STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD , PINEHURST, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/16/2025 through 6/19/2025. The facility was in compliance with requirement CFR 483.73, Emergency Preparenedness. Event ID XPOB11.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/16/2025 through 06/19/2025. Event ID# XPOB11. The following intakes were investigated: NC00221671 and NC00219022. 1 of the 2 allegations resulted in deficiency.	F0000		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with staff, pharmacy consultant, pharmacy technician and the Medical Director, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 2 residents reviewed (Resident #158). The findings included: A review of the facility's policy titled "Abuse Identification" dated and last revised on 01/2023	F0602	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. F602 For the resident involved, corrective action has been accomplished by: *Please note, all corrective actions were taken at the time of the initial incident in July 2024* 7/1/24: the Administrator and the Director of Nursing (DON) identified the alleged diverting nurse and she was suspended at that time. 7/1/24: The resident was notified and assessed for pain by the DON, no concern/complaints of pain management were noted at the time of the assessment. New pain management orders/prescriptions were obtained via the provider. 7/1/24: A 24 hour report initiated.	07/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0602 SS = D	Continued from page 1 revealed in part "Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the residents' consent". Resident #158 was admitted to the facility on 5/10/24. The resident was discharged from the facility on 7/26/24. A physician order dated 5/17/24 read oxycodone HCL (controlled pain medication used to treat moderate to severe pain) oral tablet 10mg (milligrams). Give 1 tablet by mouth every 4 hours as needed for pain. A packing slip from the pharmacy dated 6/21/24 revealed 60 Oxycodone 10 mg tablets were delivered to the facility on 6/21/24 for Resident #158 with no time noted. Nurse #5 initialed the packing slip from the pharmacy. The facility reported incident dated 7/1/24 read in part, the Director of Nursing (DON) and Administrator were notified that a count of a resident's narcotic medication revealed a discrepancy. The facility verified that the resident did not have an adequate supply of a controlled pain medication. This report was signed by the facility DON. A review of the declining narcotic count sheet in comparison with the Medication Administration Record (MAR) revealed Resident #158 received Oxycodone 10mg 25 times between the times of the delivery of the medication on 6/21/24 and the attempt to reorder on 7/1/24. The declining narcotic count sheet reflected that the resident received all 60 tablets between 6/21/24 and 7/1/24, creating a discrepancy of 35 tablets. The declining narcotic count sheet also revealed Nurse #5 signed off on 41 administrations of the oxycodone 10mg tablets including the last administration on 7/1/24. An attempt was made to reach Nurse #5 on 6/18/25 at 10:00 AM via telephone and was not successful. Her phone number was no longer valid. A progress note dated 7/1/24 at 7:28 PM by Nurse #4 revealed the Resident #158's oxycodone was	F0602	Continued from page 1 7/1/24: APS notified. 7/1/24: Pinehurst Police Department notified Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: *Please note, all corrective actions were taken at the time of the initial incident in July 2024* 7/1/24: Initial phone interview conducted with nurse S.M, and A.B. In-person interview completed with nurse J.H. 7/1/24: Drug tests initiated 7/2/24: A second in-person interview conducted with nurse S.M. The DON attempted to contact nurse A.B. and was unsuccessful despite multiple attempts. 7/2/24: In order to obtain accurate data, resident BIMs scores were reviewed to compile a list of residents to interview. Pain interviews/assessments were completed with this list of residents in the direct care of nurse A.B. Results: No concerns voiced. Additionally pain assessments were completed by the DON on current residents that were not interviewed due to cognition. These residents were assessed and staff interviewed to identify verbal or nonverbal untreated pain ques or concerns. Results included: No concerns noted. This was completed at 100% of residents in her care at the time of the report (500/600 halls). (Exhibit 1) 7/2/24: The current residents that were able to be interviewed, were interviewed using the Audit for Medication Concerns/Misappropriation. This was completed by the Social Worker and Director of Nursing. Results included: No concerns voiced. (Exhibit 2) 7/3/24: Complaint filed with Board of Nursing Addendum: July 3, 2025, the Director of Nursing audited facility narcotics at 100% by utilizing the Narcotic Checks Audit Tool. No concerns noted at that time. (Exhibit 3) Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur:	

