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 03/08/2018

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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		4/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/29/2018

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.

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure advance directive information matched in 2 places (electronic record and hard copy) for 1 of 1 sampled resident reviewed for hospice (Resident #7). Findings included: Resident #7 was admitted to the facility on 1/6/17 and was readmitted on 1/25/18 with multiple diagnoses including dementia. The quarterly Minimum Data (MDS) assessment dated 2/22/18 indicated that Resident #7 had severe cognitive impairment and was receiving hospice care. Resident #7's hard copy chart was reviewed. The front pages of the chart contained a doctor's order dated 5/4/17 for a DNR status and a yellow "Do not resuscitate" (DNR) form signed by the attending physician on 11/20/17. Resident #7's electronic records were reviewed. The records had a doctor's order dated 1/25/18 for a "FULL CODE" status. The profile section of the electronic records indicated code status "FULL CODE". Resident #7's care plan dated 2/20/18 was reviewed. One of the care plan problems was "Please honor my advance directive, I have a do not resuscitate order (DNR)". The goal was "I will maintain comfort and dignity through the end of life". The approaches included" advance directives: DNR)".	F 578	F578 Identification: Saint Joseph of the Pines Health Center does ensure that advance directives for residents are accurate. Corrective Action Resident #7 electronic medical record (EMR) and hard copy chart has been reviewed and revised by DON to reflect the residents correct code status on or before 3/12/18. All current residents' code status will be reviewed for accuracy between the EMR and the hard copy chart on or before 3/28/18 by the Assistant Director of Nursing (ADON) and the Clinical Care Coordinators (CCC). System change The ward secretaries and admissions nurses will be re-educated by the Director of Nursing (DON) on verifying upon readmission with primary care provider if resident's code status changed is accurate and reflects appropriately in the EMR and hard copy chart on or before 3/28/18. Monitoring The DON or nursing supervisor will audit all re-admissions and new admissions code status to ensure the EMR and the	

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F 578	Continued From page 2 On 3/7/18 at 9:56 AM, Nurse #2 was interviewed. She stated that Resident #7 was a DNR status when admitted and was changed to a Full code status when readmitted on 1/25/18. On 3/8/18 at 9:50 AM, the Director of Nursing (DON) was interviewed. She verified that Resident #7 was a Full code on readmission (1/25/18) and stated that she expected the yellow DNR form and the doctor's order for DNR removed from the hard copy chart when the resident changed her code status to a Full code.	F 578	hard copy chart are accurate weekly for four weeks then monthly for three months until substantial compliance is achieved. Findings and corrective measures will be reported weekly to the Vice President of Health Services. The DON will report trends of these audits to the Mission Driven Quality Assurance and Performance Improvement (MD-QAPI) Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		4/5/18

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F 585	Continued From page 3 accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 585		

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F 585	Continued From page 4 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and	F 585	F585	

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F 585	Continued From page 5 record review, the facility failed to provide a written responses to grievances for 2 (Resident #108 and Resident #191) of 2 residents reviewed for grievances. The findings included Review of the facility policy titled "Concerns, Complaint, Grievance" dated last revised August 18, 2016 read within 30 days of a written grievance, the facility must deliver a written report of the results to the person filing the complaint. 1.Resident #108 was admitted 12/21/17 with diagnosis of Multiple Sclerosis (MS). His quarterly Minimum Data Set (MDS) dated 02/11/18 indicated he was cognitively intact. In an interview on 03/06/18 at 12:20 PM, Resident #108 stated he had completed multiple grievances regarding his care. He stated he had not received written response to his grievances. Review of a grievance list indicated Resident #108 registered a written grievance on 01/08/18. The grievance was investigated by the Director of Nursing (DON) on 01/09/18 and signed by the Administrator on 01/12/18. There was no evidence of a written response to Resident #108. Review of a grievance list indicated Resident #108 registered a written grievance on 01/11/18. The grievance was investigated by the DON on 01/15/18 and signed by the Administrator on 01/19/18. There was no evidence of a written response to Resident #108. In an interview on 03/06/18 at 2:40 PM, the DON stated she addressed the content of each grievance for Resident #108. She stated she	F 585	Identification St. Joseph of the Pines does provide written responses to grievances. Corrective Action Resident #108 received written response by Vice President of Health Services to grievance dated 1/11/18 on or before 3/30/18. Resident #191 discharged from facility on 2/13/18. All resident or responsible party grievances received 3/18 will receive written response from Vice President of Health Services within 30 days of receipt. System Changes Vice President of Health Services and Social Services Director will be educated by the Director of Quality and Risk Management on timelines for resolution and written notification of resident grievances on or before 4/5/18. Monitoring The Social Services Director will review 100% of grievances after being signed by Vice President of Health Services monthly for one month, then 50% for one month, and then 25% for one month until substantial compliance is achieved, to ensure written responses are completed. Findings and corrective measures will be reported monthly to the Director of Quality and Risk Management. The Social Services Director will report	

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F 585	Continued From page 6 returned the investigations to the Administrator who was responsible for the follow up in writing to Resident #108. In an interview on 03/07/18 at 4:06 PM, the Administrator stated he was responsible for the written response to Resident #108's grievances. He stated he tried to complete all written responses but "some fell through the cracks." The Administrator stated it was his expectation that all grievances have a written response to the person filing the grievance within 30 days. 2.Resident #191 was admitted 02/27/14 with cumulative diagnoses of Congestive Heart Failure and Cerebral Vascular Accident. Her annual MDS 01/05/18 indicated severe cognitive impairment and total assistance with all her activities of daily living. Review of a grievance list indicated Resident #191's responsible party (RP) registered a written grievance on 10/05/17. The grievance was investigated by the DON on 10/05/17 and signed by the Administrator on 10/07/17. There was no evidence of a written response to Resident #108's RP. Review of a grievance list indicated Resident #191's RP registered a written grievance on 10/12/17. The grievance was investigated by the DON on 10/12/17 and signed by the Administrator on 10/20/17. There was no evidence of a written response to Resident #108's RP. Review of a grievance list indicated Resident #191's RP registered two written grievances on 12/20/17. The grievances were investigated by	F 585	trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The Vice President of Health Services is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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F 585	Continued From page 7 the DON on 12/27/17and signed by the Administrator on 01/05/18. There was no evidence of written responses to Resident #191's RP. Review of a grievance list indicated Resident #191's RP registered a written grievance on 01/13/18. The grievance was investigated by the DON 01/26/18 and signed by the Administrator on 02/02/18. There was no evidence of a written response to Resident #191's RP. In an interview on 03/06/18 at 2:40 PM, the DON stated she addressed the content of each grievance for Resident #191. She stated she returned the investigations to the Administrator who was responsible for the follow up in writing to Resident #191's RP. In an interview on 03/07/18 at 4:06 PM, the Administrator stated he was responsible for the written responses to Resident #191's RP grievances. He stated he tried to complete all written responses but "some fell through the cracks." The Administrator stated it was his expectation that all grievances have a written response to the person filing the grievance within 30 days.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, the facility failed to	F 641	F641	4/5/18

