STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	05/25/2017

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 000	INITIAL COMMENTS The Statement of Deficiencies was amended on 06/15/17 at tag F428.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		6/22/17

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

Electronically Signed | 06/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (#62), behaviors (#260), and pressure ulcers (#246) for 3 of 13 sampled residents. The findings included: 1. Resident #62 was initially admitted to the facility on 8/14/14 and most recently readmitted on 12/26/16 with multiple diagnoses that included anxiety. A physician's order dated 1/11/17 for Resident #62 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) every one hour as needed (PRN). The significant change Minimum Data Set (MDS) assessment dated 4/13/17 indicated Resident #62's cognition was intact. Section N, the Medications section, indicated Resident #62 received antianxiety medication on 4 of 7 days during the MDS look back period (4/7/17 through 4/13/17). A review of the Medication Administration Record (MAR) for the look back period of Resident #62's 4/13/17 MDS indicated she had been administered Ativan on 5 of 7 days (4/7, 4/8, 4/9, 4/10, and 4/13) during the MDS look back period (4/7/17 through 4/13/17). An interview was conducted with the MDS Nurse on 5/25/17 at 10:55 AM. Section N of the 4/13/17 MDS that indicated Resident #62 had received antianxiety medication on 4 of 7 days during MDS	F 278	Saint Joseph of the Pines Health Center (provider) seeks to provide assessments that accurately reflect the residents' statuses. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F278 Element #1 Resident #62's Minimum Data Set (MDS) has been reviewed by MDS Supervisor on 5-25-17 and accurately reflects the medication regimen at the time of assessment. Resident #260's no longer resides at facility. Resident #246's MDS has been reviewed by MDS Supervisor on 5-25-17 and accurately reflects pressure ulcers and/or skin condition at the time of the assessment. Element #2 Residents currently residing in the community and new admissions who are receiving anxiolytic/anti-anxiety	

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F 278	Continued From page 2 look back period was reviewed with the MDS Coordinator. Resident #62's MAR for the 4/13/17 MDS look back period that indicated she had received antianxiety medication on 5 of 7 days was reviewed with the MDS Coordinator. She revealed Resident #62's 4/13/17 MDS was inaccurately coded for antianxiety medication. She reported the 4/13/17 MDS should have indicated Resident #62 was administered antianxiety medication on 5 of 7 days during the look back period rather than 4 of 7 days. The MDS Nurse indicated that was an oversight. An interview was conducted with the DON on 5/25/17 at 11:10 AM. She indicated her expectation was for the MDS to be completed accurately. 2. Resident #260 was admitted to the facility on 1/3/17 with multiple diagnoses that included dementia. A nursing note dated 1/14/17 indicated Resident #260 was confused and delusional. The significant change Minimum Data Set (MDS) assessment dated 1/17/17 indicated Resident #260 had severely impaired cognition. Section E, the Behavior section, indicated Resident #260 had no delusions during the 7 day MDS look back period (1/11/17 through 1/17/17). An interview was conducted with the MDS Nurse on 5/25/17 at 10:56 AM. Section E of the 1/17/17 MDS that indicated Resident #260 had no delusions during the 7 day MDS look back period was reviewed with the MDS Coordinator. The nursing note dated 1/14/17 that indicated	F 278	medications; those exhibiting behaviors; and those with pressure ulcers have the potential to be affected. These residents will be reviewed by the Director of Nursing and MDS Interdisciplinary Team (IDT) members by 6-21-17 to ensure coding accuracy of the MDS. Element #3 The current Resident Assessment Instrument (RAI) Manual version 1.14 is available as a reference for the MDS team to ensure accurate coding of the MDSs. The MDS Nurse responsible for coding the targeted resident assessments received education on 6-22-17 from the MDS Coordinator on Section M – pressure ulcer coding including appropriate use of present on admission versus facility acquired pressure ulcers. Section N – medication use. Section E – behaviors. The MDS Interdisciplinary Team (IDT) members responsible for coding sections M, N, and E also received education on 6-22-17. Element #4 Residents' with changes to anxiolytic/anti-anxiety medication(s), those exhibiting behavioral symptoms, and those with pressure ulcers will be identified through the clinical morning meeting led by the Director of Nursing or Assistant Director of Nursing and the corresponding MDS will be audited to ensure coding accuracy in Section E,	

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F 278	Continued From page 3 Resident #260 had delusions was reviewed with the MDS Coordinator. She revealed Resident #260's 1/17/17 MDS was inaccurately coded for delusions. She reported the 1/17/17 MDS should have indicated Resident #260 had delusions during the look back period. The MDS Nurse indicated that was an oversight. An interview was conducted with the DON on 5/25/17 at 11:10 AM. She indicated her expectation was for the MDS to be completed accurately. 3. Resident #246 was admitted to the facility on 9/7/16 with multiple diagnoses including End Stage Renal Disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 5/3/17 indicated that Resident #246 had one stage 3 pressure ulcer and one stage 4 pressure ulcer. Review of the facility's weekly ulcer tracking forms was conducted. The tracking form revealed that Resident #246 was admitted on 9/7/16 with a stage 4 pressure ulcer on her right buttock. The tracking form dated 3/23/17 revealed that the stage 4 pressure ulcer on the right buttock had resolved. On 5/25/17 at 11:05 AM, the MDS Nurse was interviewed. She reviewed the MDS assessment dated 5/3/17 and the weekly wound tracking and acknowledged that the MDS assessment was not accurate. She indicated that Resident #246's pressure ulcer on the right buttock had been resolved and she had only one pressure ulcer during the assessment period. On 5/25/17 at 11:10 AM, the Director of Nursing	F 278	Section N, and Section M as applicable. Trinity Health Senior Communities Corporate Assessment Consultant(s) will perform random audits of five MDSs every week for four months then as directed by the Mission Driven Quality Assurance and Process Improvement (MD-QAPI) Committee to ensure coding accuracy and/or corrections are made prior to submission by communicating findings with the Director of Nursing/MDS Coordinator. Findings of audits will be reported to the Director of Nursing weekly. The Director of Nursing will report trends and corrective actions to the MD-QAPI Committee monthly for review and recommendation until such time that substantial compliance has been achieved. The Director of Nursing is responsible for attaining and sustaining compliance Element #5 The facility alleges compliance effective 6/22/2017	

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F 278	Continued From page 4 (DON) was interviewed. She stated that she expected the MDS assessments to be accurate.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		6/22/17

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F 280	Continued From page 5 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280		

