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 _____	12/30/2020

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 COVID-19 Focused Survey was conducted onsite 12/16/2020 and continued remotely through 12/30/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# XIZ011.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey was conducted onsite 12/16/20 and continued remotely through 12/30/20. The facility was not found in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity L. Immediate Jeopardy began on 09/09/20 and was removed on 12/23/20. Validation of the credible allegation was conducted onsite on 12/30/20.	F 000		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	12/30/2020

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 880	Continued From page 1	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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 _____	12/30/2020

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 880	Continued From page 2	F 880		

contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and physician interview, the facility failed to implement their COVID-19 policies and procedures and the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines when staff who were experiencing symptoms consistent with COVID-19 reported to work for their scheduled shift, failed to report their symptoms during screening and/or to their supervisor, and worked on general population units (Nursing Assistant #1, Nursing Assistant #2, Nursing Assistant #4, Nurse #1, and Nurse #3); and staff who reported symptoms consistent with COVID-19 during their screening and/or to their supervisor were permitted to work their scheduled assignment on general population units without authoritative clearance (Nursing Assistant #1 and Nurse #4). The facility also failed to ensure all symptoms of COVID-19 were included on their screening log. In addition, the facility failed to implement their infection control policy related to Personal

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 _____	12/30/2020

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 880	Continued From page 3	F 880		

Protective Equipment (PPE) when Nursing Assistant (NA) #4 pulled her face mask down while in 2 resident rooms (Residents #9 and #10). These failures occurred during the COVID-19 pandemic. The facility was considered to be in outbreak status after the results of testing completed on 8/11/20 confirmed a staff member (NA #5) to be positive for COVID-19. The first facility resident (Resident #3) to test positive was on 9/21/20 with no further residents until 11/16/20. From 11/16/20 through 12/16/20 a total of 42 residents out of 68 (census on 12/16/20) and 30 staff members tested positive for the COVID-19 virus.

Immediate Jeopardy began on 9/9/20 when Nurse #3 reported to work and did not inform the COVID-19 screener or his supervisor that he was experiencing a loss of taste. Nurse #3 received positive COVID-19 test results on 9/9/20 after working more than 10 hours on a general population hall (800 hall). Immediate Jeopardy was removed on 12/23/20 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of F (no actual harm with the potential for more than minimal harm) for the facility to complete staff training and ensure monitoring systems put into place are effective. Example #3 was cited at a scope and severity of D.

The findings included:

The facility ' s staff education, dated 3/5/20, titled "Infection Prevention to Prevent Respiratory Illnesses like COVID-19" included, in part, a section titled "Stay home if you are ill". This section included the following information for staff

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 _____	12/30/2020

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 880	Continued From page 4	F 880		

illness:
- The same screening is involved for staff illness as visitors
- Signs or symptoms of respiratory infection: fever, cough, and sore throat
- Health care providers who have signs and symptoms of a respiratory infection should stay home from work
- Staff that develop signs and symptoms of respiratory infection while on the job should 1) Immediately put on a facemask, stop work, and self-isolate at home; 2) Inform the Infection Preventionist; 3) Contact the local health department
- Refer to the CDC (Centers for Disease Control and Prevention) guidance that may warrant restricting healthcare personnel from reporting to work.

The facility ' s policy and procedure titled "Infection Prevention and Control Manual Coronavirus (COVID-19)" implemented on 3/28/20 and last revised on 12/11/20, indicated the signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, more persons with COVID-19 may experience one or more of the following: fevers, chills, cough, shortness of breath/breathing difficulty, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. Under the section titled "Colleague Screening and Restrictions" this policy read, in part:

1. Staff will be actively screened at the beginning of their shift for the following:
- Temperature
- Signs and Symptoms of COVID-19

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 _____	12/30/2020

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 880	Continued From page 5 - Exposure to COVID-19 2. Screening will be documented, and the facility ' s "COVID-19 Screening Guidance" will be followed. 3. Any staff that develops signs and symptoms of a respiratory infection while on the job, should: - Immediately stop work, put on a facemask, and self-isolate at home: - Inform the facility infection preventionist, and include information on individuals, equipment, and locations the person came in contact with. - Contact and follow the local health department recommendations for next steps as needed. 4. Employees who develop symptoms to COVID-19 will be instructed to not report to work and referred to public health authorities for testing, medical evaluation recommendations and return to work instructions. A review of the facility ' s "COVID-19 Screening Guidance", undated, referred to in the "Infection Prevention and Control Manual Coronavirus (COVID-19)" under the heading "Colleague Screening and Restrictions" indicated the following screening guidance for facility staff: - Step 1: TEMPERATURE. Check the individual ' s temperature. Is temperature above 99.0 [degrees Fahrenheit (F)] (using an Infrared thermometer) or 100.0F (using an oral/temporal thermometer)? If yes, wait 2-3 minutes (observing social distancing protocols), and check individual again with the same thermometer. Is individual still over 99.0 (using an infrared thermometer) or 100.0F (using an oral/temporal thermometer)? If	F 880		

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 _____	12/30/2020

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 880	Continued From page 6	F 880		

yes, proceed to screening questions below or refer to local policy for next steps, if more restrictive.

- Step 2: SIGNS AND SYMPTOMS Does individual have new-onset of any of the following: cough (unrelated to known asthma or allergies), shortness of breath or difficulty breathing, chills or shaking with chills, sore throat, diarrhea, nausea/vomiting, muscle pain, loss of smell or taste, fatigue, headache, and/or congestion/runny nose.
If yes, not permitted to enter facility. See Next Steps for Colleagues.

- NEXT STEPS: 1. Leave the building to prevent exposure; 2. Follow-up with supervisor/manager and tell them they will not be working the shift ...

A review of the staff screening log, titled "COVID 19 Screening Process Checklist", from 9/1/20 through 9/30/20 revealed the log required documentation of staff ' s temperature and a yes or no answer to the following symptoms: cough, shortness of breath, and sore throat.

A review of the staff screening log, titled "Prevent COVID-19 Start of Shift Screening Log", from 11/1/20 through 12/16/20 revealed the log required documentation of staff ' s temperature and a yes or no answer to the following symptoms: cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, and new loss of taste or smell.

During an interview with the Risk Manager (RM)

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 _____	12/30/2020

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 880	Continued From page 7	F 880		

and Infection Control Preventionist (ICP) on 12/16/20 at 12:00 PM they indicated that a staff surveillance log included documentation of all staff members who tested positive for COVID-19. The RM explained that staff members were added to the log after positive test results were received and at that time (after the positive test results were received) the staff member was interviewed to see if they had experienced any symptoms of COVID-19.

1a. A review of the staff screening log for 9/9/20 indicated Nurse #3 ' s temperature was 95.0 degrees and he answered no to each of the symptoms on the log (cough, shortness of breath, and sore throat).

A review of the staff schedule with assignments indicated Nurse #3 worked on 9/9/20 on the 800 hall which was a general population hall. His time card indicated he clocked in on 9/9/20 at 6:05 AM and clocked out at 5:04 PM with a total of 10.6 hours worked.

