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 _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 07/12/21 through 07/14/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NFO311.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on 7/12/21 through 7/14/21. Event ID # NFO311.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to place a resident's call light (Resident #11) within reach to allow for the resident to request staff assistance if needed for 1 of 1 resident reviewed for accommodation of needs. The findings included: Resident #11 was admitted to the facility on 1/22/21 with multiple diagnoses that included paraplegia, history of transient ischemic attack (TIA's-a mini-stroke), congestive heart failure (CHF) and malignant neoplasm of the endometrium.	F 558	F-558 483.10(e) Element 1: Corrective action for those residents found to have been affected by the deficient practice: A fastener to assure secure fastening of the call bell was added to resident 11's call bell and placed within reach immediately on 07/14/21 by the clinical care coordinator. Element 2: How the facility identified other residents having the potential to be affected by the same deficient practice: The clinical care coordinators assessed all other residents on 07/23/21 to ensure the resident's call bells were equipped with a fastener and were within reach of	8/20/21

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

Electronically Signed | 07/29/2021

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F 558	Continued From page 1 The quarterly Minimum Data Set (MDS) assessment dated 4/28/21 revealed Resident #11 was cognitively intact and displayed no behaviors or rejection of care. She required supervision of one person for transfers and toileting. Resident #11's care plan, last reviewed on 4/28/21, indicated she had a potential for injury associated with falls related to the need for assistance with bathing, toileting and some transferring relating to a history of TIA's, CHF and diagnosis of irritable bowel syndrome (IBS). The interventions included to keep the call light within reach and the bed in the lowest position. On 7/12/21 at 10:45 AM, an observation occurred of Resident #11 who was observed sitting up in bed watching TV. The call light cord was draped over the drawer of the nightstand, with the call bell on the floor. The nightstand was to the right and behind of Resident #11, out of her reach. An observation and interview was conducted with Resident #11 on 7/13/21 at 8:55 AM. Resident #11 was sitting upright in the bed watching TV. The call light cord was draped over the nightstand drawer touching the floor and out of her reach. Resident #11 was alert and interviewable and stated she would push the call bell for assistance but had been unable to reach it for the past few days and had resorted to yelling out for staff or motioning for them when they walked by her room. Resident #11 added she only transferred with staff assistance due to weakness in her legs and occasional pain. An interview occurred with Nurse Aide (NA) #3 on 7/13/21 at 3:40 PM. She indicated she was familiar with Resident #11, who was able to use	F 558	the resident. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: Colleagues (staff) will be educated by the Director of Nursing and the clinical care coordinator on the importance of placing call lights within reach of the resident and to assure it was securely fastened in place. Any staff member not attending the scheduled in-services by 8/20/21 will not be allowed to complete his/her shift until they have attended the in-service. Element 4: Plans to monitor performance to make sure that the solutions are sustained: The Administrator or his/her designee will assess 10 residents to determine if the call light is within reach of the resident and secured with a fastener. The audits will be completed 2x week for 2 weeks, weekly for 2 weeks and monthly for 3 months. Results will be recorded on an audit tool titled "Call Light Audit" and presented by the Director of Nursing to the Quality Assurance and Performance Improvement Committee monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021.	

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F 558	Continued From page 2 the call light to request staff assistance. NA #3 was unable to explain why the call bell had been out of reach of the resident and stated the resident had been calling out for staff or motioning for them as they walked by her room. At 3:44 PM on 7/13/21, Resident #11 was observed sitting up in the wheelchair at her bedside. The call bell cord was draped in the nightstand drawer and touching the floor, which was located behind Resident #11. She was unable to reach the cord if assistance was needed. An interview was completed with the Director of Nursing and Administrator on 7/14/21 at 3:00 PM regarding Resident #11's call light not being placed within her reach. Both parties indicated it was their expectation for staff to place resident call lights within their reach at all times.	F 558		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;	F 563		8/20/21

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F 563	Continued From page 3 (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview, the facility failed to honor a resident's right for compassionate care visitation in accordance with guidance from the Centers for Medicare and Medicaid Services (QSO-20-39-NH) and the facility's COVID-19 Policy for 1 of 1 residents reviewed for compassionate care visitation (Resident #8). The findings included: A Centers for Medicare and Medicaid Services (CMS) memo (QSO-20-39-NH) dated 9/17/20 titled "Nursing Home Visitation - COVID-19" included, in part, the following information under the heading of "Compassionate Care Visits": While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:	F 563	483.10(f)(4) Element 1: Corrective action for those residents found to have been affected by the deficient practice: Social Worker notified Resident #8's family members immediately on 07/14/21 that compassionate care visitation was allowed. Element 2: How the facility identified other residents having the potential to be affected by the same deficient practice: There were no other residents affected by the same practice because there were no visitation restrictions in place at the time of the survey. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice does not recur: Staff were re-educated on Centers for Medicare and Medicaid Services COVID-19 Nursing Home Visitation guidelines with emphasis on allowing Compassionate Care Visits by the	

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F 563	Continued From page 4 - A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support. - A resident who is grieving after a friend or family member recently passed away. - A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration. - A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past). Allowing a visit in these situations would be consistent with the intent of, 'compassionate care situations' ... Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. A review of the facility's policy titled "Infection Prevention and Control Manual Coronavirus (COVID-19)" undated, included, in part, that in person visitation would be suspended when there was a new case of COVID-19 among residents or staff. Compassionate care visits were noted to be excluded from this suspension. Resident #8 was admitted to the facility on 8/23/16 with diagnoses that included senile degeneration of the brain and dementia. Resident #8's care plan, effective 7/30/20, included the problem area of Resident #8 having a terminal diagnosis of senile degeneration of the brain and receiving hospice services. The interventions included, in part: support my family's efforts to remain at my bedside and respect my family's specific requests and support their	F 563	Director of Nursing and the Clinical Care Coordinators. Any staff member not attending the scheduled in-services by 08/20/21 will not be allowed to complete his/her shift until they have attended the in-service. All staff were instructed during the in-service to inform the Administrator of any request for visitation during periods where COVID-19 visitation restrictions may be implemented to assure Centers for Medicare and Medicaid Services COVID-19 Nursing Home Visitation guidelines are followed. Element 4: Plans to monitor performance to make sure that solutions are sustained: The Social Worker will audit 5 staff members a week for 1 month to ensure that they understand the right to receive visits even during restrictions with compassionate care visits. In addition, 3 residents or family members will be interviewed each week for 1 month to ensure they understand the resident right to receive visitors even during restrictions with a compassionate care visit. Results will be documented on a tool titled "Visitation Understanding Audit" and presented by the Director of Nursing to the Quality Assurance and Performance Improvement committee monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021.	