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F 280	Continued From page 6 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to revise the care plan for pressure ulcer for 1 (Resident #246) of 3 sampled residents reviewed. Findings included: Resident #246 was admitted to the facility on 9/7/16 with multiple diagnoses including End Stage Renal Disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 5/3/17 indicated that Resident #246 had one stage 3 pressure ulcer and one stage 4 pressure ulcer. Review of the facility's weekly ulcer tracking forms was conducted. The tracking form revealed that Resident #246 was admitted on 9/7/16 with a stage 4 pressure ulcer on her right buttock. The tracking form dated 3/23/17 revealed that the stage 4 pressure ulcer on the right buttock had resolved. Resident #246's care plan with the review date on 5/11/17 was reviewed. The care plan problem was "I have a stage 3 and stage 4 pressure ulcer related to decline in bed mobility and ambulation." The goal was "I will have improvement in sacrum and right buttock and no further pressure ulcer daily in 90 days." On 5/24/17 at 10:35 AM, Resident #246 was	F 280	F280 Element #1 Resident #246's care plan was reviewed by the MDS Coordinator and updated accordingly on 5-25-17. Element #2 Residents currently residing in the community and those newly admitted who have pressure ulcers have the potential to be affected. These residents' care plans have been reviewed by the Director of Nursing and MDS Interdisciplinary Team (IDT) members by 6-21-17 and updates made accordingly to ensure they accurately reflect the issues, goals, and interventions of the resident's active needs for pressure ulcer management. Clinical Care Coordinators (CCC)or nursing supervisors by 6-21-17 will present new admissions with pressure ulcers for review during the clinical morning meeting led by the Director of Nursing/Designee to ensure pressure ulcers are addressed on the care plan. Element #3 The MDS team will be educated by Trinity	

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F 280	Continued From page 7 observed during the dressing change. Resident #246 was observed to have only one pressure ulcer. On 5/25/17 at 11:05 AM, the MDS Nurse was interviewed. She reviewed the care plan of Resident #246 and acknowledged that the care plan should have been revised to resolve the right buttock pressure ulcer. She indicated that Resident #246's pressure ulcer on the right buttock had been resolved on 3/23/17 and she had only one pressure ulcer when the care plan was reviewed in May 2017. On 5/25/17 at 11:10 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the care plan to be reviewed and revised.	F 280	Health Senior Communities Corporate Assessment Consultant on accurately completing the care plan to reflect the residents' current wound status by 6-22-17. Element #4 The CCC's or nursing supervisor will perform audits of care plans for residents with pressure ulcers to ensure accuracy every week for one month, then every other week for one month, then monthly for three months. Findings of the audits and corrective actions taken will be reported to the Director of Nursing weekly. The Director of Nursing will report trends to the MD-QAPI Committee monthly for review and recommendations. This will continue until substantial compliance is achieved and as further directed by the MD-QAPI Committee. The Director of Nursing is responsible for attaining and sustaining compliance. Element #5 The facility alleges compliance effective 6/22/2017.	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		6/22/17

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F 314	Continued From page 8 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to assess the evolution of a pressure ulcer before the pressure ulcer became unstageable for 1 of 3 residents reviewed for pressure ulcers (Resident #282). The findings included: Resident #282 was admitted to the facility 3/17/17. Cumulative diagnoses included fracture of the left femur (bone in the upper leg), dysphagia (difficulty swallowing), chronic kidney disease, urinary incontinence, frailty and dementia. A nursing admission assessment dated 3/17/17 indicated Resident #282 was admitted with a stage 1 sacrum pressure ulcer (intact skin with non-blanchable redness of localized area). Measurements were noted as 6 centimeters in length, 4.5 centimeters in width with no depth. Skin risk screener dated 3/17/17 indicated	F 314	F314 Element #1 Resident #282 no longer resides at the facility. Element #2 Residents currently residing in the community and those newly admitted with pressure ulcers or identified as being at high risk on their most recent risk assessment have the potential to be affected. All residents by 6-21-17 have had a skin assessment completed and care plans inclusive of pressure ulcer management for those identified as high risk interventions updated/developed as appropriate by a licensed nurse. Element #3	

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F 314	Continued From page 9 Resident #282 was at moderate risk for development of pressure ulcer. Sensory perception was slightly limited. Skin was very moist. Resident #282 was bedfast with very limited mobility. Nutrition was adequate. Friction and shear was a potential problem. Risk factors included the following: bony deformities/ contractures, coronary artery disease, cerebrovascular accident, existing pressure ulcer, recent hospitalization and diabetes. A physician order dated 3/17/17 stated skin checks every shift x 3 days. Weekly skin check to be completed x 4 weeks every night shift Friday night. Cleanse sacrum with normal saline. Pat dry. Apply skin prep and allow to dry. Cover with protective dressing. Change every 3 days and as needed. An Admission Minimum Data Set dated 3/24/17 indicated Resident #282 was moderately impaired in cognition. She required extensive assistance with bed mobility, toileting, personal hygiene and total assistance with transfers and bathing. Resident #282 was frequently incontinent of bladder and always incontinent of bowel. Skin condition was documented that Resident #282 had one stage 1 pressure ulcer that was present on admission. A weekly wound tracking form completed by Nurse #4 dated 3/24/17 revealed the sacrum pressure ulcer was resolved with 100% epithelial tissue (new skin). Treatment of Skin prep continued as preventative treatment. There was no indication on the form that the physician was notified of the resolution of the pressure ulcer. A care plan dated 3/29/17 stated Resident #282	F 314	Licensed nursing staff by 6-21-17 will be reeducated by the Director of Nursing Services or nursing supervisor on skin/pressure ulcer management including: notifying physician, resident, or responsible party of the presence of and the evolution of a pressure ulcer, and completing and documenting skin assessments/evaluations as scheduled or ordered. Certified nursing assistants by 6-21-17 will be reeducated by the Director of Nursing Services or nursing supervisor on completing skin checks while providing activity of daily living cares and notifying licensed nursing staff of any noted changes of resident's skin. Licensed nurses and certified nursing assistants will not be scheduled to work after 6/22/2017 until they have received this education. Element #4 New admissions will have skin assessment, scheduled skin checks, orders, and care plans validated within 24 hours of admission by a nurse supervisor or Clinical Care Coordinator (CCC) to ensure accuracy. CCC's and nursing supervisors will begin auditing 15 residents including visual observation to ensure that weekly skin checks are completed by licensed nursing staff as scheduled or ordered and any	