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the RM. This log indicated, in part, the staff member ' s name, discipline, hall worked, date of COVID-19 test that returned with positive results, an indication of asymptomatic or symptomatic, and documentation of symptoms experienced (as applicable). The surveillance log revealed that Nurse #3 worked on the 800 hall, participated in weekly COVID-19 testing on 9/3/20 with results received on 9/9/20 due to a delay from the Labor Day holiday. The log revealed Nurse #3 was symptomatic and his symptoms were recorded as, "complained of weakness and slight loss of

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 _____	12/30/2020

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 880	Continued From page 8	F 880		

taste but didn ' t attribute it to COVID-19". No date was provided for Nurse #3 ' s symptoms on his surveillance log.

The facility ' s COVID-19 resident surveillance log indicated testing completed on 9/21/20 revealed Resident #3 tested positive for this virus. This was the first facility resident to test positive for COVID-19.

A phone interview was conducted with Nurse #3 on 12/18/20 at 1:25 PM. Nurse #3 indicated he received education from the facility that included the signs and symptoms of COVID-19 as well as the protocol for reporting any symptoms experienced. He stated that if any symptoms were experienced the staff were required to report this information during their screening or to the Nurse Supervisor, Infection Control Preventionist (ICP), or the Administrator if symptoms emerged during their shift. The staff surveillance log that indicated he received positive COVID-19 test results on 9/9/20 and had experienced symptoms of weakness and slight loss of taste was reviewed with Nurse #3. The time card and schedule with assignments that indicated Nurse #3 worked on a general population hall (800 hall) for 10.6 hours on 9/9/20 was reviewed with Nurse #3. Nurse #3 confirmed he received positive COVID-19 test results on 9/9/20 after he worked a 10.6 hour shift on a general population hall (800 hall). He reported that on the morning of 9/9/20 as he ate his morning breakfast prior to reporting to the facility for his shift he noticed that he was not able to taste the salt on his eggs. He indicated that when he arrived at the facility for his shift (9/9/20) he completed the screening process by completed

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 _____	12/30/2020

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 880	Continued From page 9	F 880		

the screening questions which had not specifically asked if he was experiencing a loss of taste. He reported that during his shift on 9/9/20 he felt some fatigue, which he attributed to normal fatigue from working. He further reported that during his lunch break on 9/9/20 he ate pizza and noted that it had not "tasted good" to him. Nurse #3 stated that he worked from 6:00 AM until about 5:00 PM at which time he was informed by management that his test results returned and were positive for COVID-19. He revealed he had not reported his fatigue or issues with his taste to the Nurse Supervisor, ICP, or Administrator prior to receiving his positive COVID-19 test results on 9/9/20. He stated that after he was told he was positive for the virus he informed one of the management staff, unable to recall who he spoke to, that he had some fatigue and a loss of taste. Nurse #3 was asked why he had not reported his symptoms to his Nurse Supervisor, ICP, or the Administrator during his shift. He stated that prior to receiving the positive test results on 9/9/20, it had not dawned on him that his loss of taste and fatigue were COVID-19 related symptoms. He acknowledged that he was aware that loss of taste and fatigue were consistent with COVID-19 symptoms. He revealed that in hindsight he made a mistake by not reporting his symptoms to his Nurse Supervisor, ICP, or the Administrator. Nurse #3 was asked what Personal Protective Equipment (PPE) was in use on the 800 hall on 9/9/20 and he indicated that believed the PPE in use at that time were surgical masks at all times and gloves during any care.

1b. A review of the staff screening log for 11/2/20 indicated Nursing Assistant (NA) #4 ' s

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 _____	12/30/2020

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 880	Continued From page 10	F 880		

temperature was 93.9 degrees and she answered no to each symptom on the log (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, and new loss of taste or smell).

A review of the staff schedule with assignments indicated NA #4 worked on 11/2/20 on the 200 hall which was a general population hall. Her time card indicated she clocked in on 11/2/20 at 8:48 AM and clocked out at 3:08 PM with a total of 5.8 hours worked.

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the RM. This log indicated, in part, the staff member ' s name, discipline, hall worked, date of COVID-19 test that returned with positive results, an indication of asymptomatic or symptomatic, and documentation of symptoms experienced (as applicable). The surveillance log revealed that NA #4 worked on the 200 hall and that her test results from routine weekly testing completed on 11/2/20 were positive for COVID-19. The log revealed NA #4 was symptomatic and her symptoms were recorded as "cold like symptoms that started on 10/31/20".

The facility's COVID-19 resident surveillance log indicated testing completed on 11/16/20 revealed 1 resident (Resident #2) tested positive for the virus. This was the second facility resident to test positive for the COVID-19.

A phone interview was conducted with NA #4 on 12/22/20 at 7:05 PM. NA #4 indicated she

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 _____	12/30/2020

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 880	Continued From page 11	F 880		

received education from the facility that included the signs and symptoms of COVID-19 as well as the protocol for reporting any symptoms she experienced. She stated that if any symptoms were experienced prior to reporting to work for their shift they were to contact their team leader and not report to work. The staff surveillance log that indicated she tested positive for COVID-19 during routine weekly testing completed on 11/2/20 and had experienced cold like symptoms that started on 10/31/20 was reviewed with NA #4. The time card and schedule with assignments that indicated NA #4 worked on a general population hall (200 hall) for 5.8 hours on 11/2/20 was reviewed with NA #4. NA #4 confirmed her test results from routine testing on 11/2/20 were positive for COVID-19 and that she worked a 5.8 hour shift on a general population hall on 11/2/20. She explained that over the weekend of 10/31/20 and 11/1/20 she was experiencing a runny nose and what she thought were cold symptoms so she took sinus medication which relieved her of the symptoms. She reported that when she arrived at the facility for her shift on 11/2/20 she completed the screening questions indicating she had none of the symptoms on the log. NA #4 was unable to recall if the screening log asked about a runny nose or cold symptoms, but that if it had she would not have reported this symptom during screening because the sinus medication she took relieved her symptoms by the time she was screened on 11/2/20. She revealed she had not reported the cold like symptoms and runny nose to any of her supervisors prior to receiving her positive COVID-19 test results. She explained that after she was informed she was positive for the virus she told one of the management staff, unable to recall who she spoke to, that she had

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 _____	12/30/2020

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 880	Continued From page 12	F 880		

cold like symptoms and a runny nose on 10/31/20 and 11/1/20. NA #4 acknowledged that she was aware that a runny nose and cold-like symptoms were consistent with possible symptoms of COVID-19. When asked why she made the choice to go to work on 11/2/20 and had not notified her supervisor that she experienced symptoms consistent with COVID-19 on 10/31/20 and 11/1/20 she reiterated that because the symptoms had subsided after taking sinus medication she assumed they were not related to COVID-19. NA #4 stated that if she thought her symptoms were related to COVID-19 that she would have followed the protocol to phone her team leader and she would not have reported to work on 11/2/20. NA #4 was asked what Personal Protective Equipment (PPE) was in use on the 200 hall on 11/2/20 and she indicated that she believed the PPE in use at that time were face masks and face shields at all times and gloves during care.

1c. A review of the staff screening log for 11/23/20 indicated Nurse #1 ' s temperature was 97.7 degrees and he answered no to each symptom on the log (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, and new loss of taste or smell).