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F 641	Continued From page 8 accurately code Minimum Data Set (MDS) assessments in the areas of pressure ulcers (Resident #104), cognition (Resident #241), diagnosis (Resident #91), dental (Resident #108) and discharge location (Resident #191) for five (5) of thirty-one (31) sampled residents. The findings included: 1. Resident #104 was admitted to the facility 11/13/17. Cumulative diagnoses included stage 4 pressure ulcer right hip (full thickness tissue loss with exposed bone, tendon or muscle. Slough (dead tissue) or eschar (black tissue) may be present.), stage 2 pressure ulcer on sacrum (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) and an unstageable pressure ulcer (not stageable due to coverage of wound bed by slough and/or eschar) right heel. A nursing admission nursing note dated 11/14/17 stated the following regarding pressure ulcers: stage 2 sacrum, stage 4 right trochanter (hip) and an unstageable to the heel. A Quarterly MDS dated 2/8/18 indicated Resident #104 was severely impaired in cognition. A review of the skin condition noted the following: Resident #104 had a stage 1 or greater pressure ulcer with one pressure ulcer unhealed. Resident #104 had a stage 4 pressure ulcer not present on admission, entry or re-entry. Measurements were 0.3 centimeters in length, 0.2 centimeters in width and 1.9 centimeters in depth. Most severe tissue type: slough. The stage 4 pressure ulcer worsened in pressure ulcer status since prior assessment. A review of the medical record revealed a weekly	F 641	Identification St. Joseph of the Pines does ensure that the resident minimum data set (MDS) assessments are accurately coded. Corrective Action The MDS for residents # 91 (4/3/18), 104 (3/8/18), 108 (4/3/18), 191 (3/7/18) and 241 (3/30/18) have been reviewed and revised by the Lead MDS Coordinator to reflect their current status on or before 4/4/18. MDS has been submitted and accepted on or before 4/5/18. All current residents with dental issues, pressure ulcers, cognitive issues and depression diagnoses coded on the MDS will be reviewed for accuracy on or before 3/28/18. Discharge MDSs for the last 90 days will be reviewed for accurate discharge status by Corporate MDS team (Regional Director of MDS Compliance, Regional Director of MDS Compliance and Reimbursement, Director of Clinical Assessments and Practice) on or before 3/30/18. System Change MDS staff will be re-educated by Corporate MDS team on accurately completing the MDS to reflect the residents' current status as required in the Resident Assessment Instrument (RAI) Manual version 1.15 dated October 2017 on or before 3/23/18. Admission nurses will be re-educated by	

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F 641	Continued From page 9 wound tracking form dated 2/8/18. It stated Resident #104 ' s right trochanter hip pressure ulcer was a stage 4 with date of onset 11/13/17 (present on admission). Measurements were 0.3 centimeters in length, 0.2 centimeters in width and 1.9 centimeters in depth. On 3/8/18 at 11:03 AM, an interview was conducted with MDS Nurse #3 who stated it was an error in coding. On 3/8/18 at 11:49 AM, an interview was conducted with the Director of Nursing who stated her expectation was for the MDS to be accurate for pressure ulcers. 2. Resident #241 was admitted to the facility 2/13/18. Cumulative diagnoses included difficulty walking, surgical amputation of toes on right foot, moderate protein calorie malnutrition, vitamin D deficiency, long term use of insulin and non-pressure chronic ulcer right thigh. A Brief Interview for Mental Status (BIMS) assessment for Resident #241 dated 2/13/18 indicated Resident #241 was cognitively intact. A social work assessment dated 2/18/18 indicated Resident #241 was cognitively intact. An Admission Minimum Data Set (MDS) dated 2/20/18 indicated Resident #241 was severely impaired in cognition. ON 3/5/18 at 11:28 AM, an interview was conducted with Resident #241. Resident #241 was cognitively intact at the time of the interview. On 3/8/18 at 10:14 AM, an interview was	F 641	DON on accurate capture of oral condition during admission assessment by DON on or before 3/28/18. Oral condition and appropriate care will be entered on Resident Summary by admission nurse and updated by facility nursing and MDS staff as indicated. MDS staff will verify accuracy with Omnibus Budget Reconciliation Act (OBRA) MDS completion. Social Service staff will be re-educated by facility Lead MDS Coordinator on appropriate documentation of cognitive status in a progress note to demonstrate supportive Brief Interview for Mental Status (BIMS) coding on or before 4/4/18. Actively working licensed nurses will be educated by DON or clinical supervisor on entering resident discharge status into EMR at time of discharge by discharging nurse to allow for accurate capture on the MDS on or before 4/5/18. Monitoring Corporate MDS team will audit MDS coding to include pressure ulcers, diagnoses and resident discharge status of five MDSs a week for three months or until substantial compliance is achieved. Facility Lead MDS Coordinator will audit MDS coding to include cognition, dental status, and discharge status of five MDS per week for three months or until substantial compliance is achieved. Findings and corrective measures will be	

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F 641	Continued From page 10	F 641		

conducted with Nurse #1. She stated she completed the BIMS assessment dated 2/13/18 and, at that time, Resident #241 was cognitively intact

The social work assessment for Resident #241 dated 2/18/18 was completed by a social worker who was no longer working at the facility and unable to be contacted.

Section C of the MDS assessment (BIMS) was completed by MDS Nurse #2 who was on vacation and unable to be contacted or interviewed.

On 3/8/18 at 11:49 AM, an interview was conducted with the Director of Nursing who stated her expectation was for the MDS to be accurate for cognition.

3. Resident #91 was admitted to the facility on 1/29/18 with multiple diagnoses that included anxiety and dementia.

The admission Minimum Data Set (MDS) assessment dated 2/5/18 indicated Resident #91 was rarely/never understood and rarely/never understands. He was assessed with short term memory problems, long term memory problems, and severely impaired decision making. Resident #91 ' s active diagnoses had not included depression. The Care Area Assessment (CAA) related to psychotropic medications for the 2/5/18 MDS contradicted the active diagnoses section. This CAA indicated Resident #91 had a diagnosis of depression.

An interview was conducted with MDS Nurse #1 on 3/7/18 at 12:10 PM. The admission MDS

reported weekly to the DON.

The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee.

The DON is responsible for attaining and sustaining compliance.

The facility alleges compliance effective 4/5/18.

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F 641	Continued From page 11	F 641		

dated 2/5/18 for Resident #91 was reviewed with MDS Nurse #1. She stated she had completed the active diagnoses section and the CAA related to psychotropic medications on Resident #91 ' s 2/5/18 MDS. She confirmed there was a discrepancy with the diagnosis of depression as it was not coded as an active diagnosis for Resident #91, but it was noted on the psychotropic CAA as a diagnosis. MDS Nurse #1 reported she had to review her records to provide additional information.

A follow up interview was conducted with MDS Nurse #1 on 3/7/18 at 1:35 PM. She revealed the psychotropic CAA for Resident #91 ' s 2/5/18 MDS was inaccurate. She stated Resident #91 had no diagnosis of depression.

An interview was conducted with the Director of Nursing on 3/8/18 at 9:45 AM. She stated she expected the MDS to be coded accurately.

4. Resident #108 was admitted 12/21/17 with diagnosis of Multiple Sclerosis (MS).

His admission Minimum Data Set (MDS) dated 12/28/17 was coded with no dental concerns. His 30-day MDS dated 02/11/18 was coded with no dental concerns.

In an interview and observation on 03/06/18 at 12:20 PM, Resident #108 stated his teeth had rotted due to the MS medications he had been taking for years. He voiced no oral pain and no problems eating. He stated he did not required any dental services on admission. Observation of Resident #108 oral cavity revealed extreme decay and tooth loss.

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In an interview on 03/07/18 at 12:05 PM, MDS Nurse #2 stated she coded his admission MDS and recent 30-day MDS incorrectly and described it as a "careless mistake."

In an interview on 03/07018 at 4:06 PM, the Administrator stated it was his expectation that Resident #108's MDS be coded accurately in the care area of oral status.

5. Resident #191 was admitted 02/27/14 with cumulative diagnoses of Congestive Heart Failure and Cerebral Vascular Accident.

Her discharge MDS dated 02/13/18 indicated Resident #191 was discharged to another skilled nursing facility.

A review of Resident #191's nursing notes indicated she was sent to the hospital on 02/13/18 for increased shortness of breath.

In an interview on 03/07/18 at 12:03 PM, MDS Nurse #1 stated she found out the next day Resident #191 was not transferred as planned to another skilled facility but rather was sent to the hospital on 02/13/18. She stated she was aware of the inaccurate coding and the MDS Supervisor was supposed to complete an MDS modification.

In an interview on 03/07/18 1:35 PM, MDS Supervisor stated she completed a MDS modification for Resident #191 on 03/07/18.