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F 563	Continued From page 5	F 563		

needs.

The quarterly Minimum Data Set (MDS) assessment dated 10/1/20 indicated Resident #8's cognition was severely impaired, she had a life expectancy of 6 months or less, and she was on hospice services.

The medical record indicated Resident #8 was confirmed positive for COVID-19 on 12/1/20. She resided on the COVID-19 unit from 12/1/20 through 12/14/20.

A nursing note dated 12/15/20 indicated Resident #8 had a decreased appetite and drank little amounts intermittently with staff's assistance. She was noted to take medication with staff's encouragement.

A nursing note dated 12/18/20 indicated Resident #8 appeared weak, fragile, and fatigued. She often had her eyes closed and needed encouragement to engage. She required assistance with eating and consumed 50% of her meal and 720 cubic centimeters (cc) of fluids. Hospice nurse stated that family had concerns due to Resident #8's COVID-19 diagnosis and had desired a visit with the resident.

Nursing notes dated 12/21/20 indicated the nurse attempted to reach Resident #8's family member by phone to discuss present condition. Resident #8 was noted to be alert and oriented to self and appeared weak and very confused.

A nursing note dated 1/2/21 at 3:17 AM indicated the Nursing Assistant (NA) reported Resident #8 had not urinated and a bladder scan was completed with 356 cc of urine in bladder.

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F 563	Continued From page 6	F 563		

Hospice staff were spoken with and an order was received for a catheter to be put in. The catheter obtained 700 cc of dark amber urine.

A nursing note dated 1/3/21 at 6:13 AM by Nurse #2 indicated the night shift nurse reported Resident #8 had not voided during the day or night shift. The night shift nurse called hospice staff and had received an order for a catheter due to urinary retention.

A nursing note dated 1/3/21 at 6:35 AM (entered at 6:42 PM) by Nurse #2 indicated Resident #8 had 350 milliliters (ml) in catheter drainage bag and based on a decline in nutrition as evidenced by not eating or drinking and minimal output, hospice stated that Resident #8 was at the end of life. Nurse #2 wrote that the family was informed. An order was received to keep the urinary catheter in place for urinary retention.

A nursing note dated 1/4/21 at 12:00 AM (entered at 6:45 PM) by Nurse #2 indicated the physician saw Resident #8 via telehealth and stated that because she had 150 ml urine in bag, she was drinking some sips, and eating small amounts intermittently that she was not at the end of life. The family and hospice nurse were noted to be aware.

A phone interview was conducted with Resident #8's Responsible Party (RP) on 7/12/21 at 3:43 PM. She stated that in December 2021 Resident #8 had COVID-19 and in the beginning of January 2021 she was informed by phone that Resident #8 had a decline in condition and was minimally eating and drinking. She reported that nursing staff, unable recall a name, indicated Resident #8 was at the end of life. She stated

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F 563	Continued From page 7	F 563		

that she informed two of her family members of this information and they both drove over 13 hours that same night to have a face to face visit with the resident on 1/3/21, but when they arrived at the facility they were not allowed to enter. She explained that the staff told the family members that Resident #8 had stabilized from the prior day and she was no longer qualified for end of life visitation. The RP stated that Resident #8 had since bounced back from her decline in condition, but at the time the family came to the facility in January 2021 they were under the impression that it was possible she would not recover and they had wanted to spend time with the resident in case it was their last chance.

An interview was conducted with the Administrator on 7/13/21 at 2:43 PM. She stated that she was not the Administrator at the facility in January 2021, but that throughout the COVID-19 pandemic the facility was following CMS guidance for compassionate care visitations.

A phone interview was conducted on 7/14/21 at 9:54 AM with one of Resident #8's family members who went to the facility on 1/3/21 for a face to face visit. He confirmed the RP's statement that he was alerted by the RP that Resident #8 had a decline in condition and was not doing well so he and another family member drove through the night over 13 hours to see the resident in person. He indicated that when he arrived at the facility the security guard contacted the charge nurse or one of the managers (unable to recall a name) and they stated that based on the visitation protocol since Resident #8 had stabilized and was not believed to be at "end of life" that they could not enter the facility to see her.

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F 563	Continued From page 8 A phone interview was attempted with Nurse #2 on 7/14/21 at 11:50 AM. She was unable to be reached. During a follow up interview with the Administrator and Director of Nursing on 7/14/21 at 2:56 PM they both indicated that they expected CMS guidance for compassionate care visitation to be followed.	F 563		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 604		8/20/21

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F 604	Continued From page 9 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure residents were free of physical restraints by pushing the bed against the wall to prevent residents from exiting the bed. This was for 2 (Resident #25 and Resident #18) of 2 sampled residents reviewed for physical restraints. The findings included: 1. Resident #25 was admitted on 2/18/21 with cumulative diagnoses of dementia, Parkinson's Disease and Cerebral Vascular Accident (CVA) with left side hemiparesis. Review of the facility's incidents/accidents log revealed that Resident #25 had falls on 3/22/21, 3/28/21, 4/12/21, 4/13/21, 5/19/21, 6/15/21 and 7/3/21. All falls were from his bed and related to transferring from his bed without assistance. Resident #25's quarterly Minimum Data Set dated 5/24/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with transfers, extensive assistance with bed mobility. He was coded for 2 falls without any injuries and 2 falls with minor injuries. Resident #25 was not coded for the use of a restraint. Resident #25's care plan created 5/24/21 and last revised on 6/18/21, read he had experienced	F 604	F-604 483.10(e)(1) Element 1: Corrective action for those residents found to have been affected by the deficient practice: Residents 18 and 25 were assessed by the Clinical Care Coordinators on 7/12/21 with no adverse effects and their beds were moved away from the wall to the center of the room. A multidisciplinary team consisting of: Therapy, Director of Nursing and Clinical Care Coordinators was held to discuss the fall prevention interventions for Residents 18 and 25 and interventions were appropriately implemented. Fall Risk Assessments for residents 18 and 25 were reviewed by the Clinical Care Coordinator on 07/12/21. Element 2: How the facility identified other residents having the potential to be affected by the same practice: On 07/12/21 the Clinical Care Coordinators audited all other residents to determine a) the bed placement and b) if the bed placement prevented the resident from exiting the bed. There were no other beds placed against the wall preventing residents from exiting the bed. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: Staff were educated on the definition of physical restraints and that beds should	

