STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING ______ B. WING ______ MAY 23 2012	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure a medication error rate less than 5% as evidenced by 3 errors out of 54 opportunities for error, resulting in an error rate of 5.5% for 2 of 10 residents observed during medication pass (Residents #445 and #183). The findings include: 1. The facility policy titled Medication Administration Enteral Tubes dated 10/2007 under Procedures #11 reads: " Flush the tube with at least 30 ml (milliliters) of water prior to medication administration. " Item #12 provides instruction related to medication administration and #13 reads: " Flush the tube with at least 30 ml of water. " Resident #445 was re-admitted to the facility on 04/05/12 and had cumulative diagnoses of Peripheral Vascular Disease, Anemia, Diabetes Mellitus, Gastro-esophageal Reflux Disease (GERD), Atherosclerosis, Congestive Heart Failure, Hypertension, Atrial Fibrillation and Urinary Retention. On 04/18/12 at 11:30 AM, Nurse #1 was observed to prepare 10ml of Metoclopramide liquid to administer to the resident via a feeding tube. Metoclopramide is a medication used to	F 332	In order to fix the problem of this nurse not properly flushing the feeding tube with at least 30 ml of water before and after medication administration, she was removed from the floor for three days in order to undergo retraining with the RN supervisor assigned to this resident and the Director of Nursing. The nurse was retrained on the proper policy and procedure for medication pass and tube feeding, including the correct amount of water needed to properly flush a feeding tube before and after medication administration. She was also retrained on proper medication pass, via educational materials supplied by facility's pharmaceutical vendor on the correct way to administer oral, topical, eyedrops, patches, injections and medication administered via feeding tube. In order to fix the problem for this particular resident, the nurse was required to perform the medication pass accurately, proving that she now understands the policy and can perform the function satisfactorily. In order to address this problem for any potentially affected residents, this nurse will continue to be observed on a random basis by the Director of Nursing or her designee to ensure continued compliance. In order to address systemic changes and determine whether the remainder of the nurses in the facility are aware of the proper policy and procedure, each nurse will be required to prove competency by demonstrating the proper technique. If any of the nurses do not perform the medication pass properly, they will be retrained immediately and will be required to demonstrate competency prior to administering medications through the tube.	5/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	5-22-12

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 332	Continued From page 1 treat GERD. The Nurse was observed to draw up the medication in a catheter tip syringe, disconnect the feeding tube from the PEG tube, insert the catheter tip syringe into the PEG tube and push the medication into the PEG tube and flush the tube with water. The Nurse reconnected the tube feeding tube to the PEG tube and stated that she flushed the tube with 10ml of water. The Nurse did not flush the PEG tube prior to administering the medication and did not flush the tube with the recommended 30ml of water after the medication administration. Nurse #1 stated in an interview on 04/18/12 at 11:41 AM that she did not usually flush the PEG tube before giving the medication and that she usually flushed the tube with 10ml of water after giving the medication. The Director of Nursing stated in an interview on 04/19/12 at 9:41 AM that the nurse should have flushed the PEG tube with 30ml of water before and after administering the medication. 2. Resident #183 was admitted on 9/20/10, with a multiple diagnoses in part, feeding difficulties, aftercare healing traumatic fracture, chronic fatigue syndrome, osteoporosis, esophageal reflux, hypertension and hypothyroidism. The physician orders dated 4/1/12 read, Prostat, Give 30 ml by mouth twice daily before meals. Synthroid 50 mcg (micrograms) QD (everyday) AC (before meals) everyday Once a day by mouth before meal. Omeprozole Give 20 mg by mouth before breakfast. The medication administration recorded indicated the times of	F 332	In order to ensure that system changes are ongoing, the Director of Nursing or her designee will conduct random audits of medication pass and tube feeding procedures. The results of these audits will be reported quarterly to the administrator and the medical director via the Quality Assurance meeting; however, any issues noted during random audits will be addressed immediately by the Director of Nursing or her designee.	5/31/12

