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 08/25/2021

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 8/23/21 through 8/25/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event # BVG511. A COVID-19 survey was conducted on 8/23/21 through 8/25/21. The facility was found in compliance with CFR 483.73 related to the E-0024(b)(c), Subpart B-Rquirements for Long Term Care Facilities. Event #BVG511.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and compliant survey was conducted on 8/23/21 through 8/25/21. One of the 8 allegations was substantiated without a deficiency. Event #BVG511. A COVID-19 survey was conducted on 8/23/21 through 8/25/21. The facility was found in compliance with CFR 483.73 related to the E-0024(b)(c), Subpart B-Rquirements for Long Term Care Facilities. Event #BVG511.	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.	F 565		9/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/09/2021

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

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F 565	Continued From page 1 (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 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 staff and resident interviews and record review, 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. The findings included: Review of the grievance policy provided by the facility and dated last revised 11/2017 read as follows: "A grievance is different from a concern. A	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	

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concern is to make a complaint about something. A grievance causes distress or is something the one has a regular problem with or something that is not easily resolved. A grievance report may be filled by a resident or if he or she is unable to do so, by a person designated by the resident or person authorized by law to act on the residents behalf. A grievance is considered to be "urgent" and in need of immediate attention, please contact the social worker or nurse supervisor who will take the grievance form and begin the review process. This will be forward to the Grievance official or designee."

In an interview on 8/23/21 at 1:31 PM, the RC president (Resident #10), stated the RC meets in person once a month. She stated the August 2021 meeting will be on Friday. Resident #10 stated the Activity Director (AD) coordinates, attends and takes the meeting notes during the meetings. Resident #10 stated the RC has expressed a problem with the incorrect items and missing items on their meal trays for several months now. She stated the Health Care Supervisor had attended the RC meeting in June 2021.

A RC meeting was conducted on 8/24/21 at 9:37AM. There were 7 resident attendees. Several residents reported ongoing issues with not getting what the ordered on their meal trays. They reported frustration with the dietary department. Resident #10 stated the AD wrote down their concerns for the meeting minutes and assumed that any issues that were ongoing would have been corrected by now. Resident #10 stated the issue had not been correct and just yesterday, they ran out of the chicken that she chose for her lunch meal. She stated the DM offered to cook

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For the residents involved, corrective action has been accomplished by:
On September 3, 2021, the Director of Nursing (DON) and Activity Director (AD) filed a grievance based on the resident interviews for the unresolved resident council (RC) complaints.

Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:
On September 3, 2021, the Director of Nursing (DON) audited 100% of resident council minutes for unresolved issues that could potentially lead to grievances from May 2021 through July 2021. For results, please see exhibit (Exhibit One). 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 September 8, 2021, the Activity Director (AD), Director of Nursing (DON), Executive Director (ED) and the Director of Social Services was educated by the Nurse Consultant on the Grievance Policy and Procedure (Exhibit Two) The Director of Nursing (DON) will complete a Grievance Quality Assurance Monitor monthly times four months. The DON will evaluate all resident council minutes to ensure any unresolved complaints are then transcribed to the Grievance Form.
The facility has implemented a quality assurance monitor:
The Director of Nursing (DON) will complete a Grievance Quality Assurance

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her a piece of chicken that they supposedly had ran out of. The residents reported that nobody from the facility offered to complete or assist with the completion of a grievance.

A review of the RC meeting minutes dated 5/28/21 was completed. The Agenda Topic was dietary. The resident discussed missing or incorrect items on the lunch trays. Action Items "read notifying the dining supervisor and create a solution for this issue." The meeting minutes were reviewed and signed by the Director of Nursing (DON) and the Administrator on 6/9/21. Four of the 7 residents were in the meeting conducted by the surveyor on 8/24/21.

A review of RC meeting minutes dated 6/25/21 was completed. The Agenda Topic was dietary. "The results from the 14 day food audit for accuracy was shared with the attendees. During the first 4 days, there were many missing items, however, by day 14, accuracy was 100%." In addition, the Health Care Supervisor (HCS) also known as the dining supervisor joined the meeting as requested. She assured the resident of the efforts to continue to make sure the meals had the correct items. She also discussed how the residents could notify her immediately with any dining concerns. The residents thanked her for attending. The Action Item section read "none". The meeting minutes were reviewed and signed by the DON and the Administrator on 7/6/21. Four of the 7 residents were in the meeting conducted by the surveyor on 8/24/21.