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F 314	Continued From page 10 was at risk for skin breakdown. Interventions included check skin every shift for redness and irritation and report all skin issues to the charge nurse. Cushion to wheelchair. Provide protective/ preventive skin care after each toileting/ incontinent episode. Turning and repositioning every two hours and as needed. A Care Area Assessment dated 3/30/17 stated Resident #282 was at risk for developing pressure ulcers due to a decline in bed mobility requiring extensive/total assistance. She had a left femur fracture, was alert with intermittent confusion and short term memory loss. Resident #282 had a stage 1 ulcer to sacrum on admission and the area was healed. Staff would continue to monitor skin condition daily during dressing, bathing or complaints of discomfort; use protective skin care as needed and continue to turn and reposition every two hours and as needed to prevent further skin breakdown. Food intake varied and a supplement had been added to increase protein and calories and to aid in wound healing. Proceed to care plan. A weekly skin check form dated 3/31/17 stated treatment continued to the sacrum for protection. A nursing note dated 4/12/17 stated sacral wound dressing has been changed this shift. Dressing is clean, dry and intact. Resident had an air mattress that was on and functioning properly. A weekly skin check form dated 4/15/17 completed by Nurse #3 stated sacrum pressure ulcer received ongoing treatment. The treatment, at this time, was the application of Skin prep to the resolved pressure ulcer area and protective foam dressing every three days and as needed.	F 314	noted changes are documented in the medical records every week for one month, then every other week for one month, then monthly for three months. Validations, audits, and actions taken will be submitted to the Director of Nursing weekly. The Director of Nursing will submit trends to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as further directed by the committee. The Director of Nursing is responsible for attaining and sustaining compliance. Element #5 The facility alleges compliance effective 6/22/2017	

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F 314	Continued From page 11	F 314		

There was not a description of the sacrum pressure ulcer.

A weekly wound tracking form completed by Nurse #4 dated 4/20/17 revealed Resident #282 had an unstageable pressure ulcer to the sacrum (slough and/or eschar known but not stageable due to coverage of the wound bed by slough and/or eschar). Date of onset: 4/20/17. Measurements were noted as 4.5 centimeters in length x 3 centimeters in width and 1.5 centimeters in depth. No undermining was noted. Serosanguinous (bloody/ clear drainage) was noted with scant exudate. 100% slough. Present treatment was Skin prep and a protective dressing. New treatment: Medihoney (honey wound care product) to the wound bed and dry with dressing daily. The physician was notified and a physician order dated 4/20/17 stated to discontinue the previous wound order to sacrum. Begin cleansing sacral wound with normal saline, pat dry, apply Skin prep to periwound and allow to dry. Apply Medihoney to wound bed and cover with dry cover dressing. Change dressing daily and as needed.

A care plan dated 4/20/17 indicated Resident #282 had a pressure ulcer on the sacrum. Interventions included limit time in chair/ wheelchair to meal time due to inability to reposition self. Treatment to the sacrum pressure ulcer as ordered by the physician. An addition to the interventions added on 4/27/17 included the use of a wedge to keep Resident #282 side to side in the bed as tolerated. On 4/27/17, ensure air mattress was in place and functioning properly every shift and as needed.

A physician order dated 4/27/17 clarification

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order: air mattress to bed due to impaired skin integrity as evidenced by a pressure ulcer.

A review of the April 2017 and May 2017 revealed documentation that the air mattress was in place from 4/27/17 through Resident #282 ' s discharge on 5/8/17.

An initial wound physician progress note dated 4/27/17 stated Resident #282 was being seen for an unstageable sacrum pressure ulcer. Modifying factors included the following: pressure, medihoney, debility, poor intake, age and immobility. The wound was open. Original cause of wound was pressure injury. Measurements: 6.5 centimeters in length x 3.5 centimeters in width x 0.1 centimeters in depth. No granulation tissue was noted in the wound bed. There was a large amount of necrotic tissue within the wound bed including eschar and adherent slough. Periwound (skin around the pressure ulcer area) skin appearance exhibited induration, localized edema, moist, cyanosis and erythema

A wound physician order dated 4/27/17 stated to apply collagenase ointment (a debriding agent) to the sacrum pressure ulcer daily and as needed followed by moistened gauze with normal saline. Cover with bordered sacral foam daily and as needed. Air mattress. Limit sitting to meals and bathroom only. Strict turn every two hours and as needed. Refer to general surgery soon for probable surgical debridement of unstageable sacrum pressure ulcer.

A weekly wound tracking form completed by Nurse #6 dated 4/28/17 revealed Resident #282 had an unstageable sacrum pressure ulcer.

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Measurements were noted as 6.5 centimeters in length x 3.5 centimeters in width and 0.1 centimeters in depth. The tissue type was necrotic (black, brown or tan tissue that adhered firmly to the wound bed or ulcer edges and could be either firmer or softer than surrounding tissue). Treatment: collagenase ointment and dressing to be changed daily and as needed.

A wound physician progress note dated 5/4/17 stated Resident #282 had a scheduled appointment with the surgeon for evaluation regarding surgical debridement of the sacrum pressure ulcer. The pressure ulcer was unstageable with 100% black necrotic tissue. Induration had resolved. There was faint erythema and not evidence of deep tissue injury noted. Measurements: 8.7 centimeters in length x 4.5 centimeters in width and 3 centimeters depth.

A physician order dated 5/4/17 stated to discontinue the collagenase. Apply (name) solution (an antiseptic solution that contained sodium hypochlorite used to treat infected wounds) and moistened gauze daily and as needed to sacrum pressure ulcer.

A physician assistant progress note dated 5/5/17 stated Resident #282 was seen due to a physical decline and elevated white blood count. Resident #282 had a sacrum ulcer that was being treated by the wound care team. The sacrum ulcer was noted to be malodorous (foul smelling). The sacrum pressure ulcer had not improved.

A nursing note dated 5/8/17 stated Resident #282 had an appointment with the surgeon for evaluation of her sacrum ulcer. She was sent

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from the physician office to the hospital with an admitting diagnosis of stage 4 pressure ulcer ((full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed).

On 5/24/17 at 2:07 PM, an interview was conducted with Nurse #4 who was also the Assistant Director of Nursing. She stated the pressure ulcer on the sacrum was resolved on 3/24/17. On 3/31/17, nursing staff continued with skin prep to the sacrum as preventative treatment. She said, according to the documentation, the sacral area was still resolved at that time. Nurse #4 said she was doing other treatments on the hall on 4/20/17 when NA#1 asked her if she was going to do the treatment for resident #282. Nurse #4 said she was not aware that Resident #282 had a wound so she went into the room and examined Resident #282. At that time, she said she found an unstageable pressure ulcer on the sacrum. It encompassed the whole area around the coccyx. The date of onset was noted as 4/20/17 because that was the day Nurse #4 was made aware of it. Nurse #4 said she changed the treatment for the sacrum wound on 4/20/17 according to the facility wound protocol. Nurse #4 said she did not see the wound after 4/20/17. She said the physician and family were made aware of the pressure ulcer area.

On 5/24/17 at 2:16 PM, an interview was conducted with the Director of Nursing. She stated the wound team stopped seeing Resident #282 after the sacrum healed on 3/24/17. She revealed that skin checks were supposed to be done by the nursing assistants every shift as part of their activity of daily living (ADL)

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documentation. If something was noted, the nursing assistant was supposed to notify the nurse, Clinical Care Coordinator or the Assistant Director of Nursing as soon as they saw a change in the skin alteration.