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F 604	Continued From page 10 multiple falls since his admission secondary to poor balance, poor trunk control, left-sided weakness and impulsiveness related to his dementia. Interventions included a defined parameter mattress (DPM), low bed and bilateral mats on the floor to the sides of the bed. Resident #25 was observed in his bed on 7/12/21 at 10:30 AM. He was lying on a DPM and his bed was at normal height. There was no mat on the right side of his bed and the left side of his bed was against the wall. Resident #25 was observed in his bed on 7/13/21 at 2:00 PM. He was lying on a DPM, his bed was at normal height and there was observed a floor mat on the right side of his bed. The left side of his bed was pushed flush against the wall. The Rehabilitation Manager (RM) was interviewed on 7/13/21 at 2:58 PM. He stated that he attended the daily clinical care meeting and incident reports including falls were reviewed. The RM indicated that he would never recommend to place resident's bed against the wall, this would keep resident from being able to get out of bed. The Clinical Care Coordinator (CCC) #1 was interviewed on 7/13/21 at 3:45 PM. She stated that she was assigned as CCC on the unit Resident #25 was residing. She reported that she was not aware that the resident's bed was against the wall. She also indicated that falls were reviewed on the daily clinical care meeting and placing the bed against the wall was never mentioned as intervention for falls. The Director of Nursing (DON) was interviewed	F 604	not be placed against the wall that may prevent a resident from exiting the bed. Any staff member that did not receive the education by August 20,, 2021 will not be allowed to complete his/her shift until they have attended the in-service. Falls will continue to be reviewed in daily Clinical Stand Up meetings attended by Therapy, Director of Nursing, Minimum Data Set Nurses and Clinical Care Coordinators to assure appropriate and least restrictive fall prevention interventions have been implemented. Element 4: Plans to monitor performance to make sure that solutions are sustained: Clinical Care Coordinators will observe all resident rooms during rounds weekly for 3 weeks to ensure beds have not been placed against the wall preventing the resident from exiting the bed. The results will be recorded on an audit tool titled "Bed Placement Audit" and presented by the Director of Nursing to the Quality Assurance and Performance Improvement committee monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be completed by August 20, 2021. The administrator is responsible for sustained compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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on 7/13/21 at 3:47 PM. The DON stated that the facility was restraint free. She stated that she was not aware that Resident #25's bed was against the wall; this would restrict resident from getting in and out of bed and would be considered a restraint. She stated that falls were reviewed on the daily clinical care meeting and placing the bed against the wall was not discussed as an intervention to prevent falls. She commented that it might have been the nursing assistants (NAs) who were moving these beds against the wall.

A third observation was completed on 7/13/21 at 4:35 PM. Resident #25 was lying on a DPM, his bed was at normal height and a floor mat on the right side of his bed. The left side of his bed was pushed flush against the wall.

Resident #25 was observed in his bed on 7/14/21 at 8:20 AM. His bed made been moved away from the wall, the bed was in the low position and floor mats were observed on both sides of the bed.

NA #2 was interviewed on 7/14/21 at 8:23 AM. She stated she was assigned Resident #25. She stated his bed was against the wall because she was told it was to keep him from falling out of bed. NA #2 was unable to remember who and when the bed was moved against the wall.

Nurse #1 was interviewed on 7/14/21 at 8:30 AM. She was assigned to Resident #25. She stated that she did not notice that the resident's bed was against the wall until yesterday (7/13/21) afternoon when the NAs were moving his bed away from the wall. Nurse #1 stated his bed against the wall would be considered a restraint.

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NA # 1 was interviewed on 7/14/21 at 11:22 AM. She stated she started working the 600 hall about 3 months ago and Resident #25's bed was already positioned against the wall at that time. NA #1 indicated that yesterday afternoon, the NAs were informed by the Nurse #1 to move his bed away from the wall.

The DON was interviewed on 7/14/21 at 2:58 PM. The DON stated that she expected residents to be free from restraints and for the staff not to move beds against the walls as this would be considered as restraints.

2. Resident # 18 was admitted to the facility on 10/14/19 with multiple diagnoses including dementia.
Review of the incident/accident log revealed that Resident #18 had falls on 1/27/21, 1/28/21 and 2/6/21. The falls on 1/27/21 and 2/6/21 were related to transfer from/to bed or chair without assistance.

The quarterly Minimum Data Set (MDS) assessment dated 5/11/21 indicated that Resident #18 had moderate cognitive impairment and was dependent on the staff for transfers. The assessment further indicated that Resident #18 did not use restraints.

Resident #18's care plan reviewed on 5/21/21 included a problem "at risk for falls and potential for injury associated with falls due to impaired mobility and vision, dementia and forget to call for assist and get up without assist." The interventions included assistance x (times) 1 when transferring and toileting using a rolling walker (RW) and physical therapy (PT)/Occupational therapy (OT) were being

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provided.

Resident #18 was observed in bed on 7/13/21 at 9:10 AM. His bed was against the wall (left side) and there was a floor mat on the right side of the bed.

The Rehabilitation (Rehab) Manager was interviewed on 7/13/21 at 2:58 PM. He stated that he attended the daily clinical care meeting and incident reports including falls were reviewed. The Rehab Manager indicated that he would never recommend to place resident's bed against the wall, this would keep resident from being able to get out of bed.

The Clinical Care Coordinator (CCC) #1 was interviewed on 7/13/21 at 3:45 PM. She stated that she was assigned as CCC on the unit Resident #18 was residing. She reported that she was not aware that the resident's bed was against the wall. She also indicated that falls were reviewed on the daily clinical care meeting and placing the bed against the wall was never mentioned as intervention for falls.

The Director of Nursing (DON) was interviewed on 7/13/21 at 3:47 PM. The DON stated that the facility was restraint free. She stated that she was not aware that Resident #18's bed was against the wall; this would restrict resident from getting in and out of bed and would be considered a restraint. She stated that falls were reviewed on the daily clinical care meeting and placing the bed against the wall was not discussed as an intervention to prevent falls. She commented that it might have been the nursing assistants (NAs) who were moving these beds against the wall.