A review of the staff schedule with assignments for 11/23/20 indicated Nurse #1 worked on the 600 hall which was a general population hall. His time card indicated he clocked in on 11/23/20 at 1:38 PM and clocked out at 10:10 PM with a total of 8.1 hours worked.

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 _____	12/30/2020

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 880	Continued From page 13	F 880		

A review of the staff screening log dated 11/24/20 indicated Nurse #1 ' s temperature was 98.0 degrees and he reported no to each symptom on the log (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, or new loss of taste or smell).

A review of the staff schedule with assignments indicated Nurse #1 was scheduled to work on the 600 hall and his time card indicated he clocked in at 1:43 PM and clocked out at 2:59 PM with a total of 1.3 hours worked.

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the RM. This log indicated, in part, the staff member ' s name, discipline, hall worked, date of COVID-19 test that returned with positive results, an indication of asymptomatic or symptomatic, and documentation of symptoms experienced (as applicable). The surveillance log revealed that Nurse #1 worked on the 600 hall and that his test results from routine weekly testing completed on 11/23/20 were positive for COVID-19. The log revealed Nurse #1 was symptomatic and his symptoms were recorded as "body aches 11/23/20". The log additionally noted that Nurse #1 last worked on 11/23/20 and 11/24/40.

The facility ' s COVID-19 resident surveillance log indicated testing completed on 11/23/20, 11/25/20, and 11/26/20 revealed 11 facility residents (Residents #1, #5, #11, #12, #13, #14, #15, #16, #17, #18, and #19) tested positive for the virus.

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 _____	12/30/2020

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 880	Continued From page 14	F 880		

A phone interview was conducted with Nurse #1 on 12/18/20 at 12:41 PM. Nurse #1 indicated he received education from the facility that included the signs and symptoms of COVID-19 as well as the protocol for reporting any symptoms he experienced. He stated that staff were to report any symptom consistent with COVID-19 during screening or to one of their supervisors. The staff surveillance log that indicated he tested positive for COVID-19 during routine weekly testing completed on 11/23/20 and had experienced body aches on 11/23/20 was reviewed with Nurse #1. The staff screening logs dated 11/23/20 and 11/24/20 that indicated Nurse #1 reported no muscle pain on both dates were reviewed with Nurse #1. The time card and schedules with assignments that indicated Nurse #1 was assigned to a general population hall (600 hall) on both dates and worked for 8.1 hours on 11/23/20 and 1.3 hours on 11/24/20 were reviewed with Nurse #1. Nurse #1 verified that on 11/23/20 he was having body aches when he reported to work, but he had not disclosed this information during his screening and he worked his regularly scheduled shift on a general population hall. He stated that he was still experiencing these body aches when he reported to work on 11/24/20, but he again had not disclosed this information during his screening. He reported that after he was screened on 11/24/20 he was notified by management, unable to recall the specific staff member, that his test results from the previous day (11/23/20) were positive for COVID-19. He indicated that at that time he was asked if he had experienced any symptoms and he revealed he had body aches that started on 11/23/20. Nurse #1 stated that after he spoke with management he was sent home from work. He reported he had not provided any resident care on 11/24/20.

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 _____	12/30/2020

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 880	Continued From page 15 When asked why he had not reported his body ache symptoms during his screenings or to any of his supervisors on 11/23/20 or 11/24/20 Nurse #1 stated that it had not occurred to him that these symptoms could have been related to COVID-19 as he sometimes experienced aches and pains that came with the aging process. He acknowledged that he was aware that muscle/body aches were consistent with possible symptoms of COVID-19 and that in hindsight he realized he should have reported these symptoms to one of his supervisors. 1d. CDC guidance dated 8/21/20 titled "Considerations for Interpreting Antigen Test Results in Nursing Homes" provided the following algorithm when utilizing a Point of Care (POC) antigen test (a rapid test for COVID-19) for Healthcare Personnel (HCP) with symptoms consistent with COVID-19: - Symptomatic HCP - Complete POC (point of care) antigen test - Presumptive negative results from antigen test - Perform confirmatory RT-PCR (Reverse-Transcriptase Polymerase Chain Reaction) test immediately. Isolate/exclude from work until RT-PCR results. Actions were dependent on the RT-PCR test alone. A review of the staff screening log for 11/25/20 indicated NA #1 ' s temperature was 97.2 degrees and she answered no to each symptom on the log (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, and new loss of	F 880		

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 _____	12/30/2020

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 880	Continued From page 16 taste or smell). A review of the staff schedule with assignments for 11/25/20 indicated NA #1 worked on the 800 hall which was a general population hall. Her time card indicated she clocked in on 11/25/20 at 5:42 AM and clocked out at 5:15 PM with a total of 12.0 hours worked. A review of the staff screening log dated 11/26/20 indicated NA #1 ' s temperature was 98.3 degrees and she reported no to each symptom on the log (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, or new loss of taste or smell). A review of the staff schedule with assignments for 11/26/20 indicated NA #1 worked on the 800 hall and her time card indicated she clocked in on 11/26/20 at 5:32 AM and clocked out at 5:09 PM with a total of 12.10 hours worked. A review of the staff screening log dated 11/30/20 indicated NA #1 ' s temperature was 96.6 degrees and she reported symptoms of cough and vomiting and/or diarrhea during her screening. She reported no to symptoms of sore throat, new shortness of breath or difficulty breathing, chills and/or repeated shaking with chills, muscle pain, headache, or new loss of taste or smell. A review of the staff schedule with assignments for 11/30/20 indicated NA #1 worked on the 800 hall and her time card indicated she clocked in on 11/30/20 at 5:59 AM and clocked out at 5:07 PM with a total of 11.60 hours worked.	F 880		

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 _____	12/30/2020

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 880	Continued From page 17	F 880		

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the RM. This log indicated, in part, the staff member ' s name, discipline, hall worked, date of COVID-19 test that returned with positive results, an indication of asymptomatic or symptomatic, and documentation of symptoms experienced (as applicable). The surveillance log revealed that NA #1 worked on the 800 hall and that her test results from routine weekly testing completed on 11/30/20 were positive for COVID-19. The log revealed NA #1 was symptomatic and her symptoms were recorded as "cough, body aches, no taste or smell on 11/25/20".

The facility ' s COVID-19 resident surveillance log indicated testing completed on 11/30/20, 12/1/20, 12/4/20, 12/5/20, and 12/6/20 revealed 22 facility residents (Residents #6, #8, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, and #39) tested positive for the virus.