On 5/24/17 at 2:46 PM, an interview was conducted with NA #1. She said she provided care for Resident #282 on 4/20/17. That was the first time she had seen Resident #282. NA #1 said she saw a pressure ulcer on the top part of the bottom. The whole area was red around the outer edges and it was black in the middle. The black area was like a golf ball. She stated she opened the door and saw Nurse #4 and asked her about the treatment for Resident #282.

On 5/24/17 at 4:13 PM, an interview was conducted with Nurse #5 and Nurse #6. They stated they saw Resident #282 one time on 4/28/17 with the wound nurse practitioner. Both stated they had not seen the sacrum pressure ulcer prior to that date and did not see her again due to the fact Resident #282 was discharged to the hospital on 5/8/17. They said, on 4/28/17, the sacrum pressure ulcer was covered with black tissue.

On 5/24/17 at 4:54 PM, an interview was conducted with Nurse #3. She stated she documented the weekly skin check form on 4/15/17. She stated there was a dressing in place over the sacrum at the time she completed the assessment and she did not remove the dressing. She stated, if there was a dressing in place at the time of the weekly skin assessment, she did not remove the dressing to see the area under the dressing. Nurse #3 also stated she changed the sacrum wound dressing on 4/14/17

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F 314	Continued From page 16 but did not remember what the sacrum area looked like at the time she completed the dressing change. Nurse #3 did not give any type of description of the sacrum area observed during the dressing change on 4/14/17. On 5/25/17 at 8:10 AM, an interview was conducted with NA#2. She stated she was the treatment aide on 4/17/17 and documented that she changed the sacrum dressing on 4/17/17. She said she did not remember the sacrum pressure ulcer ever looking bad and was unable to remember the appearance of the sacral wound on 4/17/17. She said the Assistant Director of Nursing went in with her every time she completed the pressure ulcer care but could not remember what the pressure ulcer looked like on 4/17/17. On 5/25/17 at 8:13 AM, an interview was conducted with the Director of Nursing. She stated, if the area was resolved on 3/24/17, the nursing assistants doing the skin check twice daily should have notified the nurse if the area was getting worse or reopened. With the dressing change being done by licensed staff, licensed staff should have identified a worsening of the pressure area and notified their direct supervisor, physician or Director of Nursing immediately and changed the preventive treatment earlier.	F 314		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		6/22/17

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F 329	Continued From page 17 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to document evidence to support a clinical rationale for the reinitiation of an antipsychotic medication (Resident #62), failed	F 329	F329 Element #1	

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F 329	Continued From page 18 to monitor target behaviors and side effects for a resident on an antipsychotic medication for a period of 84 days (Resident #196), and failed to discontinue Mucinex DM (a cough medicine that contains dextromethorphan, a cough suppressant, and guaifenesin, an expectorant) as ordered by the physician (Resident #240) for 3 of 6 residents reviewed for Unnecessary Medications. The findings included: 1. Resident #62 was initially admitted to the facility on 8/14/14 and most recently readmitted on 12/26/16 with multiple diagnoses that included dementia without behavioral disturbance, unspecified psychosis, depression, and anxiety. A review of Resident #62's physician's orders indicated she was discontinued from Risperdal (antipsychotic medication) 0.25 milligrams (mg) once daily on 11/10/16. A Psychiatric Nurse Practitioner (PNP) note dated 2/15/17 indicated Resident #62's moods were well controlled. She had a history of recent psychosis, but had no Auditory/Visual Hallucinations (AVH). A physician's note dated 3/2/17 indicated Resident #62 had been admitted to hospice care, but was improving in health status. She was observed to be smiling and was in no distress. A PNP note dated 3/15/17 indicated Resident #62's moods were well controlled. She had a history of recent psychosis, but had no AVH. The March 2017 Psychoactive Medication Monthly Flow Record indicated Resident #62's target behavioral symptoms were depression and	F 329	Resident #62 continues to receive her anti-psychotic medication as ordered by the physician with a clinical justification documented for continued usage. Targeted behaviors and medication side effects are monitored daily by the clinical staff. Resident #196 no longer resides at the facility. Resident #240 had Mucinex DM discontinued on 5/25/2017 Element #2 Residents currently residing in the community and those newly admitted with orders for antipsychotic medication have the potential to be affected. These residents' medication regimens by 6-21-17 have been reviewed by the Director of Nursing or nursing supervisor to ensure the order is in compliance with the regulatory requirements for antipsychotic use, that targeted behaviors are documented, and that the medications remain necessary and are transcribed accurately. Orders, targeted behaviors, medication administration records, and care plans will be updated accordingly. Element #3 Pharmacy consultant received education on 6/7/2017 from the Vice President of Health Services to identify and report in monthly consultant reports any specific residents who are missing documentation	

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F 329	Continued From page 19 anxiety. Resident #62 was noted with anxiety on 3/1/17, 3/2/17, and 3/26/17. Resident #62 was not noted with any symptoms of psychosis or AVH. The March 2017 Weekly Nursing Assessments for Resident #62 indicated she had no behaviors. The March 2017 daily Nursing Assistant (NA) documentation for Resident #62 indicated she had no behaviors. The Significant Change Minimum Data Set (MDS) assessment dated 4/13/17 (completed due to Resident #62's discontinuation of hospice services) indicated Resident #62's cognition was intact. She had no hallucinations, no delusions, no behaviors, and no rejection of care during the 7 day MDS look back period. She was noted to have received antidepressant medication on 7 days and antianxiety medication on 4 days during the 7 day MDS look back period. The Psychotropic Care Area Assessment (CAA) for the 4/13/17 MDS indicated Resident #62 used antidepressant medications daily for her diagnosis of depression and antianxiety medication for increased anxiety. Resident #62's medication was indicated as effective with no adverse reactions. The Plan of Care for Resident #62, last reviewed on 4/18/17, included the focus area of the risk for potential adverse reactions, falls, and side effects due to the daily use of psychotropic medications. On 4/19/17 an Interdisciplinary Team (IDT) meeting was held to review the plans of care with Resident #62 and her Responsible Party (RP).	F 329	regarding targeted behaviors associated with antipsychotic use. Licensed nurses by 6-21-17 will be educated by the Director of Nursing or nursing supervisor on required clinical justification for medications and transcription practices in general and antipsychotics specifically; requirements for initiating monitoring and documenting of targeted behaviors in the clinical record; and monitoring and documenting of side effect monitoring in the clinical record. Licensed nurses will not be scheduled to work after 6/22/2017 until they have received this education. Element #4 New orders for antipsychotic and cough suppressants will be brought by the CCC to the clinical morning meeting led by the Director of Nursing to audit for clinical justification, monitoring, necessity, accurate transcription, and care planning every week for one month, then every other week for one month, then monthly for three months. The Director of Nursing will report trends of audit to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as further directed by MD-QAPI Committee. The Director of Nursing is responsible for	