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F0602 SS = D	Continued from page 2 discontinued. An interview with Nurse #6 was conducted on 6/18/25 at 9:47 AM. She stated she called the pharmacy on 7/1/24 to reorder the oxycodone 10mg and was told by the pharmacist that it was too early to reorder and Resident #158 should have a supply remaining at the facility. Nurse #6 then notified the DON and Administrator of the drug discrepancy. A telephone interview with Nurse #4 was conducted on 6/19/25 at 8:55 AM. She stated she did not recall the situation with Resident #158 in July 2024. An interview with the Pharmacy Consultant on 6/18/25 at 12:40 PM revealed she consulted and reviewed charts, and she referred me to the pharmacy. An interview with the Pharmacy Technician on 6/18/25 at 12:50 PM revealed the 60 tablets of the 10mg oxycodone for Resident #158 were delivered as ordered on 6/21/25. An interview with the Medical Director was conducted on 6/18/25 10:37 AM. He stated he did not recall the facility reported event as he covers many facilities. An interview was conducted with the DON on 6/18/25 at 12:43 PM. She revealed Nurse #6 called her on 7/1/24 to notify she attempted to order Oxycodone 10mg for Resident #158. The pharmacy stated there should be tablets of the Oxycodone 10mg remaining in the facility for Resident #158. The DON then notified the Administrator. The DON went to the facility and interviewed Nurse #4, Nurse #5, and Nurse #6. She then submitted the initial 24-hour report to the Department of Health Service Regulation, suspended Nurse #5 pending investigation, and completed a pain assessment with Resident #158. The DON then notified the physician and the Pinehurst Police Department. Educational in-services began with all nursing staff on 7/1/24, which included the controlled substance, abuse prohibition, abuse education, and medication administration policies and the policy and procedure for ordering and dispensing controlled substances. An interview with the Administrator on 6/18/25 at 2:18 PM revealed Resident #158 had a physician's appointment	F0602	Continued from page 2 *Please note, all corrective actions were taken at the time of the initial incident in July 2024* On July 1, 2024, education was initiated with all nurses on the facility's policies listed below. (Exhibit 4) • Controlled Substance Process Policy • Abuse Prohibition Policy • Abuse Education Packet • The Medication Administration Policy. • Policy and Procedure for Ordering and Dispensing Controlled Substances Policy. Addendum: On June 30, 2025, education was initiated with all facility nurses on the facility's policies listed below. Education completion/compliance date 7/7/25 (Exhibit 5) • Abuse Prohibition Policy. • Abuse Identification. • Policy and Procedure for Ordering and Dispensing Controlled Substances Policy. The initiation of the Narcotic Checks Audit will be incorporated into the monthly Quality Assurance Performance Improvement Program for continuous ongoing monitoring. (Exhibit 6) The facility has implemented a Quality Assurance Monitor: The Director of nursing will monitor five residents using the Medication Concerns or Misappropriation Audit Tool in addition to the Narcotic Check Audit Tool weekly for 4 weeks and monthly for 2 months. The audit findings will be reported to the Monthly Quality of Life Team at the Monthly Quality of Life Meetings by the Administrator or Director of Nursing. Compliance will be monitored with the ongoing auditing program reviewed at the weekly QA Meeting. QA Meeting attendees include: the Administrator, DON, MDS, SDC, Therapy, HIM, and the Dietary Manager, RN supervisors, and other	

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F0602 SS = D	Continued from page 3 on 7/1/24. The oxycodone was discontinued on that day and an order for Norco (used to relieve moderate to severe pain) Oral Tablet 5-325 (Hydrocodone-Acetaminophen) was received after the visit. This medication was received as ordered and paid for by the facility. The facility provided a draft plan of correction for past non-compliance. The plan could not be accepted by the state agency due to there being no intervention to prevent misappropriation.	F0602	Continued from page 3 directors from various departments. 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.	
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to attempt alternatives prior to installing side rails for 2 of 2 residents assessed for side rails (Resident #48 and Resident #102). Findings included:	F0700	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. F700 For the resident involved, corrective action has been accomplished by: All residents who have bedrails have the potential to be affected by the alleged deficient practice. Per the State Operations Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, appropriate alternatives for bed rails include: roll guards, foam bumpers, lowering the bed, and using a concaved mattress. Upon review of resident #102 medical record, she had requested bedrails to assist with transfers, sitting up and bed mobility. She has an admitting diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side. The Interdisciplinary Team reviewed resident #102 on 6/30/25 for an appropriate alternative for bedrails per the alternatives provided. Unfortunately, not one of the alternatives provided are appropriate for resident #102 for her bed mobility, transfers or sitting up. Resident #48 has discharged. The Director of Nursing (DON) completed an updated Device and Bedrail Review UDA (user defined assessment) for resident #102 to include that alternative measures were reviewed or attempted and failed due to her diagnosis and intended use of the bedrails. The residents care plan was updated accordingly.	07/07/2025