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F 641	Continued From page 14	F 641		
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 record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of accident (Resident #13) and medications (Resident #22) for 2 of 15 sampled residents reviewed. Findings included: 1. Resident # 13 was admitted to the facility on 4/6/15 with multiple diagnoses including dementia. The quarterly MDS assessment dated 4/27/21 indicated that Resident #13 had severe cognitive impairment and with a fall with injury since admission, reentry or prior assessment. Review of the facility's incident/accident log was conducted. Resident #13 had 1 incident report dated 3/20/21. The report indicated that the resident had a skin tear to her left forearm during the transfer. The Clinical Care Coordinator (CCC) #1 was interviewed on 7/13/21 at 2:10 PM. The CCC reported that Resident #13 was noted to have a skin tear during transfer on 3/20/21 incident report, but she did not have a fall. The MDS Nurse #1 was interviewed on 7/14/21 at 1:25 PM. The MDS Nurse stated that after reviewing the incident report, she verified that	F 641	F-641 483.20(g) Element 1: Corrective action for those residents found to have been affected by the deficient practice: Residents #13 and #22 were assessed by Clinical Care Coordinators on 07/14/2021 with no adverse effects. The Minimum Data Sets for the affected residents were updated by the Minimum Data Set Nurses on 07/14/2021 to accurately reflect the skin tear and the Trazadone use as an antidepressant respectively. Element 2: All residents with a documented incident/accident and/or receiving Trazadone Minimum Data Set (MDS)'s were reviewed by the Minimum Data Set Nurses on 07/14/21 to determine if the incident/accident and medication classification were coded accurately. Any inaccuracies were corrected using the RAI modification process by the Minimum Data Set Assessment Coordinator on 07/14/21. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: The Minimum Data Set Nurse #1 was educated on a) the importance of accurately reviewing incident reports and b) following Resident Assessment Instrument guidelines to ensure accurate	8/20/21

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F 641	Continued From page 15 Resident #13 did not have a fall on 3/20/21. She indicated that she would complete a modification assessment to reflect that resident did not have a fall since admission, reentry, or prior assessment. The Director of Nursing (DON) was interviewed on 7/14/21 at 2:53 PM. She stated that she expected the MDS assessments to be coded accurately. 2. Resident #22 was most recently admitted to the facility on 6/17/21 with diagnoses that included depression and insomnia. A physician's order for Resident #22 dated 6/17/21 indicated Trazodone (antidepressant) 100 milligrams (mg) once daily prior to bed for a diagnosis of insomnia. A review of Resident #22's Medication Administration Record (MAR) from admission 6/17/21 through 6/23/21 indicated she received no hypnotic medication. The admission Minimum Data Set (MDS) assessment dated 6/23/21 indicated Resident #22's cognition was intact. She was coded with hypnotic medication on 6 of 7 days during the MDS review period. The medications section of this MDS was coded by MDS Nurse #2 An interview was conducted with MDS Nurse #2 on 7/14/21 at 11:15 AM. The medications section of Resident #22's 6/23/21 MDS that indicated the resident received hypnotic medication on 6 of 7 days was reviewed with MDS Nurse #2. The MAR which indicated Resident #22 received no hypnotic medication during the MDS review	F 641	Minimum Data Set coding. The education was provided by the Director of Nursing on 07/23/21. Element 4: Plans to monitor performance to make sure that solutions are sustained: The administrator or designee will audit a) the medication section N0410 Medications Received of 2 MDS assessments to ensure accurate pharmacological classification b) MDS assessment of 2 residents listed on the incident/accident log to assure these events were coded accurately on the MDS assessment. these audits will be completed weekly for 4 weeks. The results will be recorded on an audit tool titled "MDS Assessment Audit" and presented by the Director of Nursing to the Quality Assurance and Performance improvement committee monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021. The administrator is responsible for sustained compliance	

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F 641	Continued From page 16 period (6/17/21 through 6/23/21) was reviewed with MDS Nurse #2. She revealed that she coded Trazodone as a hypnotic medication because it was prescribed for insomnia. MDS Nurse #2 indicated that Trazodone was classified as an antidepressant and should not have been coded as hypnotic on the MDS. She stated that a modification assessment would be completed to correct the error. During an interview with the Administrator and Director of Nursing (DON) on 7/14/21 at 2:56 PM they both indicated they expected the MDS to be coded accurately.	F 641		
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 interviews, the facility failed to transcribe the correct medication administration route for 1 of 1 resident reviewed for gastric feeding tube (Resident #6). The findings included: Resident #6 was originally admitted to the facility on 7/19/19 with diagnoses that included intracranial injury, cerebral vascular accident (CVA) and presence of gastrostomy tube. The quarterly Minimum Data Set (MDS) assessment dated 4/12/21 indicated Resident #6	F 658	F-658 483.21(b)(3)(I) Element 1: Corrective action for those residents found to have been affected by the deficient practice: Resident #6 was assessed by the clinical care coordinator with no adverse effects on 07/13/21. All medications transcribed on the Medication Administration Record (MAR) to be given by mouth were changed to be provided via gastric feeding tube by the Clinical Care Coordinator immediately on 07/13/21. Element 2: How the facility identified other residents having the potential to be	8/20/21

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F 658	Continued From page 17 was cognitively intact. He required total assistance with eating and received all nutrition and fluids via a feeding tube. Review of the active care plan, last reviewed on 7/9/21, revealed Resident #6 required tube feeding for all nutrition and fluids. The active July 2021 physician orders revealed the following orders: - An order dated 10/10/19 for Folic Acid 800 micrograms (mcg) 1 tablet by mouth once a day for supplement. - An order dated 11/2/20 for Aspirin 81 milligrams (mg) 1 tab by mouth once a day for prophylaxis. - An order dated 12/4/20 for Zinc Sulfate 220 mg 1 capsule by mouth once a day for supplement. - An order dated 1/8/21 for Guaifenesin-DM 10mg-100mg/5 milliliters (ml). Give 15 ml by mouth as needed every 6 hours for cough/congestion. - An order dated 3/16/21 for Amlodipine 5mg 1 tablet by mouth once a day. All other medications were written to be provided through the gastric feeding tube. The physician orders indicated Resident #6 was to have nothing by mouth (NPO). On 7/13/21 at 3:15 PM, an interview occurred with Nurse #3 who was working the medication cart for Resident #6's hall and had administered his medications earlier. The nurse confirmed Resident #6 did not receive any medications by mouth and he had not provided the morning doses of Folic Acid, Aspirin, Zinc Sulfate or Amlodipine by mouth. Nurse #3 acknowledged the Medication Administration Record (MAR) read	F 658	affected by the same deficient practice: All residents residing in the facility with a gastrostomy tube have the potential to be affected. All orders for residents with gastrostomy tubes were checked for correct administration routes by the pharmacy consultant on 7/13/21 and changes were made as required. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses will be re-educated on safe medication administration and transcription practices by the DON or Clinical Care Coordinators by August 20, 2021. If education has not be received by August 20, 2021, the nurse will be removed from the schedule and not permitted to work until the education has been completed. Element 4: Plans to monitor performance to make sure that solutions are sustained: The Director of Nursing or designee will audit all new gastrostomy tube medications twice a week for 2 weeks, weekly for 2 weeks and monthly for 3 months on a tool titled "Gastrostomy Tube Order Audit" and presented to the Quality Assurance and Performance Improvement committee monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021. The administrator is responsible for sustained compliance.	