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F 329	Continued From page 20 Resident #62 was noted as verbal, laughing, and to have had an improvement in her overall health status. There was no mention of psychosis or AVH for Resident #62. A nursing note dated 4/30/17 indicated Resident #62's RP requested a psychiatric visit for hallucinations that the RP reportedly witnessed. The April 2017 Weekly Nursing Assessments for Resident #62 indicated she had impulsive behaviors the week of 4/3/17 and no behaviors for the remainder of the month. The April 2017 Psychoactive Medication Monthly Flow Record indicated Resident #62's target behavioral symptoms were depression and anxiety. Resident #62 was noted with depression on 4/1/17. She was also noted with anxiety on 4/3/17, 4/8/17, 4/9/17, 4/21/17, and 4/26/17. Resident #62 was not noted with any symptoms of psychosis. The April 2017 daily NA documentation for Resident #62 indicated she had no behaviors. A physician's note dated 5/4/17 indicated Resident #62 was observed smiling and in no distress. The physician reported the PNP was going to be consulted at the request of Resident #62's RP for evaluation of possible hallucinations and delusions. The PNP note dated 5/10/17 indicated Resident #62's moods were well controlled. Resident #62 was noted to previously have been ordered Risperdal (antipsychotic medication) for AVH. This had been discontinued (11/10/16). The PNP indicated Risperdal 0.25mg was to be reinitiated	F 329	attaining and sustaining compliance. Element #5 The Facility alleges compliance effective 6/22/2017.	

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at night for AVH.

A physician's order dated 5/10/17 indicated Risperdal 0.25mg at night for AVH for Resident #62.

An activity note dated 5/10/17 indicated Resident #62's status had remained unchanged over the last 90 days. Resident #62 was noted to be alert and oriented times three. She was noted to have attended a variety of activities with no behaviors indicated.

The May 2017 Weekly Nursing Assessments from 5/1/17 through 5/23/17 for Resident #62 indicated she had impulsive behaviors the week of 5/3/17 and no behaviors noted the remainder of the time period.

The May 2017 Psychoactive Medication Monthly Flow Record from 5/1/17 through 5/23/17 indicated Resident #62 ' s target behavioral symptoms were depression and anxiety. Resident #62 was noted with anxiety on 5/13/17. Resident #62 was not noted with any symptoms of psychosis.

The May 2017 daily NA documentation rom 5/1/17 through 5/23/17 for Resident #62 indicated she had no behaviors.

An observation was conducted of Resident #62 on 5/22/17 at 3:01 PM. There were no signs or symptoms of behaviors or AVH observed.

An interview was conducted with Nurse #7 on 5/23/17 at 2:20 PM. She indicated she was familiar with Resident #62. She reported Resident #62 was alert with some intermittent

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confusion. She stated Resident #62 had no behaviors, no hallucinations, and no delusions. She indicated if Resident #62 had behaviors, hallucinations, or delusions, they were documented in the Psychoactive Medication Monthly Flow Record. She stated if a resident had any new or acute behaviors they were to be documented in the Acute Episodic Documentation Record. She indicated Resident #62 was not noted with any new or acute behaviors in the Acute Episodic Documentation Record.

An interview was conducted with NA #3 on 5/24/17 at 11:23 AM. She indicated if a resident had behaviors they were documented on the kiosks and the nurse was to be informed verbally. NA #3 indicated that hallucinations or delusions were considered behaviors and those were to be reported to the nurse on the hall immediately as that may have indicated something serious was going on with the resident. She indicated she was familiar with Resident #62. She stated Resident #62 occasionally had behaviors, but she was normally able to be redirected and calmed without the use of medication. She indicated if Resident #62 was unable to be redirected she informed the nurse verbally. She stated Resident #62 had no behaviors that were unable to be redirected over the past month.

An interview was conducted with the Director of Nursing (DON) on 5/24/17 at 2:43 PM. She stated behavior documentation was completed by the nurses twice daily (once on each 12 hour shift) on the Psychoactive Medication Monthly Flow Record for any resident who was on a psychotropic medication. She indicated if a resident was having hallucinations she expected this information to be documented in a nursing

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progress note. The DON stated she expected this nursing documentation to include a description of the hallucinations, such as, what the resident saw or heard. She indicated the hallucinations were also to be added to the Acute Episodic Documentation Record. She reported that this record was kept with the Psychoactive Medication Monthly Flow Record and was to include any acute behavioral changes or newly evident behavioral issues. She stated that a resident on the Acute Episodic Documentation Record was to be documented on daily in a progress note that focused on that specific behavioral issue. The DON indicated she also expected the Psychoactive Medication Monthly Flow Record to be updated with monitoring for the target behavior of hallucinations. She revealed it was necessary to monitor for hallucinations to determine if there was a pattern of an ongoing occurrence or if it was a short term or intermittent occurrence.

The interview with the DON continued on 5/24/17 at 2:47 PM. She indicated she was familiar with Resident #62 and was unaware that she experienced hallucinations. She stated if Resident #62 had hallucinations she expected them to be documented in nursing progress notes and to be included in the Acute Episodic Documentation Record. She revealed Resident #62 was not included on the Acute Episodic Documentation Record for hallucinations. The DON reported if Resident #62 had experienced a hallucination then that should have been monitored closely for a week or two to determine if it was an ongoing occurrence prior to making any medication changes. The physician's order dated 5/10/17 that indicated the reinitiation of Risperdal for Resident #62 was reviewed with the

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F 329	Continued From page 24 DON. The DON revealed the mental health provider sometimes made changes to medications quickly rather than allowing for a period of time to determine if medication was needed. She additionally revealed she had spoken with the mental health provider's supervisor in the past regarding this type of issue. The DON stated she expected documentation in the medical record to support the need for the initiation of antipsychotic medication. 2. Resident #196 was admitted to the facility on 2/24/17 with diagnoses that included paranoid schizophrenia. Resident #196's physician's orders included Risperdal (antipsychotic medication) 6 milligrams (mg) at bed for schizophrenia. This medication was initiated on 2/24/17. Resident #196's plan of care, initiated on 2/24/17, included the focus area of risk for adverse reactions, side effects, and falls due to the daily use of psychotropic medication. The February 2017 Psychoactive Medication Monthly Flow Record indicated Resident #196's target behavioral symptoms were hitting, kicking, and paranoia. Resident #196 was noted with no behaviors or side effects. The admission Minimum Data Set (MDS) assessment dated 3/3/17 indicated Resident #196 was a Preadmission Screening and Resident Review Level II for serious mental illness. Her cognition was indicated to be intact. Resident #196 was noted to have no behaviors,	F 329		

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no hallucinations, and no rejection of care during the 7 day MDS look back period. She had received antipsychotics on 7 of 7 days during the MDS look back period.