In an interview on 03/07018 at 4:06 PM, the Administrator stated it was his expectation that Resident #191's MDS be coded accurately in the

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F 641	Continued From page 13 care area of discharge location.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		4/5/18

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F 656	Continued From page 14 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for hospice care for 1 of 1 sampled resident reviewed for hospice (Resident #7). Findings included: Resident #7 was admitted to the facility on 1/6/17 and was readmitted on 1/25/18 with multiple diagnoses including dementia. The quarterly Minimum Data (MDS) assessment dated 2/22/18 indicated that Resident #7 had severe cognitive impairment and was receiving hospice care. On 5/18/17, Resident #7 had a doctor's order for hospice services related to dysphagia following cerebral infraction. Resident #7's care plan dated 2/20/18 was reviewed. There was no care plan problem, goal and approaches developed for hospice care. On 3/7/18 at 12:12 PM, MDS Nurse #1 was interviewed. She stated that she did not have to develop a comprehensive care plan for a hospice resident because the hospice agency had a care plan for the resident. On 3/7/18 at 5:20 PM, the Director of Nursing (DON) was interviewed. She verified that Resident #7 was a hospice resident and stated that she expected a comprehensive care plan	F 656	F656 Identification St. Joseph of the Pines does develop comprehensive care plans for Hospice care. Corrective Action Resident # 7 care plan has been reviewed and revised by Lead MDS Coordinator to reflect hospice status on or before 3/29/18. All current residents on hospice were identified and their care plans reviewed to ensure accuracy and reflection of integrated hospice services on or before 3/29/18 by the MDS nurses. System change MDS nurses will be re-educated by Corporate MDS team on Hospice care plan management process on or before 3/23/18. Social Services will be re-educated by Corporate MDS team on ensuring comprehensive care plans are developed and reflect integrated facility and hospice services upon initiation of Hospice services on or before 3/23/18.	

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F 656	Continued From page 15 developed for a hospice resident. On 3/7/18 at 5:10 PM, MDS Nurse #1 provided additional information. She stated that she did not develop a care plan for hospice because she thought Resident #7 was no longer a hospice resident when readmitted on 1/25/18. She further stated that she would develop a hospice care plan for Resident #7.	F 656	Admission nurses will be educated by DON regarding incorporation of hospice care plan into admission and baseline care plans at the time of admission/readmission on or before 3/23/18. Hospice care plans will be verified by the MDS nurses within the first 21 days of the resident stay and during the completion of OBRA MDSs. Monitoring ADON will verify Hospice care plans are in place for all residents enrolled in Hospice on a weekly basis for four weeks and then monthly for three months until substantial compliance is achieved. Facility Lead MDS Coordinator will monitor for completion or correction of Hospice care plan with significant change assessments. Findings and corrective measures will be reported weekly to the DON. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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F 657	Continued From page 16	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the care plan for advance directive for 1 of 1 sampled resident reviewed for hospice (Resident #7). Findings included:	F 657	F657 Identification: St. Joseph of the Pines does review and revise care plans. Corrective Action Resident # 7 EMR and hard copy chart	4/5/18

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F 657	Continued From page 17 Resident #7 was admitted to the facility on 1/6/17 and was readmitted on 1/25/18 with multiple diagnoses including dementia. The quarterly Minimum Data (MDS) assessment dated 2/22/18 indicated that Resident #7 had severe cognitive impairment and was receiving hospice care. On 5/4/17, Resident #7 had a doctor's order for Do not resuscitate (DNR) status. On 1/25/18, Resident #7 had a doctor's order for "FULL CODE" status. Resident #7's care plan dated 2/20/18 was reviewed. One of the care plan problems was "Please honor my advance directive, I have a do not resuscitate order (DNR)". The goal was "I will maintain comfort and dignity through the end of life". The approaches included" advance directives: DNR)". On 3/7/18 at 9:56 AM, Nurse #2 was interviewed. She stated that Resident #7 was a DNR status when admitted and was changed to a Full code status when readmitted on 1/25/18. On 3/7/18 at 12:12 PM, MDS Nurse #1 was interviewed. She stated that she was not aware that Resident #7's code status was changed to a Full code on 1/25/18 and so she did not revise the care plan from a DNR status to a Full code status. On 3/8/18 at 9:50 AM, the Director of Nursing (DON) was interviewed. She verified that Resident #7 was a Full code on readmission (1/25/18) and stated that she expected the care plan to be revised when the resident's code status had changed.	F 657	has been reviewed and revised by the CCC to reflect the residents correct code status on or before 3/28/18. Resident # 7 care plan has been reviewed and revised by Lead MDS Coordinator to reflect the change in advance directive on or before 3/29/18. All current residents' code status will be reviewed for accuracy between the EMR and the hard copy chart by the ADON and the CCC on or before 3/28/18. All current residents advance directives have been removed from their care plan and placed in physician orders under Advance Directives in EMR on or before 3/28/18. System change The ward secretaries and admissions nurses will be re-educated by the DON on verifying upon readmission with primary care provider if resident's code status changed is accurate and reflects appropriately in the EMR and hard copy chart on or before 3/28/18. Actively working licensed nurses will be educated by DON or clinical supervisor on entering advance directives into EMR located in physician orders under Advance Directives on or before 4/5/18. Monitoring The DON or nursing supervisor will audit all re-admissions and new admissions code status to ensure the EMR and the	

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F 657	Continued From page 18	F 657	hard copy chart are accurate weekly for four weeks then monthly for three months until substantial compliance is achieved. Findings and corrective measures will be reported weekly to the Vice President of Health Services. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow through with the pharmacist recommendations and agreed by the attending physician on 1 of 2 sampled residents reviewed for tube feeding (Resident #2). Findings included: Resident #2 was admitted to the facility on 10/9/17 with multiple diagnoses including failure to thrive. The quarterly Minimum Data Set (MDS)	F 658	F658 Identification St. Joseph of the Pines does meet professional standards of quality. Corrective Action Resident #2 orders were reviewed by the physician and reflects recommendations by the consulting pharmacist entered by the staff nurse on or before 3/22/18.	4/5/18

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F 658	Continued From page 19 assessment dated 2/24/18 indicated that Resident #2 had severe cognitive impairment and he was receiving tube feeding. Resident #2's doctor's orders were reviewed. On 1/19/18, there were orders for Flomax (used to treat Benign Prostatic Hypertrophy (BPH) 0.4 milligrams (mgs) via Gastrostomy (G) tube at bedtime for BPH and Seroquel (antipsychotic drug) ER (extended release) 400 mgs via G tube at bedtime for psychotic thought process. On 1/20/18, there was an order for Mirabegron (used to treat overactive bladder) ER 25 mgs via G tube in the morning for urinary urgency. Resident #2's drug regimen reviews were reviewed. On 2/1/18, the pharmacy consultant indicated that Flomax, Seroquel ER and Mirabegron ER could not be crushed and administered via G tube. She recommended to the attending physician to change Mirabegron to Oxybutynin IR 5 mgs twice a day, Seroquel ER to Seroquel 200 mgs twice a day and Flomax to Cardura 1 mgs at bedtime. The attending physician agreed and signed the recommendation on 2/18/18 and indicated for the staff to write an order. Review of Resident #2's physician's orders and Medication Administration Records (MARs) for February and March 2018 revealed that Resident #2 was still receiving Flomax, Seroquel ER and Mirabegron ER. On 3/7/18 at 1:33 PM, Nurse #2 was interviewed. She stated that the Director of Nursing (DON) was responsible for ensuring the pharmacy recommendations were responded by the attending physician. Once the recommendations	F 658	All consultant pharmacist recommendations received 3/18 were reviewed by DON to determine if physician indicated any new orders they were completed and documented accurately on or before 3/26/18. System Changes The CCC will be re-educated by the DON on entering physician orders from pharmacist recommendations accurately on or before 4/5/18. Monitoring The DON or ADON will review 100% of consultant pharmacy recommendations after being signed by physician monthly for one month, then 50% for one month, and then 25% for one month until substantial compliance is achieved, to ensure physician orders are completed and documented accurately. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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F 658	Continued From page 20 were signed by the physician, the DON handed the forms to her or the nurse on the floor to write the order. Nurse #2 stated that she had not seen the recommendation form for Resident #2 that was signed by the physician on 2/18/18. On 3/7/18 at 4:20 PM, the DON was interviewed. The DON stated that she and the Assistant DON were responsible for ensuring the pharmacy recommendations were responded by the attending physician. After the forms were signed by the physician, she handed them to the unit managers or nurses on the floor to write the order and to transcribe the order to the MAR. She verified that the pharmacy recommendations signed by the physician on 2/18/18 for Resident #2 were not followed through. The DON further stated that she expected the pharmacy recommendations signed and agreed by the physician to have orders written and transcribed to the MAR.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to provide nail care to 1 of 7 sampled residents reviewed for activities of daily living (ADL) (Resident #97). Findings included: Resident #97 was admitted to the facility on 6/20/15 and was readmitted on 8/31/17 with	F 677	F677 Identification St. Joseph of the Pines does provide activities of daily living (ADL) care for dependent residents. Corrective Action Resident #97 nails will be cleaned and	4/5/18