A phone interview was conducted with NA #1 on 12/17/20 at 3:30 PM. NA #1 indicated she received education from the facility that included the signs and symptoms of COVID-19 as well as the protocol for reporting any symptoms she experienced. She stated that staff were to report any symptom consistent with COVID-19 during screening or to one of their supervisors. The staff surveillance log that indicated she tested positive for COVID-19 during routine weekly testing completed on 11/30/20 and had experienced "cough, body aches, no taste or smell on 11/25/20" was reviewed with NA #1. The staff

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 _____	12/30/2020

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 880	Continued From page 18	F 880		

screening logs dated 11/25/20 and 11/26/20 which indicated NA #1 reported no symptoms on these dates as well as the staff screening log dated 11/30/20 that indicated she reported symptoms of a cough and vomiting and/or diarrhea were reviewed with NA #1. NA #1 stated that when she arrived for her shift on 11/25/20 she was not experiencing any COVID-19 symptoms. She explained that during her shift on 11/25/20, sometime around 9:00 AM, she reported symptoms of body aches, to her team leader (Nurse #2) during her shift (6:00 AM to 6:00 PM). She explained that she was aware body aches were a symptom consistent with COVID-19 and per the facility protocol she was supposed to report this information to her supervisor immediately. NA #1 indicated that Nurse #2 informed the Administrator of her symptom (body aches) and she was tested for COVID-19 using a POC rapid antigen test at the facility and her results were negative and she was afebrile. NA #1 indicated she was instructed by the Administrator and Nurse #2 to finish her shift. She reported she had been working on the 800 hall, a general population hall, on 11/25/20 and she completed her shift on this same hall. She indicated that she thought the Personal Protective Equipment (PPE) in use on the 800 hall at this time were surgical masks, face shields, and gloves. NA #1 revealed she had received no medical clearance from a physician to continue her shift on 11/25/20. She stated that she was just doing what she was told. NA #1 reported that when she arrived at the facility on 11/26/20 for her shift she was still experiencing the same symptoms of body aches as on the previous day (11/25/20), but she answered the screening questions inaccurately by reporting no symptoms. She explained that since she had the same

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 _____	12/30/2020

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 880	Continued From page 19	F 880		

symptoms as she did on 11/25/20 and she continued to have no fever that she assumed it had not mattered if she answered the screening questions accurately as she thought she would still have to work anyway. She further explained that this was Thanksgiving Day (11/26/20) and due to the holiday there most likely would not have been someone available to cover her shift. NA #1 indicated that she worked her shift from 6:00 AM to 6:00 PM on 11/26/20 on the 800 hall. She stated the next date she worked was 11/30/20 and this was a routine weekly COVID-19 testing date (testing completed by an RT-PCR) for staff and residents. She reported that testing was done prior to entering the facility. NA #1 stated her testing was completed around 5:45 AM and Nurse Supervisor #1 was at the testing station. She stated that she told Nurse Supervisor #1 that she wasn ' t feeling well during her testing. When asked what Nurse Supervisor #1 ' s response was she stated that she provided no instructions to her so she figured that she needed to report in for her shift. NA #1 indicated that upon entry to the facility for the 6:00 AM to 6:00 PM shift she reported symptoms of cough, vomiting, and diarrhea on her screening. She stated that the screener, unable to recall who this was, reviewed the symptoms and indicated to NA #1 that she had not known what to do. NA #1 explained that since she had been telling her supervisors she had symptoms since last week (11/25/20) and she was still instructed to work and she also reported her symptoms to Nurse Supervisor #1 that morning (11/30/20) and she provided no instruction, that she assumed she was going to have to work anyway so she proceeded to the 800 hall where she worked the 6:00 AM to 6:00 PM shift. During this shift on 11/30/20, NA #1 stated she again reported 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 _____	12/30/2020

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 880	Continued From page 20	F 880		

symptoms of cough, vomiting and diarrhea, as well as the loss of taste and smell to Nurse Supervisor #1. NA #1 stated that Nurse Supervisor #1 provided her with no instructions so she continued working and finished her shift. She revealed that on 12/1/20 or 12/2/20 she was informed of the results from her 11/30/20 COVID-19 test and she was positive for the virus.

During a phone interview with Nurse #2 on 12/21/20 at 4:31 PM she confirmed she was the team leader for the 6:00 AM to 6:00 PM shift on 11/25/20. She recalled NA #1 reporting to her that she wasn ' t feeling well and that she had body aches. She was not sure what time this conversation occurred, but she believed it was before lunchtime. She indicated she asked NA #1 if she had a temperature and she reported that she had no temperature. Nurse #2 explained that as the team leader, she was basically a messenger and she made no decisions. She stated that she called the Administrator and informed her NA #1 had body aches and no temperature. She indicated that the Administrator instructed her to have NA #1 go to her office. A rapid test (antigen test) was conducted and was negative. Nurse #2 indicated that NA #1 was sent back to the 800 hall where she completed her shift. She confirmed the 800 hall was a general population hall.

A phone interview was conducted with Nurse Supervisor #1 on 12/22/20 at 2:53 PM. She stated that staff were expected to report any symptoms they were experiencing during screening to the staff member who was at the screening desk. She indicated that if symptoms began during a staff member ' s shift that they

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 _____	12/30/2020

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 880	Continued From page 21	F 880		

were to immediately report this to their supervisor. Nurse Supervisor #1 stated that she had a vague recollection of speaking with NA #1 on 11/30/20 during her shift, but she had not recalled speaking to her at the testing station on 11/30/20. She explained that she remembered talking to NA #1 in passing on 11/30/20 and that she said she was not feeling well and she had symptoms of no taste or smell. She had not recalled NA #1 informing her of symptoms of cough, vomiting, and diarrhea. Nurse Supervisor #1 stated that she had heard from another staff member (unable to recall who) that NA #1 spoke with the Administrator the previous week and was tested by the rapid test and was negative for COVID-19. Nurse Supervisor #1 revealed that since this new symptom of no taste or smell was not anything that affected her ability to do her job that she felt it was okay for her to continue working. She stated that she reminded NA #1 to wear her face mask at all times and instructed her to continue working on her assigned hall (800 hall). Nurse Supervisor #1 stated that the normal protocol for when a staff reported a newly emerged symptom was to inform the Administrator. She was unable to explain why she had not informed the Administrator of NA #1 ' s report to her on 11/30/20.

A phone interview was conducted with Screener #1 on 12/23/20 at 12:15 PM. Screener #1 indicated that she was a contracted employee and she began working at the facility in September or October of 2020. She stated that she received training from her company prior to working at the facility. Screener #1 was asked what the protocol was for a staff member who entered the building and had a fever and/or reported symptoms on the screening log. She

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 _____	12/30/2020

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 880	Continued From page 22	F 880		

stated she was trained to notify one of the facility supervisors and not to let the staff member in the facility. Screener #1 confirmed she was working on 11/30/20 when NA #1 entered the facility and that she recalled her reporting the symptoms of cough, vomiting, and diarrhea during her screening. She stated that she had not observed these symptoms for NA #1. She explained that NA #1 had not looked sick to her and she also had no fever. She revealed that she let NA #1 into the facility and had not notified the facility supervisor. Screener #1 stated, "this was a mistake". She indicated she thought about this afterwards and realized that she should not have let NA #1 enter the facility and that she should have contacted one of the facility supervisors as her training had instructed her to do.

1e. A review of the staff screening log for 11/26/20 indicated Nurse #4 ' s temperature was 101.3 degrees and reported symptoms of cough, muscle pain, and a headache. He reported no to symptoms of sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, and new loss of taste or smell.

A review of the staff schedule with assignments for 11/26/20 indicated Nurse #4 worked on the 800 hall which was a general population hall. His time card indicated he clocked in on 11/26/20 at 6:06 PM and clocked out at 6:27 AM with a total of 11.90 hours worked.