The Psychotropic Medication Care Area Assessment (CAA) for the 3/3/17 MDS indicated Resident #196 had a diagnosis of paranoid schizophrenia and received antipsychotic medication. Resident #196 had the potential for side effects from psychotropic medication use. Staff was to monitor Resident #196 for adverse effects and effectiveness of medication use.

A physician's note dated 3/13/17 indicated a mental status exam was performed for Resident #196 and she was calm, pleasant, awake, alert, and oriented times three. Her mood and affect were indicated to be appropriate.

A review of the nursing progress notes for March 2017 indicated Resident #196 had no behaviors.

A review of the nursing progress notes for April 2017 indicated Resident #196 had no behaviors.

A Psychiatric Nurse Practitioner (PNP) note dated 5/10/17 indicated Resident #196 was on Risperdal for schizophrenia and her medications were working very well.

A review of the nursing progress notes from 5/1/17 through 5/23/17 indicated Resident #196 had no behaviors.

A review of the medical record revealed there was no monitoring of target behaviors and/or side effects for Resident #196 from 3/1/17 through 5/23/17 (84 days).

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An interview was conducted with the Director of Nursing (DON) on 5/24/17 at 2:43 PM. She stated behavior documentation was completed by the nurses twice daily (once on each 12 hour shift) on the Psychoactive Medication Monthly Flow Record for any resident who was on a psychotropic medication. She indicated it was necessary to monitor for behaviors to determine if there was a pattern of ongoing occurrences, short term occurrences, or intermittent occurrences.

An observation was conducted of Resident #196 on 5/24/17 at 3:35 PM. There were no observed behavioral symptoms.

A second interview was conducted with the Director of Nursing on 5/24/17 at 4:11 PM. The medical record that revealed Resident #196 had no monitoring for target behaviors or side effects from 3/1/17 through 5/23/17 was reviewed with the DON. She verified that she had also reviewed the record and this monitoring had not been completed for Resident #196 from 3/1/17 through 5/23/17. The DON stated it was her expectation that this monitoring would have been completed twice daily for Resident #196. She indicated she was not sure how this had been missed for a period of nearly 3 months.

A phone interview was conducted with the Pharmacist on 5/25/17 at 10:45 AM. She indicated that for residents who were on antipsychotic medications she reviewed the medical record for the Psychoactive Medication Monitoring Flow Records to determine if there were any behaviors or adverse effects of the medication. The Pharmacist stated she expected this monitoring to be completed by the nurses

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twice daily (once per shift). The medical record that revealed Resident #196 had no monitoring for target behaviors or side effects from 3/1/17 through 5/23/17 was reviewed with the Pharmacist. The DON's confirmation that no monitoring for target behaviors or side effects had been completed for a period of nearly 3 months was reviewed with the pharmacist. She reported that she was unable to recall anything specific about Resident #196 and had not known the behavior monitoring was not completed.

An interview was conducted with Nurse #8 on 5/25/17 at 11:28 AM. She indicated she worked as a Nurse Supervisor from 3:00 PM to 11:00 PM. She stated if a resident was on an antipsychotic medication they were to be monitored for behaviors on the Psychoactive Medication Monthly Flow Record twice daily. She indicated she was familiar with Resident #196. She stated Resident #196 had no behaviors.

3. Resident #240 was readmitted to the facility on 12/27/16. Cumulative diagnoses included chronic obstructive pulmonary disease. A Quarterly Minimum Data Set dated 3/18/17 indicated Resident #240 had short term and long term memory impairment and was severely impaired in decision-making skills.

A physician order dated 5/6/17 stated to discontinue Mucinex DM, a cough medicine that contains dextromethorphan, a cough suppressant, and guaifenesin, an expectorant) and begin Mucinex 12 hour twice daily for 7 days for pneumonia.

A review of the Medication Administration Record (MAR) for May 2017 revealed Resident #240

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F 329	Continued From page 28 received Mucinex twice daily from 5/5/17 through 8:00 AM 5/25/17 at 8:00 AM. On 5/25/17 at 9:50 AM, an interview was conducted with the Director of Nursing. She reviewed the physician order and the May 2017 MAR and stated she expected nursing staff to discontinue medications per the physician ' s order. On 5/25/17 at 10:00 AM, an interview was conducted with Nurse #1 who reviewed the MAR and said it was overlooked. She said she should have seen it was for seven days and should have followed the doctor's orders. On 5/25/2017 at 11:06 AM, an interview was conducted with Resident #240 ' s physician via phone. She stated she expected nursing staff to follow her orders. On 5/25/2017 at 11:38 AM, an interview was conducted with Nurse #2. She said she did not remember that order and it must have been an oversight if she continued to give it.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		6/21/17

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F 371	Continued From page 29 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews the facility failed to dispose of expired dairy product in four of six sub kitchens. The facility failed to maintain door gaskets on five of six reach in cooler doors. The facility failed to protect food from possible contamination as evidenced by the failure of dietary staff to properly restrain facial hair while preparing or serving food in two of the seven food preparation and food service areas. Findings Included: A. Observation of the main kitchen on 5/22/17 at 9:44 AM revealed the following: 1. Three of three Single or double door reach in coolers, labeled number 4, 5, and 7, had torn gaskets on the doors. 2. Dietary employee #1 was observed preparing food with unrestrained facial hair. B. A continuous observation of the Golden Oaks sub kitchen (Bistro) plating of food on 5/22/17	F 371	F371 Element #1 Dairy products in all six sub kitchens were inspected for expiration date by the Dietary Manager and any expired items were disposed of by 5-25-17. Door gaskets on affected cooler doors have been replaced by 6-13-17 by Saint Joseph of the Pines Maintenance Department. All food providers with facial hair began utilizing “beard guards” by 5-25-17. Element #2 Residents currently residing in the community and newly admitted residents receiving meals from the kitchen have the potential to be affected.	