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for the medications to be provided by mouth, which was inaccurate as all medications were provided via the gastric feeding tube.

An interview was conducted with the facility Nurse Practitioner (NP) on 7/14/21 at 9:15 AM, who stated she had ordered the Amlodipine 5mg on 3/16/21. The NP explained she entered the medication, dose, and frequency into the Electronic Medical System as a draft. When the nurse completed the order the medication route should have been changed to gastrostomy tube (G-tube) instead of leaving at the default route of oral.

On 7/14/21 at 9:55 AM, an interview was completed with Nurse #4 who was working on the medication cart for Resident #6's hall. She stated she was familiar with Resident #6 and had administered his medications many times and confirmed he did not receive any medications by mouth. Nurse #4 acknowledged the MAR read for the medications to be provided by mouth and was inaccurate as all his medications were provided through the gastric feeding tube.

The Director of Nursing (DON) was interviewed on 7/14/21 at 11:23 AM. She reviewed Resident #6's physician orders and the July 2021 MAR's and confirmed the route for Folic Acid, Aspirin, Zinc Sulfate, Guaifenesin-DM and Amlodipine were entered as oral instead of via G-tube. She further explained when entering the medication into the electronic medical system the default route was oral and she felt it was an oversight that when the nurses entered the medications, they failed to change the route to G-tube. The DON stated it was her expectation for all medication administration routes to be entered

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F 658	Continued From page 19 correctly when the order was received and/or reviewed.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview with the Wound Nurse Practitioner and staff, the facility failed to obtain order for treatment to the pressure ulcers on admission and failed to treat the pressure ulcer for 1 of 1 sampled resident reviewed for pressure ulcers (Resident # 99). Findings included: Resident #99 was admitted to the facility on 5/28/21 with multiple diagnoses including cellulitis to right lower extremity and chronic osteomyelitis. The modification to the admission Minimum Data Set (MDS) assessment dated 6/11/21 indicated that Resident #99 had 2 pressure ulcers.	F 686	F-686 483.25(b)(1)(I)(ii) Element 1: Corrective action for the residents affected by the deficient practice: The treatment administration record (TAR) was reviewed by the Clinical Care Coordinator on 07/14/21 to assure the Physician order for treatment of resident #99's pressure ulcer was accurate. Element 2:How the facility identified other residents having the potential to be affected by the same deficient practice: All residents in the facility have the potential to be affected. Director of Nursing and Clinical Care Coordinators preformed head to toe assessment of all residents on 7/2/2021 to ensure all pressure ulcers	8/20/21

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F 686	Continued From page 20 Review of the admission doctor's orders (5/28/21) for Resident #99 revealed that there was no order for treatment to the left and right calcaneous (heel) pressure ulcers. Review of the facility's wound assessment dated 5/29/21 revealed that Resident #99 had pressure ulcers to the left calcaneous measuring 3 x (times) 4 x 0.2 centimeter (cm) and to the right calcaneous measuring 2 x 3 x 0.2 cm. Resident #99's care plan problems initiated on 6/11/21 included pressure ulcers to left heel (unstageable) and to right heel (stage IV). The goal was for the ulcer to show evidence of healing by decrease in size, length, width, depth, and no sign/symptoms of infection. The approaches included notify physician of any impaired skin integrity issues and obtain orders as needed, implement, and modify care plan as needed. Review of Resident #99's Treatment Administration Records (TARs) for May 2021 revealed that there was no treatment provided to the left and right calcaneous pressure ulcers from 5/29/21 through 5/31/21. Resident #99 was seen by the wound clinic on 6/4/21. The note indicated that Resident #99 was seen for follow up evaluation of multiple bilateral feet wounds. The left calcaneous pressure ulcer was larger than during the hospitalization and was covered with dry eschar. The left calcaneous was unstageable measuring 2.3 x 2 x 0.1 cm with large amount of necrotic tissue within the wound bed including eschar and adherent slough. The right calcaneous was stage IV measuring 2 x 2 x 0.4 cm with large amount of necrotic tissue within	F 686	were identified and a treatment was in place. A prescribed treatment was ordered and being administered. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing colleagues (staff) will be re-educated by the DON and Clinical Care Coordinators on admission skin assessments by 8/20/21. Clinical Care Coordinators will monitor all new admissions to assure appropriate treatment orders have been obtained and implemented for skin impairments/wounds. Element 4: Plans to monitor performance to make sure that solutions are sustained: A) The Director of Nursing or designee will audit new admission skin assessments twice weekly for 2 weeks, weekly for 2 weeks and monthly for 3 months to make sure treatment orders for wounds have been obtained and implemented. Audit results will be monitored on a tool titled "New Admission Skin Assessment Audit" and presented to by the Director of Nursing to the Quality Assurance and Performance Improvement committee monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021.	

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the wound bed including adherent slough. The note indicated to continue the treatment with the Medihoney. The note did not indicate the frequency of the treatment.

Review of Resident #99's TARs for June 2021 revealed that there was no treatment provided to the left and right calcaneous pressure ulcers from 6/1/21 through 6/10/21.

Resident #99 was observed during the dressing change on 7/13/21 at 9:45 AM. The resident was observed to have pressure ulcers to the left and right calcaneous. The ulcers were dry with no signs of infection noted. Nurse #2 was observed to clean the left calcaneous pressure ulcer with Normal Saline, Medihoney was applied, covered with dry gauze and secured with roll gauze. The pressure ulcer to the right calcaneous was cleaned with Normal Saline, covered with wet to dry betadine gauze and secured with roll gauze.