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the RM.

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 _____	12/30/2020

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 880	Continued From page 23	F 880		

This log indicated, in part, the staff member ' s name, discipline, hall worked, date of COVID-19 test that returned with positive results, an indication of asymptomatic or symptomatic, and documentation of symptoms experienced (as applicable). The surveillance log revealed that Nurse #4 worked on the 800 hall and that his test results from routine weekly testing completed on 11/30/20 were positive for COVID-19. The log revealed Nurse #4 experienced "cold symptoms, nasal congestion, cough". No date was noted for when Nurse #4 experienced these symptoms.

A phone interview was attempted with Nurse #4 on 12/22/20 at 2:49 PM and he was unable to be reached.

A phone interview was conducted with Screener #2 on 12/23/20 at 12:07 PM. Screener #2 indicated that he was a contracted employee and his first day working at the facility was 11/26/20. He stated that he received training from his company prior to working at the facility. Screener #2 was asked what the protocol was for a staff member who entered the building and had a fever and/or reported symptoms during the screening. He stated he was trained to notify one of the facility supervisors and not to let the staff member in the facility unless he received further instruction from the facility supervisor. The screening log dated 11/26/20 for Nurse #4 that indicated he had a temperature of 101.3 degrees and reported symptoms of cough, muscle pain, and headache was reviewed with Screener #2. Screener #2 revealed he recalled this screening for Nurse #4 as this occurred on his first day working at the facility (11/26/20). He stated that Nurse #4 entered the building and was coughing during the screening. He indicated Nurse #4

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 _____	12/30/2020

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 880	Continued From page 24	F 880		

personally took his temperature with his own thermometer and reported a temperature of 101.3 degrees. Screener #2 stated that to he recalled taking Nurse #4 ' s temperature using the thermometer from the screening station (the thermometer that was routinely used for screening) and that this showed Nurse #4 ' s temperature as 97.0 degrees. He explained that at that point of the screening Nurse #4 wrote down the 101.3 degrees temperature on the screening log himself and proceeded to tell him (Screener #2) that he had already spoke with his supervisor and was told he could work his scheduled shift. Screener #2 revealed that he let Nurse #4 enter the facility without following the protocol from his training. He stated that he should have contacted the facility supervisor himself to receive further instructions first hand. Screener #2 reported that this was a mistake.

A phone interview was attempted with Nurse Supervisor #1 on 12/23/20 at 9:29 AM and she was unable to be reached. Nurse Supervisor #1 was Nurse #4 ' s supervisor.

1f. A review of the staff screening log for 12/7/20 indicated Nursing Assistant (NA) #2 ' s temperature was 97.3 degrees and she answered no to each symptom on the log (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, and new loss of taste or smell).

A review of the staff schedule with assignments indicated NA #2 worked on 12/7/20 on the 600 hall which was a general population hall. Her time

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 _____	12/30/2020

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 880	Continued From page 25	F 880		

card indicated she clocked in on 12/7/20 at 6:00 AM and clocked out at 2:17 PM with a total of 7.8 hours worked.

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the RM. This log indicated, in part, the staff member ' s name, discipline, hall worked, date of COVID-19 test that returned with positive results, an indication of asymptomatic or symptomatic, and documentation of symptoms experienced (as applicable). The surveillance log revealed that NA #2 worked on the 600 hall and that her test results from routine weekly testing completed on 12/7/20 were positive for COVID-19. The log revealed NA #2 was symptomatic and her symptoms were recorded as "runny nose, sinus like [signs/symptoms]". No date was noted for when these symptoms occurred.

The facility ' s COVID-19 resident surveillance log indicated testing completed on 12/7/20, 12/9/20, 12/12/20, and 12/14/20 revealed 8 facility residents (Residents #4, #10, #40, #41, #42, #43, #44, and #45) tested positive for the virus.

A phone interview was conducted with NA #2 on 12/21/20 at 2:13 PM. The staff surveillance log that indicated NA #2 tested positive for COVID-19 during routine weekly testing completed on 12/7/20 and that she had experienced a runny nose and sinus like symptoms was reviewed with NA #2. The time card and schedules with assignments that indicated NA #2 worked on a general population hall (600 hall) for 7.8 hours on 12/7/20 was reviewed with NA #2. NA #2 confirmed her test results from routine testing on 12/7/20 were positive for COVID-19 and that she

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 _____	12/30/2020

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 880	Continued From page 26	F 880		

worked a 7.8 hour shift on a general population hall on 12/7/20. She explained that over the weekend of 12/5/20 and 12/6/20 she began experiencing what she thought were sinus problems and a runny nose. She stated that these symptoms continued through 12/7/20 when she was scheduled to work. NA #2 reported that when she arrived at the facility for her shift on 12/7/20 she completed the screening questions and responded "No" when asked about each symptom on the screening (cough, sore throat, new shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, and new loss of taste or smell). She revealed she was unable to recall if the symptoms she was experiencing (runny nose and sinus problems) were asked during the screening questions. NA #2 further revealed that she had not reported these symptoms to any of her supervisors on 12/7/20 as she had not realized that her runny nose and sinus problems could have been COVID-19 related. When asked if she received education on the symptoms of COVID-19 she stated that she was unable to recall if she had received this education. She stated that after she was informed she was positive for the virus she told one of the management staff, unable to recall who she spoke to, that she had a runny nose and sinus-like symptoms that began on 12/5/20 and continued through 12/7/20. NA #2 stated that if she had known her symptoms were related to COVID-19 that she would have reported this information to one of her supervisors. NA #2 was asked what Personal Protective Equipment (PPE) was in use on the 600 hall on 12/7/20 and she indicated that she believed the PPE in use at that time were N-95 masks, face shields, gowns, and gloves.

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 _____	12/30/2020

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 880	Continued From page 27	F 880		

During a phone interview on 12/22/20 at 5:45 PM the ICP was asked what the protocol was for a staff member who was experiencing symptoms consistent with COVID-19 prior to reporting to work. She stated that if a staff member had symptoms prior to reporting to work they were to contact their team leader and not to report to work. She explained that there was 1 team leader per shift for the facility. The ICP indicated that the team leader most often would tell them the staff not to come to work. She went onto explain that there was a period of time around late October 2020 and the beginning of November 2020 that they were having a lot of call offs, so they had to be a little more stringent on the call offs to maintain sufficient staff levels. The ICP further explained that staff were then required to report to the team leader additional information about their symptoms to their team leader such as the duration and severity of symptoms and if they had been around anyone who was suspected or confirmed positive for COVID-19. She stated that if the team leader was not sure what to do, or they were unable to cover the staff member ' s shift, the team leader was to contact their Nurse Supervisor or the Administrator for further instructions. The ICP reported that if a staff member reported to work and was experiencing symptoms at the time of their screening they were expected to report this information to the screener. She indicated there was a screener at the facility 24 hours per day. She stated that the screeners were from a contracted security company and they received training to notify the Nurse Supervisor or the Administrator if any symptoms were reported.