A review of the RC meeting minutes dated 7/23/21 was completed. The Agenda Topic was dietary. Overall, positive feedback was given about the meals. Two residents in this RC

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Monitor monthly times four months. The DON will evaluate all resident council minutes to ensure any unresolved complaints are then transcribed to the Grievance Form. 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. Any corrective action required will be made by the Quality of Life Team at that time.

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meeting voiced concerns about undercook rice. The Action Items read on 7/21/21 the HCS "actively listened to feedback and assured the resident that she will accompany all lunch meal served in the dining room. This will for immediate responses to any corners or compliments. In addition, she shared the new chef will start 8/9/21." The meeting minutes were reviewed and signed by the Director of Nursing (DON) and the Administrator on 7/23/21. Six of the 7 residents were in the meeting conducted by the surveyor on 8/24/21.

During an interview on 8/24/21 at 11:00 AM, the Dietary Manager (DM) stated she started late June 2021. She stated the prior DM was aware of the concerns voiced in the RC meetings and updated her on the issues when she took over. The DM stated the HCS participated in the RC meetings when the residents voiced issues with food. The DM stated she spoke with all new admissions and readmissions. She stated she was unaware of any recent complaints regarding undercooked rice in the soup or that incorrect or missing items was still ongoing. The DM stated residents choose their meals for the day, but unfortunately some things would have to be substituted if they run out.

During an interview on 8/24/21 at 2:00 PM, the HSC (dining supervisor) stated she attended to last two RC meetings. She stated she was aware of concerns with residents not getting what they ordered or wrong items on their meal trays. She stated this had been a topic discussed in every RC meeting since May 2021. The HCS stated she completed a tray audit for 2 weeks in June without any noted errors. She stated she did not write out any grievances about the food and

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thought the AD wrote the grievances identified in the RC meetings. The HCS stated she was aware that Resident #10 did not get what she had ordered on her lunch tray yesterday because they ran out of the chicken on last resident who ordered chicken. She stated she offered to drop a piece of chicken in the fryer but Resident #10 declined. The HCS was unable to explain why she didn't fry another piece of chicken when she knew they had ran out the chicken and needed another piece.

During an interview on 8/24/21 at 2:30 PM, the AD stated she did not write any grievances for identified concerns voiced during the RC meetings. She stated she was told to report any RC concerns to the appropriate department manager. She stated she thought things had improved and was not aware that the residents were still not getting what they ordered. She confirmed the next RC meeting was scheduled for 8/27/21.

During an interview on 8/25/21 at 10:24 AM, the Director of Nursing (DON) stated the social worker (SW) was the facility grievance officer. She stated the previous SW resigned without notice on 6/20/21. At the time the SW left, she assumed the role of the facility grievance officer for June, July and now August 2021. The DON stated the facility had hired a new SW but she was still in training. She stated she did not complete a grievance about RC voiced concerns.

An interview was conducted on 8/25/21 at 11:13 AM with the Administrator. She stated anyone can complete a grievance and she was aware of ongoing food issues. She stated she expected the facility to complete a grievance and resolve

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F 565	Continued From page 6 the food concerns that have been ongoing for several months.	F 565		
F 641 SS=D	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 code the Minimum Data Set (MDS) assessment accurately in the areas of falls (Resident #24) and discharge disposition (Resident #39). This affected 2 of 15 residents reviewed. The findings included: 1) Resident #24 was admitted to the facility on 6/14/21 with diagnoses that included dementia, hypertension, and muscle weakness. The admission MDS assessment was completed on 6/21/21 indicating Resident #24 had severe cognitive impairment. She was not coded with any falls since admission/reentry or prior assessment. A review of Resident #24's medical record revealed she had a fall on 6/24/21 without major injury. A significant change in status MDS assessment dated 7/20/21 indicated Resident #24 had moderately impaired cognition and was not coded with any falls since admission/reentry or prior assessment.	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 August 25, 2021, the Minimum Data Set (MDS) for Resident #24 was updated to reflect a fall without major injury by the Minimum Date Set (MDS) nurse. On August 25, 2021, the Minimum Date Set (MDS) for Resident #39 was updated to reflect actual discharge location. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On September 3, 2021, the Director of Nursing (DON) completed a 100 % audit	9/3/21

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On 8/25/21 at 9:19 AM, an interview was conducted with the MDS Nurse. She reviewed the MDS dated 7/20/21 and confirmed she had coded this section of the MDS and stated it was an oversight not to code the fall noted in Resident #24's medical record.