Clinical Care Coordinator (CCC) #1 was interviewed on 7/14/21 at 1:15 PM. The CCC reviewed the May 2021 and June 2021 doctor's orders and TARs and verified that there was no treatment order on admission for the pressure ulcers and there was no treatment provided from 5/29/21 through 6/10/21. She stated that Resident #99 was being followed by the wound clinic weekly and was first seen on 6/4/21.

The Wound Nurse Practitioner (NP) was called on 7/14/21 at 1:45 PM and she called back at 3:45 PM. She reported that Resident #99 was being followed by the wound clinic prior to admission to the hospital and to the nursing facility. He had pressure ulcers to his bilateral heels and other venous stasis ulcers to the lower

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F 686	Continued From page 22 extremities. Her first visit at the facility was on 6/9/21. Resident #99's pressure ulcer on the right calcaneous was a stage IV, with eschar and adherent slough but no exudate/odor. The left calcaneous pressure ulcer was unstageable with large necrosis but with no exudate/odor. She added that she had recommended to treat the ulcers with Medihoney 3 times a week. The Wound NP stated that she didn't know what type of treatment the resident was provided at the hospital, but she expected the facility to obtain a treatment order and to treat the ulcers at least 3 times a week. She also indicated that Resident #99 was seen by the wound clinic on 6/4/21 and had recommended to continue Medihoney 3 times a week to the ulcers. The Director of Nursing (DON) was interviewed on 7/14/21 at 2:53 PM. The DON stated that the admitting nurse was responsible for notifying the doctor and for obtaining treatment order if a resident was admitted with pressure ulcer. The DON reported that the admitting nurse for Resident #99 was no longer employed at the facility. She stated that the admitting nurse missed to call the doctor for the treatment order and nobody was responsible for monitoring pressure ulcers since the facility did not have a treatment nurse.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		8/20/21

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F 688	Continued From page 23 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to apply a splint as ordered to a resident with a contracture for 1 of 2 residents (Resident #8) reviewed for range of motion. The findings included: Resident #8 was admitted to the facility on 8/23/16 with diagnoses that included senile degeneration of the brain and dementia. An Occupational Therapy (OT) progress and discharge summary for Resident #8 dated 7/24/20 indicated she received OT from 5/25/20 through 7/24/20 for a diagnosis of left hand contracture. Resident #8 was noted with a contracture of the 3rd, 4th, and 5th digits of her left hand. The form indicated that Resident #8 was tolerating her splint well, but she had not met her long term goal of wearing the soft splint for 8 hours per day due to an early discharge from therapy related to a hospice referral. She was noted to require total assistance with donning the splint. The discharge instructions stated that	F 688	F-688 483.25(c), 483.25(c)(2) Element 1: Corrective action for the resident found to have been affected by the deficient practice: Resident #8 was assessed by Clinical Care Coordinator on 07/14/21 and had no adverse affects. The resident's splint was applied at that time. Element 2: How the facility identified other residents having the potential to be affected by the same deficient practice: All residents residing in the facility with limited range of motion have the potential to be affected. All residents with orders for splints or braces were assessed by the clinical care coordinators on 7/23/2021 to ensure they had the proper orders in place and that the orders were being completed as directed. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: A) Nursing colleagues (staff) will be re-educated by the Director of Nursing and the Clinical Care Coordinators by	

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F 688	Continued From page 24 caregiver education was initiated with nursing staff focusing on the application and wear schedule of splint. A physician's order dated 7/24/20 indicated a soft splint was to be applied to Resident #8's left hand for 4 to 6 hours daily with skin checks every 2 hours. The quarterly Minimum Data Set (MDS) assessment dated 4/22/21 indicated Resident #8's cognition was severely impaired. She had no behaviors and no rejection of care. Resident #8 was dependent on staff for assistance with Activities of Daily Living (ADLs) and she had impairment on 1 side of her upper extremities. Resident #8's active care plan (last reviewed on 3/29/21) as of 7/12/21 included the problem area of the risk for skin breakdown or injury related to impaired bed mobility, incontinence, poor nutritional intake, decreased activity due to staying in bed frequently, and wearing a splint on left hand for contracture. The interventions included, in part, a soft splint to left hand/finger contracture, apply in the morning and remove after 4 hours as will allow for contracture management, and check skin under splint when removed for cleaning and passive range of motion. An observation was conducting of Resident #8 on 7/12/21 at 10:40 AM. Her left hand was contracted and she had no splint in place. During an interview with the Rehabilitation Manager on 7/13/21 at 3:00 PM he stated that if a resident was supposed to have a splint in place there would be a physician's order for it. He was	F 688	August 20, 2021 on the importance of splints and braces that are used to prevent decreased range of motion. Nursing staff that do not receive the education by 08/20/21 will be removed from the schedule until the education has been completed. B) An audit of all residents with orders for braces or splints was completed on 7/23/21 by the Clinical Care Coordinators to ensure that every resident that should have a splint or brace had one in place. Element 4: Plans to monitor performance to make sure that solutions are sustained: The DON or designee will audit all splints/braces on a tool titled "Splint/Brace Order Audit" twice weekly x 2 weeks, weekly x 2 weeks and monthly x 3 months to ensure that splints and braces are in place as ordered. Audit results will be presented to Quality Assurance and Performance Improvement committee by the Director of Nursing monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021.	

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unsure if Resident #8 had an active splint order as she had not been in therapy since 2020.

A review of Resident #8's active orders on of 7/13/21 indicated the 7/24/20 order for soft splint application to the left hand for 4 to 6 hours daily remained in place.

An observation was conducted of Resident #8 on 7/14/21 at 9:00 AM. Her left hand was contracted and she had no splint in place.

An interview was conducted with Nurse #1 on 7/14/21 at 9:05 AM. She was asked if Resident #8 wore a splint. She stated that she had not believed Resident #8 had a splint, but that it would have been in the care plan if she required this intervention. Resident #8's care plan was reviewed with Nurse #1 and she verified that Resident #8 was supposed to have a soft splint to her left hand 4 hours daily as indicated in the care plan. She revealed she had not known this was on the care plan. Nurse #1 stated that this left hand splint had not appeared on the MAR for the nurse to check off daily so she had not realized Resident #8 required this intervention.