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 _____	12/30/2020

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 880	Continued From page 28	F 880		

The ICP indicated that the screening log had not included all of the symptoms of COVID-19 and that staff were trained on all of the possible symptoms of COVID-19 and were instructed to inform of their supervisors of any symptom they experienced. She reported that if a symptom emerged during a staff member ' s shift they were inform their team leader, Nurse Supervisor, or the Administrator immediately. Nurse #3 ' s interview that indicated he had symptoms of fatigue and loss of taste on 9/9/20, but had not reported these symptoms to any of his supervisors was reviewed with the ICP. The ICP verified that fatigue and loss of taste were symptoms consistent with COVID-19. She stated that Nurse #3 should have followed protocol and contacted his team leader for further instructions prior to coming to work. She was unable to explain why Nurse #3 had not followed this protocol. NA #4 ' s interview that indicated she had a runny nose and cold like symptoms on 10/31/20 and 11/1/20, but had not reported these symptoms to any of her supervisors was reviewed with the ICP. The ICP verified that a runny nose and other cold-like symptoms were consistent with COVID-19. She indicated that NA #4 should have followed protocol and contacted her team leader for further instructions prior to coming to work. She was unable to explain why NA #4 had not followed this protocol. Nurse #1 ' s interview that indicated he had body aches on 11/23/20 and 11/24/20, but had not reported this symptom during his screenings or to any of his supervisors until after he received his positive COVID-19 test results on 11/24/20 was reviewed with the ICP. She was unable to explain why Nurse #1 had not followed the protocol for reporting symptoms. NA #2 ' s interview that indicated she had a runny nose and sinus like symptoms on 12/5/20 through 12/7/20

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 _____	12/30/2020

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 880	Continued From page 29	F 880		

but had not reported these symptoms to any of her supervisors when she worked on 12/7/20 were reviewed with ICP. The ICP verified that a runny nose and other sinus like symptoms were consistent with COVID-19. She was unable to explain why NA #2 had not followed the protocol for reporting symptoms. NA #2 ' s statement that she had not recalled receiving any education on the symptoms of COVID-19 was reviewed with the ICP. The ICP stated that 100% of staff received education on the symptoms of COVID-19 and she was unable to explain why NA #2 had no recollection of this information. The ICP revealed that she realized during this current survey that staff may not have been aware of all of the symptoms that were consistent with the COVID-19 virus. She stated that she and the Nurse Supervisors created a new training with additional information on the signs and the symptoms of COVID-19 and this was going to be implemented for all staff beginning on 12/23/20.

This phone interview with the ICP (12/22/20 at 5:45 PM) continued. NA #1 ' s interview that indicated she reported symptoms of body aches with no fever to her team leader (Nurse #2) and the Administrator on 11/25/20, was tested for COVID-19 via a rapid antigen test with negative results, and then continued to work on a general population hall (800 hall) for the remainder of her shift was reviewed with the ICP. She revealed she was unaware that NA #1 continued to work on a general population hall after reporting symptoms consistent with COVID-19 without receiving medical clearance or an RT-PCR test to confirm she was negative. She stated that she was aware CDC guidance indicated that if a staff member was symptomatic that an antigen test was to be conducted and that if those results

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 _____	12/30/2020

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 880	Continued From page 30	F 880		

were negative that an RT-PCR test was to completed with a confirmatory negative result received prior to the staff member returning to work. The ICP revealed that according to the CDC guidance NA #1 should have been sent home from work until an RT-PCR test was conducted and results were received to verify if she was negative or positive for the virus. She was unable to explain why this protocol was not followed. The screening log for 11/26/20 that indicated NA #1 reported no symptoms of COVID-19 and NA #1 ' s interview that indicated she was experiencing body aches but had not reported this during her screening were reviewed with the ICP. The ICP stated that NA #1 should have followed the facility protocol and contacted the team leader prior to her shift to report her symptoms and to follow the team leader ' s instructions. She was unable to explain why this protocol was not followed. The screening log for 11/30/20 that indicated NA #1 reported symptoms of cough, vomiting, and diarrhea during screening and NA #1 ' s interview that confirmed she reported these symptoms to the screener on 11/30/20 was reviewed with the ICP. The ICP stated that the screener should have contacted Nurse Supervisor #1 or the Administrator for further instruction and should not have permitted NA #1 to enter the facility until these instructions were received. She was unable to explain why this protocol was not followed. The ICP further revealed that NA #1 should not have worked her shift with symptoms of vomiting, diarrhea, and cough as these were symptoms of COVID-19 and this created the potential for resident exposure and transmission of the virus. NA #1 ' s interview that she reported symptoms of cough, vomiting, diarrhea and loss of taste and smell to Nurse Supervisor #1 on 11/30/20 and Nurse Supervisor

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 _____	12/30/2020

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 880	Continued From page 31	F 880		

#1 ' s interview that she had a vague recollection of NA #1 reporting symptoms of a loss of taste and smell were reviewed with the ICP. The ICP stated that Nurse Supervisor #1 should have contacted the Administrator for instructions when these symptoms were reported. She was unable to explain why Nurse Supervisor #1 had not followed this protocol. The screening log for 11/26/20 that indicated Nurse #4 ' s temperature was 101.3 degrees and reported symptoms of cough, muscle pain, and headache during his screening was reviewed with the ICP. The ICP stated that Nurse #4 should have called his Nurse Supervisor or Administrator prior to reporting to the facility and he should not have been permitted to work. She further stated that the screener should have contacted a Nurse Supervisor or the Administrator for further instruction and should not have permitted Nurse #4 to enter the facility until these instructions were received. She was unable to explain why these protocols were not followed by Nurse #4 or by the screener. The ICP revealed that Nurse #4 should not have worked his shift with a fever and symptoms of cough, muscle pain, and a headache as these symptoms were consistent with COVID-19 and this created the potential for resident exposure and transmission of the virus. The ICP was asked if there was any monitoring of the screening log completed in order to ensure no staff entered the building after reporting symptoms of COVID-19 unless medical clearance had been received. She indicated she believed the Administrator had a process in place for reviewing the log, but she (the ICP) was not a part of this screening log monitoring.

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 _____	12/30/2020

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 880	Continued From page 32	F 880		

A phone interview was conducted with the Administrator on 12/22/20 at 6:40 PM. She was asked what the protocol was for a staff member who was experiencing signs and symptoms consistent with COVID-19. She stated that if a staff member had symptoms prior to reporting to work they were to contact the scheduler or their team leader. She explained that if this was during normal business hours the staff member was to call the scheduler and she would fill in their shift and the staff member would not report to work. She indicated that if this was after normal business hours the staff member was to call their team leader. The Administrator stated that if the team leader had any questions about whether or not the staff member should report to work that they were to contact her for further instructions. She indicated that if staff came to the facility and reported symptoms to the screener and/or had a fever, the screener was to contact the either a Nurse Supervisor or herself. She indicated that the screener was also the security guard for the building and this position was staffed 24 hours per day. She explained that the screeners had all been trained not to permit anyone with symptoms and/or a fever to enter the building without speaking to herself or a Nurse Supervisor. The Administrator stated that she expected staff to report any symptom consistent with COVID-19 according to the facility ' s protocol and that staff were not to work while experiencing symptoms unless they were medically cleared.