During an interview on 8/25/21 at 2:15 PM, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately.
2. Resident #39 was admitted to the facility on 5/18/2021 with diagnoses that included osteomyelitis of the ankle and foot.

Resident #39's discharge Minimum Data Set (MDS) completed 6/5/2021 indicated the resident was discharged to acute hospital setting.

A review of Resident #39's medical record, progress notes, revealed she was discharged home on 6/5/2021.

On 8/25/21 at 10:17 AM an interview was conducted with the MDS nurse. She reviewed the discharge assessment dated 6/5/2021 and confirmed the discharge MDS inidcated the resident was discharged to acute hospital setting. The MDS stated the resident discharged to her home and not to acute hospital as entered on the discharge MDS. She further stated the entry was an error.

During an interview with the Director of Nursing (DON) on 8/25/2021 at 2:15 PM, she indicated it was her expectation the MDS be coded accurately.

F 641

on discharged residents within the dates August 2, 2021 through September 2, 2021 to ensure accurate coding of discharge location and falls without major injury are coded correctly. No other assessments (Section A2100 and J1800) were coded incorrectly during the audited time period.

Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur:
On September 3, 2021 the Director of Nursing (DON) completed an in-service training for the MDS Nurse on how to accurately code falls without injury and accurate coding of discharge location . Education information was taken directly from the Resident Assessment Instrument (RAI). Education was provided on: Section A2100 and Section J1800 specifically the process of accurately coding Minimum Data Set. The Director of Nursing (DON) will complete a MDS Accuracy Section A2100 and Section J1800 Assurance Monitor on five residents monthly times four weeks then monthly for three months.
The facility has implemented a quality assurance monitor:
The Director of Nursing (DON) will complete a MDS Accuracy Section A2100 and Section J1800 Assurance Tool on five residents monthly times four weeks then monthly for three months. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life

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F 641	Continued From page 8	F 641	Meeting. Meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator, 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. Any corrective action required will be made by the Quality of Life Team at that time.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident with a diagnosis of mental illness on admission to the appropriate	F 644	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the	9/8/21

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F 644	Continued From page 9 state designated authority for level II Pre-Admission Screening and Resident Review (PASARR) evaluation and determination for 1 of 5 sampled resident reviewed for PASARR (Resident #9). Findings included: Resident #9 was admitted to the facility on 9/6/19 with multiple diagnoses including delusional disorder and psychotic disorder. Resident #9 was admitted to the facility with PASARR level 1 screen dated 9/3/19. The admission Minimum Data Set (MDS) assessment dated 9/13/19 indicated that Resident #9 had a diagnosis of psychotic disorder and she was not screened for level II PASARR. Review of the quarterly MDS assessment dated 6/15/21 revealed that Resident #9 had a diagnosis of psychotic disorder and she was not screened for level II PASARR. Resident #9 has a doctor's order for Ativan (anti-anxiety drug) 1 milligram (mg) by mouth every 6 hours for anxiety. The Social Worker (SW) was interviewed on 8/25/21 at 10:30 AM. The SW verified that she was responsible for ensuring resident's PASARR information were up to date. She reported that she just started working at the facility in July 2021 and was not trained on PASARR yet. She verified that Resident #9 has a diagnosis of psychotic disorder. She indicated that she didn't know that she has to refer the resident to the state for level II PASARR screening when the resident has a	F 644	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. F644 For the residents involved the following corrective action has been accomplished by: On September 7, 2021, the Director of Social Services referred resident # 9 to the appropriate state designated authority for level ll Pre-Admission Screening and Resident Review (PASARR) evaluation and determination. As of September 15, 2021, the appropriate state designated authority has requested additional records. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On September 8, 2021, the Director of Nursing (DON) audited all current residents with a new psychotropic or diagnosis of mental illness to ensure the PASARR evaluation was completed. During the audit seven additional residents will require an additional review. 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 September 7, 2021, the Executive	

