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	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inn at Quail Haven Village	155 Blake Boulevard Pinehurst, NC 28374

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]. 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. (continued on next page)

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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 7/1/24 at 7:28 PM by Nurse #4 revealed the Resident #158's oxycodone was 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 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.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: 1. Resident #48 was admitted to the facility on [DATE] 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 [DATE] 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. 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. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #102 was admitted to the facility on [DATE] 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 [DATE] 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. 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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. 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 [NAME] #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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 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: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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 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 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.