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F 677	Continued From page 21 multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/8/18 indicated that Resident #97 had moderate cognitive impairment and needed extensive assistance with personal hygiene. Resident #97's care plan dated 2/8/18 was reviewed. One of the care plan problems was "I am at risk for skin breakdown and injury related to dry fragile skin, impaired mobility and bowel incontinence". The goal was "I will be free of skin injury/breakdown as evidenced by no skin tears, abrasions, lacerations, bruises, pressure areas daily in 90 days". The approaches included "please keep my finger nails and toe nails short, filed and clean, and check them during bath times". On 3/5/18 at 4:12 PM, Resident #97 was observed in bed. His finger nails were observed long, jagged and dirty. Resident #97 stated that his finger nails had not been trimmed for a long time. His left and right arms and legs were observed to have scratch marks and were bleeding. He stated that he itched a lot. On 3/6/18 at 10:30 AM and on 3/7/18 at 3:29 PM, Resident #97's finger nails were observed long, jagged and dirty. He had small amount of fresh blood on his arms and legs from scratching. On 3/7/18 at 3:30 PM, Nurse Aide (NA) #1 was interviewed. She stated that resident's finger nails were trimmed during their bath days and Resident #97 had refused to have his nails trimmed. NA #1 stated that Resident #97 had been scratching a lot on his arms and legs which caused them to bleed. She stated that the nurses were aware of his scratching.	F 677	trimmed on or before 3/7/18. All residents' nails will be visually inspected by DON or clinical supervisors to verify nails are clean and trimmed on or before 3/30/18. System Changes Actively working licensed nurses will be educated by the DON or clinical supervisors on visually inspecting resident's nails twice a week to ensure nails are clean and trimmed on or by 4/5/18. Nurses are to refer diabetic residents to podiatrist if toenails need to be trimmed. Monitoring The CCC will visually inspect 100% of resident weekly for one month, then 50% of residents weekly for one month, and then 25% of residents monthly for one month until substantial compliance is achieved, to ensure nails are clean and trimmed. Findings and corrective measures will be reported weekly to the DON. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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F 677	Continued From page 22 On 3/7/18 at 3:31 PM, Resident #97 was interviewed and he stated that nobody had asked him to trim his nails and he never refused nail care. On 3/8/18 at 9:50 AM, the Director of Nursing (DON) was interviewed. She stated that she expected staff to trim resident's nails during bath days and as needed. The DON also indicated that Resident #97 normally did not refuse care.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to intervene when a resident was found to have multiple open areas from scratching for 1 of 1 sampled resident reviewed for skin condition (Resident #97). Findings included: Resident #97 was admitted to the facility on 6/20/15 and was readmitted on 8/31/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/8/18 indicated that Resident #97 had moderate cognitive impairment and needed	F 684	F684 Identification St. Joseph of the Pines does ensure residents receive treatment and care in accordance to resident's choice. Corrective Action Resident #97 physician ordered treatment for itching on or before 3/7/18. Resident #97 nails will be cleaned and trimmed on or before 3/7/18.	4/5/18

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F 684	Continued From page 23 extensive assistance with personal hygiene. Resident #97's care plan dated 2/8/18 was reviewed. One of the care plan problems was "I am at risk for skin breakdown and injury related to dry fragile skin, impaired mobility and bowel incontinence". The goal was "I will be free of skin injury/breakdown as evidenced by no skin tears, abrasions, lacerations, bruises, pressure areas daily in 90 days". The approaches included "please check my skin every shift for redness/irritation during baths or showers and report all skin issues to charge nurse and please keep my finger nails and toe nails short, filed and clean, and check them during bath times". Resident #97's weekly nursing assessments were reviewed. The assessments dated 1/3/18, 1/10/18 and 1/24/18 revealed that Resident #97's skin had scratches and discoloration to bilateral arms. The assessments dated 2/8/18 and 2/14/18 revealed that Resident #97's skin had scratches and discoloration to bilateral arms and bilateral lower extremities. On 3/5/18 at 4:12 PM, Resident #97 was observed in bed. His finger nails were observed long, jagged and dirty. Resident #97 stated that his finger nails had not been trimmed for a long time. His left and right arms and legs were observed to have scratch marks and were bleeding. He stated that he itched a lot. On 3/6/18 at 10:30 AM and on 3/7/18 at 3:29 PM, Resident #97's finger nails were observed long, jagged and dirty. He had small amount of fresh blood on his arms and legs from scratching. On 3/7/18 at 3:30 PM, Nurse Aide (NA) #1 was	F 684	All residents' nails will be visually inspected by DON or clinical supervisors to verify nails are clean and trimmed on or before 3/30/18. System Changes Actively working licensed nurses will be educated by the DON or clinical supervisors on visually inspecting residents' nails twice weekly to assess nails to be clean and trimmed on or by 4/5/18. Nurses are to refer diabetic residents to podiatrist if toenails need to be trimmed. Nurses are to contact physician if resident complains of pruritus. Actively working licensed nurses will be re-educated by the DON or clinical supervisors on incident/ accident reporting, documentation, interventions of skin conditions to include recording on weekly skin assessments on or by 4/5/18. Monitoring The CCC will visually inspect 100% of resident weekly for one month, then 50% of residents weekly for one month, and then 25% of residents monthly for one month until substantial compliance is achieved, to ensure nails are clean and trimmed. The CCC will audit 50% of skin assessments weekly for one month, then 25% of skin assessments weekly for one month, and then 10% of skin assessment monthly for one month until substantial compliance is achieved, to ensure if skin conditions reported have been addressed	

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F 684	Continued From page 24 interviewed. She stated that resident's finger nails were trimmed during their bath days and Resident #97 had refused to have his nails trimmed. NA #1 stated that Resident #97 had been scratching a lot on his arms and legs which caused them to bleed. She stated that the nurses were aware of his scratching. On 3/7/18 at 3:31 PM, Resident #97 was interviewed and he stated that nobody had asked him to trim his nails and he never refused nail care. On 3/7/18 at 3:38 PM, Nurse #4 was interviewed. She stated that she had seen Resident #97's skin few days ago with scratch marks but she never thought of calling the physician for treatment orders. Nurse #4 indicated that she would call the physician to start a cream for the itching. She also added that as far as she knew there was nothing done for his itching and skin issues. On 3/8/18 at 9:50 AM, the Director of Nursing (DON) was interviewed. She stated that she expected staff to trim resident's nails during bath days and as needed. The DON also indicated that Resident #97 normally did not refuse care. The DON further stated that she expected the nurses to intervene especially if the resident's skin was dry which caused him to scratch. On 3/8/18 at 10:58 AM, Nurse #4 was interviewed. She stated that she assessed Resident #97's skin on 2/14/18 and noted the scratch marks on his skin. Nurse #4 indicated that she didn't know why she didn't intervene then but she had called the physician yesterday (3/7/18) and he ordered a cream and she put the resident on acute charting to monitor his skin and	F 684	by physician. Findings and corrective measures will be reported weekly to the DON. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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F 684	Continued From page 25 his scratching,.	F 684		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, and pharmacy consultant interview, the facility administered an antibiotic without the presence of an active infection and failed to discontinue the antibiotic as ordered for 1 of 5 residents (Resident #91) reviewed for unnecessary medications. The findings included:	F 757	F757 Identification St. Joseph of the Pines provide a drug regimen free from unnecessary drugs. Corrective Action Resident # 91 Cipro was discontinued by physician on or by 3/7/18. All current residents with antibiotic orders	4/5/18