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F 371	Continued From page 30 from 12:04 PM through 12:32 PM revealed dietary employee #2 plating food with exposed facial hair. C. Observation of the main kitchen on 5/24/17 at 9:31 AM revealed the following: 1. Dietary employee #1 was observed to be preparing food with unrestrained facial hair. 2. Dietary employee #3 was observed to be in the main kitchen and in the walk in cooler with unrestrained facial hair. An interview with General Manager of Food Service on 5/24/17 at 9:37 AM revealed his expectation was any facial hair longer than a quarter inch should be restrained when the dietary employee is preparing food in the production area and when serving food (plating food). The General Manager of Food Service acknowledged dietary employee #1 and dietary employee #3 should have had facial hair restraints on in the main kitchen. D. Observation of the Willow Oaks sub kitchen on 5/24/17 at 9:54 AM revealed two of seven 8 ounce containers of whole milk with a stamped expiration date of 5/21/17 in the refrigerator. E. Observation of the Pine Hollow sub kitchen on 5/24/17 at 9:59 AM revealed two of five 8 ounce containers of whole milk with a stamped expiration date of 5/21/17 in the refrigerator. F. Observation of the Pine Meadow kitchen on 5/24/17 at 10:05 AM revealed the following: 1. Two of two 8 ounce containers of fat free milk with a stamped expiration date of 5/23/17 in the refrigerator in the general kitchen area. 2. One of two 8 ounce containers of fat free milk	F 371	All food items in all six sub kitchens were inspected for expiration date and any expired items were disposed of by 5-25-17. Door gaskets on all other coolers were inspected by Dietary Manager to verify no other gaskets needed replacement by 6-9-17. Element #3 All food providers were re-educated by the Dietary Manager on disposing expired food on the date of expiration by 5-25-17. All food providers were re-educated by the Dietary Manager on the expectation of placing work orders for maintenance repairs to kitchen equipment by 6-13-17. All food providers were re-educated by the Dietary Manager on the importance and requirement of covering head and facial hair by 5-25-17. Element #4 Dietary Manager or dietary supervisor will perform daily inspections in all six sub kitchens for expired food items for two weeks, then daily in three random sub kitchens for two weeks, then one random sub kitchen daily by 6-12-17. Dietary Manager will report results of inspections to the MD-QAPI committee until substantial compliance has been achieved.	

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F 371	Continued From page 31 with a stamped expiration date of 5/23/17 in the single door reach in cooler in the dishware room. 3. Single door reach in cooler in the dishware room had a torn door gasket. G. Observation of the Whispering Oaks sub kitchen on 5/24/17 at 10:13 AM revealed a torn door gasket on the single door reach in cooler in the dishware room. H. Observation of the Golden Oaks sub kitchen on 5/24/17 at 10:16 AM revealed two of twenty-six 8 ounce containers of 2% milk with a stamped expiration date of 5/22/17 in the refrigerator. I. Observation of the main kitchen on 5/24/17 at 10:20 AM revealed three of three single or double door reach in coolers, labeled number 4, 5, and 7, had torn gaskets on the doors. An interview with the General Manager of Food Service on 5/24/17 at 10:25 AM revealed his expectation was for the dietary employees to complete a work order for torn gaskets on reach in cooler doors. The General Manager of Food Service reviewed the recorded maintenance requests and discovered no work order request forms had been completed for the torn gaskets on the reach in cooler doors. The General Manager of Food Service further added his expectation was for the dietary staff to dispose of expired food products. An interview on 5/24/17 at 1:53 PM with the Administrator revealed his expectations were: kitchen equipment to be maintained in proper working condition, facial hair to be restrained, and expired food products to be disposed of.	F 371	Dietary Manager or dietary supervisor will perform daily inspections in all six sub kitchens cooler doors for two weeks, then daily in three random sub kitchens for two weeks, then one random sub kitchen daily by 6-12-17. Dietary Manager will report results of inspections to the MD-QAPI committee until substantial compliance has been achieved. Dietary Manager or dietary supervisor will perform inspections on every shift of food providers wearing hair protection daily for two weeks, then every shift three random days a week for two weeks, then every shift weekly once a week for one month, then every shift once monthly by 6-12-17. Dietary Manager will report results of inspections to the MD-QAPI committee until substantial compliance has been achieved. The Dietary Manager is responsible for attaining and sustaining compliance. Element #5 The facility alleges compliance effective 6/21/2017	

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F 371	Continued From page 32 A review of Uniform Policy, dated January 2016, received on 5/24/17 at 3:30 PM revealed the following: "All team members with a beard/mustache working in production areas must wear a beard guard required by local health department code." According to the North Carolina Food Code for Hair Restraints, 2-402.11, Effectiveness: FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. A review of the Food Storage and Handling policy, with a revised date of 1/4/11, received on 5/24/17 at 3:30 PM revealed the following: "All manufacturer packaged foods are used or discarded by their used by date, which is determined by either their open date or manufacture's use-by date whichever is lesser."	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 428		6/22/17

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F 428	Continued From page 33 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 428		

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F 428	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and pharmacist interview, the pharmacist failed to report missing behavioral monitoring records for a resident on an antipsychotic medication for 1 of 1 resident (Resident #196) reviewed for Preadmission Screening and Resident Review (PASRR) Level II. The findings included: Resident #196 was admitted to the facility on 2/24/17 with diagnoses that included paranoid schizophrenia. Resident #196's physician's orders included Risperdal (antipsychotic medication) 6 milligrams (mg) at bed for schizophrenia. This medication was initiated on 2/24/17. Resident #196's plan of care, initiated on 2/24/17, included the focus area of risk for adverse reactions, side effects, and falls due to the daily use of psychotropic medication. The February 2017 Psychoactive Medication Monthly Flow Record indicated Resident #196's target behavioral symptoms were hitting, kicking, and paranoia. Resident #196 was noted with no behaviors or side effects. A pharmacy review was conducted on 3/1/17 and Resident #196 was indicated to be ordered Risperdal. The admission Minimum Data Set (MDS) assessment dated 3/3/17 indicated Resident #196 was a Preadmission Screening and Resident Review Level II for serious mental illness. Her cognition was indicated to be intact.	F 428	F428 Element #1 Resident #196 no longer resides in the facility. Element #2 Residents currently residing in the community and new admissions receiving antipsychotic medications have the potential to be affected. These residents by 6-21-17 have been audited by the Director of Nursing and have appropriate clinical rationale including targeted behaviors and daily monitoring of medication side effects. Element #3 Pharmacy consultant received education on 6/7/2017 from the Vice President of Health Services to identify and report in monthly consultant reports any specific residents who are missing documentation regarding targeted behaviors associated with antipsychotic use. Licensed nurses by 6-21-17 will be educated by the Director of Nursing or nursing supervisor on required clinical justification for antipsychotics; requirements for initiating monitoring and documenting of targeted behaviors in the clinical record; and monitoring and documenting of side effect monitoring in	

