| 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 _____ | C 06/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | F 580 | | 7/10/18 |

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

Electronically Signed | 07/03/2018

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| F 580 | Continued From page 1<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews, the facility failed to notify the physician of an incident/accident that occurred on 5/29/18 resulting in facial bruising for one of three residents reviewed for incident/accidents (Resident #1). The findings included:<br><br>Resident #1 was admitted to the facility on 3/22/17. Cumulative diagnoses included, in part, osteoporosis, atherosclerotic heart disease, chronic pain syndrome, dysphagia (difficulty swallowing), hypertension, localized edema, major depressive disorder and dementia without behavioral disturbance.<br><br>A care plan initiated 3/22/17 and last reviewed on 12/21/17 stated Resident #1 was at risk for falls related to impaired mobility during transfers/ ambulation, poor safety awareness and history of falls. Interventions included the following: Resident #1 had an air mattress on her bed. Monitor Resident #1 frequently. Assist her with all transfers, mobility and activity of daily living (ADL) functions. Keep area free of debris/ clutter. Keep call bell and personal items within reach when resident #1 was in the room. | F 580 | F580<br><br>Identification:<br>Saint Joseph of the Pines Health Center does consult with resident's physician when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.<br><br>Corrective Action<br>Resident #1 electronic medical record (EMR) was updated to include documentation of physician notification of bruising on 5/29/18 by Nurse #2 on or before 7/10/18.<br><br>All current residents' with reported incidents from 5/2018 to present will be reviewed for complete documentation of incident in EMR of physician notification on or before 7/10/18 by the Clinical Care Coordinators (CCC) or nursing supervisors. If notification is not documented, physician will be notified and documented. | |

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| F 580 | Continued From page 2<br>A quarterly Minimum Data Set (MDS) dated 3/9/18 indicated Resident #1 was severely impaired in cognition. No behaviors were noted. Resident #1 required total assistance of 2 persons for bed mobility and transfers, total assistance for locomotion on and off the unit, personal hygiene, toileting and bathing and extensive assistance with eating. No falls were noted during the assessment period.<br><br>An incident/accident report dated 5/29/18 stated the nursing assistant went in to do care. She noticed bruising to right side of forehead and right upper shoulder. The Clinical Care Coordinator who notified the Director of Nursing. The incident/accident report did not document the vital signs and time and date of notification of the physician and the Resident Representative.<br><br>A review of the electronic medical record revealed a nursing note dated 5/29/18 at 5:17 PM which stated the following: During ADL (activities of daily living) care, Resident #1 was noted to have a small abrasive area and a bruise to right side of forehead. Resident #1's Power of Attorney (POA)was notified. There was no documentation as to when the POA was notified. There was no notification that the physician for Resident #1 was notified.<br><br>On 6/13/18 at 2:26 PM, an interview was conducted with the Clinical Care Coordinator. She stated the nursing assistants were doing their morning care and noticed Resident #1 had a bruise to the right side of her forehead and right shoulder. She said she went to the room and saw a bruise on the right side of Resident #1's forehead. The Clinical Care Coordinator stated she filled out the incident report and asked the | F 580 | System change<br>Actively working licensed nursing staff will be re-educated by the Vice President of Health Services or Interim-Director of Nursing (DON) on complete documentation of resident incidents in EMR to include physician notification including date and time on or before 7/10/18.<br><br>Licensed nurses not receiving re-education by 7/10/18 will be re-educated by Interim-DON, CCC, Nursing Supervisors or Team Leaders when working on next scheduled workday.<br><br>Monitoring<br>The Interim-DON, CCC, or nursing supervisors will audit reported incident documentation in the EMR within 72 hours to verify complete documentation of resident incident to include physician notification. Findings and corrective measures will be reported weekly to the Vice President of Health Services.<br><br>The Interim-DON will report trends of these audits to the Mission Driven Quality Assurance and Performance Improvement (MD-QAPI) Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee.<br><br>The Interim-DON is responsible for attaining and sustaining compliance.<br><br>The facility alleges compliance effective 7/10/18. | |

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| F 580 | Continued From page 3<br>floor nurse to notify the family and the physician. She said the notification of the family and physician would be documented in the electronic medical record and on the incident/ accident report. She said she did not finish the report and should have completed the incident report with vital signs, the size of the areas, and date and time of notification.<br><br>On 6/14/18 at 8:09 AM, an interview was conducted with Nurse #2. She stated the nursing assistant came to her somewhere between 11:00 AM-12:00 noon and told her Resident #1 had a bruise on her forehead and her arm or shoulder. She stated she told the POA about the bruises when the POA came to the facility. Nurse #2 said she notified the physician later sometime that evening and was not sure of the time but it should have been documented in the nursing notes.<br><br>On 6/14/18 at 11:41 AM, an interview was conducted with the interim Director of Nursing who stated she expected the physician and POA to be notified at the time of the incident for any fall/ bruises that cannot be explained or justified. | F 580 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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. | F 842 | | 7/10/18 |

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| F 842 | Continued From page 4<br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or | F 842 | | |

