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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE 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 survey was conducted on 4/29/19 through 5/2/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FF0W11.	E 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		5/30/19

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

Electronically Signed | 05/24/2019

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F 623	Continued From page 1	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 2 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the Regional Ombudsman and the responsible party (RP) in writing of the reason for hospital discharge for 5 of 5 sampled residents reviewed for hospitalization (Residents #70, #53, #83, #96 and #143). Findings included: 1. Resident #70 was originally admitted to the facility on 3/10/18.	F 623	F623 Identification: Saint Joseph of the Pines Health Center does provide notice of transfer to a hospital. Corrective Action Resident #70, #53, #83, #96, and #143 responsible parties have received in writing of the reason for hospital discharge by Director of Social Services on or before 5/30/19.	

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F 623	Continued From page 3 Review of a nursing note dated 3/19/19 indicated Resident #70 was sent to the hospital for an evaluation related to a suspected gastrointestinal bleed. He was admitted to the hospital on 3/19/19 and did not return to the facility until 4/2/19. During an interview on 5/1/19 at 10:41 AM, the Administrator stated the facility had not been notifying the Regional Ombudsman of resident transfers to the hospital because he was not aware it was necessary. He stated it was his expectation that the facility notifies the Regional Ombudsman of resident transfers to the hospital and that the resident RP receives written information as to the reason a resident was transferred to the hospital. During an interview on 5/1/19 at 3:15 PM, the Social Worker stated he was not aware that the RP was supposed to receive written information regarding the reason Resident #70 was transferred to the hospital on 3/19/19. During an interview on 5/2/19 at 10:24 AM, the Director of Nursing stated it was his expectation that the facility provides the Regional Ombudsman written notice and the resident RP written information regarding the reason for transferring to the hospital. 2. Resident #53 was originally admitted to the facility on 5/4/16. Review of a nursing note dated 3/20/19 indicated Resident #53 was sent to the hospital for an evaluation related to a suspected infection. He was admitted to the hospital on 3/20/19 and did not return to the facility until 3/22/19.	F 623	Director of Medical Records notified regional Ombudsman of hospital discharge of residents #70, #53, #83, #96, and #143 on or before 5/30/19. All responsible parties of current residents discharged to hospital have received in writing of the reason for hospital discharge by Director of Social Services on or before 5/30/19. Regional Ombudsman has been notified of current residents discharged to hospital by the Director of Medical Records on or before 5/30/19. System change Social Services and Medical Records personnel will be educated by the Vice President of Health Services on providing written notification to the responsible party and Regional Ombudsman of a resident discharge to the hospital on or before 5/30/19. Monitoring The Vice President of Health Services or Administrative Assistant will audit written notifications to the responsible party and Regional Ombudsman notification for all resident discharges to the hospital for weekly for one month, then 50% of resident discharges to the hospital weekly for one month, and then 25% of residents discharges to the hospital weekly for one month. The Vice President of Health Services will report trends, findings, and corrective	

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F 623	Continued From page 4 During an interview on 5/1/19 at 10:41 AM, the Administrator stated the facility had not been notifying the Regional Ombudsman of resident transfers to the hospital because he was not aware it was necessary. He stated it was his expectation that the facility notifies the Regional Ombudsman of resident transfers to the hospital and that the resident RP receives written information as to the reason a resident was transferred to the hospital. During an interview on 5/1/19 at 3:15 PM, the Social Worker stated he was not aware that the RP was supposed to receive written information regarding the reason Resident #53 was transferred to the hospital on 3/19/19. During an interview on 5/2/19 at 10:24 AM, the Director of Nursing stated it was his expectation that the facility provides the Regional Ombudsman written notice and the resident RP written information regarding the reason for transferring to the hospital. 3. Resident #83 was initially admitted to the facility on 3/21/18 and most recently readmitted on 9/10/18 with diagnoses that included Alzheimer ' s disease. The quarterly Minimum Data Set (MDS) assessment dated 6/24/18 indicated Resident #83 ' s cognition was severely impaired. A medical record review revealed Resident #83 was transferred to the hospital on 9/5/18. There	F 623	measures of these audits to the Mission Driven Quality Assurance and Performance Improvement (MD-QAPI) Sub-Committee weekly for review and recommendations until substantial compliance is achieved or as directed by the MD-QAPI Committee. The Vice President of Health Services is responsible for attaining and sustaining compliance. The facility alleges compliance effective 5/30/19	

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F 623	Continued From page 5	F 623		

was no documentation that a written notice of hospital discharge was provided to Resident #83 ' s Responsible Party (RP) or to the Regional Ombudsman.

Resident #83 was readmitted to the facility on 9/10/18.

On 5/1/19 at 10:41 AM the Administrator stated they were not aware of the requirement to send written notification to the resident and/or RP and a copy to the Ombudsman of a resident's transfer or discharge to the hospital. The Administrator indicated the facility had not provided any written information to the resident, RP or the Ombudsman when a resident was transferred from the facility to the hospital.

During an interview with the Social Worker on 5/1/19 at 3:15 PM, he stated that a written notice for the reason of transfer/discharge to the hospital was not provided to the resident and/or RP. He indicated he was not aware of the requirement.

On 5/2/19 at 10:24 AM the Director of Nursing stated it was his expectation for the Regional Ombudsman and the resident and/or RP to be notified in writing as per the regulations when a resident was discharged to the hospital.

On 5/2/19 at 10:33 AM a phone call was received from the Regional Ombudsman. She confirmed the facility was not sending her written notification of discharges to the hospital, but she had corresponded with the Administrator on 5/1/19 and 5/2/19 and that the facility would be sending a list of all discharges at the end of each month.

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F 623	Continued From page 6	F 623		

4. Resident #96 was initially admitted to the facility on 8/25/15 and most recently readmitted on 3/1/19 with diagnoses that included dementia.

The annual Minimum Data Set (MDS) assessment dated 1/4/19 indicated Resident #96 had short term memory problems, long term memory problems, and moderately impaired skills for decision making.

A medical record review revealed Resident #96 was transferred to the hospital on 2/28/19. There was no documentation that a written notice of hospital discharge was provided to Resident #96 ' s Responsible Party (RP) or to the Regional Ombudsman.

Resident #96 was readmitted to the facility on 3/1/19.

On 5/1/19 at 10:41 AM the Administrator stated they were not aware of the requirement to send written notification to the resident and/or RP and a copy to the Ombudsman of a resident's transfer or discharge to the hospital. The Administrator indicated the facility had not provided any written information to the resident, RP or the Ombudsman when a resident was transferred from the facility to the hospital.

During an interview with the Social Worker on 5/1/19 at 3:15 PM, he stated that a written notice for the reason of transfer/discharge to the hospital was not provided to the resident and/or RP. He indicated he was not aware of the requirement.

On 5/2/19 at 10:24 AM the Director of Nursing

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F 623	Continued From page 7	F 623		

stated it was his expectation for the Regional Ombudsman and the resident and/or RP to be notified in writing as per the regulations when a resident was discharged to the hospital.

On 5/2/19 at 10:33 AM a phone call was received from the Regional Ombudsman. She confirmed the facility was not sending her written notification of discharges to the hospital, but she had corresponded with the Administrator on 5/1/19 and 5/2/19 and that the facility would be sending a list of all discharges at the end of each month.

5) Resident #143 was admitted to the facility on 1/30/19 with diagnoses that included, Thalamic subacute infarct (a type of stroke that happens in the thalamus of the brain), Atrial Fibrillation and Chronic Obstructive Pulmonary Disease (COPD).

A medical record review revealed the resident was transferred to the hospital on 2/8/19. There was no documentation of a written notice of transfer provided to the resident and/or responsible party.

On 5/1/19 at 10:41am the Administrator stated they were not aware of the requirement to send written notification to the resident and/or responsible party and a copy to the Ombudsman of a resident's transfer or discharge to the hospital. The Administrator indicated the facility had not provided any written information to the resident, responsible party or the Ombudsman when a resident was transferred from the facility to the hospital.