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F0700 SS = D	Continued from page 4 1. Resident #48 was admitted to the facility on 5/16/25 with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left dominant side. Resident #48's record revealed an assessment titled "Device and Bed Rail Review" dated 5/16/25 and completed by Nurse #1 revealed there was no question on the evaluation regarding attempts to use alternatives prior to installing side rails. A care plan with the latest review date of 5/19/25 revealed a focus of the use of quarter length side rails to enable independence with bed mobility, with increased risk for complications including entrapment and injuries. The goal stated Resident #48's risks for complications related to the use of side rails will be minimized through current interventions x 90 days. Interventions included: correct positioning, evaluate current use of side rails, observe resident for changes in condition and reassess for least restrictive device. An Admission Minimum Data Set (MDS) dated 5/22/25 revealed Resident #48 was severely cognitively impaired. The MDS indicated Resident #48 required partial to moderate assistance with bed mobility, transfers, and ambulation. The MDS revealed Resident #48 had impairment to one side on both upper and lower extremities and side rails were not used as a restraint. An observation was conducted on 6/16/25 at 11:10 AM. Resident #48 was lying in bed with left side quarter length bed rail in the raised position. A follow up observation was conducted on 6/18/25 at 1:11 PM. Resident #48 was lying in bed with the left side quarter length bed rail in the raised position. An interview with Nurse #1 was conducted on 6/17/25 at 2:28 PM. Nurse #1 stated she completed the Device and Bed Rail Review for Resident #48 on admission. Nurse #1 revealed the facility did not try alternative interventions before installing the left quarter length side rail for Resident #48. Nurse #1 indicated she was unaware alternative interventions were required before side rails were implemented.	F0700	Continued from page 4 Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On June 30, 2025, the Director of Nursing (DON) utilized the Bedrail Audit Tool to audit all residents with bedrails at 100%. This was to ensure that appropriate alternatives were offered prior to the application of bedrails per DHSR guidelines. For any issues noted, updated UDAs were initiated and corrective actions were completed at this time. (Exhibit 7) On July 1, 2025, the Device and Bedrail Review UDA was updated by the corporate office to include alternatives options for trial prior to the application of bedrails. Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur: On June 30, 2025, The Director of Nursing and Staff Development Coordinator initiated education for all staff on the following Liberty Policy and the State Operations Manual section F700. On July 1, 2025 all nurses were educated on the use of the new Device and Bedrail Review UDA via the Director of Nursing. Education completion/compliance date 7/7/25. (Exhibit 8) • Bed and Bedrail Utilization and Safety Policy • State Operations Manual for Long Term Care Facilities: Section F700 The facility has implemented a Quality Assurance Monitor: The Bedrail Audit Tool will be completed on five residents by the DON weekly x4 weeks and monthly x2 months to ensure compliance with bedrail guidelines. The audit findings will be reported to the Monthly Quality of Life Team at the Monthly Quality of Life Meetings. . QA Meeting attendees include: the Administrator, DON, MDS, SDC, Therapy, HIM, and the Dietary Manager, RN supervisors, and other directors from various departments. 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	