An interview was conducted with Nursing Assistant (NA) #2 on 7/14/21 at 9:07 AM. She stated that Resident #8 used to have a splint when she was on 800 hall, but she had no splint in place since been on the 600 hall. NA #2 was not sure of the exact date Resident #8 moved to the 600 hall, but indicated it had been several months.

A review of the room history for Resident #8 was conducted on 7/14/21 at 9:15 AM. Resident #8 resided on the 600 hall beginning on 2/4/21

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F 688	Continued From page 26 through 3/8/21, she resided on the 400 hall from 3/9/21 through 3/21/21, and then moved back to the 600 hall from 3/22/21 through present. An interview was conducted with MDS Nurse #1 on 7/14/21 at 11:10 AM. She verified that Resident #8 had an active physician's order for a soft splint to the left hand for 4-6 hours daily. She stated that she revised this order this morning (7/14/21) so it would appear on the Medication Administration Record (MAR) and would require check off from the nurse when the splint was applied and when it was removed. She explained that the previous order was entered as a "continuous" order and these types of orders had not appeared on the MAR. She reported that this was an error that occurred when the order was entered in July 2020 and was not an issue until Resident #8 moved to a new unit with staff who had not worked with her regularly and had not known that she was supposed to have the soft splint applied daily. During an interview with the Administrator and Director of Nursing on 7/14/21 at 2:56 PM they both stated that they expected splints to be applied as ordered.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		8/20/21

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F 689	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to complete a thorough fall investigation to determine the root cause, failed to timely address falls with effective interventions. The facility also failed to implement interventions as care planned to prevent further falls. This was for 2 (Resident #25 and Resident #18) of 5 sampled residents reviewed for accidents. The findings included: 1. Resident #25 was admitted on 2/18/21 with cumulative diagnoses of dementia, Parkinson's Disease and Cerebral Vascular Accident (CVA) with left side hemiparesis. Resident #25's quarterly Minimum Data Set (MDS) dated 5/24/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with transfers, extensive assistance with bed mobility. He was coded for 2 falls without any injuries and 2 falls with minor injuries. Resident #25's care plan created 5/24/21 and last revised on 6/18/21 read he had experienced multiple falls since his admission secondary to poor balance, poor trunk control, left-sided weakness and impulsiveness related to his dementia. Interventions included a defined parameter mattress (DPM), low bed and bilateral mats on the floor to the sides of the bed. Review of an incident report dated 3/22/21 at 7:15 PM read Resident #25 was heard yelling. He was found on the fall mat beside his bed and sustained an abrasion. The intervention implemented by the floor staff on 3/22/21 was to	F 689	F-689 483.25(d)(1), 483.25(d)(2) Element 1: Corrective action for those residents found to have been affected by the deficient practice: Residents #25 and #18 were assessed by the Clinical Care Coordinators on 7/14/21 and had no adverse affects. Resident #25 and #18'S Care Plans were reviewed by the Clinical Care Coordinator and all listed interventions were checked to ensure they were appropriate, in place and being followed as directed. Element 2: How the facility identified other residents having the potential to be affected by the same deficient practice: All residents residing in the facility that have had a fall have the potential to be affected. On 07/27/21 the Director of Nursing reviewed all falls occurring in the month of July to ensure a thorough root cause analysis was completed and interventions were implemented according to the root cause analysis. Element 3: Measures put into place or systemic changes made to ensure that the deficient practice will not recur: A) The facility will continue to use the Post Fall Huddle process to help identify the root cause of each fall. In addition the Interdisciplinary Team consisting of but not limited to the Director of Nursing, Therapy representative, Clinical Care Coordinators and Assessment Coordinator will review each fall incident report to determine if the root cause analysis is thorough and appropriate intervention implemented. The team may	

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F 689	Continued From page 28 take him to the common area in a recliner for close observation. The incident report read there needed to be an action plan. There was no other documentation regarding an action plan. The incident report was signed off by the DON on 3/26/21 (4 days later). Review of a nursing note dated 3/28/21 at 3:30 PM read a nursing note read Resident #25 was found on the floor mat beside his bed. The DON stated on 7/13/21 at 3:47 PM, there was no incident report for this fall and she was not aware of this fall until the survey. Review of an incident report dated 4/12/21 at 7:30 PM read Resident #25 was found on the fall mat beside his bed. The floor staff moved him to the common area for closer observation. The incident report read there needed to be an action plan. There was no other documentation regarding an action plan. The incident report was signed off by the DON on 4/19/21 (7 days later). Review of an incident report dated 4/13/21 at 3:00 PM read Resident #25 was found lying on the floor mat beside his bed. The report indicated he had just been moved from the 800 hall to the 600 hall where he was currently residing. There were no interventions documented but the report read to allow him to be on the floor as he wishes. The incident report for this fall was incomplete with the following sections not answered: post fall analysis was not completed which included: medical Factors, cognitive factors, functional factors, sensory factors, environmental factors and the post fall huddle. The incident report read there needed to be an action plan. There was no other documentation regarding an action plan. The incident report was signed off by the DON on	F 689	expound upon the root cause analysis, revise, change interventions if needed. B) Colleagues (staff) will be re-educated by DON or designee by 8/20/2021 on the importance of the fall huddle after each fall in the facility to identify the root cause and activate a new and appropriate intervention. Element 4: Plans to monitor performance to make sure that solutions are sustained: The Director of Nursing or designee will audit all falls twice weekly x 2 weeks, weekly x 2 weeks and monthly x 3 months to ensure that a fall huddle was completed and that an appropriate intervention was put into place for each fall to ensure that a post fall huddle was completed and that an appropriate intervention was put into place for each fall. The results will be recorded on an audit tool titled "Post Fall Huddle Audit" and presented to the Quality Assurance and Performance Improvement committee by the Director of Nursing monthly for review and revisions as deemed appropriate. Element 5: Completion Date: The facility is confident that these corrective measures will be fully implemented by August 20, 2021.	

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4/19/21 (7 days later).

On 5/19/21 at 3:30 PM, a nursing note read Resident #25 was found with the lower half of his body on the floor. The DON stated on 7/13/21 at 3:47 PM, there was no incident report for this fall because it wasn't considered a fall.