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F 757	Continued From page 26 Resident #91 was admitted to the facility on 1/29/18 with diagnoses that included benign prostatic hyperplasia (prostate gland enlargement), urinary retention, and encounter for fitting and adjustment of urinary device (indwelling urinary catheter). The admission Minimum Data Set (MDS) assessment dated 2/5/18 indicated Resident #91 was rarely/never understood and rarely/never understands. He was assessed with short term memory problems, long term memory problems, and severely impaired decision making. Resident #91 had an indwelling urinary catheter, no active diagnosis of infection, and no antibiotic use during the 7-day MDS look back period. A Urology Consultation Report dated 2/7/18 indicated Resident #91 kept removing his catheter and disconnecting the bag. The urologist indicated a procedure was scheduled for 2/15/18 to reinsert the catheter for Resident #91. The urologist ordered Cipro (antibiotic medication) 500 milligrams (mg) twice daily for 14 days starting on 2/12/18 for Resident #91. A nursing note written by Nurse #3 dated 2/8/18 indicated the pharmacy had requested a diagnosis for Resident #91's Cipro. The nurse indicated she spoke with the physician and he stated it was prophylaxis (preventative) due to reinsertion of Resident #91's urinary catheter scheduled for 2/15/18. A physician's clarification order dated 2/8/18 indicated Cipro 500 mg twice daily for 14 days starting on 2/12/18 for prophylaxis related to the reinsertion of Resident #91's urinary catheter.	F 757	will be evaluated by Staff Development Coordinator (SDC) to ensure antibiotic is prescribed in accordance with the Antibiotic Stewardship Program and the duration of administration is ordered and entered into EMR accurately on or before 4/5/18. System Changes Actively working licensed nurses, physicians, and consultant pharmacist will be re-educated by the DON or clinical supervisors on guidelines for antibiotic orders as outlined in our Antibiotic Stewardship Program on or by 4/5/18. Monitoring The SDC will review all antibiotic orders written, then entered into EMR, and the medication administration record weekly for four weeks, then all antibiotic orders every other week for eight weeks until substantial compliance is achieved, to ensure antibiotic is prescribed in accordance with Antibiotic Stewardship Program and has a specified duration. Findings and corrective measures will be reported weekly to the DON. The SDC will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective	

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F 757	Continued From page 27 A physician's order dated 2/15/18 indicated Cipro 500 mg twice daily for 5 days for Urinary Tract Infection (UTI) prevention for Resident #91. A review was conducted of the February 2018 Medication Administration Record (MAR) for Resident #91. - Resident #91 began receiving prophylactic Cipro 500 mg twice daily on 2/12/18 in accordance with the 2/7/18 physician's order and the 2/8/18 physician's clarification order. Resident #91 received Cipro 500 mg twice on 2/12/18, 2/13/18, 2/14/18, and once on 2/15/18. - On 2/15/18 Resident #91 had an outpatient procedure to reinsert his urinary catheter and he returned to the facility with an order for prophylactic Cipro 500 mg twice daily for 5 days with a stop date of 2/20/18. The previous order for Cipro 500 mg (dated 2/7/18 and clarified on 2/8/18 for twice daily Cipro 500 mg for 14 days starting on 2/12/18) was discontinued. Resident #91 received Cipro 500 mg twice daily on 2/16/18, 2/17/18, 2/18/18, 2/19/18, and 2/20/18. - On 2/21/18 Cipro 500 mg twice daily was added to Resident #91's MAR with a start date of 2/21/18 and an end date of 3/26/18. There was no corresponding physician's order in Resident #91's medical record. The February 2018 MAR indicated Resident #91 received Cipro 500 mg twice daily from 2/21/18 through 2/28/18 with no corresponding physician's order for the antibiotic and no active infection. A review was conducted on 3/6/18 at 2:00 PM of Resident #91's March 2018 MAR from 3/1/18 through 3/6/18. This March MAR indicated Resident #91 received Cipro 500 mg twice daily from 3/1/18 through 3/5/18 and once on 3/6/18 with no corresponding physician's order for the	F 757	4/5/18.	

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antibiotic and no active infection.

An interview was conducted with Nurse #3 on 3/6/18 at 2:07 PM. She reported Resident #91 was currently on a prophylactic antibiotic (Cipro) for UTI prevention related to the reinsertion of his urinary catheter. She stated Resident #91 had no active infection.

An interview was conducted with the physician on 3/7/18 at 10:30 AM. The urology consultation dated 2/7/18, the physician's orders related to Cipro, and the February and March 2018 MARs for Resident #91 were reviewed with the physician. He stated he believed the Urologist prescribed the Cipro as a prophylactic related to the reinsertion of Resident #91's urinary catheter. The physician indicated the dosage of 500 mg twice daily for Cipro was normally a treatment dose and not a prophylactic dose. He reported he wanted to review the record to determine why 500 mg Cipro twice daily was ordered for Resident #91 when he had no active infection.

A follow up interview was conducted with the physician on 3/7/18 at 11:03 AM. He confirmed the Cipro 500 mg twice daily was prescribed as a prophylactic medication related the reinsertion of Resident #91's urinary catheter. He indicated Resident #91 had no active infection. He stated the Urologist prescribed the medication on 2/7/18 with a start date of 2/12/18 for 14 days related to Resident #91's procedure scheduled on 2/15/18. The physician reported when Resident #91 returned from the procedure on 2/15/18 the Urologist indicated a continuation of the Cipro for 5 more days. He revealed the Cipro 500 mg should have been discontinued on 2/21/18 as per the urologist's orders. He stated this was an

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unnecessary medication administered to Resident #91 and he was going to discontinue the medication today (3/7/18).

A physician's order dated 3/7/18 indicated a discontinuation of Cipro for Resident #91.

An interview was conducted with the Staff Development Coordinator (SDC) on 3/7/18 at 11:30 AM. She stated she was responsible for monitoring antibiotic usage at the facility. The SDC revealed Resident #91 was the only resident in the facility who was prescribed a prophylactic antibiotic (Cipro).

An interview was conducted with the Pharmacy Consultant on 3/7/18 at 11:50 AM. The Pharmacy Consultant stated she had just completed the March 2018 drug regimen review for Resident #91. She stated she noted on her review that Resident #91 was on an antibiotic (Cipro) with no active infection.

An interview was conducted with the Director of Nursing (DON) on 3/7/18 at 4:15 PM. She stated she reviewed Resident #91's medical record and was unable to determine why the Cipro 500 mg twice daily was placed back on Resident #91's MAR on 2/21/18 with a stop date of 3/26/18. She verified there was no corresponding physician ' s order in Resident #91's medical record. She indicated she believed this was a transcription error that was not previously identified. The DON additionally added that the facility had transitioned from one electronic medical records system to a new electronic medical records system as of last week. She stated multiple staff were assisting with the transfer of orders from the old system to the new system over the past few weeks.