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F 644	Continued From page 10 diagnosis of mental disorder/illness. The Director of Nursing (DON) was interviewed on 8/25/21 at 1:55 PM. The DON stated that the SW was responsible for resident's PASARR information. She added that she expected the SW to ensure the regulation on PASARR screening was followed.	F 644	Director (ED) educated the DON and Director of Social Services (SW) on the regulation regarding the PASARR screening process. The DON will review residents with a new psych diagnosis or psychotropic medication orders to ensure PASAAR is sent for review. This will be documented on the New Psychotropic Orders & New Psych Diagnosis Quality Assurance Audit Tool. The PASARR New Psychotropic Orders & New Psych Diagnosis Quality Assurance Audit Tool will be completed by the DON at 100% for all residents with new psychotropic orders or new mental health diagnosis times four months. The facility has implemented a quality assurance monitor: The PASARR New Psychotropic Orders & New Psych Diagnosis Quality Assurance Audit Tool will be completed by the DON at 100% for all residents with new psychotropic orders or new mental health diagnosis times four months. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. Meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Date 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. 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	F 686		9/9/21

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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 11 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. 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, observation and staff interview, the facility failed to provide pressure ulcer treatment as ordered for 1 of 4 sampled residents reviewed for pressure ulcers (Resident # 30). Findings included: Resident #30 was originally admitted to the facility on 6/15/21 with multiple diagnoses including dementia with Lewy body. The admission Minimum Data Set (MDS) assessment dated 7/29/21 indicated that Resident #30 had memory and decision -making problems and has one unstageable pressure ulcer, which was not present on admission. The assessment further indicated that Resident #30 was receiving hospice care. Resident #30's care plan dated 7/29/21 was reviewed. One of the care plan problems was "I	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 August 24, 2021, the Wound Care Nurse notified the Medical Director of the change in the treatment order for resident #30. A progress note was noted in Point Click Care (PCC).	

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F 686

Continued From page 12

currently have a pressure ulcer to my coccyx, and I am at risk for development of additional pressure ulcer due to decreased ability to re-position and incontinence." The goal was for the pressure ulcer to show signs of healing and remain free from infection. The approaches included to administer treatment as ordered.

Resident #30 has a doctor's order dated 8/20/21 to cleanse the coccyx/sacral ulcer with normal saline, pat dry, apply collagen sheet (helps stimulates new tissue growth and promotes wound healing) to wound bed, then pack with Dakin ' s (used to prevent and treat wound infections) damp 4 x 4 gauze into proximal ulcer towards distal ulcer, cover with dry gauze and secure with medipore tape or foam dressing.

The assessment of the coccyx/sacral pressure ulcer dated 8/20/21 was 6.1 x 3 x 2 centimeter (cm), undermining 3 cm, with 30% slough and 20% eschar.

Resident #30 was observed during the dressing change on 8/24/21 at 2:45 PM. The treatment Nurse was observed to clean the ulcer with Normal Saline, packed with Dakin's damp gauze and covered with foam dressing. The Treatment Nurse was not observed to apply the collagen sheet to the wound bed.

The Treatment Nurse was interviewed on 8/24/21 at 3:02 PM. She stated that she was responsible for the assessment of the pressure ulcers. She assessed the wounds/ulcers every Wednesday and provided the treatment after the assessment. She reported that the Nurses assigned to the residents with pressure ulcers/wounds were responsible for providing the treatment every day

F 686

Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:
Between August 30, 2021 and September 3, 2021, the Director on Nursing observed current residents that are receiving pressure ulcer treatments to ensure the doctors orders were followed as prescribed. During pressure ulcer treatment wound care observations no discrepancies noted were at that time and all orders were implemented as prescribed. On September 3, 2021, the DON educated the wound care nurse on the following Orders Management Policy and Procedure; Physician Orders and Wound Documentation.

Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur:
On September 3, 2021 the Staff Development Coordinator (SDC) began in-servicing all nurses and medication aides, part-time and fulltime, on the expectation of following physician orders and how to document any issues. All nurses, fulltime and part time and all medication aides were in-serviced. The in-service was completed by September 10, 2021 at which time all nurses and medication aides must be in-serviced prior to working. The Director of Nursing will complete Pressure Ulcer Quality Assurance Monitor for five residents weekly times four weeks and monthly for three months.