During an interview with the Social Worker on 5/1/19 at 3:15pm, he stated that a written notice

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F 623	Continued From page 8 for the reason of transfer/discharge to the hospital was not provided to the resident and/or responsible party. He indicated he was not aware of the requirement. On 5/2/19 at 10:24am the Director of Nursing stated it was his expectation for the Ombudsman and the resident and/or resident representative to be notified in writing, per the regulations. On 5/2/19 at 10:33am a phone call was received from the Ombudsman. She confirmed the facility was not sending her written notification of discharges to the hospital, but she had spoken with the Administrator and the facility would be sending a list of all discharges at the end of each month.	F 623		
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, observation, and staff interview, the facility failed to code the Minimum Data Set Assessment accurately in the areas of cognition (Residents #66, #96, and #291), medications (Resident #291), and active diagnoses (Resident #291) for 3 of 29 residents reviewed. The findings included: 1a. Resident #291 was admitted to the facility on 4/9/19 with diagnoses that included Alzheimer ' s disease and dementia.	F 641	F641 Identification: Saint Joseph of the Pines Health Center assessment does accurately reflect the resident's status, based on information obtained through resident, family and staff interviews, resident observation and review of the medical record. Saint Joseph of the Pines Health Center utilizes the direction and guidance detailed in the Resident Assessment Instrument (RAI) Manual as it pertains to	5/30/19

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F 641	Continued From page 9 A physician ' s order for Resident #291 dated 4/9/19 indicated Haldol (antipsychotic medication) 5 milligrams (mg) as needed (PRN) twice daily. A review of Resident #291 ' s Medication Administration Record (MAR) for April 2019 indicated he was administered PRN Haldol one time on 4/12/19. This was the only administration of Haldol for Resident #291 in April 2019. The admission Minimum Data Set (MDS) assessment dated 4/17/19 indicated Resident #291 had short term memory problems, long term memory problems, and severely impaired decision-making skills. He was administered antipsychotic medication on 1 of 7 days during the MDS look back period. Resident #291 was coded with antipsychotic medications administered on a routine basis only. An interview was conducted with MDS Nurse #2 on 5/1/19 at 9:00 AM. The 4/17/19 MDS for Resident #291 that indicated he received antipsychotic medication on a routine basis only was reviewed with MDS Nurse #2. The physician ' s orders and the April 2019 MAR that indicated Resident #291 was administered PRN Haldol one time only on 4/12/19 was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she had coded this MDS assessment inaccurately for Resident #291. She stated this was a typo and that the MDS should have been coded to indicate that antipsychotic medication was received on a PRN basis only. An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He indicated he expected the MDS to be coded accurately. 1b. Resident #291 was admitted to the facility on	F 641	coding all items contained on the Minimum Data Set (MDS). Coding rule as found in Chapter 3, Section B, page 7 of the RAI Manual V1.16 is detailed below: Code 0, understood: if the resident expresses requests and ideas clearly. Code 1, usually understood: if the resident has difficulty communicating some words or finishing thoughts but is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood. Code 2, sometimes understood: if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet). Code 3, rarely or never understood: if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet). The RAI Manual directs that resident interviews should be attempted with all residents. If the determination is made during the interview that the resident is rarely or never understood, the gateway questions (C0100 and D0100) for resident interviews will be coded as "0". The coding of "0" in C0100 or D0100 generates a skip pattern that does not allow coding in items C0200 through C0500 or D0200 through D0350 forcing the interviewer to proceed to the Staff	

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F 641	Continued From page 10 4/9/19 with diagnoses that included Alzheimer ' s disease and dementia. A physician ' s order for Resident #291 dated 4/9/19 indicated Paxil (antidepressant medication) 20 milligrams (mg) once daily. This order included a notation that a telephone order was received on 4/9/19 that indicated Resident #291 ' s Paxil was for a diagnosis of depression. A review of Resident #291 ' s Medication Administration Record (MAR) for April 2019 indicated he was administered Paxil for depression on 7 of 7 days during the 4/17/19 MDS review period (4/11/19 through 4/17/19). The admission Minimum Data Set (MDS) assessment dated 4/17/19 indicated Resident #291 had short term memory problems, long term memory problems, and severely impaired decision-making skills. He was administered antidepressant medication on 7 of 7 days during the MDS look back period. Resident #291 was not coded with an active diagnosis of depression. An interview was conducted with MDS Nurse #2 on 5/1/19 at 9:00 AM. The 4/17/19 MDS for Resident #291 that indicated he received antidepressant medication on 7 of 7 days and was not coded with an active diagnosis of depression was reviewed with MDS Nurse #2. The physician ' s order dated 4/9/19 that indicated Resident #291 was ordered Paxil 20 mg once daily for a diagnosis of depression was reviewed with MDS Nurse #2. The April 2019 MAR that indicated Resident #291 received Paxil on 7 of 7 days during the 4/17/19 MDS look back period was reviewed with MDS Nurse #2. MDS Nurse #2 stated that Resident #291 ' s history and physical had not included a diagnosis of depression. She reported that she was unaware	F 641	Assessment. The medical record for resident #291 was reviewed by the Clinical Resource Manager (CRM) and Director of Social Service to determine any coding disparity between the medical record and coding on the 4/17/19 MDS. Resident #291 did make occasional statements, but was unable to express concrete care needs or requests. Therefore, in accordance with the coding instruction for item B0700, the resident was determined to be rarely or never understood during the reference period and at the time of the resident interview. As noted by the surveyor during communication with the facility and corporate staff, the Director of Social Services did attempt to interview resident #291 and determined the resident was unable to complete said interview. The interview attempt was documented in both a social service progress note and in the Care Area Assessment Summary detail of the 4/17/19 comprehensive MDS. The medical record for Resident #66 was reviewed by the CRM and Director of Social Services for resident communication during the period of time encompassing the assessment reference period for the 2/20/19 MDS. Record review found the resident did not make clear concrete requests, but in fact was unable to be understood. As noted in the statement of deficiencies, the Social	

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F 641	Continued From page 11 that the diagnosis of depression had been added to the 4/9/19 physician ' s order for Resident #291 ' s Paxil. A phone interview was conducted with the facility ' s Director of Clinical Standards on 5/2/19 at 9:30 AM. She confirmed that based on Resident #291 ' s physician ' s orders, he was ordered Paxil for depression. An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 9:40 AM. The physician ' s order dated 4/9/19 for Resident #291 that indicated Paxil 20 mg once daily was reviewed with the DON. The DON verified that a telephone order was received on 4/9/19 that indicated the Paxil 20 mg once daily was related to a diagnosis of depression for Resident #291. A follow up interview was conducted with the DON on 5/2/19 at 10:25 AM. He indicated he expected the MDS to be coded accurately. 1c. Resident #291 was admitted to the facility on 4/9/19 with diagnoses that included Alzheimer ' s disease and dementia. A comprehensive nursing assessment dated 4/9/19 indicated Resident #291 only responded when spoken to with an elevated voice near his ear. A nursing note dated 4/10/19 stated that Resident #291 was mainly non-verbal, but when asked his name he had a delayed, slow response of "I don ' t know". A Social Worker (SW) note dated 4/16/19 indicated he had attempted the Brief Interview for Mental Status (BIMS) with Resident #291, but he was unable to be roused. The SW indicated that	F 641	Service Director attempted to interview the resident and was unsuccessful and documented his attempts in a social service progress note and proceeded to the staff assessment. Surveyor observation of the resident during the survey period in May of 2019 should not be an indicator of resident performance/ability three months prior. The medical record for Resident #96 was reviewed by the CRM and Director of Social Services for communication during the assessment reference period. The resident had no communication documented during that time. The nurse's note date 3/4/19 is not reflective of resident performance during the reference period or during the resident interview attempt by the Director of Social Services. Additionally, while outside the reference period, there is no context in the nursing note to the "yes" or "no" responses to determine if the resident was capable of communicating concrete requests. Corrective Action Resident #291 Minimum Data Set (MDS) from 4/12/19 was modified by the CRM on or before 5/30/19. Modification of MDS included changing antipsychotic medication from being administered on a routine basis only to being administered on an as needed (PRN) basis and added the diagnosis of depression. Residents #66, #96 and #291 will be assessed by the interdisciplinary team for ability to complete resident interviews on	