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F0700 SS = D	Continued from page 5 In an interview with the Director of Nursing (DON) and Administrator on 6/17/25 at 2:54 PM, they stated alternative interventions to side rails were not tried before implementation as they were unaware that this was a requirement. 2. Resident #102 was admitted to the facility on 6/4/25 with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side. Resident #102's record revealed an assessment titled "Device and Bed Rail Review" dated 6/4/25 and completed by Nurse #1 revealed there was no question on the evaluation regarding attempts to use alternatives prior to installing side rails. A care plan with the latest review date of 6/4/25 revealed a focus of the use of quarter length side rails to enable independence with bed mobility, with increased risk for complications including entrapment and injuries. The goal stated Resident #102's risks for complications related to the use of side rails will be minimized through current interventions x 90 days. Interventions included: correct positioning, evaluate current use of side rails, observe resident for changes in condition and reassess for least restrictive device. An Admission Minimum Data Set (MDS) dated 6/11/25 revealed Resident #102 was severely cognitively impaired. The MDS indicated Resident #102 required substantial/maximum assistance with bed mobility and transfers. The MDS revealed Resident #102 had impairment to one side on both upper and lower extremities and that side rails were not used as a restraint. An observation was conducted on 6/16/25 at 11:50 AM. Resident #102 was lying in bed with bilateral quarter length bed rails in the raised position. A follow up observation was conducted on 6/17/25 at 1:45 PM. Resident #102 was lying in bed with bilateral quarter length bed rails in the raised position.	F0700	Continued from page 5 ¬¬¬¬	

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F0700 SS = D	Continued from page 6 An interview with Nurse #1 was conducted on 6/17/25 at 2:28 PM. Nurse #1 stated she completed the Device and Bed Rail Review for Resident #102 on admission. Nurse #1 revealed she did not try alternative interventions before installing bilateral quarter length side rails for Resident #102. Nurse #1 indicated she was unaware alternative interventions were required before side rails were implemented. In an interview with the Director of Nursing (DON) and Administrator on 6/17/25 at 2:54 PM, they stated alternative interventions to side rails were not tried before implementation as they were unaware that it was a requirement.	F0700		
F0812 SS = E	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 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 label opened food items stored in 1 of 2 walk-in freezers with the date opened and use-by or expiration dates. This deficient practice had the potential to affect foods served to the residents.	F0812	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 6/16/25 both the chicken nuggets and tilapia were discarded. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On July 1, 2025, the Director of Dining Services audited the walk-in freezers by utilizing the Department Daily Opening Procedures Audit tool to ensure each item was labeled and dated (Exhibit 9). Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On June 23, 2025, all dining staff were in-serviced by the Director of Dining Services on the following policy. Education completion/compliance date 7/7/25. (Exhibit 10)	07/07/2025

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F0812 SS = E	Continued from page 7 The findings included: On 6/16/25 at 10:45 AM an observation of the walk-in freezer was conducted with the Dietary Director. The observation revealed the following: --bag of opened chicken nuggets with no date opened, use by or expiration date labels posted on the bag that was sitting on a shelf. --carton of tilapia was opened with the inner plastic bag opened and exposing the tilapia to room air. The bag nor the carton were sealed, there was not a received on, opened or used by label in place. An interview was conducted with the Dietary Director on 6/16/25 at 10:55 AM. He stated food that was opened should have a received on, opened and used by sticker place on the package. An interview was conducted with Cook #1 on 6/18/25 at 9:24 AM. She revealed when a package of frozen food was taken out of the freezer and partially used it was the cook's responsibility to ensure the partial package was labeled with an open date and use by date prior to placing the remainder of the package back into the freezer. An interview with the Executive Director on 6/18/25 at 12:57 PM revealed she would expect when a staff member used a portion of an item it would be returned to the freezer with a label signifying the opened and used by dates.	F0812	Continued from page 7 • Morrison's Policy: Production, Purchasing and Storage (food and supply storage). The facility has implemented a quality assurance monitor: The Director of Dining Services will complete the Department Daily Opening Procedures Audit two times a week x2 weeks, then once a week x2 weeks, then resume monthly at a minimum to monitor labeling/ dating, needing to discard unlabeled or expired food items. Compliance and effectiveness of the auditing program will be reviewed at the monthly Quality Assurance Performance Improvement meeting. . QA Meeting attendees include: the Administrator, DON, MDS, SDC, Therapy, HIM, and the Dietary Manager, RN supervisors, and other directors from various departments. The Dietary Manager (DM) will present the results 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 1 month. Any corrective action required will be made by the Quality of Life Team at that time.	
F0880 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.	F0880	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	07/07/2025

