DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345044	B. WING _			C 04/05/2023
	ROVIDER OR SUPPLIER SEPH OF THE PINES H	EALTH CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COE 103 GOSSMAN ROAD PINEHURST, NC 28374)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
	complaint investigat 04/03/23 through 04 found in compliance 483.73, Emergency 6G6F11.	ecertification survey and ion was conducted on /05/23. The facility was with the requirement CFR Preparedness. Event ID				
F 000	INITIAL COMMENT	S	F 0	00		
F 550 SS=D	Four of the nine con deficiencies (NC193 NC00187945). See	mducted 4/3/23 to 4/5/23. nplaint allegations resulted in 3977, NC00192004 and Event # 6G6F11. ercise of Rights	F 5	50		4/28/23
	§483.10(a) Resident The resident has a r self-determination, a access to persons a					
	with respect and dig resident in a manne promotes maintenar her quality of life, red	lity must treat each resident nity and care for each r and in an environment that nee or enhancement of his or cognizing each resident's bility must protect and f the resident.				
	access to quality can severity of condition must establish and r practices regarding provision of services	acility must provide equal re regardless of diagnosis, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all				
ABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE

Electronically Signed 04/21/2023

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		D 187910			C // 05/2023			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		10312023		
				103 GOSSMAN ROAD				
SAINT JO	SEPH OF THE PINES HE	ALTH CENTER		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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 550	Continued From page residents regardless		F 5	50				
		right to exercise his or her the facility and as a citizen						
	resident can exercise	cility must ensure that the his or her rights without , discrimination, or reprisal						
	free of interference, c reprisal from the facili rights and to be suppo exercise of his or her subpart. This REQUIREMENT by:	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this						
	interviews the facility dignity and respect by from a resident's cloth trays were removed for dignity (Resident # concept was applied to individuals have the ewith dignity while in the	eir home environment.		This plan of correction constitute written allegation of compliance. Preparation and submission of the correction does not constitute an admission or agreement by the p the truth of the facts or alleged or correctness of the conclusions see on the statement of deficiencies. of correction is prepared and subsolely because of the requirement of the requir	orovider of r the et forth The plan omitted nt under			
	01/04/19 with multiple Parkinson's Disease a The quarterly Minimul assessment dated 02 #28 had a severe cog	mitted to the facility on diagnoses which included and Alzheimer's Disease.		state and federal law, and to den the good faith attempts by the pro- improve the quality of life of each 1. On 04/05/23 after being notifie surveyor that Resident # 28 had debris on clothing, CNA #3 remo- food debris from resident #28.	ovider to n resident. ed by the food			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED			
		345044	B. WING			C		
NAME OF P	AME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 04/05/2023				
NAME OF PROVIDER OR SUPPLIER				103 GOSSMAN ROAD	_			
SAINT JO	SEPH OF THE PINES H	EALTH CENTER		PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 550	Continued From pag	e 2	F 55	0				
F 550	member. Resident #28 was ob AM to be lying aslee pieces of brown food and clothing protector resident's neck and observation and clothing. There was a room. Resident #28 was ob AM to be lying awake wearing a clothing provided by the same large protector around her be the same large brown her face and in her book located in her room. Resident #28 was ob AM to be lying asleed protector around her be the same large brown her face and in her book located in her room. Resident #28 was ob PM. She was lying a wearing a clothing propieces of food debris tray located in her room. An observation and in occurred on 04/05/20	pin her bed. She had large debris on her face, clothing, or, an article worn around a drapes over the resident's drom soiling the resident's no meal tray located in the deserved on 04/04/23 at 11:00 at in her bed. She was rotector around her chest brown food debris on her at and a large brown piece of and sheet. There was no meal om. Deserved on 04/04/23 at 11:26 ap in her bed with a clothing chest with what appeared to rown pieces of food debris on her was no meal tray. Deserved on 04/05/23 at 1:05 wake in her bed. She was rotector with large brown so it. There was no meal	F 55	2. On 04/06/23 nursing staff of facility wide observation during meal pass, to identify other recould have been affected by the deficient practice. No addition were identified through the obhave been affected. 3. Effective 04/24/23 to 04/27/Staff Development Coordinate in-service all nursing staff, to in nights and weekends, to clear immediately after meal tray reensure all residents are free firemaining food particles to prodignity. Any nursing staff not ender of the coordinators/Designee will corandom observations of reside and after mealtimes to ensure are free from food particles and dignity is maintained, 5 random will be observed daily for 2 weeks, then 10 reside for 2 weeks, then 10 residents 2 months. Any areas of conce will be addressed promptly. Robservations will be reported a meeting weekly and monthly a the Director of Nursing Service pattern of compliance is establed.	g and after sidents that he same al residents servation to 2023 the or will include in residents moval to rom any pomote educated by ed to work. Cal Care induct ents during a residents in that in residents eks ents weekly is monthly for irri identified esults of the at the risk at QAPI by es or until a blished.			