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F 641	Continued From page 12 staff reported Resident #291 had been heard to make clear statements at times, but he was observed with no verbal communication on 4/16/19. An activity/therapeutic recreation assessment dated 4/17/19 indicated Resident #291 was sometimes understood and that he had clear speech with distinct intelligible words. The admission Minimum Data Set (MDS) assessment dated 4/17/19 indicated Resident #291 was not in a persistent vegetative state. Section C, the Cognitive Patterns section, was coded to indicate Resident #291 was rarely/never understood and that a Brief Interview for Mental Status (BIMS) was not conducted. The cognitive loss Care Area Assessment (CAA) for Resident #291 ' s 4/17/19 MDS indicated Resident #291 had been heard by staff to make clear statements, such as, "There goes my blonde". An interview was conducted with the SW on 4/30/19 at 4:05 PM. The 4/17/19 MDS for Resident #291 that indicated the BIMS was not conducted for this resident because he was rarely/never understood was reviewed with the SW. The SW revealed that he was aware Resident #291 had some speech at times. He further revealed that he had attempted the BIMS for Resident #291 ' s 4/17/19 MDS assessment but had coded the MDS to indicate that the BIMS was not attempted. A phone interview was conducted with the facility ' s Director of Clinical Standards on 5/2/19 at 9:30 AM. She stated that she had reviewed the	F 641	or before 5/30/19 and updated MDSs will be completed if the residents are found to be currently interviewable. All current residents' coded with antipsychotic mediation use will be reviewed and corrected for MDS accuracy on or before 5/30/19 by the CRM and MDS Coordinators. All current residents' receiving antidepressant mediations will be reviewed to determine if medication is for the diagnosis of depression to verify accuracy of diagnosis in MDS on or before 5/30/19 by the CRM and MDS Coordinators. All residents with coding in B0700 reflective of rarely or never understood (coded "3") will be reviewed by the interdisciplinary team to determine if the resident is currently interviewable on or before 5/30/19 and updated MDSs completed if warranted. System change The MDS Coordinators will be re-educated by the CRM on accuracy of coding MDS on Section I Active Diagnosis and Section N Medications on or before 5/30/19. The Social Workers will be re-educated by the CRM on accuracy of coding MDS on Section B Speech, Section C Cognitive Pattern, and Section D Mood on or before 5/30/19.	

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F 641	Continued From page 13 medical record for Resident #291 as well as the 4/17/19 MDS. She stated that the SW had attempted to complete the BIMS with Resident #291, but he had inaccurately coded the MDS to indicate the BIMS was not attempted. An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He indicated he expected the MDS to be coded accurately. 2. Resident #66 was admitted to the facility on 4/9/19 with diagnoses that included dementia. A nursing note dated 2/20/19 indicated Resident #66 was able to answer yes and no questions at times, but due to cognitive impairment her speech was difficult to understand. A Social Worker (SW) note dated 2/20/19 indicated he had attempted the Brief Interview for Mental Status (BIMS) with Resident #66, but she was unable to complete the interview. The SW wrote that Resident #66 spoke in broken English and Spanish, but she was unable to speak in complete sentences. The quarterly Minimum Data Set (MDS) assessment dated 2/20/19 indicated Resident #66 was not in a persistent vegetative state. Section C, the Cognitive Patterns section, was coded to indicate Resident #66 was rarely/never understood and that a Brief Interview for Mental Status (BIMS) was not conducted. An interview was conducted with Nurse #2 on 5/1/19 at 11:50 AM. She reported that Resident #66 spoke in broken English and Spanish, but that she was difficult to understand at times.	F 641	Monitoring The CRM will randomly audit eight MDS's for accuracy of coding in Sections B, C, D, I, and N weekly for one month, then four MDS's weekly for two months until substantial compliance is achieved. The CRM will report trends, findings, and corrective measures of these audits to the MD-QAPI Sub-Committee weekly for review and recommendations until substantial compliance is achieved or as directed by the MD-QAPI Committee. The CRM is responsible for attaining and sustaining compliance. The facility alleges compliance effective 5/30/19.	

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During this interview, Resident #66 was observed to approach Nurse #2 and state the Spanish word "abuela" in clear distinguishable speech.

An interview was conducted with the SW on 5/1/19 at 12:10 PM. The 2/20/19 MDS for Resident #66 that indicated the BIMS was not conducted for this resident because she was rarely/never understood was reviewed with the SW. The SW revealed that he was aware Resident #66 had some speech at times. He further revealed that he had attempted the BIMS for Resident #66 ' s 2/20/19 MDS assessment but had coded the MDS to indicate that the BIMS was not attempted.

An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He indicated he expected the MDS to be coded accurately.

3. Resident #96 was admitted to the facility on 8/25/15 and most recently readmitted on 3/1/19 with diagnoses that included dementia.

A nursing note dated 3/4/19 indicated Resident #96 was alert and was answering yes and no questions.

A nursing note dated 3/11/19 indicated Resident #96 was humming continuously and stated "Oh" after administering his medications.

The quarterly Minimum Data Set (MDS) assessment dated 3/19/19 indicated Resident #96 was not in a persistent vegetative state. Section C, the Cognitive Patterns section, was coded to indicate Resident #96 was rarely/never understood and a Brief Interview for Mental

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F 641	Continued From page 15 Status (BIMS) was not conducted. An interview was conducted with the SW on 5/1/19 at 12:10 PM. The 3/19/19 MDS for Resident #96 that indicated the BIMS was not conducted for this resident because he was rarely/never understood was reviewed with the SW. The SW revealed that he was aware Resident #96 had minimal speech at times. He further revealed that he had attempted the BIMS for Resident #96 ' s 3/19/19 MDS assessment but had coded the MDS to indicate that the BIMS was not attempted. An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He indicated he expected the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		5/30/19

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F 656	Continued From page 16 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and family interviews, the facility failed to develop a comprehensive care plan for new diagnosis (Resident #100), skin condition (Resident #130), and range of motion and splinting (Resident #53) for 3 of 29 residents reviewed. Findings included: 1. Resident #100 was admitted to the facility 9/23/16 with diagnoses of nutritional anemia, iron deficiency, and acute embolism and thrombosis. A review of Resident #100 ' s care plan initiated	F 656	F656 Identification St. Joseph of the Pines does develop a comprehensive care for new diagnosis, skin conditions, range of motion, and splinting. Corrective Action Resident #100 care plan has been updated to reflect status of anti-coagulant therapy related to pulmonary embolism by the CRM on or before 5/30/19. Resident #130 care plan has been	

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F 656	Continued From page 17 on 10/17/18 and updated on 3/19/19 did not revealed a problem, goal or intervention for pulmonary embolism, anti-coagulant complication, and/or gastrointestinal bleed. A review of Resident #100 ' s physician order dated 2/21/19 for a complete blood count and to check stool for occult blood. A review of Resident #100 ' s physician monthly order dated 3/1/19 revealed ferrous sulfate 325 mg three times a day (for anemia). Resident #100 ' s lab results dated 3/4/19 revealed anemia and positive for blood in the stool. A review of Resident #100 ' s nursing note reveled she returned on 3/19/19 from the hospital for treatment for a pulmonary embolism. Resident #100 ' s nursing note dated 3/20/19 revealed "put note on the doctor's order for him to review conversation with husband and resident yesterday and their refusal stating there is nothing more they want to do" (with the gastroenterologist). Nurses ' note dated 3/21/19 documented the resident ' s spouse informed nursing that the "gastrointestinal consultant felt any workup would be too risky" (for gastrointestinal bleed). A review of Resident #100 ' s comprehensive Minimum Data Set (MDS) dated 3/23/19 revealed the resident was readmitted from the hospital. The resident had highly impaired vision. The resident had moderately impaired cognition. The resident required extensive assistance of 2 staff for bed mobility and transfer and toilet use and of	F 656	updated to reflect status of malignant melanoma masses by the CRM on or before 5/30/19. Resident #53 care plan has been updated to reflect status of hand contracture requiring range of motion (ROM) and splinting along with resident refusal of placement of splint application by the CRM or MDS Coordinator on or before 5/30/19. All current residents' receiving anticoagulant medication, have melanomas, or receiving restorative ROM and splinting will be reviewed and corrected for care plan accuracy on or before 5/30/19 by the CRM or MDS Coordinators. System Changes The Clinical Care Coordinators (CCC) will be re-educated by the CRM on initiating and accurately care planning residents receiving anticoagulant medications, skin conditions, and restorative programs on or before 5/30/19. Monitoring The Director of Nursing (DON), CRM, and/ or MDS Coordinators will randomly audit six care plans for accuracy weekly for one month, then three care plans weekly for two months until regulatory compliance is achieved. The DON will report trends, findings, and corrective measures of these audits to the MD-QAPI Sub-Committee weekly for	