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F 757	Continued From page 30 A follow up interview was conducted with the DON on 3/8/18 at 9:45 AM. She stated she expected medications to be administered and discontinued as ordered. She additionally stated she expected an active infection to be present prior to the administration of an antibiotic.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		4/5/18

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F 758	Continued From page 31 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, and pharmacy consultant interview, the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 2 of 5 residents (Residents #7 and #91) reviewed for unnecessary medications. The findings included: 1. Resident #91 was admitted to the facility on 1/29/18 with diagnoses that included anxiety. A physician ' s order for Resident #91 dated 1/30/18 indicated Ativan (antianxiety medication) 1 milligram (mg) as needed (PRN) every 12 hours. There was no stop date for this PRN Ativan order.	F 758	F758 Identification St. Joseph of the Pines does ensure physician orders for as needed (PRN) psychotropic medications are time limited. Corrective Action Resident #91 PRN Ativan was discontinued by physician on or by 3/6/18. Resident #7 PRN Ativan was discontinued by physician on or by 3/8/18. All residents with PRN orders for psychotropic drugs orders will be evaluated by DON or clinical supervisors to ensure PRN orders are limited to 14 days or that the attending physician has appropriate documentation for extending	

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F 758	Continued From page 32 A physician ' s order for Resident #91 dated 1/30/18 indicated Ativan 0.5 mg half tablet (0.25 mg) three times daily. A Pharmacy Consultation Report dated 2/1/18 and written by the Pharmacy Consultant indicated Resident #91 had a PRN order for Ativan which had been in place greater than 14 days and had no stop date. The dosage of the PRN Ativan was indicated to be 0.5 mg. The Pharmacy Consultant ' s recommendation was for the prescribing practitioner to document their rationale, including that the medication was necessary to treat a specific condition in the progress notes and to indicate the duration for the PRN order if the order was to be continued. The physician signed the form on 2/18/18 and indicated discontinuation of the Ativan 0.5 mg PRN. The admission Minimum Data Set (MDS) assessment dated 2/5/18 indicated Resident #91 was rarely/never understood and rarely/never understands. He was assessed with short term memory problems, long term memory problems, and severely impaired decision making. Resident #91 had an active diagnosis of anxiety and had received antianxiety medication on 7 of 7 days during the MDS review period. A review of the current physician ' s orders for Resident #91 was conducted on 3/6/18. The current physician ' s orders included the 1/30/18 order for PRN Ativan 1 mg every 12 hours. There was no stop date for the PRN Ativan order. An interview was conducted with the Director of Nursing (DON) on 3/6/18 at 4:10 PM. The physician ' s order dated 1/30/18 for Resident #91	F 758	the medication beyond 14 days and the duration is indicated on or before 4/5/18. System Changes Actively working licensed nurses, attending physicians, and consulting pharmacist will be educated by the DON or ADON on requirements of F758 on or before 4/5/18. Monitoring The DON or clinical supervisor will review orders of three residents per week for four weeks, then two residents per week for eight weeks until substantial compliance is achieved, to ensure prn orders are limited to 14 days or that the attending physician has appropriate documentation for extending the medication beyond 14 days and the duration is indicated. Findings and corrective measures will be reported weekly to the Vice President of Health Services. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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for Ativan 1 mg PRN was reviewed with the DON. The Pharmacy Consultation Report (dated 2/1/18) for Resident #91 that recommended a discontinuation of the PRN Ativan 0.5 mg or documentation of the physician ' s rationale to continue the medication as well the duration of the PRN order was reviewed with the DON. The physician ' s documentation dated 2/18/18 on this Pharmacy Consultation Report (dated 2/1/18) that indicated a discontinuation of the PRN Ativan 0.5 mg was reviewed with the DON. The DON explained that the Pharmacy Consultant had indicated the incorrect dosage of PRN Ativan on the Pharmacy Consultation Report. She stated the dosage noted on the 2/1/18 Pharmacy Consultation Report indicated PRN Ativan 0.5 mg when Resident #91 was actually prescribed PRN Ativan 1 mg. The DON further explained that the nurse who reviewed the 2/1/18 Pharmacy Consultation Report following the physician ' s review on 2/18/18 was unable to discontinue the PRN Ativan 1 mg for Resident #91 because of the discrepancy in the dosage. The DON verified Resident #91 ' s PRN Ativan 1 mg was still an active order and had been in place since 1/30/18.

An interview was conducted with the physician on 3/7/18 at 10:30 AM. The physician ' s order for Resident #91 for Ativan 1 mg PRN was reviewed with the physician. The Pharmacy Consultation Report (dated 2/1/18) for Resident #91 that recommended a discontinuation of the PRN Ativan 0.5 mg or documentation of the physician ' s rationale to continue the medication as well the duration of the PRN order was reviewed with the physician. The physician ' s documentation on 2/18/18 on this Pharmacy Consultation Report (dated 2/1/18) that indicated a discontinuation of the PRN Ativan 0.5 mg was reviewed with the

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ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE PINEHURST, NC 28374

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physician.
The physician reiterated the DON ' s explanation that the Pharmacy Consultant had indicated the incorrect dosage of PRN Ativan on the 2/1/18 Pharmacy Consultation Report. He stated he had not realized that information at the time of his review on 2/18/18. He further verified that Resident #91 ' s PRN Ativan 1 mg was still an active order and had been in place since 1/30/18 with no stop date.

An interview was conducted with the Pharmacy Consultant on 3/7/18 at 11:50 AM. The physician ' s order for Resident #91 for Ativan 1 mg PRN was reviewed with the Pharmacy Consultant. The Pharmacy Consultation Report (dated 2/1/18) for Resident #91 that recommended a discontinuation of the PRN Ativan 0.5 mg or documentation of the physician ' s rationale to continue the medication as well the duration of the PRN order was reviewed with the Pharmacy Consultant. The physician ' s documentation on 2/18/18 on this Pharmacy Consultation Report (dated 2/1/18) that indicated a discontinuation of the PRN Ativan 0.5 mg was reviewed with the Pharmacy Consultant. The Pharmacy Consultant confirmed she had noted the wrong dosage of PRN Ativan on the 2/1/18 Pharmacy Consultation Report for Resident #91. She explained that she manually input the dosages onto these reports and she had made an error. She stated her March 2018 Pharmacy Consultation Report would include the same recommendation for the correct dosage of PRN Ativan (1 mg) for Resident #91.

A follow up interview was conducted with the DON on 3/8/18 at 9:45 AM. She indicated she expected all PRN orders for psychotropic

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medications to have a time limited duration as per the regulations. She additionally indicated she expected the prescriber to document a rationale and indicate the time limited duration if the PRN psychotropic order was to extend past 14 days.
2. Resident #7 was admitted to the facility on 1/6/17 and was readmitted on 1/25/18 with multiple diagnoses including dementia. The quarterly Minimum Data (MDS) assessment dated 2/22/18 indicated that Resident #7 had severe cognitive impairment and did not receive an antianxiety medication during the last 7 day assessment period.

Review of Resident #7's drug regimen review dated 2/1/18 revealed that the pharmacist had requested from the attending physician to indicate the duration for the as needed (PRN) Ativan (antianxiety drug) order. The attending physician responded on 2/18/18 to administer "Ativan 0.5 milligrams (mgs) every one hour PRN for anxiety for six months".

Resident #7 physician's order dated 2/20/18 included "Ativan 0.5 mgs by mouth every hour PRN for anxiety x (for) 6 months".

On 3/7/18 at 9:56 AM, Nurse #2 was interviewed. She stated that she was not aware that Resident #7 had a doctor's order for PRN Ativan for 6 months. Nurse #2 indicated that PRN psychotropic drugs should only be ordered for 14 days duration but she was not sure if that applied for hospice residents.

On 3/7/18 at 10:40 AM, the Attending physician of Resident #7 was interviewed. He stated that he understood the mega rule for the use of the PRN psychotropic drugs which was 14 days. He

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F 758	Continued From page 36 further stated that he wrote the order for the PRN Ativan for the duration of 6 months because Resident #7 was a hospice resident. He also stated that Resident #7 did not need the Ativan but he wanted it available because it was difficult for the staff to get Ativan for emergency use from the pharmacy or from the facility's emergency kit. On 3/7/18 at 11:50 AM, the Pharmacist was interviewed. She stated that she thought six months duration for PRN psychotropic drug was acceptable for a hospice resident. On 3/8/18 at 9:50 AM, the Director of Nursing (DON) was interviewed. She stated that she expected all PRN psychotropic drugs orders to have a duration of 14 days including hospice residents.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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 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. §483.60(i)(2) - Store, prepare, distribute and	F 812		4/5/18