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F 686	Continued From page 13 except on Wednesday. When asked about the treatment order for Resident #30, she responded that she forgot to apply the collagen sheet to Resident #30's pressure ulcer during the dressing change. The Director of Nursing (DON) was interviewed on 8/25/21 at 1:55 PM. She stated that she expected that treatments be provided as ordered. She reported that the nurses were responsible for the treatment every day except on Wednesday when the Treatment Nurse assessed the wounds/ulcers and provided the treatment after the assessment.	F 686	The facility has implemented a quality assurance monitor: The Director of Nursing will complete Pressure Ulcer Quality Assurance Monitor for five residents weekly times four weeks and monthly for three months. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. Meeting consisting of the Administrator, Director of Nursing, Staff Development Coordinator, 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. Any corrective action required will be made by the Quality of Life Team at that time.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		9/9/21

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F 690

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(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

This REQUIREMENT is not met as evidenced by:

Based on record reviews, staff and physician assistant interviews, the facility failed to complete a urine analysis with culture and sensitivity as ordered by the physician assistant for a resident (Resident #29) who had been identified by staff with symptoms of urinary tract infection for 1 of 1 residents reviewed for urinary tract infections.

The findings included:

Resident #29 was admitted to the facility on 6/14/2021 with diagnoses that included neuromuscular dysfunction of the bladder.

Resident #29's admission Minimum Data Set (MDS) dated 6/21/2021 indicated the resident was mildly cognitively impaired. She was coded as able to understand others and understood by others. Additionally, the resident was coded for an

F 690

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F690

For the residents involved, corrective action has been accomplished by:

The Medical Director (MD) had been notified on August 20, 2021 the facility failed to complete a urine analysis with culture and sensitivity for resident #29.

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F 690

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indwelling urinary catheter.

The resident's care plan dated 8/5/2021 had a focus for 16 French indwelling foley catheter with a ten cubic centimeter (cc) balloon due to neurogenic bladder. Interventions included: Monitor, record, and report any signs or symptoms of urinary tract infection to the medical provider. Signs and symptoms listed included altered mental status or change in behavior.

A review of the resident's electronic medical record revealed on 8/13/2021 Nurse #1 documented Resident #29 exhibited increased confusion. Nurse #1 made the facility's Physician Assistant aware of the change.

A record review revealed the facility's Physician Assistant evaluated Resident #29 on 8/13/2021 and noted the staff and family were concerned about the resident's increased confusion along with her history of confusion associated with urinary tract infections. The Physician Assistant documented a urine analysis with culture and sensitivity via in and out catherization would be obtained and sent out by staff.

The resident's electronic medical record was reviewed. There were no results of a urine analysis with culture and sensitivity on or around 8/13/2021.

Progress noted dated 8/15/2021 revealed Nurse #2 removed Resident #29's indwelling urinary catheter, inserted a new indwelling urinary catheter, and collected a urine sample for urine analysis with culture and sensitivity.

An interview was conducted with Nurse #2 on

F 690

The progress note is located in Point Click Care (PCC).
Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:
On September 2, 2021, the Director of Nursing (DON) audited all current orders in the month of August 2020 to ensure all urine specimens ordered were obtained. No other discrepancies noted at the time of audit.

Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur:
On September 3, 2021, the Staff Development Coordinator (SDC) began in-servicing all nurses and medication aides, part-time and fulltime, on the expectation of following physician orders and how to document any issues. The education are as follows: Orders Management Policy & Procedure and Physician Orders. All nurses, fulltime and part time and all medication aides were in-serviced. The in-service was completed by September 10, 2021 at which time all nurses and medication aides must be in-serviced prior to working. The Director of Nursing will complete the Urinalysis Order Implementation and Specimen Obtained Quality Assurance Monitor weekly times four weeks and monthly for three months.
The facility has implemented a quality assurance monitor:
The Director of Nursing will complete the Urinalysis Order Implementation and

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8/24/2021 at 4:22pm. She stated she did collect a urine sample from Resident #29 on 8/14/2021. She stated she collected the sample from the resident's collection bag and was told by another nurse she could not use urine from the collection bag for a urine analysis with culture and sensitivity. Nurse #2 stated she was a new nurse and did not understand the Physician Assistant's order. She further stated the sample was discarded. She stated she got busy and did not collect another sample on 8/14/2021. Nurse #2 stated she collected the urine sample on 8/15/2021 but due to short staffing, the sample was never taken to the lab.