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F 656	Continued From page 18 1 staff for locomotion and dressing. The active diagnoses were anemia and deep vein thrombosis. On 4/30/19 an interview was conducted with Resident #100 ' s family member who stated that the resident had a history of gastrointestinal bleeding from anticoagulant. The resident had a recent pulmonary embolism and anemia from blood loss. On 5/2/19 at 9:30 am an interview was conducted with MDS Nurse #1 who stated that the new diagnosis for Resident #1 was missed and not added to her care plan. On 5/2/19 at 10:00 am an interview was conducted with the Director of Nursing who stated he expected staff to develop an individualized care plan to meet the needs of each resident. 2) Resident #130 was admitted to the facility on 3/27/19 with diagnoses that included malignant melanoma to the face, chronic kidney disease and Chronic Obstructive Pulmonary Disease (COPD). The hospital history and physical dated 3/14/19 stated Resident #130's facial melanoma was the polypoid exophytic (a raised outward growing lesion) variation of the nodular form which was pedunculated (had formed a mass) to the left side of her neck and forehead. A review of the resident's active care plan dated 3/27/19 revealed there was a problem area for having a pressure ulcer to the sacrum that was present on admission as well as being at risk for	F 656	review and recommendations until regulatory compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 5/30/19.	

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skin breakdown related to fragility, Diabetes and decline in mobility. There was no care plan in place for the malignant melanoma masses present to Resident 130's face and neck.

The Minimum Data Set (MDS) coded as an admission assessment and dated 4/3/19 indicated Resident #130 was cognitively intact. On the Active Diagnoses portion of the MDS she was coded for cancer as well as malignant melanoma of an unspecified part of the face.

The Care Area Assessment (CAA) Summary dated 4/8/19 indicated the resident had skin cancer to her face.

On 4/29/19 at 9:50am, an interview was conducted with Resident #130. She explained that the large malignant melanoma masses to the left side of her neck and forehead had been there for many years and were unable to be removed. She further stated the masses were painful to the touch especially during bathing and hair care.

During an interview with MDS Nurse #2 on 5/1/19 at 9:25am, she indicated it was an oversight not to have included the malignant melanoma masses to the resident's face and neck on the care plan.

An interview occurred with the Director of Nursing on 5/2/19 at 10:24am. He stated it was his expectation for the care plan to be comprehensive and patient centered.
3. Resident #53 was admitted 5/4/16 with cumulative diagnoses of Hemiplegia, Dysphagia and Neurogenic Bladder.

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Review of an Occupational Therapy (OT) Discharge Summary dated 5/10/18 read the nursing staff were educated on the proper application of his left-hand splint and scheduling.

Review of a Restorative Care Referral dated 5/22/18 completed by the Occupational Therapist read Resident #53 was to receive range of motion (ROM) to his left-hand contracture prior to the application of his left-hand splint for 8 hours daily 7 days a week.

Review of Resident #53 Significant Change Minimum Data Set (MDS) dated 2/8/19 indicated he exhibited impairment on one side upper extremity and one side lower extremity.

Review of Resident #53 comprehensive care plan revised 2/14/19 did not include the problem of a left-hand contracture requiring ROM and splinting.

Review of the facility electric medical record from 4/1/19 to 4/30/19 indicated Resident #53 was receiving his ROM and splinting at night with 7 refusals.

In an interview w on 4/30/19 at 2:15 PM, Nursing Assistant (NA) #1 stated when he came in at 6:00 AM, he removed the left-hand splint off Resident #53's left hand on the mornings it was on him.

In a telephone interview on 4/30/19 at 4:30 PM, NA #2 stated she applied Resident #53 left-hand splint when she came in at 10:00 PM nightly. She further stated Resident #53 had a history of refusing his left-hand splint. NA #2 stated when he refused the splint, she documented his refusal in the electronic medical record.

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F 656	Continued From page 21 In an interview on 5/1/19 at 8:00 AM, the Administrator stated it was his expectation that Resident #53's left-hand contracture with orders for ROM and splinting be included on his comprehensive care plan to also include his pattern of refusing the left-hand splint. In an interview on 5/2/19 at 9:20 AM, MDS Nurse #1 stated Resident #53's left-hand contracture, left-hand ROM and splinting as well as his refusal should be indicated on his care plan. She stated it was an oversight. In a telephone interview on 5/2/19 at 9:30 AM, the Director of Clinical Standards and Practice stated it was her expectation that Resident #53's left-hand contracture, left-hand ROM and splinting as well as his refusal should be indicated on his care plan. She agreed that it was an oversight. In an interview on 5/2/19 at 10:24 AM, the Director of Nursing stated it was his expectation that Resident #53's left-hand contracture, left-hand ROM and splinting as well as his refusal should be indicated on his care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		5/30/19

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F 657	Continued From page 22 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise a comprehensive care plan for psychotropic medications for 1 (Resident #24) of 2 residents reviewed for behaviors. The findings included: Resident #24 was admitted to the facility on 5/19/17 with cumulative diagnoses of Alzheimer's Disease, Vascular Dementia and Psychosis. Review of Resident #24's January 2019 cumulative physician orders indicated his antipsychotic medication was discontinued on 1/8/19 and he was prescribed an antianxiety medication on 1/14/19. Resident #24's Significant Change Minimum Data Set (MDS) dated 1/19/19 indicated he was	F 657	F657 Identification St. Joseph of the Pines does revise comprehensive care plans for psychotropic medications. Corrective Action Resident #24 care plan has been updated to reflect status of discontinued antipsychotic medication and the addition of an antianxiety medication by the CRM on or before 5/30/19. All current residents' receiving psychotropic mediations care plans reviewed and corrected for accuracy on or before 5/30/19 by the CRM and MDS Coordinators.	

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F 657	Continued From page 23 severely cognitively impaired and exhibited verbal behaviors. He was coded for taking antianxiety and antidepressant medications. Review of Resident #24's comprehensive care plan dated revised 1/23/19 read he was at risk for side effects from the psychoactive medications including antidepressants and antipsychotics. There was no mention of the use of antianxiety medications. In an interview on 5/1/19 at 2:55 PM, MDS Nurse #1 stated every morning she received the yellow copy of any new or discontinued physician orders. It was at time, she would revise the care plan for any resident needed. She stated it was an oversight that she missed the discontinuation of Resident #24's antipsychotic on 1/8/19 and the addition of an antianxiety medication on 1/14/19. In an interview on 5/1/19 at 3:30 PM, the Administrator confirmed the process for revising Resident #24's care plan and stated the discontinuation of his antipsychotic medication and addition of his antianxiety medication in January 2019 should have been captured on his revised care plan. The Administrator stated it was his expectation that Resident #24's care plan for psychotropic medications should have been revised to reflect his medication changes. In a telephone interview on 5/2/19 at 9:30 AM, the Director of Clinical Standards and Practice stated it was her expectation that Resident #24's care plan was revised to reflect the discontinuation of an antipsychotic medication and the addition of an antianxiety medication.	F 657	System Changes The CCC's will be re-educated by the CRM on revising and accurately care planning residents receiving psychotropic medications on or before 5/30/19. Monitoring The DON, CRM, and/ or MDS Coordinators will randomly audit two care plans of residents receiving psychotropic medications for accuracy weekly for three months until regulatory compliance is achieved. The DON will report trends, findings, and corrective measures of these audits to the MD-QAPI Sub-Committee weekly for review and recommendations until regulatory compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 5/30/19.	
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		5/30/19

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F 758 SS=E	Continued From page 24 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 25 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the physician, Psychiatric Nurse Practitioner (PNP), Pharmacy Consultant, and staff, the facility failed to have an adequate clinical indication for the use of antipsychotic medication (Residents #83 and #291), failed to complete an Abnormal Involuntary Movement Scale (AIMS) test (used to assess for extrapyramidal symptoms for residents receiving antipsychotic medication) prior to the administration of an antipsychotic medication (Resident #291), and failed to ensure as needed (PRN) psychotropic medications were time limited in duration (Residents #43 and #291). This was for 3 of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #83 was initially admitted to the facility on 3/21/18 and most recently readmitted on 9/10/18 with multiple diagnoses that included Alzheimer ' s disease, dementia, and anxiety. A physician ' s order dated 3/21/18 indicated Seroquel (antipsychotic medication) 12.5 milligrams (mg) at rising and 25 mg at bed for	F 758	F758 Identification St. Joseph of the Pines does provide adequate clinical indication, assessment, and time appropriate limitations for the use of antipsychotic medication. Corrective Action Resident #83 has undergone a gradual dose reduction (GDR) trial as ordered by the primary physician or Psychiatric Nurse Practitioner (PNP) of the prescribed antipsychotic medication on or before 5/30/19. Resident #291 has an Abnormal Involuntary Movement Scale (AIMS) test completed by the CCC on or before 5/30/19. Resident #291 as needed antipsychotic medication was discontinued as ordered by the primary physician or PNP on or before 5/30/19. Resident #43 antianxiety medication every one hour as needed was discontinued as	