This phone interview with the Administrator (12/22/20 at 6:40 PM) continued. NA #1 ' s interview that indicated on 11/25/20 during her shift she reported symptoms of body aches with no fever to her team leader (Nurse #1), her team

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 _____	12/30/2020

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 880	Continued From page 33	F 880		

leader informed the Administrator, she (NA #1) was then tested for COVID-19 via a rapid antigen test with negative results, and she was then instructed to continue working on a general population hall (800 hall) for the remainder of her shift was reviewed with the Administrator. The Administrator stated that she thought NA #1 was moved to the COVID-19 unit (the 400 hall) after the antigen test was completed with negative results on 11/25/20. She revealed she found out on 12/21/20 that this information was inaccurate and that NA #1 completed her shift on the 800 hall, a general population hall, on 11/25/20 and worked on the same hall on 11/26/20 and 11/30/20. The Administrator explained that she recalled telling one of the staff members, unable to recall who, that NA #1 was to be moved to the COVID-19 unit on the 400 hall. She indicated that she thought it was okay for NA #1 to continue working as long as she was on the COVID-19 unit. The screening log for 11/26/20 that indicated NA #1 reported no symptoms of COVID-19 and NA #1 ' s interview that indicated she was experiencing body aches but had not reported this during her screening were reviewed with the Administrator. The Administrator indicated that NA #1 should have followed protocol and contacted either the scheduler or her team leader to report her symptoms prior to coming to the facility for her shift. She was unable to explain why this protocol was not followed. The screening log for 11/30/20 that indicated NA #1 reported symptoms of cough, vomiting, and diarrhea to the screener and NA #1 ' s interview that confirmed she reported these symptoms to the screener on 11/30/20 were reviewed with the Administrator. The Administrator stated that the screener should have contacted a Nurse Supervisor or the herself for further instruction

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 _____	12/30/2020

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 880	Continued From page 34	F 880		

and should not have permitted NA #1 to enter the facility until these instructions were received. She was unable to explain why this protocol was not followed. NA #1 ' s interview that she reported the symptoms of cough, vomiting, diarrhea, and loss of taste and smell to Nurse Supervisor #1 on 11/30/20 as well as Nurse Supervisor #1 ' s interview that she recalled NA #1 informing her of the loss of taste and smell on 11/30/20 and thought it was okay for NA #1 to continue working on a general population hall (800 hall) were reviewed with the Administrator. The Administrator stated that Nurse Supervisor #1 should have contacted her for instructions when these new symptoms were reported. She was unable to explain why Nurse Supervisor #1 had not followed this protocol. The screening log for 11/26/20 that indicated Nurse #4 had a temperature of 101.3 degrees and reported symptoms of cough, muscle pain, and headache during his screening was reviewed with the Administrator. The Administrator stated that the screener should have contacted Nurse Supervisor #1 or herself for further instruction and should not have permitted Nurse #4 to enter the facility until these instructions were received. She was unable to explain why this protocol was not followed. The Administrator further revealed that Nurse #4 should not have worked his shift with a fever and symptoms of cough, muscle pain, and a headache as these symptoms were consistent with COVID-19 and this created the potential for resident exposure and transmission of the virus. The Administrator was asked if there was any monitoring of the screening log routinely conducted. She indicated that the receptionist maintained all of the screening logs and that she, herself, randomly reviewed them to ensure all questions were answered, all blanks were filled

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 _____	12/30/2020

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 880	Continued From page 35	F 880		

in, and that no staff entered the facility after reporting a fever and symptoms of COVID-19. The Administrator revealed she had not noticed this 11/26/20 entry for Nurse #4 and was unaware he had a fever of 101.3 degrees and reported these symptoms (cough, muscle pain, and headache) to the screener and then worked on a general population hall (800 hall) during the 6:00 PM to 6:00 AM shift. She further revealed she had not noticed the 11/30/20 screening log entry for NA #1 (indicating symptoms of cough, vomiting, and diarrhea) when she reviewed the screening log.

A phone interview was conducted with Physician #1 on 12/21/20 at 4:05 PM. He stated that there were a variety of symptoms of COVID-19 and that each symptom could range from mild to severe. He reported that he expected the staff to report each and every symptom they experienced during screening or to one of their supervisors in accordance with the facility protocol. Physician #1 stated that some of the COVID-19 symptoms overlapped with cold, sinus, and/or allergy symptoms and that he still expected the staff to report these symptoms in accordance with the facility ' s protocol. He indicated that if a staff member reported symptoms that he expected an RT-PCR (Reverse-Transcriptase Polymerase Chain Reaction) test to be completed immediately and for the staff member not to work until those results were received and the staff was confirmed to be negative. He further indicated that he had not considered the antigen test (rapid test) to be a reliable instrument. Physician #1 revealed he was unaware that NA #1 reported symptoms of COVID-19 on 11/25/20 and was permitted to continue working on 11/25/20, 11/26/20, and

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 _____	12/30/2020

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 880	Continued From page 36	F 880		

11/30/20. He stated that NA #1 should have been sent home when she reported her symptoms (11/25/20) and not permitted to work until an RT-PCR test was completed and returned with negative results. Physician #1 further revealed he was unaware that Nurse #4 reported symptoms of COVID-19 on 11/26/20 during his screening and was permitted to enter the facility and work his scheduled shift. He stated that Nurse #4 should have been sent home and not permitted to work until an RT-PCR test was completed and returned with negative results.

2. During a phone interview on 12/22/20 at 5:45 PM the Infection Control Preventionist (ICP) acknowledged that not all of the symptoms noted in the facility ' s COVID-19 infection control policy (fevers, chills, cough, shortness of breath/breathing difficulty, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) were included on the facility ' s screening log. The screening log had not included fatigue, congestion or runny nose, and nausea. The ICP explained that staff were trained on all of the possible symptoms in accordance with their policy and were instructed to inform one of their supervisors of any symptom they experienced.

On 12/30/20 at 11:00 AM during an interview with the Administrator she provided a revised screening log that incorporated additional symptoms of COVID-19 that were now required to be asked during screening. The revised log included documentation of temperature and yes or no answers to all symptoms noted in the facility

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 _____	12/30/2020

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 880	Continued From page 37 ' s COVID-19 policy. The symptoms on the revised log were as follows: cough, sore throat, new shortness of breath or difficulty breathing, congestion or runny nose, fatigue, nausea, vomiting, diarrhea, chills and/or repeated shaking with chills, muscle or body aches, headache, and a new loss of taste or smell. The Administrator was notified of Immediate Jeopardy by phone on 12/23/20 at 10:17 AM. The facility provided the following credible allegation of Immediate Jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: All residents currently residing in the facility and staff working in the community have the potential to be exposed to COVID19. COVID-19 Is a highly contagious virus and can be easily spread in a congregate living setting among staff and residents. Failure of the staff to understand and report the signs and symptoms of COVID-19 could lead to transmission of the virus within the facility. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. 1) Staff Screening Tool has been reviewed and revised to reflect all signs and symptoms of	F 880		

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 _____	12/30/2020

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 880	Continued From page 38	F 880		

COVID-19 per the CDC guidelines. These updates were completed by Director of Quality and Risk.
The screening tool was updated on: 12/23/20 at 12:21 pm

2) All staff currently working have been interviewed to determine if they were experiencing any signs or symptoms of COVID19 based on CDC guidance. No staff currently working have symptoms or temperature. This screening of all staff currently working was completed by the Interim DON.
The staff screening was completed on 12/23/20 at 3:20 pm

3) Those staff who are assigned to screen staff entering the building will be re-educated to the process for what to do if a staff member reports ANY of the symptoms being screened for.

