STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	C 01/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to implement care plan interventions by not ensuring ear cushions were in place on oxygen tubing, that bedside floor mats were in place, that oxygen be in place at all times, that glenn sleeves were applied to both arms and that a gait belt was used for safe transfers for 1 of 3 residents. (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/21/2016 from an acute care hospital after receiving treatment for a left hip fracture. Her cumulative diagnosis included COPD, congestive heart failure (CHF), respiratory failure with hypoxia and dependent on oxygen administration. Review of the comprehensive significant change Minimum Data Set (MDS) dated 01/09/2017 revealed that Resident #1 was unable to participate in the cognitive assessment, had short and long term memory impairments with no memory or recall ability. The resident received oxygen therapy and Hospice care. Resident #1 also required extensive assist for transfers and toilet use. The MDS also revealed that Resident #1 also had skin tears. The MDS also revealed that Resident #1 had had 2 falls without injury and 1 fall with an injury that was not major.	F 282	F282 483.21(b)(3)(ii) SERVICES BY QUALIFID PERSONS/ PER CARE PLAN Saint Joseph of the Pines Health Center does provide services as outlined by the comprehensive care plan by qualified persons in accordance with each resident's written plan of care. Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Corrective Action: Resident #1 was discharged from facility on 1-23-17. All residents with orders with ear cushions for oxygen tubing were verified in place on 2-10-17. All residents with orders for bedside mats were verified in place on 2-10-17. All residents with orders for oxygen were	2/20/17

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

Electronically Signed | 02/12/2017

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F 282	Continued From page 1 Review of Resident #1 ' s care plans revised on 01/16/2017 revealed that oxygen was administered via nasal cannula (NC) and that the resident received nebulizer treatments. The goal was that Resident #1 would not experience shortness of breath (SOB) or respiratory distress times 90 days. The interventions included to ensure that ear cushions were in place on the oxygen tubing at all times, assess lung sounds every shift and as needed (prn), assess for SOB, assess oxygen saturation level every shift and prn and to check the oxygen tank in frequent intervals to ensure enough oxygen supply. Resident #1 had a care plan for risk for skin injury related to fragile skin as evidenced by skin tears and bruises. The goal included that Resident #1 ' s right arm skin tear would improve and have no further skin impairment times 90 days and intervention included glenn sleeves to bilateral arms at all times as tolerated. Resident #1 had a care plan that revealed in part that 1 to 2 staff were needed for transfers related to poor safety awareness. The goal was to maintain maximum hygiene and appearance ...times 90 days. Interventions included to have 2 persons and a gait belt for all transfers. A care plan was reviewed that revealed that Resident #1 was at risk for falls related to fall history, poor safety awareness and impaired safety awareness and a decline in physical function with a goal to remain free of major injuries from falls during " my stay. " The interventions included a low bed with bilateral mats for safety. A review of the cumulative monthly physician orders effective on 01/01/2017 included an MD order to check oxygen ear cushion placement every shift. An observation on 01/19/2017 at 11:35AM of Resident #1 in low bed with nasal cannula oxygen	F 282	verified to have oxygen on and at current prescribed setting on 2-10-17. Systemic Change: By 2-17-17 all residents with oxygen will have nursing interventions/orders updated to verify oxygen placement at prescribed oxygen setting every four hours and as needed on the Treatment Administration Record (TAR). Residents with orders for ear cushions for oxygen tubing will also require documentation to verify placement every shift on TAR. By 2-17-17 all residents with orders for glenn sleeves will be updated to include “or long sleeves”. Residents with orders for glenn sleeves or long sleeves will require documentation on TAR to verify placement every shift. By 2-17-17 all residents with orders for bedside mats will require documentation on TAR to verify placement every shift. By 2-20-17 nursing staff will be re-educated on adhering to the plan of care for residents meeting the following criteria: • Residents on oxygen requiring ear cushions for oxygen tubing. • Residents requiring bed mats on the floor. • Residents requiring the use of glenn sleeves • Residents requiring the use of gait belts for one and two person transfers. By 2-20-17 nursing staff will be	