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F 758	Continued From page 26 Resident #83. The plan of care for Resident #83, effective on 4/2/18, included, in part, the problem area of behaviors noted as yelling out, resisting care, throwing dentures accords the room, removing clothing, and being combative. The interventions included, in part, record behaviors on behavior tracking form and monitor pattern of behavior (time of day, precipitating factors, specific staff or situations). A pharmacy recommendation dated 4/9/18 indicated Resident #83 was admitted with an order for Seroquel 12.5 mg at rising and 25mg at bed for dementia with no history of Seroquel utilized as a home medication in the hospital records. The recommendation was to attempt a Gradual Dose Reduction (GDR) of Seroquel with the goal of discontinuation. The pharmacy recommendation additionally requested that if antipsychotic therapy was to continue, that the physician provide detailed documentation of: 1. Specific diagnosis/indication requiring treatment 2. Symptom criteria/target behaviors 3. Facility interdisciplinary team should ensure ongoing monitoring of specific target behaviors and document a) whether danger to self or others, b) desired outcome(s), c) the efficacy of individualized, nonpharmacological approaches, and d) potential adverse consequences This recommendation was marked as accepted and was signed by Resident #83 ' s physician on 4/30/18 and a GDR of Seroquel was to be completed. There was no additional documentation on this pharmacy recommendation by Resident #83 ' s physician.	F 758	ordered by the primary physician on or before 5/30/19. All current residents with psychotropic medication orders will be evaluated by the DON or clinical supervisors to ensure psychotropic orders have specific condition diagnosis and documented in the clinical record on or before 5/30/19. All current residents receiving psychotropic medications will be reviewed and corrected for AIMS assessment by the DON or clinical supervisors on or before 5/30/19. All current residents with psychotropic medication orders as needed will be evaluated by the DON or clinical supervisors to ensure psychotropic orders are limited to 14 days or that the attending physician has appropriate documentation for extending the medication beyond 14 days and the duration is indicated on or before 5/30/19. System Changes The DON or Staff Development Coordinator (SDC) will educate actively working licensed nurses and attending physicians on requirements of F758 on or before 5/30/19. Licensed nurses not receiving re-education by 5/30/19 will be re-educated by DON, CCC, Nursing Supervisors or Team Leaders when working on next scheduled workday. The CCC's will be re-educated by the CRM on the completion of AIMS	

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F 758	Continued From page 27 A physician ' s order dated 5/2/18 indicated a discontinuation of Resident #83 ' s Seroquel 12.5 mg at rising and a decrease in the 25 mg at bed to 12.5 mg at bed. The quarterly Minimum Data Set (MDS) assessment dated 6/24/18 indicated Resident #83 ' s cognition was severely impaired. She had no mood issues, no potential indicators of psychosis, no behaviors, and no rejection of care. Resident #83 was administered antipsychotic medication on 7 of 7 days, she received antipsychotic medications on a routine basis only, and the date of her last GDR was 5/2/18. There was no physician documentation that a GDR was clinically contraindicated for Resident #83. A Psychiatric Nurse Practitioner (PNP) note dated 8/14/18 indicated Resident #83 was on a very low dose of Seroquel (12.5 mg at bed) for behaviors and the family ' s request to continue the medication. The PNP noted Resident #83 ' s presentation as energetic and smiling with no symptoms of anxiety and no interference with Activities of Daily Living (ADLs). She wrote that she would discontinue Seroquel at some point, with family support. Resident #83 was discharged to the hospital on 9/5/18 following a fall resulting in injury. She was readmitted on 9/10/18. The hospital discharge summary dated 9/10/18 included a physician ' s order for Seroquel 12.5 mg daily and 25 mg at night. This was an increase in the Seroquel dosage she was on when she was admitted to the hospital on 9/5/18. At that time, she was on Seroquel 12.5 mg at bed.	F 758	assessment on or before 5/30/19. Monitoring The DON or clinical supervisor will review orders of four residents per week for four weeks, then two residents per week for eight weeks until regulatory compliance is achieved, to ensure psychotropic orders have specific condition diagnosed and documented in the clinical record and if medication is ordered as needed are limited to 14 days or that the attending physician has appropriate documentation for extending the medication beyond 14 days and the duration is indicated. The DON, SDC or MDS Coordinators will audit all residents receiving a newly prescribed psychotropic medication for AIMS assessment completion weekly for one month and then monthly for two months until regulatory compliance is achieved. The DON will report trends, findings, and corrective measures of these audits to the MD-QAPI Sub-Committee weekly for review and recommendations until regulatory compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 5/30/19.	

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A PNP note dated 9/11/18 indicated Resident #83 was on Seroquel with no chart diagnosis of psychotic disorder and that this medication had been increased by the hospital on discharge (9/10/18). The PNP wrote that she would GDR Seroquel for no supporting diagnosis and no reports of Auditory Verbal Hallucinations (AVH). Medication orders by the PNP indicated to discontinue Seroquel 12.5 mg once daily.

A physician ' s order dated 9/11/18 indicated a discontinuation of Seroquel 12.5 mg once daily for Resident #83. She remained on 25 mg of Seroquel at night.

A Social Worker (SW) note dated 9/13/18 indicated Resident was alert and oriented to self only. She was noted to be an exit seeker but was easily redirected. Resident #83 had a recent fall with injury to her leg and subsequent pain that caused her yell out and refuse ADL care when the leg was moved.

The significant change MDS dated 9/17/18 indicated Resident #83 ' s cognition was severely impaired. She had no mood issues and no potential indicators of psychosis. Resident #83 had verbal behaviors on 1 to 3 days and rejection of care on 1 to 3 days. She was on PRN (as needed) pain medications and was noted with vocal complaints of pain and/or facial expressions indicating possible pain on 3 to 4 days during the 5-day MDS look back period. Resident #83 was administered opioid medication and antipsychotic medication on 7 of 7 days. Antipsychotic medications were received on a routine basis only and there was no physician documentation that a GDR was clinically contraindicated for Resident #83.

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A PNP note dated 9/25/18 indicated Resident #83 was on Seroquel for behaviors with no supporting diagnosis. Resident #83 was witnessed with no symptoms of anxiety and staff had reported that she had both good and bad days. The PNP indicated she deferred a further GDR of Seroquel at this time.

A review of the behavior monitoring flow record for September 2018 indicated Resident #83 was monitored for the behaviors of yelling and resisting care. She was documented with one episode of yelling (9/29/18) and one episode of resisting care (9/13/18).

A PNP note dated 10/16/18 indicated Resident #83 was on a low dose of Seroquel for behaviors. The PNP wrote that the low dose of Seroquel was a recently reinstated dose due to a GDR fail. (Based on the medical record, there was no evidence of GDR fail of Seroquel). This PNP note also indicated that Resident #83 had no witnessed anxiety and that staff reported no concerns.

A nursing note dated 10/22/18 at 3:30 PM indicated Resident #83 was self-propelling her wheelchair around the unit and yelling at others who walked by. She entered another resident ' s room and became more agitated when staff attempted to approach her.

A nursing note dated 10/22/18 at 6:33 PM indicated Resident #83 continued to yell out and when asked if she was in pain she replied yes. PRN pain medication was provided.

A nursing note dated 10/29/18 indicated Resident

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#83 yelled out frequently and when asked if she was in pain she confirmed she was.

A nursing note dated 10/30/18 indicated Resident #83 was frequently yelling at staff, "leave me alone, can ' t you see I ' m hurting". Her PRN pain medication was administered.

A review of the behavior monitoring flow record for October 2018 indicated Resident #83 was monitored for the behaviors of yelling and resisting care. She was documented with two episodes of yelling (10/30/18 x2) and no episodes of resisting care.