The individual assigned to screening staff on 12/23/20 received education and competency evaluation in the form of a post-test at 5:00 pm by the Director of Quality and Risk. All other staff assigned to screen staff at the entrance will have the re-education and post-test competency completed before working their next scheduled shift. The Director of Quality and Risk or designee will complete the education and competency testing for those assigned staff.

4) Education was immediately initiated on 12/23/20 at 5:00 pm to all staff currently working:
a. The signs and symptoms of COVID 19 based on CDC guidance
b. What they must do if they have ANY of these signs or symptoms regardless if they think it is COVID-19 related or not which includes:

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 _____	12/30/2020

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 880	Continued From page 39	F 880		

i. Call and notify DON, Administrator, or Infection Control nurse of any symptoms they are experiencing. Do not come to work if they have not arrived yet
ii. For any symptoms experienced at any time during your shift report the symptoms immediately to their supervisor, and exit the building
iii. Wait for further instruction from the DON, Administrator, or Infection Control Nurse or designee.
c. The screening process
i. the importance of answering these questions on the screening based on the symptoms you have, not based on why you believe you have the symptoms
d. They may not return to work until they have received clearance from the infection control nurse or designee who will follow current CDC guidelines.
e. Who to speak to if they have any questions about their symptoms
i. This will be the DON, Administrator, or the Infection Control Nurse

All other staff not currently working will have re-education and competency evaluation, to determine that the staff understand the material presented to them, completed before working their next scheduled shift. The education and competency validation will be completed by the Director of Nursing or designee.

5) The Administrator, Infection Control Nurse, DON, and nursing supervisors will be re-educated by VP of Operations to CDC guidance and the process to follow when a staff member reports having symptoms including isolating the staff member from the facility until cleared to work per

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 _____	12/30/2020

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 880	Continued From page 40	F 880		

CDC guidelines.
This re-education and competency testing in the form of a post-test to determine that they understand the information presented to them was initiated on: 12/23/20 at 5:10 pm for all of the required leaders.

6) The Administrator or designee will randomly round and interview 10 staff per week to ensure they understand signs and symptoms of COVID19 and feel comfortable reporting their symptoms.
These weekly audits will begin starting 12/24/20.

7) The Policy for Infection Control Chapter 13 on COVID-19 has been reviewed and revised as necessary by VP Of Quality based on CDC guidance.
This update occurred on 12/23/20 at 3:47 pm

The facility alleged the removal of Immediate Jeopardy on 12/23/20.

On 12/30/20 the credible allegation of Immediate Jeopardy (IJ) removal was validated by onsite verification. An interview was conducted with the screener (Screener #1) upon entrance to the facility and she confirmed she received education and completed a competency validation test. A review was conducted of the revised screening log, implemented 12/23/20, and it was confirmed to reflect all signs and symptoms of COVID-19 per CDC guidance. The facility ' s policy and procedures for COVID-19, titled "Infection Prevention and Control Manual Coronavirus (COVID-19)", was reviewed and confirmed to be revised. A review of inservice sign in sheets confirmed the screener working on 12/23/20

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 _____	12/30/2020

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 880	Continued From page 41 received education and a competency validation test and that all other screeners completed the education and competency validation test prior to working their next scheduled shift. A review of inservices, inservice sign in sheets, interview documentation, as well as staff interviews with various disciplines (Nurses, NAs, Housekeeping staff, Rehabilitation staff, Activities staff) verified the following information: 1) All staff who were working on 12/23/20 were interviewed to determine if they were experiencing any signs or symptoms of COVID-19 based on CDC guidance. 2) All staff received education on: the signs and symptoms of COVID 19 based on CDC guidance; what they must do if they have any of these signs or symptoms regardless if they think it is COVID-19 related or not; the screening process and the importance of answering these questions on the screening based on the symptoms you have, not based on why you believe you have the symptoms; that staff may not return to work after experiencing symptoms until they have received clearance from the infection control nurse or designee who will follow current CDC guidelines; and who to speak to if they have any questions about their symptoms (DON, Administrator, or the Infection Control Nurse). The inservice education was confirmed to be conducted for all staff working on 12/23/20 and for all other staff the education was completed prior to working their next scheduled shift. 3) All staff were required to complete a competency validation test on all education received. This competency validation test was conducted for all staff working on 12/23/20 and for all other staff the competency validation was completed prior to working their next scheduled shift.	F 880		

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 _____	12/30/2020

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 880	Continued From page 42	F 880		

The inservice sign in sheets and an interview with the Administrator confirmed education was provided to herself, the ICP, DON, and nursing supervisors by the Vice President of Operations and that competency validation testing was also completed. This education and competency validation testing was conducted for all of the noted staff members who were working on 12/23/20 and for all other noted staff members prior to working their next scheduled shift. A review was conducted of the facility ' s screening logs from 12/23/20 through present with no concerns identified. A review of the weekly monitoring audits through 12/30/20 confirmed 10 staff were interviewed per week to ensure they understood the signs and symptoms of COVID-19 and felt comfortable reporting their symptoms. The facility ' s IJ removal date of 12/23/20 was validated.

3. The facility ' s policy and procedure titled "Infection Prevention and Control Manual Coronavirus (COVID-19)" implemented on 3/28/20 and last revised on 12/11/20, stated "For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility."

The facility ' s COVID-19 staff surveillance log was provided on 12/16/20 at 1:39 PM by the Risk Manager (RM). This log revealed NA #4 tested positive for COVID-19 during weekly testing completed on 11/2/20. This log further revealed a notation that NA #4 reported that she sometimes pulled her mask down in resident rooms if the room was too hot and that she noted 2 resident rooms (Residents #9 and #10) that she potentially may have pulled her mask down in on 11/2/20.

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 _____	12/30/2020

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 880	Continued From page 43 A review of the facility ' s COVID-19 resident surveillance log was conducted on 12/16/20. This log indicated Resident #10 tested positive for COVID-19 during routine testing on 12/14/20 and there were no positive test results noted for Resident #9. A phone interview was conducted with NA #4 on 12/22/20 at 7:05 PM. The COVID-19 staff surveillance log that indicated she reported that she sometimes pulled her mask down in resident rooms if the room was too hot and that she noted 2 resident rooms (Residents #9 and #10) that she potentially may have pulled her mask down on 11/2/20 was reviewed with NA #4. NA #4 verified that during her shift on 11/2/20 she had pulled her mask down a couple of times when it was hot in a resident ' s room as she was having difficulty breathing. She stated that she was trained to wear her facemask at all times in resident care areas and that if she needed to remove her mask she should exit the resident care areas and ensure she followed social distancing guidelines before removing her mask. During an interview with the Infection Control Preventionist and Administrator on 12/16/20 at 12:00 PM they both indicated that staff were not to remove their facemask at anytime while in a resident care area.	F 880		