On 8/24/21 at 4:31 PM an interview was conducted with the Director of Nursing (DON). She stated she called the lab on 8/16/2021 and the lab told her no sample was submitted. She stated she was not aware the sample was collected but not delivered to the lab. When asked what should have happened, she stated a staff member should have taken the sample to the lab. She further stated the nursing supervisor covering that weekend should have been contacted to take the sample to the lab. It was her expectations all orders by the Physician's Assistant be completed.

On 8/25/21 at 12:13 PM an interview was conducted with the nursing supervisor on the weekend of 8/14/2021 and 8/15/2021. She stated she was not made aware of a sample that needed to go to the lab. If she had known, she would have taken it to the lab herself.

An interview was conducted with the facility's Physician Assistant on 8/25/2021 at 11:46 PM. He stated he did order the urine analysis with culture

F 690

Specimen Obtained Quality Assurance Monitor weekly times four weeks and monthly for three months. The Director of Nursing will audit all urine specimen orders to ensure all orders were completed. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. Meeting consisting of the Administrator, Director of Nursing, 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. Any corrective action required will be made by the Quality of Life Team at that time

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F 690	Continued From page 17 and sensitivity and was aware the order was never completed. He stated he expected staff to complete his orders.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		9/9/21

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F 755	Continued From page 18 by: Based on record reviews and staff interviews, the facility failed to obtain an eye medication from the pharmacy for 1 of 5 residents (Resident #13) reviewed for unnecessary medications. The findings included: Resident #13 was admitted to the facility on 5/26/2021 with diagnoses that included cerebral vascular accident (stroke) and glaucoma. The resident's significant change Minimum Data Set (MDS) dated 6/22/2021 indicated the resident was severely cognitively impaired, had moderately impaired vision, and required extensive assistance by staff for all activities of daily living and personal hygiene. Resident #13's most recent comprehensive care plan dated 6/3/2021 had a focus for impaired vision related to glaucoma. A review of Resident #13's active orders revealed an order for dorzolamide 2% ophthalmic solution; instill 1 drop in both eyes three times a day for glaucoma. A review of Resident #13's Medication Administration Record (MAR) for July 2021 revealed the resident did not receive dorzolamide on July 31st at 9:00 AM or 2:00 PM. The documented reason for the missed administrations; medication not available. On 8/24/2021 at 1:49 PM an interview was conducted with Nurse #2. The nurse stated she did work the med cart on 7/31/2021. She stated the resident's dorzolamide was not on the cart.	F 755	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. F755 For the residents involved, corrective action has been accomplished by: At the time of the survey, the eye drop medication was ordered through the back up pharmacy for Resident # 13. Medication was delivered on July 31, 2021 verified by pharmacy. Director of Nursing (DON) located eye drops in the fridge. No additional eye drops were omitted. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On September 8, 2021, the Director of Nursing audited all current residents for medication compliance using the Not Administered Med Pass Last Twenty-Four Hour Report. The report was used to identify any missed administrations. Eight residents were noted with medication not administered due to refusal and or hospitalization. Measures put into place or systematic	

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F 755

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She had to order the drops and they were not in the facility for the 9:00 AM or the 2:00 PM administrations. When asked about the process for eye medications, she stated the nurses date the eye drops with the date they are opened. The date is not a reorder date, but it helps them estimate how long the drops may last. She further stated nurses are expected to reorder when they determine the drops are low.

Attempts to contact the nurse who administered the dorzolamide on 7/30/2021 at 9:00 PM were unsuccessful.

A review of the August 2021 MAR revealed the resident did not received scheduled administration of dorzolamide on August 23rd at 9:00 AM and 2:00 PM.

Progress notes documented by Nurse # 3, dated 8/23/2021 read: Dorzolamide eye drops not given due to being out of stock. Reordered and waiting on delivery.

On 8/24/21 at 2:00 PM an interview was conducted with Nurse #3. She stated the dorzolamide drops were not on the medication cart 8/23/2021. She further stated she was an agency nurse and could not reorder medications from the pharmacy so she notified the nursing supervisor. The nursing supervisor ordered the drops for the resident. The drops were not in the facility for the 9:00 AM or the 2:00 PM administrations.