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F0880 SS = D	Continued from page 8 §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 arrangement based upon the facility assessment conducted according to §483.71 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	F0880	Continued from page 8 For the resident involved, corrective action has been accomplished by: All residents who have wounds or receive finger stick blood sugars have the potential to be affected by the alleged deficient practice. On June 17, 2025, at the time of the survey, the Director of Nursing completed one on one education with nurse #1 on the Liberty Policies: Prevention of Infection with Wound Care, and Hand Hygiene. (Exhibit 11) On June 18, 2025, at the time of the survey, the Director of Nursing completed one on one education with nurse #3 on the Liberty Policy: Blood Sugar Monitoring. In addition, to the Assure Prism User Instruction Manual related to the amount of wipes used and disinfection contact times of two minutes. (Exhibit 12) Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On July 1, 2025, the Director of Nursing (DON) utilized the Infection Control: Wound Care Audit Tool to review wound care observations of non-pressure and pressure wounds at 100%. This is to ensure that infection control policies are being utilized during wound care. (Exhibit 13) On July 2, 2025, the Director of Nursing (DON) utilized the Infection Control: Glucometer Audit Tool to audit all resident with blood sugar monitoring at 100%. This is to ensure that infection control policies are being utilized during finger stick blood sugar monitoring. (Exhibit 14) Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur: On June 30, 2025, the Director of Nursing and Staff Development Coordinator initiated education for all nursing staff on the following Liberty Policies and manufacturer guideline. Education completion/compliance date 7/7/25. (Exhibit 15) • Prevention of Infection with Wound Care Policy • Hand Hygiene • Blood Sugar Monitoring Policy	

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

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F0880 SS = D	Continued from page 9 actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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 observations, record review, and staff and Medical Director interviews, the facility failed to implement infection control policies when Nurse #1 did not perform hand hygiene before donning (putting on) gloves prior to assisting with wound care. The facility also failed to clean and disinfect an individually assigned glucometer stored outside the resident's room per manufacturer's recommendations. This was for 2 of 12 staff observed for infection control practices (Nurse #1 and Nurse #3). Findings included: 1. Review of the facilities updated policy titled "Prevention of Infection with Wound Care" dated 12/2024 stated in part: To reduce the risk of wound infections within the facility: 2. Wash hands after removal of gloves for 10 seconds with soap and friction, then rinse with running water. An observation of wound care was conducted on 6/17/25 at 3:53 PM. Nurse #1 was observed walking the length of the 400 hall, past a hand sanitizer dispenser that she did not use. Nurse #1 then donned a gown and clean gloves just inside the door of the resident's room, without first performing hand hygiene. Nurse #1 was assisting Nurse #2 with the dressing change of an open, draining, furuncle (boil) on Resident #48's left buttock. Nurse #1 assisted Nurse #2 to position the resident on her right side facing Nurse #1. While Nurse #2 was washing her hands after removing the soiled dressing, Nurse #1 was observed to reach over the resident and touch the area of the open boil several times with her gloved right hand as she was assessing a new boil developing below the open one. When the	F0880	Continued from page 9 • Assure Prism User Instruction Manual: Wipes and Contact times The Medication Cart Audit form has been updated to reflect the ongoing monitor of the cleaning technique of glucometers per manufacture guidelines. (Exhibit 16) The facility has implemented a Quality Assurance Monitor: Infection Control Wound Care Audit Tool and the Infection Control Glucometer Audit Tool will be completed on five residents each by the DON weekly x4 weeks and monthly x2 months to ensure compliance with bedrail guidelines. The audit findings will be reported to the Monthly Quality of Life Team at the Monthly Quality of Life Meetings. . QA Meeting attendees include: the Administrator, DON, MDS, SDC, Therapy, HIM, and the Dietary Manager, RN supervisors, and other directors from various departments. 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.	