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F 332	Continued From page 2 administration for Synthroid, Omeprozole and Prostat was 7:00 am. On 4/18/12, at 9:00 am Resident #183 was observed sitting in the dining room and had finished her breakfast. During a medication pass on 4/18/12 at 9:15 am, nurse #2 was observed to prepare one Omeprozole 20 mg (milligram) capsule (for esophageal reflux), two Synthroid 25 mg tablet (for hypothyroidism), and Prostat liquid 30 ml (milliliter) a dietary supplement, Calcium Carbonate 500 mg (for osteoporosis), Vitamin D 1000 u (units) capsule, Singulair 10 mg tablet (for sinusitis), Alphagan eye drops (for glaucoma), Amlodipine 2.5 mg (for hypertension). Nurse # 2 indicated her computerized medicine administration record (MAR) was flagging red, because Resident #183 ' s 7:00 am, medications were late. She indicated the construction and the residents being out of their rooms she caused her to be disorganized. She indicated she had not notified her supervisor or asked for assistance and she was behind. During an interview on 4/18/12 at 9:30 am, the director of nursing indicated once made aware nurse # 2 was late giving her medications. Another nurse gave her assistance to get back on schedule with her medication administration. The expectation was nursing staff to administer medications as ordered and in a timely manner.	F 332	In order to fix the problem of this nurse not giving her medications in a timely manner she was removed from the floor for three days in order to undergo retraining with the RN supervisor assigned to this resident and the Director of Nursing. The nurse was retrained on the proper policy and procedure for medication pass including the correct times that medications need to be administered. Her retraining included leadership training on the delegation of tasks in order to maintain timeliness of duties. This nurse was then reintroduced to the schedule and observed for leadership technique and ability to delegate tasks. She was also retrained on proper medication pass, via educational materials supplied by facility's pharmaceutical vendor on the correct way to administer oral, topical, eyedrops, patches, injections and medication administered via feeding tube. In order to address this problem for any potentially affected residents, this nurse will continue to be observed on a random basis by the Director of Nursing or her designee to ensure continued compliance with timeliness of medication pass. In order to ensure that system changes are ongoing, the Director of Nursing or her designee will conduct random audits of medication pass noting, specifically, the timeliness of such passes.	
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334	In order to ensure that systemic changes will be monitored, the results of these audits will be reported quarterly to the administrator and the medical director via the Quality Assurance meeting; however, any issues noted during random audits will be addressed immediately by the Director of Nursing or her designee.	

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F 334	Continued From page 3 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334	In order to address the issue of any residents who might be potentially affected by the lack of documentation regarding the benefits and potential side effects of the influenza vaccine, and to address systemic changes, the policy has been revised to reflect that residents and/or their responsible parties will receive education from the admission nurses or their designee regarding risks & benefits as well as potential side effects of receiving the influenza vaccine. In order to ensure that systemic changes will be monitored, this policy will be reviewed annually by the policy committee to ensure continued relevance and random audits will be conducted by the Director of Nursing or her designee to ensure that residents and responsible parties are being properly educated. In order to ensure that systemic changes are monitored the results of these audits will be reported quarterly to the administrator and the medical director via the Quality Assurance meeting; however, any issues noted during random audits will be addressed immediately by the Director of Nursing or her designee.	

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F 334	Continued From page 4 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop policies and procedures to ensure that each resident or legal representative was provided education regarding the benefits and potential side effects of the influenza Vaccine. The findings include: The facility policy titled Infection Control: Influenza Virus dated September 2004, did not indicate that the resident or legal representative would be educated about the benefits and potential side effects of the influenza vaccine. The Director of Nursing (DON) stated in an interview on 04/19/12 at 10:30 AM that the 2 admission nurses were responsible for obtaining consent for the Influenza Vaccine.	F 334		

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F 334	Continued From page 5 Nurse #3 stated in an interview on 04/19/12 at 10:43 AM that verbal consent for the influenza vaccine was obtained from the resident or the responsible party and that the potential side effects of the vaccine were explained at that time. Nurse #4 stated in an interview on 04/19/12 at 12:45 PM that verbal consent for the influenza vaccine was obtained from the resident or the responsible party and that the person giving consent for the vaccine was told of the potential side effects of the vaccine. In an interview with the administrator and the DON on 04/19/12 at 1:20 PM, the Administrator acknowledged that the influenza policy did not include the provision of education to residents and their legal representatives. The Administrator stated that the policy would be revised to include this information.	F 334		5/31/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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RECEIVED
JUN 11 2012
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/22/2012

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K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating.. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) The corridor wall between the existing and area under renovation is not being maintained. At the nurse station on 600 hall the sheetrock beween the area under renovation and existing is missing with plastic used as a form of dust controll. 42 CFR 483.70(a)	K 017	K017 The plastic partition was up in order to create a temporary barrier in order to contain the dust created during the drywall work. In order to fix this issue the partition was removed the next day. In order to address this issue for future residents, plastic partitions will no longer be used for the duration of the construction projects. In order to address systemic changes and determine whether the remainder of the construction crew is aware of the proper policy and procedures the administrator or her designee will conduct rounds weekly to ensure compliance. In order to ensure that system changes are ongoing the administrator will report the results of rounding to the QA committee until the cessation of the construction.	6-29-1
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction	K 020		