The facility's medication aide was interviewed via phone 8/25/2021 at 11:14 AM. She stated she worked the medication cart on 8/22/202. She administered the 9:00 PM scheduled dose of

F 755

changes made to ensure the alleged deficient practice does not occur:
On September 3, 2021 the Staff Development Coordinator (SDC) began in-servicing all nurses and medication aides, part-time and fulltime, on the expectation of following physician orders, obtain medications through the back up pharmacy and how to document any issues. The education was as follows: Orders Management Policy and Procedure & Physician Orders. All nurses, fulltime and part time and all medication aides were in-serviced. The in-service was completed by September 10, 2021 at which time all nurses and medication aides must be in-serviced prior to working (Exhibit Fourteen).
The facility has implemented a quality assurance monitor:
The Director of Nursing will complete the Missed Medication Quality Assurance Monitor weekly times four weeks and monthly for three months. The Director of Nursing will evaluate three residents to ensure medication administration is correct. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. Meeting consisting of the Administrator, Director of Nursing, 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. Any corrective action required will be made by the Quality of Life Team

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F 755	Continued From page 20 dorzolamide but did not recall if the dorzolamide drops were getting low or out. When asked what she would do if the drops were out or getting low, she stated she was part time and was not able to order medications from pharmacy. She would notify the nursing supervisor and they would reorder the medication. On 8/24/2021 at 2:15 PM an interview was conducted with the Director of Nursing (DON). She stated the eye medication bottles are marked, by the nurses, with the date the bottle is open. The DON stated the staff have a list of eye medications with how long they typically last and can reorder before the drops run out. The DON also stated the staff should have reordered the medication when the medication was low. When asked how to prevent residents from missing medication administrations due to medication not being in the facility, she stated it could be corrected with nursing education. The DON stated she expected nursing staff to reorder medications before they ran out.	F 755		
F 842 SS=E	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	F 842		9/2/21

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F 842	Continued From page 21 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, 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.	F 842		

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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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§483.70(i)(5) The medical record must contain-
(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 staff interviews and record review, the facility failed to maintain complete medical records in the area of wound consultant progress notes for 3 (Resident #33, #3 and #16) of 3 medical records reviewed for wound care.
Findings included:

1. Resident #33 was admitted on 1/20/21 with quadriplegia and pressure ulcers.

Resident #33's quarterly Minimum Data Set dated 8/3/21 indicated severe cognitive impairment, he exhibited no behaviors and required total assistance with his activities of daily living. He was also coded for 4 unstageable pressure ulcers.

A review of the electronic medical record for Resident #33 did not include any evidence of the wound consultant notes.

In an interview with the Treatment Nurse on 8/24/21 at 2:40 PM, she stated Resident #33 was first seen on 8/18/21. She stated she was not

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 the following corrective action has been accomplished by:
On August 22, 2021, the Health Information Management (HIM) obtained and uploaded all wound consults into electronic health record (EHR) matched the hard chart for residents #33, #3 and #16.
Corrective action has been accomplished on all residents with the potential to be

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aware that the wound consultant notes were not in his medical record.

On 8/24/21 at 4:10 PM, the Director of Nursing (DON) stated the wound consultant notes had been received and were printing. The DON stated she was unsure why the wound consultant notes were not in the medical record. She stated she received a report about the wound consultant's visits but the wound consultant progress notes were not in the medical record. The DON stated she expected Resident #33's wound consultant notes be available and part of the medical record.

In an interview on 8/25/21 at 2:45 PM, the medical records supervisor stated she had worked at the facility for 4 or 5 years and she could not recall a time when the wound consultant's wound progress notes were included in the hard chart or electronic medical record. She stated she was instructed yesterday that wound consultant notes needed to be uploaded into Resident #33's medical record.

In an interview on 8/25/21 at 11:13 AM with the Administrator stated it was her expectation that Resident #33's medical record be complete and accurate.
2. Resident #3 was admitted to the facility on 5/26/2021 with diagnoses that included a dementia and multiple chronic pressure ulcers.

A review of the resident's active orders revealed a physician's order, dated 6/1/2021, for wound consult by wound consultant.