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F 428	Continued From page 35 Resident #196 was noted to have no behaviors, no hallucinations, and no rejection of care during the 7 day MDS look back period. She had received antipsychotics on 7 of 7 days during the MDS look back period. The Psychotropic Medication Care Area Assessment (CAA) for the 3/3/17 MDS indicated Resident #196 had a diagnosis of paranoid schizophrenia and received antipsychotic medication. She had the potential for side effects from psychotropic medication use. Staff was to monitor Resident #196 for adverse effects and effectiveness of medication use. A pharmacy review was conducted on 4/3/17 and 5/1/17 and Resident #196 was indicated to continue on Risperdal. A review of the medical record revealed there was no monitoring of target behaviors and/or side effects for Resident #196 from 3/1/17 through 5/23/17 (84 days). An interview was conducted with the Director of Nursing (DON) on 5/24/17 at 2:43 PM. She stated behavior documentation was completed by the nurses twice daily (once on each 12 hour shift) on the Psychoactive Medication Monthly Flow Record for any resident who was on a psychotropic medication. She indicated it was necessary to monitor for behaviors to determine if there was a pattern of ongoing occurrences, short term occurrences, or intermittent occurrences. A second interview was conducted with the Director of Nursing on 5/24/17 at 4:11 PM. The medical record that revealed Resident #196 had no monitoring for target behaviors or side effects	F 428	the clinical record. Licensed nurses will not be scheduled to work after 6/22/2017 until they have received this education. Element #4 New orders for antipsychotic medications will be brought by the CCC to the clinical morning meeting led by the Director of Nursing to audit for clinical justification, monitoring, necessity, accurate transcription, and care planning. The Director of Nursing will report trends of audit to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as further directed by MD-QAPI Committee. The Director of Nursing is responsible for attaining and sustaining compliance. Element #5 The facility alleges compliance effective 6/22/2017	

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from 3/1/17 through 5/23/17 was reviewed with the DON. She verified that she had also reviewed the record and this monitoring had not been completed for Resident #196 from 3/1/17 through 5/23/17. The DON stated it was her expectation that this monitoring would have been completed twice daily for Resident #196. She indicated she was not sure how this had been missed for a period of nearly 3 months.

A phone interview was conducted with the Pharmacist on 5/25/17 at 10:45 AM. She indicated that for residents who were on antipsychotic medications she reviewed the medical record for the Psychoactive Medication Monitoring Flow Records to determine if there were any behaviors or adverse effects of the medication. The Pharmacist stated she expected this monitoring to be completed by the nurses twice daily (once per shift). The medical record that revealed Resident #196 had no monitoring for target behaviors or side effects from 3/1/17 through 5/23/17 was reviewed with the Pharmacist. The DON's confirmation that no monitoring for target behaviors or side effects had been completed for a period of nearly 3 months was reviewed with the pharmacist. She reported that she was unable to recall anything specific about Resident #196 and had not known the behavior monitoring was not completed.

A follow up interview was conducted with the DON on 5/25/17 at 11:10 AM. She indicated it was her expectation for the pharmacist to have identified the missing Psychoactive Medication Monitoring Flow Sheet. She stated the pharmacist reviewed the medication list and the medical record for behavior monitoring of antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	05/25/2017

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 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 38 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assessment (QA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 6/3/16 recertification survey and the 2/21/17 complaint survey. This was for two recited deficiencies in the areas of: Assessment Accuracy (F278) and Treatment to Prevent Pressure Ulcers (F314). The deficiencies were cited again on the current recertification survey of 5/25/17. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F278-Based on medical record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (#62), behaviors (#260), and pressure ulcers (#246) for 3 of 13 sampled residents. During the recertification survey of 6/3/16 the facility was cited F278 for failing to accurately code the MDS assessment for Preadmission Screening and Resident Review (PASRR) for 2 of 3 sampled residents. During the complaint survey of 2/21/17 the failed to accurately code the MDS in the area of skin condition and medications for one of three sampled residents. On the current recertification survey of 5/25/17, the facility failed to code the MDS assessment accurately in the areas of medications, behaviors,	F 520	F520 Element #1 Refer to F278 and F314 plans of correction specific to systems to ensure compliance with intent of regulation Element #2 Residents currently residing in the community and those newly admitted have the potential to be affected. The President of St. Joseph of the Pines or Vice President of Health Services will complete a QAPI Self-Assessment Tool to obtain a baseline of the facility's progress with QAPI. This assessment will be used to direct the committee in development of a MD-QAPI Committee Functional Improvement PIP. Element #3 The President of St. Joseph of the Pines by 6-21-17 will re-educate the MD-QAPI committee on developing, implementing, and monitoring appropriate plans of action on identified quality areas prior to the next full MD-QAPI Committee meeting. Element #4 A sub-committee will be established to meet every week for one month, then	

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F 520	Continued From page 39 and pressure ulcers for 3 of 13 sampled residents. 2. F314-Based on medical record review and staff interviews, the facility failed to assess the evolution of a pressure ulcer before the pressure ulcer became unstageable for 1 of 3 residents reviewed for pressure ulcers (Resident #282). During the complaint survey of 2/21/17 the failed to treat a pressure ulcer per physician orders and failed to change a dressing for a pressure ulcer for two of three residents observed for pressure ulcer care. On the current recertification survey of 5/25/17, the facility failed to assess the evolution of a pressure ulcer before the pressure ulcer became unstageable for 1 of 3 residents reviewed for pressure ulcers. An interview was conducted with the Administrator on 5/25/17 at 11:39 AM. The Administrator stated that the facility had a Quality Assurance (QA) Committee. The QA Committee consisted of the Administrator, Director of Nursing (DON), Medical Director, Director of Social Services, Dietary Manager, Pharmacist, Assistant Director of Nursing (ADON), and Clinical Care Coordinator. The QA Committee met quarterly. Department Heads submit QA tools and improvement tools the QA Committee. If the QA Committee identified any concerns, a subcommittee would be developed and it would be headed by a Quality Assessment and Performance Improvement (QAPI) member. The subcommittees met based on their need, i.e. the nursing subcommittee has been meeting weekly. In regards to MDS assessment accuracy the Administrator stated that during the State of North Carolina Division of Medical Assistance Medicaid MDS validation review the facility did not exceed	F 520	every other week for one month, then monthly for three months regarding regulatory compliance to review, monitor for trends, and determine if changes to current practices, monitoring activities, or process improvement plan development/modifications are necessary. The members of this subcommittee include, but are not limited to: Vice President of Health Services, Director of Nursing Services, Dietary Manger, and MDS Supervisor. The full MD-QAPI Committee will be chaired by the Vice President of Health Services and will meet every month for three month, then every other month for four months to review progress on the MD-QAPI Committee Functional Improvement PIP. The Vice President of Health Services will submit MD-QAPI Committee minutes to the President of St. Joseph of the Pines monthly including status updates on the PIP to provide opportunity for oversight and recommendations for ongoing improvement of the committee's functionality. The Vice President of Health Services is responsible for attaining and sustaining compliance. Element #5 The Facility alleges compliance effective 6/22/2017.	

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F 520	Continued From page 40 the state threshold which allows an error rate which was contradictory to the findings of the recertification which did not allow an error rate. In response to the repeat observed deficiency related to pressure ulcers the administrator stated, pressure ulcers had been cited previously due to the appropriate application of a treatment by a nurse. The observed deficiency from the current recertification was the identification of a pressure ulcer. There were no further identified issues regarding the application of the appropriate treatment of pressure ulcers and the QA committee discontinued the monitoring. The Administrator further clarified that he perceived that the facility will review and revamp the complete skin assessment and treatment process for pressure ulcers rather than just one area.	F 520		