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F 282	Continued From page 2 in place without ear cushions on tubing around either ear. Glenn sleeves were not observed on either of Resident #1 ' s arms. One fall mat was next to the bed on the right side of Resident #1 ' s bed. An observation on 01/20/2017 at 10:00 AM of Resident #1 sitting in chair in the common area oxygen tubing around ears with no ear cushions in place and glenn sleeves not in place to either arm. An interview conducted on 01/20/2017 at 10:03 AM with Nurse #2 revealed that she checked the oxygen settings on the oxygen concentrator or the oxygen tank for Resident # 1 at random times during the shift and documented the correct setting on the Medication Administration Record (MAR), but that there were not any specific times to check if oxygen tanks had oxygen in them or were set at the proper setting and that she just checked the oxygen tanks and concentrators randomly during her shift and replaced them if the valve indicated the tank was empty or set the ordered oxygen setting as ordered by the MD if it needed to be adjusted. Nurse #2 stated that she had not had a chance to check if Resident #1 had glenn sleeves on or if the oxygen tubing around Resident #1 ' s ears had cushions in place. Nurse Assistant (NA) #3 was interviewed on 01/20/2016 at 5:34 PM and revealed that on 01/17/2017, she was assigned to Resident #1 and that she had been told by the nurse that Resident #1 needed to be toileted. NA #3 stated that she transferred Resident #1 from the bed to the wheel chair without assistance and that she did not recall that she had used a gait belt during the transfer of Resident #1. NA #3 revealed that prior to transferring Resident #1 to the wheel chair and taking her to the toilet that she, NA #3, had removed the oxygen from resident #1 and	F 282	re-educated on how to safely transfer resident with gait belt with one-person and two-person assistance with and without oxygen. Monitoring: Assistant Director of Nursing or nursing supervisor will perform an audit monitoring each resident receiving oxygen for documentation of oxygen placement and setting checked, and documentation of placement of ear cushions, glenn sleeves or longs sleeves, and bedside mats for two weeks; then, weekly for one month; then monthly for three months. Assistant Director of Nursing will report results of the audits to the MDQAPI committee until substantial compliance has been achieved. Nursing Supervisor or charge nurse will observe the safe transfer of five residents by nursing staff using a gait belt to include at least one transfer of an oxygen dependent resident every day for two weeks; then one resident daily for one month, then one resident weekly for three months. Director of Nursing will report results of the audits to the MDQAPI committee until substantial compliance has been achieved.	

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F 282	Continued From page 3	F 282		

that oxygen was not used during transfer and toileting, but was placed back on Resident #1 when she was finished using the toilet. NA #3 was not able to confirm if a gait belt was needed when transferring or toileting Resident #1, but that she carried a gait belt and would use it if she determined that a resident was " wobbly or unstable. " NA #3 could not recall if Resident #1 needed to have oxygen in place during transfers or when toileting.

An interview with Nurse # 3 was conducted on 01/20/2017 at 5:36 PM. Nurse #3 stated that on 01/17/2017 she was present in the room of Resident #1, meeting with family members of Resident #1, when NA #3 was asked to take assist Resident #1 to the toilet. Nurse #3 did recall that there was only one floor mat on one side of the bed which was moved when NA #3 transferred the Resident from the bed to the wheel chair to the bathroom and that the NA (#3), did not use a gait belt when she transferred Resident #1 from surface to surface and that Resident #1 did not have any oxygen on during the transfer or while she was using the toilet. Nurse #3 stated that the oxygen was replaced after Resident #1 was brought back to her bedside and that she (Nurse #3) had observed that Resident #1 was experiencing shortness of breath at that time. Nurse #3 revealed that she was aware that Resident #1 was to wear oxygen at all times, that a gait belt should have been used to transfer Resident #1 and that there was only one floor mat next to the bed instead of 2, but she had been in conversation with the family of Resident #1 and had not realized that the interventions that had been care planned for Resident #1 had not been implemented until interviewed at the time of the interview on 01/17/2017 at 5:36 PM.

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F 282	Continued From page 4 The Director of Nurses (DON) was interviewed on 01/20/2017 at 6:13PM and revealed that there was no way to determine the oxygen amount in an oxygen tank, but it was the licensed nurse responsibility to check both oxygen tank and oxygen concentrator settings at least every shift or as ordered by the MD and to record that information on the MAR or a nurse progress note as ordered by the MD. The DON stated that her expectation was that oxygen be administered as the MD ordered and that both oxygen tanks and oxygen concentrators settings be checked at least once a shift and that the licensed nurse replace empty tanks and verify correct oxygen settings randomly during their shift. The DON stated that NAs could remove and replace oxygen tubing as needed during care, but were not to adjust the oxygen settings on the oxygen tank or concentrator and not to replace empty tanks or to turn either device on or off as this was a licensed nurse responsibility. The DON also revealed that her expectation was that MD orders and care plan interventions be implemented by all staff members as directed and that care plan interventions needed to be appropriate and individualized for each resident.	F 282		