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F 812	Continued From page 37 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label and date opened food items in one of two kitchen freezers. The findings included: On 3/5/18 at 9:10 AM, an initial tour of the kitchen was conducted with the Dietary Manager. The backup freezer in the kitchen area was observed and contained three (3) bags of meat opened and not labeled or dated and two (2) packages of French fries opened and not labeled or dated. On 3/5/18 at 9:10 AM, an interview was conducted with the Dietary Manager. She stated the 3 bags of meat was chicken tenders. The Dietary Manager stated all food items should have been labeled and dated when they were opened.	F 812	F812 Identification St. Joseph of the Pines does store food in accordance with professional standards for food service safety. Corrective Action On 3/5/18, the Dining Service Manager disposed of three bags of chicken tenders and two packages of french fries. The Dining Service Manager verified at that time there were no other food items opened and not labeled or dated in the kitchen. System Changes Food service providers will be re-educated by the Dining Service Manager on the proper storage of food in accordance with professional standards to include labeling and dating when food items are open on or before 4/4/18. Monitoring The Dining Service Manager or dietary supervisor will perform daily inspections in kitchen for properly stored food items to include label and dated open items for one month, then every other day for one month, then weekly. Findings and corrective measures will be reported weekly to the Vice President of Health Services. Dining Service Manager will report trends	

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F 812	Continued From page 38	F 812	of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The Vice President of Health Services is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/2018	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		4/5/18

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 40 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to maintain accurate medical records for one (1) of four (4) sampled residents reviewed for pressure ulcers (Resident #241). The findings included: Resident #241 was admitted to the facility 2/13/18. Cumulative diagnoses included surgical amputation of toes on right foot, diabetes, peripheral vascular disease and moderate protein calorie malnutrition. An admission nursing note dated 2/13/18 revealed Resident #241 had the following skin condition: a left heel unstageable pressure ulcer that measured 3.4 centimeters in length and 3.0 centimeters wide. An unstageable pressure ulcer is an ulcer that is not stageable due to coverage of wound bed by slough and/or eschar. A weekly wound assessment dated 2/14/18 stated Resident #241 had an unstageable pressure ulcer on the left heel with 100% eschar tissue (black). An Admission Minimum Data Set (MDS) dated 2/20/18 indicated Resident #241 had one unstageable pressure ulcer that was present on admission. Measurements were documented as 3.4 centimeters in length, 3.0 centimeters in width with no depth. A weekly wound assessment dated 2/22/18 stated Resident #241 had a stage two (2) pressure ulcer on her left heel that had been	F 842	F842 Identification St. Joseph of the Pines does maintain accurate medical records. Corrective Action Resident # 241 weekly wound assessments on 2/22/2018 and 2/28/2018 have been corrected by CCC to reflect the proper staging of tissue present at that time on or before 3/27/18. All residents with pressure ulcers were assessed and documented by DON or clinical supervisors to ensure accurate documentation on or before 3/29/18. System Changes Actively working licensed nurses will be re-educated by the DON or clinical supervisors on assessing pressure ulcers and documenting findings accurately on or by 4/5/18. Monitoring The DON or clinical supervisor will visually assess all residents with pressure ulcers and review the wound documentation for three residents with pressure ulcers per week for four weeks, then two residents per week for eight weeks until substantial compliance is achieved to ensure accurate documentation. Findings and corrective measures will be reported weekly to the Vice President of Health	

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F 842	Continued From page 41 present on admission. The tissue type indicated the pressure ulcer had 100% eschar tissue. A stage 2 pressure ulcer has partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed. A weekly wound assessment dated 2/28/18 stated Resident #241 had a stage two (2) pressure ulcer on her left heel that had been present on admission. The tissue type was noted as 100% eschar tissue. On 3/8/18 at 10:14 AM, an interview was conducted with Nurse #1. She stated she had completed the admission nursing note on 2/13/18 and the weekly wound assessment dated 2/14/18 for Resident #241. Nurse #1 said Resident #241 was admitted with a pressure ulcer on the left heel. She stated the skin was intact and the skin tissue was completely black (necrotic) so she knew it was unstageable. On 3/8/18 at 10:55 AM, an interview was conducted with Nurse #2 who stated she had completed the weekly wound assessments for Resident #241 on 2/22/18 and 2/28/18. She stated the left heel pressure ulcer documentation dated 2/22/18 and 2/28/18 was in error and the left heel pressure ulcer should have been staged as unstageable on both wound assessments. Nurse #2 said she did not know how the error happened. On 3/8/18 at 11:49 AM, an interview was conducted with the Director of Nursing who stated she wound expect the weekly wound tracking assessments to be accurate. She said 100% eschar tissue would classify the pressure ulcer as an unstageable pressure ulcer.	F 842	Services. The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and physician, pharmacy consultant, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and failed to monitor the interventions put into place following the 5/25/17 recertification survey. This was for three recited deficiencies on accuracy of assessments (483.20), unnecessary drugs (483.45), and food and nutrition services (483.60) on the recertification survey of 3/8/18. The continued failure of the facility during the two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referred to:	F 865	F865 Identification St. Joseph of the Pines does maintain a Quality Assessment and Assurance (QAA) Committee that addressed and corrected specific instances identified in previous federal survey. Corrective Action Refer to F641, F757, and F812 plans of correction specific to systems to ensure compliance with intent of regulation. System Changes The MD-QAPI committee will re-educated by the Vice President of Health Services on developing, implementing, and	4/5/18

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F 865	Continued From page 43 F 641 (Accuracy of assessments) Based on observation, medical record review, resident and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of pressure ulcers (Resident #104), cognition (Resident #241), diagnosis (Resident #91), dental (Resident #108,) and discharge location (Resident #191) for 5 of 31 sampled residents. During the 5/25/17 recertification survey, the facility was cited 483.20 accuracy of assessments in the areas of medication, behaviors and pressure ulcer for 3 of 13 residents sampled. F757 (Unnecessary drugs) - Based on record review, staff interview, physician interview, and pharmacy consultant interview, the facility administered an antibiotic without the presence of an active infection and failed to discontinue the antibiotic as ordered for 1 of 5 residents (Resident #91) reviewed for unnecessary medications. F758 (Unnecessary drugs) - Based on record review, staff interview, physician interview, and pharmacy consultant interview, the facility failed to ensure physician's orders for as needed (PRN) psychotropic medications were time limited in duration for 2 of 5 residents (Residents #7 and #91) reviewed for unnecessary medications. During the 5/25/17 recertification survey, the facility was cited 483.45 for failure to support a clinical rationale for the re-initiation of an antipsychotic medication, to monitor behaviors and side effects of an antipsychotic medication, and to discontinue medication as ordered for 3 of	F 865	monitoring appropriate plans of action on identified quality areas prior to the next full MD-QAPI Committee meeting. A sub-committee within the MD-QAPI Committee will meet weekly beginning on or before 4/5/18 for the next three months regarding regulatory compliance to review, monitor for trends, and determine if changes to current practices, monitoring activities, or process improvement plan development/modifications are necessary. The member of this subcommittee include, but are not limited to the colleagues responsible for attaining and sustaining compliance with cited deficiencies. Monitoring The Vice President of Health Services will report findings and actions of the sub-committee to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. 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.	