Review of an incident report dated 6/15/21 at 7:20 PM read Resident #25 was found on the mat beside the bed. He sustained a hematoma to the right side of the back of his head. The intervention implemented by the floor staff on 6/15/21 was to take him to the common area in a recliner for close observation and neurological checks. The incident report read there needed to be an action plan. There was no other documentation regarding an action plan. The incident report was signed off by the DON on 6/18/21 (3 days later).

Review of a Nurse Practitioner (NP) note dated 6/17/21 referenced that fall on 6/15/21. The note read his hematoma was not discovered until 6/17/21 when an aide was providing is morning care. He was sent to the emergency room for imaging due to the use of an anticoagulant.

Review of Resident #25's hospital records dated 6/17/21 read he was sent to the emergency room for an evaluation related to a fall on 6/15/21 because Resident #25 was prescribed an anticoagulant (blood thinner). His CT Scan at the hospital was negative for injury and he returned to the facility on the same day with no new orders.

Review of an incident report dated 7/3/21 at 6:30 PM read Resident #25 was found on the floor mat. The intervention implemented by the floor

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staff on 7/3/21 was incontinence care and he was remined to use his call bell. The incident report was unsigned by the DON. The follow up actions section was blank. The DON stated on 7/13/21 at 3:47 PM, she was not sure why this fall had not yet been reviewed to date (7/13/21).

Resident #25 was observed in his bed on 7/12/21 at 10:30 AM. He was lying on a defined perimeter mattress (DPM) and his bed was at normal height. There was no mat on the right side of his bed and the left side of his bed was pushed up flush against the wall.

Resident #25 was observed in his bed on 7/13/21 at 2:00 PM. He was lying on a DPM, his bed was at normal height and there was observed a floor mat on the right side of his bed. The left side of his bed was pushed against the wall.

The Rehabilitation Manager (RM) was interviewed on 7/13/21 at 2:58 PM. He stated that he attended the daily clinical care meeting. He stated the incident reports including falls were reviewed, investigated and interventions identified during those meetings. The RM stated the following staff attended the daily clinical are meetings: MDS Nurse, himself, the DON and the Clinical Care Coordinators (CCC).

The Clinical Care Coordinator (CCC) #1 was interviewed on 7/13/21 at 3:45 PM. She stated that she was assigned as CCC on the unit Resident #25 was residing. She indicated that falls were reviewed in the daily clinical care meeting and the floor staff's immediate interventions were reviewed and new or ineffective interventions were discussed at that time. She stated the MDS Nurse updated the

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care plan during the meetings.

The Director of Nursing (DON) was interviewed on 7/13/21 at 3:47 PM. She stated that falls were reviewed in the daily clinical care meetings and possible new interventions were discussed during the meetings. The DON stated Resident #25 had a long standing history of falls and fortunately, he hadn't experienced any serious injuries. The DON stated she had not recognized that all of Resident #25's falls from his bed occurred on 2nds shift. She stated she was late in reviewing the fall incidents because she and the CCC were working on the floor on occasion. The DON stated all falls should be reviewed daily in the clinical care meeting. The DON stated in their computer system, the areas post fall analysis of medical Factors, cognitive factors, functional factors, sensory factors, environmental factors and the post fall huddle were all optional for documentation in the computer system. She stated the optional areas on the incident report should be required to complete to get an accurate assessment of Resident #25's root cause analysis (RCA) for his falls.

A third observation was completed on 7/13/21 at 4:35 PM. Resident #25 was lying on a DPM, his bed was at normal height and a floor mat on the right side of his bed. The left side of his bed was pushed against the wall.

Resident #25 was observed in his bed on 7/14/21 at 8:20 AM. His bed made been moved away from the wall, the bed was in the low position and floor mats were observed on both sides of the bed.

NA #2 was interviewed on 7/14/21 at 8:23 AM.

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She stated she was assigned Resident #25. She stated his cognition had declined and he could not understand to use his call bell for assistance. She stated she rounds on Resident #35 frequently on her shift which ends at 3:00 PM.

Nurse #1 was interviewed on 7/14/21 at 8:30 AM. She was assigned to Resident #25. She stated he had a long history of falls due to his impaired cognation and his left sided weakness. She stated the first shift aides were very good about frequent monitoring of Resident #25 but the second shift aides were obviously no implementing his fall interventions and closely monitoring Resident #25. Nurse #1 stated Resident #25's behaviors increased in the late afternoon and evenings.

The DON was interviewed on 7/14/21 at 2:58 PM. The DON stated that she expected Resident #25's fall investigations to be thoroughly completed, addressed timely and effective interventions to be implemented.

2. Resident # 18 was admitted to the facility on 10/14/19 with multiple diagnoses including dementia.

Review of the facility's incident/accident log revealed that Resident #18 had falls on 1/27/21, 1/28/21 and 2/6/21. The incident report revealed that the fall on 1/28/21, Resident #18 slid out of the recliner.

The quarterly Minimum Data Set (MDS) assessment dated 5/11/21 indicated that

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Resident #18 had moderate cognitive impairment and was dependent on the staff for transfers. The assessment further indicated that Resident #18 did not have a fall since admission, reentry, or prior assessment.

Resident #18's care plan reviewed on 5/21/21 included a problem "at risk for falls and potential for injury associated with falls due to impaired mobility and vision, dementia and forget to call for assist and get up without assist." The interventions included seat cushion with dycem to recliner to prevent cushion from sliding out (added 2/5/21).

Resident #18 was observed up in a recliner on 7/14/21 at 11:20 AM. There was no seat cushion with dycem noted on the recliner.

Nurse #1, assigned to Resident #18, was interviewed on 7/14/21 at 11:21 AM. She stated that she had not seen a seat cushion with dycem on Resident #18's recliner. Nurse #1 reviewed Resident #18's care plan and she verified that the resident was supposed to have a seat cushion with dycem on his recliner when he was up. Nurse #1 went into the resident's room and verified that the resident did not have a cushion with dycem on his recliner.

NA #1, assigned to Resident #18, was interviewed on 7/14/21 at 11:22 AM. NA #1 reported that she had not seen a seat cushion with dycem on the resident's recliner. She reviewed the resident's care plan on the kiosk (a machine where NAs obtained and entered resident's information) and stated that the resident's care guide did not include to provide cushion with dycem on the resident's recliner.

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 _____	07/14/2021

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 689	Continued From page 34 The DON was interviewed on 7/14/21 at 2:58 PM. The DON stated that she expected the staff to implement the care plan interventions to prevent further falls.	F 689		