewed for enhanced droplet/contact precautions when staff, who were assigned to care for both COVID positive residents and residents in the general	F 867	c. Accuracy of Assessments At the time of the survey, the Minimum Data Set (MDS) was updated to reflect Hospice designation, and life expectancy by the Minimum Data Set (MDS) Nurse. The MDS Nurse corrected the MDS to accurately reflect Antipsychotics received on a routine basis. d. Treatment and services to prevent pressure injury At the time of the survey, the Nursing Supervisor adjusted the air mattress setting to accurately reflect the resident s current weight. e. Resident Records At the time of the survey, weights were obtained for the residents and residents with missed documentation were assessed Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: A QAPI meeting was held on April 7, 2023; to discuss the following repeated tags: F867 QAPI/QAA Improvement Activities, F880 Infection Prevention and Control, F695 Respiratory/ Tracheostomy Care and Suctioning, F641 Accuracy of Assessments, F686 Treatment /Svcs to Prevent/Heal Pressure Ulcer and F842 Resident Records. On April 7, 2023, the Regional Consultant educated the Interdisciplinary Team (IDT) on Quality Assurance Performance Improvement Policy (Exhibit 45). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: A weekly QAPI meeting will be held for a period of four (4) weeks then Monthly to	

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	345518	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 867	Continued From page 67 population, did not wear the required Personal Protective Equipment (PPE), failed to perform hand hygiene when entering/exiting resident rooms, and failed to store used isolation gowns in a manner that would reduce the chance of spreading COVID-19. These failures occurred during a COVID19 pandemic. In an interview with the Administrator and Director of Nursing on 3/23/23 at 10:00 AM, they stated at the time of the observation the basket on the blood pressure machine was out of sanitizing wipes and were replaced. They stated that all the staff were familiar with the need to sanitize multi-use equipment between residents. 3. F565- Based on observation, record review and staff and resident interviews, the facility failed to resolve repeat grievances related to dietary services which were reported in the Resident Council meetings for 7 out of 9 months reviewed (June 2022, July 2022, August 2022, October 2022, December 2022, January 2023, and February 2023). During the facility's recertification survey of 8/25/21, the facility failed to implement the facility's grievance policy for continued unresolved resident council (RC) complaints about getting the incorrect items and missing items on their meal trays for the last 3 months. In an interview with the Administrator on 3/23/23 at 10:00 AM, she felt the grievances had been resolved at each occurrence. 4. F641- Based on record review and staff	F 867	review and discuss the facility adherence to the monitoring of Infection Control, Respiratory Care, Accuracy of Assessments, Treatment of services to prevent pressure injury and Resident Records. For Infection Control the team will review; completed Infection Prevention & Control Audit Quality Assurance Tool. The audit will evaluate five staff members to ensure each multiuse medical equipment is disinfected between residents. The audit will be completed weekly for four weeks and monthly for three months. In the area of Respiratory Care, the following audit will be reviewed using the Oxygen Tubing and Titration Order Quality Assurance Audit Tool to ensure that all titration orders have parameters. In addition, to following physician orders related to tubing changing. The monitor will be completed weekly for four weeks and monthly for three months and the DON will audit 5 residents weekly for four weeks and monthly for three months to ensure the oxygen tubing was changed per Physician□s order and each titration order includes parameters. The QAPI team will review Accuracy of Assessments utilizing the following tool The Accurate Coding of MDS Audit Tool this will be completed by the DON weekly for four weeks and monthly for three months: Accurate Coding of MDS Section J1400, Section O0100 and Section N0450 the MDS Coding Accuracy Audit Tool. The Director of Nursing will audit all current residents□ receiving Hospice Services and residents receiving antipsychotics on their most	

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F 867	Continued From page 68 interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Resident #25), hospice and prognosis (Resident #53) for 2 of 20 sampled residents whose MDS were reviewed. During the facility's recertification survey of 8/25/21, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of falls and discharge disposition. This affected 2 of 15 residents reviewed. In an interview with the Administrator on 3/23/23 at 10:00 AM, she felt the repeat citation in MDS accuracy was related to human error. She explained the MDS Nurse was fairly new to the role and had no prior experience. 5. F686- Based on record review, observations, and staff interviews, the facility failed to ensure the low air loss mattress was set according to the resident's weight for 3 of 4 residents reviewed for pressure ulcers (Resident #21, #32, and #34). During the facility's recertification survey of 8/25/21, the facility failed to provide pressure ulcer treatment as ordered for 1 of 4 sampled residents reviewed for pressure ulcers. In an interview with the Administrator and Director of Nursing on 3/23/23 at 10:00 AM, they both acknowledged the alternating pressure mattress machines indicated to set according to the resident's weight but also felt the machines could be adjusted for comfort. 6. F842- Based on record review and staff	F 867	recent MDS for accuracy in coding of hospice, life expectancy and antipsychotics. Review of the area of Treatment and prevention of pressure ulcers the QAPI team will utilize the completed Low Air Loss Mattress Quality Assurance Monitor weekly for four weeks and monthly for three months. The Director of Nursing will evaluate 5 residents with orders for a low air loss mattress to ensure each is properly inflated according to the resident□s current weight. QAPI team will also audit residents record utilizing the Weight Loss/ Gain Quality Assurance Audit and Missed Treatment Quality Assurance Monitor this will be done weekly for four weeks and monthly for three months. The Director of Nursing will evaluate three residents to ensure treatment administration and accurate weights are correct. Education will be provided to Certified Nurse Assistants, Licensed Nurses, Medication Aides and Nurse Supervisors on the above topics. The audit process will continue to be a part of the education process for current staff and newly hired members of the IDT team upon orientation. See (Exhibit 46) for all audit tools. The facility has implemented a quality assurance monitor: The Director of Nursing will report the audit findings to the QAPI committee monthly for 3 months. The QAPI committee consists of Executive Director, DON, SDC, MDS, Nurse Managers, Director of Culinary Services, Culinary Supervisor, Activities Coordinator, Social	

