STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345044	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/16/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff and family interviews the facility failed to notify the Responsible Party or other resident contacts of a fall for 1 of 3 sampled residents with falls (Resident #1). The findings include:

Resident #1 was admitted to the facility on 11/16/12 with diagnoses that included Left Hip Fracture, Left Hemiarthroplasty and Alzheimer ' s Disease.

The Admission Minimum Data Set (MDS) Assessment dated 11/22/12 showed that the resident had short and long term memory loss, had poor decision making skills and cues and supervision was required.

The Care Area Assessment (CAA) for Activities of Daily Living dated 11/29/12 showed that the resident was oriented to self only and was usually unable to make her needs known to the staff. The CAA showed that the resident was living in an assisted living facility where she fell and sustained a fracture of the femoral neck and after having surgery was admitted to the facility for therapy.

A review of the medical record revealed a nurse ' s note dated 12/06/12 at 6:12 PM that showed at 5:55 PM staff heard someone yelling and Resident #1 was found on the floor near the closet door. The note showed that there were no injuries and that range of motion was within normal limits with no rotation of the lower extremities. There was no documentation in the nurse ' s notes that the family was notified of the fall.

A nursing progress note dated 12/07/12 at 3:33 PM showed that the resident was sent to the Emergency Room

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345044	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/16/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	Continued From Page 1

(ER) for evaluation due to increased right hip pain.

A review of the Admission Record for Resident #1 under Contacts listed a Responsible Party that was a family member as the first contact, the name of a friend as a second contact and the name of another family member as the third contact. There was one phone number listed for each contact.

A review of the facility ' s incident report revealed a note dated 12/6/12 that read: " Called (name of family member), got voice mail. Left call back number for facility to update him re (regarding) fall. " The note was signed by Nurse #1.

An interview was conducted with the RP and contact #3 on 01/16/13 at 8:45 AM. The RP stated that on 12/6/12 he was at work and saw that someone had called his cell phone but he did not recognize the number and there was no message. The RP stated that on 12/7/12 (name of Contact #3) called him and told him that their mother had fallen the day before and was being sent to the hospital. The Third Contact stated that he was not notified of the resident ' s fall until 12/7/12. The RP stated that after receiving the call from (name of Contact #3) he wondered if the number on his cell phone on 12/6/12 was the facility calling him. The RP stated that he called the number and staff at the facility answered the phone. The RP stated that there were other contacts listed on the resident ' s chart and that the staff should have notified someone on the list on 12/6/12 of the resident ' s fall.

In an interview on 1/15/13 at 12:35 PM the nurse that worked on 12/6/12 on the 6AM-6PM shift (Nurse#1) stated that she called the RP and left a message to call the facility at the earliest convenience. The Nurse stated that the fall occurred near the end of her shift and she did not receive a call from the RP prior to the end of her shift. The Nurse stated that she reported to the on-coming nurse to expect a call from the RP.

In an interview on 1/16/13 at 10:37 AM the nurse that worked on 12/6/12 on the 6PM-6AM shift (Nurse #2) stated that she did not recall having a conversation with the resident ' s RP on that day and was unable to recall any specific information about the resident.

On 1/16/13 at 2:44 PM the Assistant Director of Nursing (ADON) (present on the unit on 12/6/12 when the fall occurred) stated in an interview that she was not aware if the staff spoke with the RP about the resident ' s fall. The ADON stated that staff are not allowed to leave detailed information on voice mails due to HIPPA (Health Insurance Portability and Accountability ACT) laws. The ADON stated that the fall occurred close to the end of the shift. The ADON stated that the staff usually try again to call the RP and then go down the list and try to notify someone on the list.

On 1/17/13 at 10:25 AM Contact #2 stated in an interview that she was not notified on 12/6/12 of the resident ' s fall.