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F 865	Continued From page 44 6 residents reviewed for unnecessary medication. F812 (Kitchen sanitation) - Based on observation and staff interview, the facility failed to label and date opened food items in one of two kitchen freezers. During the 5/25/17 recertification survey, the facility was cited 483.60 for failure to maintain the seal on five of six reach-in cooler doors, properly restrain facial hair, failed to dispose of expired dairy products in 2 of the 7 food prep areas. On 3/11/18 at 1:00 pm the Administrator and was interviewed for Quality Assurance (QA). The Administrator indicated that the facility had a QA committee that consisted of all the department heads, the Pharmacist and Medical Director. The committee had met quarterly with all the department heads, the Medical Director, and the Pharmacist. They indicated that they were aware of the repeat tags. The Administrator felt the accuracy of assessments was an ongoing development, the psychotropic medication time limitation was a new regulation, and the kitchen deficiency was an unrelated area.	F 865	The Facility alleges compliance effective 4/5/2018.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	F 881		4/5/18

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F 881	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, and pharmacy consultant interview, the facility failed to follow its Antibiotic Stewardship Program as evidenced by the administration of an antibiotic without the presence of an active infection and the failure to discontinue the antibiotic as ordered for 1 of 5 residents (Resident #91) reviewed for unnecessary medications. The findings included: A review of the Antibiotic Stewardship Program ' s policy indicated recommendations and interventions of an effective antibiotic stewardship program were designed to ensure that residents who met the criteria for infection received the right antibiotic at the right dose, at the right time, and for the right duration. An infection was defined as more than a single sign or symptom. Resident #91 was admitted to the facility on 1/29/18 with diagnoses that included benign prostatic hyperplasia (prostate gland enlargement), urinary retention, and encounter for fitting and adjustment of urinary device (indwelling urinary catheter). The admission Minimum Data Set (MDS) assessment dated 2/5/18 indicated Resident #91 was rarely/never understood and rarely/never understands. He was assessed with short term memory problems, long term memory problems, and severely impaired decision making. Resident #91 had an indwelling urinary catheter, no active diagnosis of infection, and no antibiotic use during the 7-day MDS look back period.	F 881	F881 Identification St. Joseph of the Pines does provide an infection control and prevention program that includes the antibiotic stewardship program Corrective Action Resident # 91 Cipro was discontinued by physician on or by 3/7/18. All current residents with antibiotic orders will be evaluated by Staff Development Coordinator (SDC) to ensure antibiotic is prescribed in accordance with Antibiotic Stewardship Program and the duration of administration is ordered and entered into EMR accurately on or before 4/5/18. System Changes The SDC and attending physicians will be educated by the DON or ADON on requirements of F881 on or before 4/5/18. Monitoring The SDC will review all antibiotic orders weekly for four weeks, then all antibiotic orders every other week for eight weeks until substantial compliance is achieved, to ensure antibiotic is prescribed in accordance with Antibiotic Stewardship Program and has a specified duration. Findings and corrective measures will be reported weekly to the DON. The SDC will report trends of these audits to the MD-QAPI Committee monthly for	

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F 881	Continued From page 46 A Urology Consultation Report dated 2/7/18 indicated Resident #91 kept removing his catheter and disconnecting the bag. The urologist indicated a procedure was scheduled for 2/15/18 to reinsert the catheter for Resident #91. The urologist ordered Cipro (antibiotic medication) 500 milligrams (mg) twice daily for 14 days starting on 2/12/18 for Resident #91. A nursing note written by Nurse #3 dated 2/8/18 indicated the pharmacy had requested a diagnosis for Resident #91 ' s Cipro. The nurse indicated she spoke with the physician and he stated it was prophylaxis (preventative) due to reinsertion of Resident #91 ' s urinary catheter scheduled for 2/15/18. A physician ' s clarification order dated 2/8/18 indicated Cipro 500 mg twice daily for 14 days starting on 2/12/18 for prophylaxis related to the reinsertion of Resident #91 ' s urinary catheter. A physician ' s order dated 2/15/18 indicated Cipro 500 mg twice daily for 5 days for Urinary Tract Infection (UTI) prevention for Resident #91. A review was conducted of the February 2018 Medication Administration Record (MAR) for Resident #91. - Resident #91 began receiving prophylactic Cipro 500 mg twice daily on 2/12/18 in accordance with the 2/7/18 physician ' s order and the 2/8/18 physician ' s clarification order. Resident #91 received Cipro 500 mg twice on 2/12/18, 2/13/18, 2/14/18, and once on 2/15/18. - On 2/15/18 Resident #91 had an outpatient procedure to reinsert his urinary catheter and he returned to the facility with an order for	F 881	review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee. The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 4/5/18.	

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prophylactic Cipro 500 mg twice daily for 5 days with a stop date of 2/20/18. The previous order for Cipro 500 mg (dated 2/7/18 and clarified on 2/8/18 for twice daily Cipro 500 mg for 14 days starting on 2/12/18) was discontinued. Resident #91 received Cipro 500 mg twice daily on 2/16/18, 2/17/18, 2/18/18, 2/19/18, and 2/20/18. - On 2/21/18 Cipro 500 mg twice daily was added to Resident #91 ' s MAR with a start date of 2/21/18 and an end date of 3/26/18. There was no corresponding physician ' s order in Resident #91 ' s medical record. The February 2018 MAR indicated Resident #91 received Cipro 500 mg twice daily from 2/21/18 through 2/28/18 with no corresponding physician ' s order for the antibiotic and no active infection.

A review was conducted on 3/6/18 at 2:00 PM of Resident #91 ' s March 2018 MAR from 3/1/18 through 3/6/18. This March MAR indicated Resident #91 received Cipro 500 mg twice daily from 3/1/18 through 3/5/18 and once on 3/6/18 with no corresponding physician ' s order for the antibiotic and no active infection.

An interview was conducted with Nurse #3 on 3/6/18 at 2:07 PM. She reported Resident #91 was currently on a prophylactic antibiotic (Cipro) for UTI prevention related to the reinsertion of his urinary catheter. She stated Resident #91 had no active infection.

An interview was conducted with the Director of Nursing (DON) on 3/6/18 at 4:10 PM. She indicated the Staff Development Coordinator (SDC) was responsible for monitoring the Antibiotic Stewardship Program at the facility.

An interview was conducted with the physician on

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3/7/18 at 10:30 AM. The urology consultation dated 2/7/18, the physician ' s orders related to Cipro, and the February and March 2018 MARs for Resident #91 were reviewed with the physician. He stated he believed the Urologist prescribed the Cipro as a prophylactic related to the reinsertion of Resident #91 ' s urinary catheter. The physician indicated the dosage of 500 mg twice daily for Cipro was normally a treatment dose and not a prophylactic dose. He reported he wanted to review the record to determine why 500 mg Cipro twice daily was ordered for Resident #91 when he had no active infection.

A follow up interview was conducted with the physician on 3/7/18 at 11:03 AM. He confirmed the Cipro 500 mg twice daily was prescribed as a prophylactic medication related the reinsertion of Resident #91 ' s urinary catheter. He indicated Resident #91 had no active infection. He stated the Urologist prescribed the medication on 2/7/18 with a start date of 2/12/18 for 14 days related to Resident #91 ' s procedure scheduled on 2/15/18. The physician reported when Resident #91 returned from the procedure on 2/15/18 the Urologist indicated a continuation of the Cipro for 5 more days. He revealed the Cipro 500 mg should have been discontinued on 2/21/18 as per the urologist ' s orders. He stated this was an unnecessary medication administered to Resident #91 and he was going to discontinue the medication today (3/7/18). The physician also stated that administration of a prophylactic antibiotic was not in accordance with the facility ' s Antibiotic Stewardship Program ' s policy.

A physician ' s order dated 3/7/18 indicated a discontinuation of Cipro for Resident #91.

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An interview was conducted with the SDC on 3/7/18 at 11:30 AM. She indicated she was the point person for the Antibiotic Stewardship Program and she was responsible for monitoring antibiotic usage at the facility. She stated she expected the criteria in the Antibiotic Stewardship Program ' s policy be followed. She indicated the administration of prophylactic antibiotics was not in accordance with the Antibiotic Stewardship Program ' s policy. The SDC revealed Resident #91 was the only resident in the facility who was prescribed a prophylactic antibiotic (Cipro).

An interview was conducted with the Pharmacy Consultant on 3/7/18 at 11:50 AM. The Pharmacy Consultant stated she had just completed the March 2018 drug regimen review for Resident #91. She stated she noted that Resident #91 was on an antibiotic (Cipro) with no active infection. She reported she expected the facility ' s Antibiotic Stewardship Program ' s policy to be followed and for antibiotics to be administered only when the criteria for an active infection was met.

An interview was conducted with the DON on 3/8/18 at 9:45 AM. She stated she expected medications to be administered and discontinued as ordered and for the Antibiotic Stewardship Program to be followed.

A follow up interview was conducted with the DON on 3/8/18 at 9:45 AM. She stated she expected medications to be administered and discontinued as ordered. She additionally stated she expected the facility ' s Antibiotic Stewardship Program ' s policy to be followed and for antibiotics to be administered only when the

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F 881	Continued From page 50 criteria for an active infection was met.	F 881		