A pharmacy recommendation dated 11/5/18 indicated Resident #83 had noted pain per nursing documentation when she was exhibiting behaviors. She had no routine pain therapy in place. Resident #83 was noted with Seroquel and the pharmacy consultant wrote, "Please note surveyors may consider inappropriate use of antipsychotic if resident ' s behaviors are related to pain". The recommendation was to re-evaluate to determine if routine pain medication could be started for Resident #83. The physician indicated on this form that Resident #83 was okay on Seroquel and no routine pain medications. The form was signed by Resident #83 ' s physician on 12/20/18.

A nursing note dated 11/12/18 indicated Resident #83 began to sundown around 3:00 PM and was noted to yell out at staff and at other residents. Resident #83 ' s family had reported that she could be pain when she exhibited this behavior. She had PRN pain medication which was effective.

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A PNP note dated 11/13/18 indicated Resident #83 was on a low dose of Seroquel for behaviors. The PNP again wrote that the low dose of Seroquel was a recently reinstated dose due to a GDR fail. (Based on the medical record, there was no evidence of GDR fail of Seroquel). Staff reported Resident #83 had been without sleep for 24 hours. Trazodone (antidepressant) was to be initiated for sleep and Seroquel was to be changed from 25 mg at bed to 25 mg at morning.

A physician ' s order dated 11/13/18 indicated to change in Seroquel 25 mg at bed to 25 mg at morning for Resident #83.

A nursing note dated 11/19/18 indicated Resident #83 was self-propelling her wheelchair around the unit and was "meowing like a cat". She continued to yell out frequently and ignore staff when she was spoken to.

A nursing note dated 11/20/18 indicated Resident #83 continued to remove her clothing in the common area. She attempted to stand up unassisted and stated, "I ' ll just fall and go to the hospital".

A PNP note dated 11/27/18 indicated Resident #83 was on a low dose of Seroquel for behaviors. The PNP again wrote that the low dose of Seroquel was a recently reinstated dose due to a GDR fail. (Based on the medical record, there was no evidence of GDR fail of Seroquel). Resident #83 ' s presentation was described as calm and cooperative, mood was stable, and sleep and appetite were reported to be adequate. The staff reported no concerns.

A review of the behavior monitoring flow record

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for November 2018 indicated Resident #83 was monitored for the behaviors of yelling out and resisting care. She was documented with five episodes of yelling out (11/2/18 x 2 and 11/8/18 x 3) and 7 episodes of resisting care (11/19/18 x 3, 11/20/18 x 2, and 11/21/18 x 2).

A nursing note dated 12/7/18 indicated Resident #83 was noted to be very combative and using profanity at staff.

A SW note dated 12/17/18 indicated Resident #83 could become easily agitated and combative both verbally and physically. She had exit seeking behaviors and entered other resident ' s rooms looking for her mother or father. Staff reported she refused care at times and was combative with ADL care.

A PNP note dated 12/28/18 indicated Resident #28 was on a low dose of Seroquel for behaviors and staff reported this was beneficial for delusions.

A review of the behavior monitoring flow record for December 2018 indicated Resident #83 was monitored for the behaviors of yelling out, resisting care, and sleeplessness. She was documented with two episodes of yelling out (12/10/18 x2) and no episodes of resisting care or sleeplessness.

A nursing note dated 1/7/19 indicated Resident #83 began to sundown around 3:00 PM and was noted to yell out at staff and at other residents. Resident #83 ' s family had reported that she could be pain when she exhibited these behaviors. She had an order for PRN pain medication which was effective.

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A PNP note dated 1/29/19 indicated staff reported no recent behaviors or concerns for Resident #83. The PNP recommended to taper and discontinue Seroquel if Resident #83 remained stable. She advised staff to consider her behaviors as consistent with dementia.

A review of the behavior monitoring flow record for January 2019 indicated Resident #83 was monitored for the behaviors of loss of interest in eating, paranoia, and insomnia. She was documented with no episodes of any of these behaviors.

A nursing note dated 2/1/19 indicated Resident #83 was reportedly awake all night. She was cooperative with taking her medications but refused her laboratory draw. During breakfast Resident #83 was taking other residents ' plates and when redirected she threw them on the floor.

A nursing note dated 2/13/19 indicated Resident #83 began to sundown around 3:00 PM and was noted to yell out at staff and at other residents. Resident #83 ' s family had reported that she could be pain when she exhibited these behaviors. She had an order for PRN pain medication which was effective.

A nursing note dated 2/17/19 indicated Resident #83 was having outbursts of yelling at staff, using profanity, and taking items from other residents.

A nursing note dated 2/19/19 indicated Resident #83 was picking up dining room chairs off the floor and carrying them around by way of her wheelchair. Redirection was attempted, and her PRN pain medication was offered, and she spit it

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(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
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on the floor.

A PNP note dated 2/26/19 indicated Resident #83 was on low dose of Seroquel for behaviors. Staff reported a disturbed sleep pattern and intermittent irritability. A medication adjustment was made with Resident #83 ' s Trazodone prescribed for sleep.

A review of the behavior monitoring flow record for February 2019 indicated Resident #83 was monitored for the behaviors of loss of interest in eating and paranoia. She was documented with no episodes of loss of interest in eating and 9 episodes of paranoia (2/14/19 x 2, 2/19/19 x 2, 2/20/19 x 4, and 2/21/19 x 1).

A nursing note dated 3/4/19 (entered as late entry note on 3/6/19) indicated Resident #83 refused to go to sleep and she talked continuously to anyone and everyone. Redirection was noted to be effective for a short period of time.

A PNP note dated 3/12/19 indicated Resident #83 was on a low dose of Seroquel for behaviors. A recent dose increase in Trazodone for sleep had showed no obvious changes per staff report. Resident #83 was observed by the PNP to be calm, pleasantly confused, and in no distress.

A review of the behavior monitoring flow record for March 2019 indicated Resident #83 was monitored for the behaviors of loss of interest in eating and paranoia. She was documented with no episodes of these behaviors.

A nursing note dated 4/9/19 indicated Resident #83 began to sundown around 3:00 PM and was noted to yell out at staff and at other residents.

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Resident #83 ' s family had reported that she could be pain when she exhibited these behaviors. She had an order for PRN pain medication which was effective.

A PNP note dated 4/9/19 indicated Resident #83 was on a low dose of Seroquel prescribed by her primary care physician for behaviors. Resident #83 was noted to be calm with a witnessed stable mood.

A review of the behavior monitoring flow record for April 2019 indicated Resident #83 was monitored for the behaviors of loss of interest and paranoia. She was documented with no episodes of loss of interest and 4 episodes of paranoia (4/1/19 x 2 and 4/2/19 x 2).

An observation was conducted of Resident #83 on 4/29/18 at 12:20 PM. Resident #83 was observed eating her lunch in the dining room of the secured memory care unit. At the completion of her meal she picked up her plate and began self-propelling her wheelchair out of the dining room as she carried her plate. Staff attempted to redirect Resident #83 and to take the plate from her. Resident #83 yelled "no, no" to the staff and she had not let go of the plate. Staff proceeded to let Resident #83 leave the dining room area and she had no further behaviors observed at this time.

An interview was conducted with Nurse #2 on 5/1/19 at 10:35 AM. She reported that she was very familiar with Resident #83 and that she had worked with her since her admission to the facility. She indicated that Resident #83 had behaviors that included yelling out, refusing care, standing up without assistance, and exit seeking.

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She stated that the behaviors seemed to worsen in the afternoon with sundowning. Nurse #2 also indicated that she believed some of Resident #83 ' s behaviors were related to pain that the resident was unable to express. She reported that Resident #83 was on Seroquel since her admission to the facility and that the family reported she was on it in the past. She stated that she had witnessed no disturbing delusions or AVH for Resident #83.

An interview was conducted with the Pharmacy Consultant on 5/2/19 at 8:25 AM. The pharmacy recommendation dated 11/5/18 that indicated Resident #83 had noted pain per nursing documentation when she was exhibiting behaviors was reviewed with the Pharmacy Consultant. She reported that based on her review of the nursing notes, Resident #83 ' s behaviors were related to pain. She stated that the only place she saw a mention of delusions was in the PNP notes.