The resident's admission Minimum Data Set (MDS) dated 6/1/2021 indicated Resident #3 was moderately cognitively impaired and total

F 842

affected by the alleged deficient practice by:
On September 1, 2021 the Director of Nursing (DON) audited 100% of current residents currently receiving wound care services to ensure their wound consultant progress notes were uploaded in the EHR. All current residents consultant progress notes were uploaded into EHR, no discrepancies noted.

Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur:
The Healogic�s Wound Audit form was amended to include uploading the wound consultant progress notes in the HER. On September 2, 2021, the DON educated the Wound Care Registered Nurse (RN) on the appropriate use of the Healogic�s Wound Audit form to ensure wound consultant progress notes are uploaded into the HER. If the wound nurse is absent the DON will ensure the wound consultant progress notes are uploaded into the EHR. The Director of Nursing will begin weekly observation. The DON will audit five residents receiving pressure ulcer wound services using the Healogics Wound Audit form. The monitor will be completed weekly times four weeks then monthly times three months.
The facility has implemented a Quality Assurance Monitor:
The Director of Nursing will begin weekly observation. The DON will audit five residents receiving pressure ulcer wound services using the Healogics Wound Audit

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F 842	Continued From page 24 dependent for all activities of daily living and personal hygiene. The resident was coded as at risk for pressure injuries with a stage 2, stage 4, and three deep tissue injuries present on admission. On 8/24/2021 at 1:48 PM an during a wound care observation by the Treatment Nurse, she stated the wound consultant assessed and treated Resident #3 once weekly on Wednesdays. She further stated wound measurements were obtained by the wound consultant at that time. She stated the wound consultant notes were in the resident's electronic medical record. A review of Resident #3's electronic medical record did not include any evidence of the wound consultant's documentation of wound care. On 8/24/2021 at 4:10 PM the Director of Nursing (DON) stated she received progress notes from the wound care consultant for each visit with Resident #3. She was not able to state why the notes were not in the resident's electronic medical record. The DON further stated she expected the wound consultant notes to be available and part of the resident's electronic medical record. An interview was conducted with the Medical Records Supervisor on 8/25/2021 at 2:45 PM. She stated she had been employed by the facility for 4 to 5 years and did not recall the wound consultant progress notes ever being part of the medical record. She stated she had been instructed yesterday to upload wound consultant notes into resident records going forward. An interview was conducted with the	F 842	form. The DON will present the results monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. Meeting consisting of the Administrator, Director of Nursing, SDC, Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Support Nurse, Health Information Manager and Physical Therapist. 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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F 842	Continued From page 25 Administrator on 8/25/2021 at 11:13 AM and stated it was her expectation for all residents' medical records to be complete. 3) Resident #16 was originally admitted to the facility on 1/27/18 with a recent readmission date of 7/6/20. Her diagnoses included dementia, non-pressure chronic ulcer of the right calf and venous insufficiency. A physician's order dated 5/21/21 indicated the facility may consult with Healogics (wound care consultant) for Resident #16's wound care . The quarterly Minimum Data Set (MDS) assessment dated 7/1/21 indicated Resident #16 had severe cognitive impairment and received extensive assistance with activities of daily living. She was also coded with 3 venous ulcers. A review of Resident #16's electronic medical record did not include any evidence of wound consultant notes. The Treatment Nurse was interviewed on 8/24/21 at 1:14 PM, who stated Resident #16 was first evaluated by the wound care consultant on 5/26/21 for lower extremity venous ulcers. She further explained the wound care consultant assessed Resident #16's wounds weekly. The Treatment Nurse stated she was not aware the wound consultant notes were not in the medical record. On 8/24/21 at 4:10 PM, the Director of Nursing (DON) stated she received a report about the wound consultant's visits but was unable to state why the progress notes were not in Resident	F 842		

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F 842	Continued From page 26 #16's medical record. The DON further stated she expected Resident #16's wound consultant notes to be available and part of the medical record. In an interview with the Medical Records supervisor on 8/25/21 at 2:45 PM, she stated she had been employed at the facility for 4 to 5 years and could not recall a time when the wound care consultant progress notes had been a part of the medical record. She stated she had been instructed yesterday to upload wound consultant notes into Resident #16's medical record. An interview occurred with the Administrator on 8/25/21 at 11:13 AM and stated it was her expectation for Resident #16's medical record to be accurate and complete.	F 842		