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F 867	Continued From page 69 interviews, the facility failed to maintain complete and accurate medical records in the areas of wound care (Resident #34) and weights (Resident #17 and Resident #41). This was for 3 of 13 resident records reviewed. During the facility's recertification survey of 8/25/21, the facility failed to maintain complete medical records in the areas of wound consultant progress notes for 3 of 3 medical records reviewed for wound care. In an interview with the Administrator and Director of Nursing on 3/23/23 at 10:00 AM, they indicated the facility was utilizing agency staff and felt the repeat citation could be a result of human error.	F 867	Worker, BOM, Medical Director and Pharmacy Rep. QAPI to ensure compliance is ongoing and determinate the need for further audits. For each month with less than 100% compliance, the monitor will be extended 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		4/11/23

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F 880	Continued From page 70	F 880		

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 71 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview the facility failed to disinfect multi use medical equipment between residents for 1 of 1 Nursing Assistant (NA) observed for infection control practices. (NA #4) The findings included: The facility provided a copy of the policy and procedure for cleaning of non-critical, reusable patient care equipment. The policy was dated October 2022 and read in part, facility will implement and maintain processes to ensure all non-critical, reusable patient care equipment is cleaned before and after reuse. A continuous observation on 03/20/23 from 10:58 AM until 11:09 AM was conducted. NA #4 was observed retrieving multi-use patient care medical equipment from the hall to obtain blood pressure, temperature, and oxygenation and entering room 300. She did not disinfect the equipment prior to using it on resident in room 300. She proceeded to room 301 and used the device on resident in A bed. She did not clean the device between residents. She then rolled the monitor into the hall, leaving it against the wall. NA #4 then entered room 303 to provide care. She did not disinfect the equipment after use. A continuous observation on 03/21/23 from 10:15	F 880	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 For the residents involved, corrective action has been accomplished by: At the time of the survey, the aides were educated on disinfecting the multiuse medical equipment between residents (Exhibit 47). Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On April 4, 2023, the maintenance director attached cages on each vital sign machine for easy access to disinfectant wipes. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 7, 2023, the Staff Development	

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F 880	Continued From page 72 AM until 10:30 AM was conducted. NA #4 was observed retrieving multi-use patient care medical equipment from the hall to obtain blood pressure, temperature, and oxygenation and entering room 300. She did not disinfect the equipment prior to using it on resident in room 300. She proceeded to room 301 and used the device on resident in A bed then on resident in B bed. She did not clean the device between residents. No cleaning wipes located on device. An interview was conducted on 03/21/23 at 10:30 AM with Nurse Aide (NA) #4. She stated she did not clean the multi-use patient care medical equipment between the 3 residents, and she will get cleaning wipes to clean the machine before using it again. She stated she should have disinfected the medical equipment prior to using it on a different resident and before leaving it for someone else to use. An interview was conducted on 03/23/23 at 11:15 AM with the Director of Nursing (DON). The DON indicated staff should follow the facility's policy on cleaning multi-use patient care medical equipment.	F 880	Coordinator (SDC) and Director of Nursing (DON) completed education at 100% for current nurses and aides, part-time and fulltime to ensure they understand the importance of disinfecting multiuse medical equipment between residents (Exhibit 48). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Infection Prevention & Control Audit Quality Assurance Tool. The audit will evaluate five staff members to ensure each multiuse medical equipment is disinfected between residents. The audit will be completed weekly for four weeks and monthly for three months. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the	F 947		4/11/23

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F 947	Continued From page 73 continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide annual dementia training and mandatory twelve hours of annual in-servicing for 1 of 5 nursing assistants (NA) #2 reviewed for competent nursing staff. The findings included: NA #2 date of hire was 12/7/21. Review of NA #2's educational record did not include any dementia training for 2022 and did not include 12 hours of the annual mandatory in-servicing for 2022. The Staff Development Coordinator was interviewed on 3/22/23 at 10:00 AM. She stated the facility utilized an online in-servicing program that should have identified NA #2's missed training, but she was unable to explain how NA #2's training requirements were missed. The Director of Nursing (DON) provided	F 947	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F947 For the residents involved, corrective action has been accomplished by: No residents were affected by this practice. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On March 22, 2023, the Director of	

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F 947	Continued From page 74 documentation on 3/23/23 at 9:42 AM of NA #2's completed dementia and annual mandatory in-servicing on 3/22/23.	F 947	Nursing educated the employee on training requirements. On March 27, 2023, the DON audited 100% of current aides for training on Dementia and 12 hour requirements (Exhibit 49). Any issues were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On April 7, 2023, the Staff Development Coordinator (SDC) completed education with all aides on Dementia Training, Abuse Training and the 12 hour education requirements (Exhibit 50). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Training for Nurse Aide Audit Tool for 5 aides monthly for 3 months. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. This meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. For each month with less than 100% compliance, the monitor will be extended for 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	