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| F 842 | Continued From page 5<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews, the facility failed to have complete and accurate medical records as evidenced by the omission of nursing documentation in the medical record of an incident/ accident that occurred on 5/30/18 for one of three sampled residents (Resident #1). The findings included:<br><br>Resident #1 was admitted to the facility on 3/22/17. Cumulative diagnoses included, in part, osteoporosis, atherosclerotic heart disease, chronic pain syndrome, dysphagia (difficulty swallowing), hypertension, localized edema, major depressive disorder and dementia without behavioral disturbance.<br><br>A care plan dated 6/27/17 and last reviewed on 12/20/17 indicated Resident #1 was at risk for skin injury related to fragile skin. Resident #1 was at risk for skin tears, abrasions and bruises. Interventions included, in part, Gerisleeves (protection for the arm area) or long sleeves to | F 842 | F842<br>Identification<br>St. Joseph of the Pines does maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized.<br><br>Corrective Action<br>Resident #1 EMR was updated to include documentation of incident occurring on 5/30/18 by Nurse #1 on or before 7/10/18.<br><br>All current residents' with reported incidents from 5/2018 to present will be reviewed for complete documentation of incident in EMR on or before 7/6/18 by the CCC or nursing supervisors. If an incident is not documented in EMR, then complete documentation of incident will be entered.<br><br>System change | |

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| F 842 | Continued From page 6<br>bilateral arms. Assess skin every shift and as needed and report any skin issues to the charge nurse. Keep fingernails and toenails clean, short and filed. Please provide protective clothing/ sleeves to Resident #1's arms/ legs as needed.<br><br>A quarterly Minimum Data Set (MDS) dated 3/9/18 indicated Resident #1 was severely impaired in cognition. No behaviors were noted. Resident #1 required total assistance of 2 persons for bed mobility and transfers, total assistance for locomotion on and off the unit, personal hygiene, toileting and bathing and extensive assistance with eating. No falls were noted during the assessment period.<br><br>A review of incident/ accident reports for the past six months revealed an incident/accident report dated 5/30/18 at 12:30 PM stated Resident #1 sustained a skin tear. A nursing assistant reported that another resident propelled herself in the wheelchair to resident #1 and grabbed resident #1's arm. While trying to pull the other resident away from Resident #1, Resident #1 sustained two skin tears on the left arm. The area was cleaned and new treatment orders entered. Resident #1's physician was notified at 2:00 PM. Resident #1's power of attorney (POA) was notified at 2:30 PM.<br><br>A review of the nursing notes in the electronic medical record revealed there was no nursing note documenting the incident on 5/30/18.<br><br>On 6/13/18 at 1:19 PM, an interview was conducted with Nurse #1. She stated there was a resident who could become frustrated very easily and get agitated. Nurse #1 said she did not see that resident was getting close to Resident #1. | F 842 | Actively working licensed nursing staff will be re-educated by the Vice President of Health Services or Interim- DON on complete documentation of resident incidents in EMR on or before 7/10/18.<br><br>Licensed nurses not receiving re-education by 7/10/18 will be re-educated by Interim-DON, CCC, Nursing Supervisors or Team Leaders when working on next scheduled workday.<br><br>Monitoring<br>The Interim-DON, CCC, or nursing supervisors will audit reported incident documentation in the EMR within 72 hours to verify complete documentation of resident incident. Findings and corrective measures will be reported weekly to the Vice President of Health Services.<br><br>The Interim-DON will report trends of these audits to the Mission Driven Quality Assurance and Performance Improvement (MD-QAPI) Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee.<br><br>The Interim-DON is responsible for attaining and sustaining compliance.<br><br>The facility alleges compliance effective 7/10/18. | |

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| F 842 | Continued From page 7<br>Resident #1 told the other resident to get away. At that time, the other resident grabbed Resident #1 ' s left arm with both hands causing two skin tears to the left lower arm. Nurse #1 further stated the staff try to dress Resident #1 with long sleeves but she will pull the sleeves up. She said she called the family and the physician and completed the incident report for the skin tear and forgot to write a nursing note. Nurse #1 stated she should have documented the incident in the electronic medical record.<br><br>On 6/14/18 at 11:41 AM, an interview was conducted with the interim Director of Nursing who stated her expectation was that nursing document/ complete a nursing progress note in the electronic medical record when an incident/accident report is filled out. | F 842 | | |
| F 865 SS=D | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as | F 865 | | 7/5/18 |

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| F 865 | Continued From page 8<br>a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place in March 2018. This was for one (1) recited deficiencies for accurate medical records (F842) which was originally cited on 3/8/18 during the recertification/ complaint investigation survey and on the current complaint investigation survey on 6/14/18. The continued failure of the facility during the federal survey of record and the complaint investigation show a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included:<br><br>This tag is cross referenced to F842 Resident Records-identifiable information. Based on medical record review and staff interviews, the facility failed to have complete and accurate medical records as evidenced by the omission of nursing documentation in the medical record of an incident/ accident that occurred on 5/30/18 for one of three sampled residents (Resident #1).<br><br>On 6/14/18 at 12:30 PM, an interview was conducted with the Administrator and the interim Director of Nursing. The Administrator stated the nursing staff were used to the prior electronic system. In that system, the documentation that was completed on the incident/ accident reporting system was automatically carried over to the electronic nursing documentation site (nursing notes). The electronic system was implemented in March 2018 and staff were still getting used to the new electronic system. | F 865 | F865<br>Identification<br>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.<br><br>Corrective Action<br>Refer to F580 and F842 plans of correction for specific systems to ensure compliance with intent of regulation.<br><br>System Changes<br>A sub-committee within the MD-QAPI Committee will meet weekly beginning on or before 7/5/18 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 members of this subcommittee include, but are not limited to the colleagues responsible for attaining and sustaining compliance with cited deficiencies.<br><br>Monitoring<br>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 substantial compliance is achieved or as directed by the MD-QAPI Committee. | |

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| F 865 | Continued From page 9 | F 865 | The Vice President of Health Services will submit MD-QAPI Committee minutes to the President of St. Joseph of the Pines monthly including status updates on the PIP to provide opportunity for oversight and recommendations for ongoing improvement of the committee's functionality.<br><br>The Vice President of Health Services is responsible for attaining and sustaining compliance.<br><br>The Facility alleges compliance effective 7/5/2018. | |