A phone interview was conducted with the PNP on 5/1/19 at 2:45 PM. The PNP was asked what the clinical indication for Resident #83 ' s Seroquel was. She reported that from her recollection, Resident #83 had no known history of a true psychiatric disorder requiring antipsychotic medication. She stated that Resident #83 was on Seroquel when she first began treating her and that she had not initiated the order. The PNP explained that she normally did not initiate an antipsychotic medication for a diagnosis of dementia unless the resident was having disturbing delusions and an SSRI (Selective serotonin reuptake inhibitor)/SNRI (Serotonin and norepinephrine reuptake inhibitor), and a mood stabilizing medication had been

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attempted and unsuccessful. She further explained that an example of a disturbing delusion was seeing snakes in their food causing the resident not to eat. She reported that to her knowledge Resident #83 had some delusions, but they were not disturbing delusions and that her behaviors were typical for a resident with dementia. The PNP stated that Resident #83 ' s family and the facility were resistant to discontinuing the Seroquel.

A phone interview was conducted with Resident #83 ' s physician on 5/2/19 at 10:05 AM. The physician was asked what the clinical indication for Resident #83 ' s Seroquel was. He reported that he believed this was for behavior modification. He indicated that Resident #83 was impulsive which put her at a safety risk and that she had a history of falls with injury.
The pharmacy recommendation dated 11/5/18 that indicated Resident #83 had noted pain per nursing documentation when she was exhibiting behaviors was reviewed with the physician. He reported that he had no evidence that Resident #83 ' s pain correlated to her behaviors and that he thought it was completely unrelated. He stated that he talked to the nursing staff and depended on their interpretation of the behaviors.

An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He stated he expected all antipsychotics to have an adequate clinical indication for use.

2a. Resident #291 was admitted to the facility on 4/9/19 with diagnoses that included Alzheimer ' s disease and dementia.

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A physician ' s order for Resident #291 dated 4/9/19 indicated Haldol (antipsychotic medication) 5 milligrams (mg) as needed (PRN) twice daily. A review of Resident #291 ' s Medication Administration Record (MAR) for April 2019 indicated he was administered PRN Haldol one time on 4/12/19.

The admission Minimum Data Set (MDS) assessment dated 4/17/19 indicated Resident #291 had short term memory problems, long term memory problems, and severely impaired decision-making skills. He was administered antipsychotic medication on 1 of 7 days during the MDS look back period.

A review of the medical record revealed there was no AIMS (Abnormal Involuntary Movement Scale) test completed for Resident #291.

An interview was conducted with the Director of Nursing (DON) on 4/30/19 at 3:10 PM. He verified that there was no AIMS completed for Resident #291. He stated that he expected an AIMS to be conducted prior to the initiation of an antipsychotic medication.

2b. Resident #291 was admitted to the facility on 4/9/19 with diagnoses that included Alzheimer ' s disease and dementia.
A review of Resident #291 ' s admission documentation included a Psychiatric Nurse Practitioner (PNP) note dated 3/26/19 that indicated he was prescribed as needed (PRN) Haldol (antipsychotic medication) for agitation. She indicated that there was no supporting diagnosis for this Haldol and that Resident #291 ' s behaviors were typical for advanced dementia. The PNP noted that she was considering a

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discontinuation of Resident #291 ' s PRN Haldol. A physician ' s order for Resident #291 dated 4/9/19 indicated Haldol 5 milligrams (mg) PRN twice daily. There was no stop date for this PRN Haldol order.

A physician ' s note dated 4/10/19 indicated Resident #291 was on PRN Haldol and that he was going to follow up with psychiatric services to see if this Haldol could be discontinued.

A review of Resident #291 ' s Medication Administration Record (MAR) for April 2019 indicated he was administered PRN Haldol one time (4/12/19) since admission.

A review of Resident #291 ' s active physician ' s orders was conducted on 5/1/19. Resident #291 continued to have an active order for PRN Haldol with no stop date.

A phone interview was conducted with the PNP on 5/1/19 at 2:45 PM. The 3/26/19 PNP note for Resident #291 that indicated he was prescribed PRN Haldol with no supporting diagnosis was reviewed with the PNP. She stated that she was not the original prescriber of this PRN Haldol and she confirmed there was no supporting diagnosis. She additionally indicated that she was aware of the regulation for PRN antipsychotics to be limited to a 14-day duration. The PNP stated she would discontinue the PRN Haldol at her next visit with Resident #291.

An interview was conducted with Resident #291 ' s physician/the facility ' s Medical Director on 5/2/19 at 8:30 AM. The 4/9/19 physician ' s order for PRN Haldol with no stop date was reviewed with the physician. He reported that the PRN

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Haldol was in place for agitation and adjustment. He indicated he was aware of the regulation for PRN antipsychotics to be limited to a 14-day duration. He reported that the PRN Haldol should be discontinued as per the regulations.

An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He stated he expected all antipsychotics to have an adequate clinical indication for use and for PRN antipsychotic medication orders to be limited to a 14-day duration.

3. Resident #43 was admitted on 10/6/17 with the diagnoses of secondary malignant of bone, collapsed thoracic vertebrae, and anxiety

Resident #43 ' s physician order dated 1/4/19 revealed Ativan 0.5 mg every 1 hour as needed (second order since admission).

A review of the pharmacist ' s Medication Review Forms for Resident #43 dated 11/14/18, 2/4/19 and 4/2/19, the pharmacist recommended to discontinue psychotropic medication Ativan 0.5 mg every hour as needed, to provide stop date of 14 days or be evaluated every 14 days as required by State regulation. Physician #1 responded and declined the recommendation dated 4/15/19.

A review of Resident #43 ' s care plan created 11/21/18 and updated on 2/21/19 revealed the resident had bone cancer with Hospice services. There was pain management for bone cancer and Hospice (and staff) to provide comfort medications as ordered.

A review of the nurse practitioner notes for

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Resident #43 dated 1/10/19 and 3/14/19 revealed to continue Ativan 0.5 mg as needed, the resident was stable.

A review of Resident #43 ' s Medication Administration Record for January through April 2019 revealed there was no as needed Ativan 0.5 mg documented as being administered.

A review of Resident #43 ' s nurses' note dated 1/30/19 revealed the resident was alert to person only and able to make needs known.

On 5/1/19 at 9:30 am and 2:10 pm an observation was done of the resident in her bed sleeping. The resident looked comfortable. She was clean and without odor. The resident was not interviewed.

5/1/19 at 11:50 am an interview was conducted with Nurse #2 who stated that the resident was calm and alert on her current medication. Nurse #2 commented that the resident had not required as needed Ativan. The resident received Hospice services and had terminal/comfort care medications for pain and anxiety.

On 5/2/19 at 9:30 am an interview was conducted with Physician #1 via telephone who was the attending for Resident #43. Physician #1 stated that Ativan (for anxiety) 0.5 mg every 1 hour as needed was a terminal care medication and would not need a stop date. Physician #1 commented that he was aware of the pharmacist ' s medication reviews and recommendations. Physician #1 declined the recommendation, signed the form and did not provide a rationale. Physician #1 did not believe it was necessary to re-evaluate the Ativan (anti-psychotic) for a

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F 758	Continued From page 42 terminal resident. Physician #1 was aware of the 14-day stop date or re-evaluation, justification for use and reorder periodically for psychotropic medication that was required to be documented. On 5/2/19 at 11:00 am an interview was conducted with the Administrator who stated he expected all medical staff to provide a stop date and reorder according to regulation for all psychotropic medications.	F 758		
F 842 SS=D	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 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	F 842		5/30/19

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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.

§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.