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F0880 SS = D	Continued from page 10 dressing change was complete and the resident repositioned, Nurse #1 removed her gown and gloves and placed them in the trash receptacle and was observed to use a wall mounted hand sanitizer dispenser in the hall, several feet from the resident's room. An interview was conducted with Nurse #1 on 6/17/25 at 4:10 PM. Nurse #1 stated she was the Nurse Supervisor and oversaw the wound care in the facility. Nurse #1 further stated she did not regularly perform wound care but would assist if needed, as she did with Resident #48 today. Nurse #1 indicated she (Nurse #1) should have performed hand hygiene before donning clean gloves and again after she removed the soiled gloves. Nurse #1 further stated that hand hygiene before and after wound care was an infection control measure to decrease the chance of spreading infection in the facility. In an interview with the Administrator and Director of Nursing (DON), who was also the Infection Preventionist on 6/17/25 at 4:22 PM, the DON stated Nurse #1 should have performed hand hygiene either by washing her hands with soap and water or using alcohol-based hand rub (AHBR) before donning clean gloves after she entered the residents room and she should have also performed hand hygiene after removing the soiled gloves before leaving the resident's room. The Administrator agreed with the DON about Nurse #1 regarding hand hygiene. An interview with the Medical Director was conducted on 6/19/25 at 9:30 AM. He stated in order to prevent the cause or spread of infection in the facility, Nurse #1 should have washed her hands with soap and water or used ABHR before putting on clean gloves at the start of wound care and after removing soiled gloves when wound care was completed. 2. The policy titled "Blood Sugar Monitoring" dated 12/24 stated in part: - Follow manufacturer's directions for use and care of the equipment (glucometer) used in your facility. The glucometer manufacturer's recommendations for cleaning and disinfecting the individually assigned glucometer recommended the Environmental Protection Agency (EPA)'s registered germicidal and disinfectant wipes that the facility used. The manufacturer's	F0880		

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F0880 SS = D	Continued from page 11 instructions noted, "To ensure compliance, (the manufacturer) recommends that blood glucose meters be cleaned and disinfected after each use." Guidelines for cleaning and disinfecting the glucometer included: - Each time the cleaning and disinfecting procedure is performed, two wipes are needed. One to wipe clean the glucometer and one to disinfect. - Wipe entire surface of the meter using the first wipe at least three times vertically and three times horizontally. - Repeat above steps with a new wipe to disinfect the meter. - Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions. Manufacturer's instructions for the EPA approved disinfectant wipe the facility used stated the surface must stay wet for two minutes and then wiped dry with a clean cloth. On 6/18/25 at 11:22 AM Nurse #3 was observed performing a blood glucose check on Resident #4. Nurse #3 obtained a glucometer from the medication cart drawer. The glucometer was stored in a clear plastic bag labeled with the resident's name. Nurse #3 gathered supplies to perform the blood glucose check, performed the blood glucose check, then returned to the cart. Nurse #3 used one EPA approved wipe to clean the glucometer for 8 to 10 seconds then set it on the top of the cart. One and one half to two minutes later, Nurse #3 put the glucometer back into the labeled clear bag and returned it to the drawer. Nurse #3 was interviewed on 6/18/25 at 1:56 PM. Nurse #3 stated she thought she had cleaned the glucometer correctly and had already received an in-service on the correct procedure at around 11:45 AM, after the blood glucose check on Resident #4. Nurse #3 indicated she should have kept the glucometer wet with the EPA approved disinfectant for two minutes and then wiped dry before returning the glucometer back to the clear plastic bag belonging to Resident #4. Nurse #3 revealed she had glucometer disinfection training within the	F0880		

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F0880 SS = D	Continued from page 12 last 6 months but wasn't sure when as they have infection prevention training on various topics monthly. Nurse #3 further stated she did not properly disinfect the glucometer during the observation because she "just wasn't thinking". The Administrator and Director of Nursing (DON), who was also the Infection Preventionist, were interviewed on 6/18/25 at 2:02 PM. The Administrator stated they had reviewed the manufacturer's instructions for both the glucometer and the disinfectant wipes. The Administrator indicated Nurse #3 should have used two disinfectant wipes per the glucometer manufacturer's instructions and should have left the glucometer wet for two minutes to properly disinfect per the disinfectant wipe instructions. The DON indicated she agreed with the Administrator regarding the proper technique to disinfect a glucometer after use, which would be to follow the manufacturer's instructions.	F0880		