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

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K 020	Continued From page 1 having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) A new stairwell is being added to the end of 600 hall in the new addition being added and the stairwell has unprotected openings at both the upper and lower levels due to missing doors. The walls between the existing and renovated areas open in areas with plastic used to controll dust. 2) There are pore holes in the renovted area next to 600 Hall that have not been sealed	K 020	K020 In order to fix this issue the doors were hung and core holes were sealed the next day. In order to address this issue for future residents, doors will be hung immediately for the duration of the construction projects. In order to address systemic changes and determine whether the remainder of the construction crew is aware of the proper policy and procedures the administrator or her designee will conduct rounds weekly to ensure compliance. In order to ensure that system changes are ongoing the administrator will report the results of rounding to the QA committee until the cessation of the construction.	6-29-12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) The dry storage room in the kitchen did not	K 029	K029 In order to address these issues: 1) The door to the dry storage area has been replaced as of 6/3/12. 2) The contractor has been contacted and will be installing the proper damper by 6/29/12. 3) All doors have been inspected for materials stuck in strike plates and any foreign materials have been removed.	6-29-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 05/29/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 029	Continued From page 2 close, latch and seal. Door is warped and would not latch. 2) The corridor wall between the clean linen side of the laundry room and corridor has a vent opening that is not equipped with a smoke and fire damper. Opening has a fire damper only. 3) The corridor door to the 850 Hall laundry/storage room did not latch. The strike plate was plugged preventing the door from latching. 4) The corridor door to the soiled lined side of the laundry room did not close and latch. 42 CFR 483.70(a)	K 029	4) The self-closing apparatus has been adjusted for full closure on 6/8/12. In order to address this problem for potentially affected residents, the entire staff has been inserviced on the danger of doors not being able to close properly. To address systemic changes and ensure that the strike plates remain free of debris the administrator or her designee will inspect all strike plates during weekly rounds. To ensure that system changes are ongoing, the results of rounds will be reported to the QA committee on a quarterly basis.	6.29.12
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) The corridor to stairwell 600 Hall and adjoing hall exit door did not release upon activation of fire alarm. 42 CFR 483.70(a)	K 038	K038 Mechanical failure of the relay switch has been fixed by a qualified contractor as of 6/7/12. To address this problem for potentially affected residents, the entire staff has been inserviced on the proper use of the Mag Locks including how to disengage them in the event that they do not respond appropriately. To address systemic changes the administrator or her designee will inspect all Mag Logs during all fire drills to ensure that they are working properly.. To ensure that system changes are ongoing, the results of rounds will be reported to the QA committee on a quarterly basis.	6.29.1
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	K 050		

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K 050	Continued From page 3 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted 1) During the inspection of the facility the fire alarm was activated due to construction work in the area. When the alarm was sounded the facility silenced the alarm and announced over the intercom the location of the reported alarm. The staff on 1st floor was observed responding to the alarm located on 2nd with fire extinguishers and when attempting to enter the stair the door did not release upon activation of fire alarm. When the staff could not enter the stairwell the staff attempted to use the key pad to unlock the door but it was deactivated when the alarm sounded and would not unlock the doors and the staff were not familiar with the override switch at the door to unlock the doors. Staff should be aware that the mag lock doors should release upon activation of fire alarm and the procedures to open the door if the did not. 2) During the survey a second fire alarm was sounded and due to construction work and on the 450 Hall the staff did not close and secure the doors from opening. 42 CFR 483.70(a)	K 050	K050 The staff has been educated regarding the proper operation of the Mag Locks, all staff has been inserviced on how to disable the locks in the event of an emergency. To address the systemic changes and ensure that the Mag Locks work properly the administrator or her designee will test all doors during monthly fire drills. To ensure that system changes are ongoing, the results of rounds will be reported to the QA committee on a quarterly basis.	6·29·12
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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K 056	Continued From page 4 Installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) At the overhang outside Physical Therpy there are sprinkler heads rated for Intermediate Temperature Classification, Glass Bulb Color of Blue (225°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). 2) In the Central Store room there are sprinkler heads in the facility rated for Intermediate Temperature Classification, Glass Bulb Color of Green (200°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). 42 CFR 483.70(a)	K 056	To fix the issue of improper sprinkler heads, a qualified contractor will replace the sprinkler heads with the properly rated heads in all instances where improperly rated head were found. To address the systemic changes and ensure that the sprinkler heads are properly rated the administrator or her designee will inspect sprinkler heads on a monthly basis during rounds to ensure that they are properly rated. To ensure that system changes are ongoing, the results of rounds will be reported to the QA committee on a quarterly basis. K072 The shelf has been removed and the nurse c all system has been located back to the nurse's station. The desk and shredder have been removed from the corridor. To address the systemic changes and ensure that the corridors remain clear the administrator or her designee will round on a weekly basis. To ensure that system changes are ongoing, the results of rounds will be reported to the QA committee on a quarterly basis.	6-29-12 6-29-12
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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K 072	Continued From page 5 furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) At the 600 Hall nurse station a shelf was installed on the corridor wall that protrude more than 7 inched in to the corridor. 2) In the corridor by the exit in front of Physical Therapy a desk, shredder and other item were setup as a work station. 42 CFR 483.70(a)	K 072		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on 5/22/2012 between 11:30 AM and 5:00 PM the following was noted: 1) The Normal lights on the Onan transfer switch were not operational. 2) The Med refrigerator located on 100 Hall was not connected to emergency power. 42 CFR 483.70(a)	K 147	K147 Wire connected to the light has been fixed and the electrical outlets have been configured to be able to connect both the Omnicell and the refrigerator on the emergency circuit. To address the systemic changes and ensure that the appliances remain plugged in to the emergency outlets the administrator or her designee will round on a weekly basis. To ensure that system changes are ongoing, the results of rounds will be reported to the QA committee on a quarterly basis.	6.29.1