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F 842	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on record review, interviews with the Psychiatric Nurse Practitioner and staff, the facility failed to have accurate medical records related to medications for 1 of 5 residents (Resident #83) reviewed for unnecessary medications. The findings included: Resident #83 was initially admitted to the facility on 3/21/18 and most recently readmitted on 9/10/18 with multiple diagnoses that included Alzheimer ' s disease, dementia, and anxiety. A physician ' s order dated 5/2/18 indicated a Gradual Dose Reduction (GDR) of Seroquel (antipsychotic medication) for Resident #83. Resident #83 ' s Seroquel 12.5 milligrams (mg) at rising was discontinued and Seroquel 25 mg at bed was decreased to 12.5 mg at bed. The Medication Administration Records (MARs) from 5/2/18 through 9/5/18 indicated Resident #83 was administered Seroquel 12.5 mg at bed as ordered. Resident #83 was discharged to the hospital on 9/5/18. She was readmitted on 9/10/18. The hospital discharge summary dated 9/10/18 included a physician ' s order for Seroquel 12.5 mg daily and 25 mg at night. This was an increase in the Seroquel dosage she was on when she was admitted to the hospital on 9/5/18. At that time, she was on Seroquel 12.5 mg at bed. A Psychiatric Nurse Practitioner (PNP) note dated	F 842	F842 Identification St. Joseph of the Pines does maintain accurate medical records. Corrective Action Resident #83 has undergone a correctly documented GDR trial as ordered by the primary physician or PNP of prescribed antipsychotic medication on or before 5/30/19. All consultant pharmacist recommendations received in May 2019 were reviewed by the DON to determine if pharmacist indicated any new GDR recommendations were ordered by physician and documented accurately on or before 5/30/19. All PNP consults received in May 2019 were reviewed by DON to determine if PNP indicated any recommended GDR's were completed and documented accurately on or before 5/30/19. System Changes The DON, Medical Records Director, or SDC will educate licensed pharmacist, attending physicians, and other prescribing providers on facility requirements of medical records on or before 5/30/19. Those not receiving education by 5/30/19 will be educated by DON, Medical Records Director, or SDC when working on next scheduled workday.	

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F 842	Continued From page 45 9/11/18 indicated Resident #83 was on Seroquel with no chart diagnosis of psychotic disorder and that this medication had been increased by the hospital on discharge (9/10/18). The PNP wrote that she would GDR Seroquel for no supporting diagnosis and no reports of Auditory Verbal Hallucinations (AVH). Medication orders by the PNP indicated to discontinue Seroquel 12.5 mg once daily. A physician ' s order dated 9/11/18 indicated a discontinuation of Seroquel 12.5 mg once daily for Resident #83. She remained on 25 mg of Seroquel at night. The significant change MDS dated 9/17/18 indicated Resident #83 ' s cognition was severely impaired. Resident #83 was administered antipsychotic medication on 7 of 7 days. Antipsychotic medications were received on a routine basis only and there was no physician documentation that a GDR was clinically contraindicated for Resident #83. A PNP note dated 10/16/18 indicated Resident #83 was on a low dose of Seroquel for behaviors. The PNP wrote that the low dose of Seroquel was a recently reinstated dose due to a GDR fail. Based on the medical record, there was no evidence of a GDR fail of Seroquel for Resident #83 that corresponded to the 10/16/19 PNP note. A pharmacy recommendation dated 11/5/18 indicated Resident #83 ' s Seroquel had been increased on 10/22/18. Based on the medical record, there was no evidence Resident #83 ' s Seroquel had been	F 842	Monitoring The DON or ADON will review 100% of consultant pharmacy recommendations for GDR after being signed by physician monthly for one month, then 50% for one month, and then 25% for one month until regulatory compliance is achieved, to ensure GDR are completed and documented accurately. The DON or ADON will review 100% of PNP consults for recommendations of GDR one month, then 50% for one month, and then 25% for one month until regulatory compliance is achieved, to ensure GDR are completed and documented accurately. The DON will report trends, findings, and corrective measures of these audits to the MD-QAPI Sub-Committee weekly for review and recommendations until regulatory compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 5/30/19.	

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increased on 10/22/18 as indicated in the 11/5/18 pharmacy recommendation.

A PNP note dated 11/13/18 indicated Resident #83 was on a low dose of Seroquel for behaviors. The PNP again wrote that the low dose of Seroquel was a recently reinstated dose due to a GDR fail.

Based on the medical record, there was no evidence of a GDR fail of Seroquel for Resident #83 that corresponded to the 11/13/18 PNP note.

A PNP note dated 11/27/18 indicated Resident #83 was on a low dose of Seroquel for behaviors. The PNP again wrote that the low dose of Seroquel was a recently reinstated dose due to a GDR fail.

Based on the medical record, there was no evidence of a GDR fail of Seroquel for Resident #83 that corresponded to the 11/27/18 PNP note.

An interview was conducted with the Administrator on 5/1/19 at 10:15 AM. Resident #83 ' s physician ' s orders and MARs from 9/1/18 through 11/30/18 were reviewed with the Administrator. The PNP notes dated 10/16/18, 11/13/18, and 11/27/18 that indicated Resident #83 failed a GDR of Seroquel were reviewed with the Administrator. The Administrator verified that there was no evidence in the medical record that Resident #83 had a failed a GDR of Seroquel that corresponded to the 10/16/18, 11/13/18, or 11/27/18 PNP notes. The 11/5/18 pharmacy recommendation that indicated Resident #83 ' s Seroquel had been increased on 10/22/18 was reviewed with the Administrator. The

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE 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 842	Continued From page 47 Administrator verified that Resident #83 ' s Seroquel was not increased on 10/22/18. He stated that his expectation was for the medical record to be accurate. A phone interview was conducted with the PNP on 5/1/19 at 2:45 PM. Resident #83 ' s physician ' s orders and Medication Administration Records from 9/1/18 through 11/30/18 were reviewed with the PNP. The PNP notes dated 10/16/18, 11/13/18, and 11/27/18 that indicated Resident #83 failed a GDR of Seroquel were reviewed with the PNP. The PNP stated that she couldn ' t recall why she had noted that Resident #83 had a GDR fail on her 10/16/18, 11/13/18, or 11/27/18 notes. An interview was conducted with the Director of Nursing (DON) on 5/2/19 at 10:25 AM. He stated he expected the medical records to be accurate.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and resident, staff, and physician interviews the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 3/18/18. This	F 867	F867 Identification St. Joseph of the Pines does maintain a Quality Assessment and Assurance (QAA) Committee that addressed and corrected specific instances identified in previous federal survey.	5/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE PINEHURST, NC 28374

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F 867	Continued From page 48 was for 2 deficiencies originally cited 3/18/18 and were subsequently recited on the current recertification survey of 5/2/19. The two recited deficiencies were in the areas of Minimum Data Set accuracy and psychotropic drug use. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to: 1.a F-641 Accuracy of Assessments: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set Assessment accurately in the areas of cognition (Residents #66, #96, and #291), medications (Resident #291), and active diagnoses (Resident #291) for 3 of 29 residents reviewed. During the prior survey of 3/18/18 the facility failed to have accurately coded the Minimum Data Set assessments in the areas of pressure ulcers (Resident #104), cognition (Resident #241), diagnosis (Resident #91), dental (Resident #108), and discharge location (Resident #191) for 5 of thirty-one 31 sampled residents. 1.b F-758 Psychotropic Drug Use: Based on record review, observation, and interviews with the physician, Psychiatric Nurse Practitioner, Pharmacy Consultant, and staff, the facility failed to have an adequate clinical indication for the use of antipsychotic medication (Residents #83 and #291), failed to complete an Abnormal Involuntary Movement Scale test (used to assess for extrapyramidal symptoms for residents receiving antipsychotic medication) prior to the	F 867	Corrective Action Refer to F641 and F758 plans of correction for specific corrections to ensure compliance with intent of regulation. System Changes A sub-committee within the MD-QAPI Committee will meet weekly beginning on or before 5/30/19 for the next three months regarding regulatory compliance to review, monitor for trends, and determine if changes to current practices, monitoring activities, or process improvement plan development/modifications are necessary. The member of this subcommittee include, but are not limited to the colleagues responsible for attaining and sustaining compliance with cited deficiencies. Monitoring The Vice President of Health Services will report findings and actions of the sub-committee to the MD-QAPI Committee monthly for review and recommendation until regulatory compliance with identified deficiencies is achieved or as directed by the MD-QAPI Committee. The Vice President of Health Services is responsible for attaining and sustaining compliance. The Facility alleges compliance effective 5/30/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE PINEHURST, NC 28374

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F 867	Continued From page 49 administration of an antipsychotic medication (Resident #291), and failed to ensure as needed psychotropic medications were time limited in duration (Residents #43 and #291). This was for 3 of 5 residents reviewed for unnecessary medications. During the prior survey of 3/18/18 the facility failed to ensure physician ' s orders for as needed psychotropic medications were time limited in duration for 2 of 5 residents (Residents #7 and #91) reviewed for unnecessary medications. On 5/2/19 at 11:00 am an interview was conducted with the Administrator who stated the root cause for repeat tags was human error.	F 867		