	occurred on 04/05/23 was familiar with Res was assigned to wor day and stated she h #28 the other two da	3 at 1:12 PM. She stated she		5. Compliance date: 04/28/20				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH OF THE PINES HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES ((A4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 3 feed herself. She stated Resident #28 often dropped food on her clothing. She stated she did not remove the clothing protector or the food from Resident #28's clothing when she removed her lunch tray because she was busy assisting other residents A joint interview with the Director of Nursing and Administrator on 04/05/23 at 2:49 PM revealed it was their expectation for the staff to come back after removing trays and clean residents after meals to promote dignity. F 677 SS=D CFR(s): 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, observations and staff interviews, the facility failed to trim and clean a dependent resident's nails (Resident #35) for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). STREET ADDRESS, CITY, STATE, ZIP CODE 133 GOSSMAN ROAD PINEHURST, NC 28374 SCHEACH CORRECTION PREFIX TAG SOSSMAN FOAD PINEHURST, NC 28374 PREFIX TAG PROVIDERS PLAN OF CORRECTION THE APPROPRIATE PREFIX TAG PREFIX TAG PROVIDERS TAG PROVIDERS TAG PREFIX TAG PREFIX TAG PROVIDERS TAG PREFIX TAG PROVIDERS TAG PROVIDERS TAG PREFIX TA	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
SAINT JOSEPH OF THE PINES HEALTH CENTER CANAJID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL TAG PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX TAG PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX TAG PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX TAG PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX TAG PREPRIX			345044	B. WING		C 04/05/2023	
FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 3 feed herself. She stated Resident #28 often dropped food on her clothing. She stated she did not remove the clothing protector or the food from Resident #28's clothing when she removed her lunch tray because she was busy assisting other residents A joint interview with the Director of Nursing and Administrator on 04/05/23 at 2:49 PM revealed it was their expectation for the staff to come back after removing trays and clean residents after meals to promote dignity. F 677 ADL Care Provided for Dependent Residents CFR(s): 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 REOUREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to trim and clean a dependent resident's nails (Resident #35) for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). FREFIX TAG CROSS-REFERRENCE DE TO THE APPROPRIATE CROSS-REFERRENCED TO HEAPPROPRIATE F 550 F 550 F 550 F 677 F 550 F 550 F 577 4/28/2: This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of			EALTH CENTER		103 GOSSMAN ROAD	1 0 1100/2020	
feed herself. She stated Resident #28 often dropped food on her clothing. She stated she did not remove the clothing protector or the food from Resident #28's clothing when she removed her lunch tray because she was busy assisting other residents A joint interview with the Director of Nursing and Administrator on 04/05/23 at 2:49 PM revealed it was their expectation for the staff to come back after removing trays and clean residents after meals to promote dignity. 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, observations and staff interviews, the facility failed to trim and clean a dependent resident's nails (Resident #35) for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE COMPLETION	_
the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Resident #35's active care plan, with an effective date of 12/30/22, included a problem area for self-care deficit associated with the need for assistance with ADLs related to weakness, the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1.On 04/05/2023 resident # 35 nails were trimmed and cleaned by the CNA # 2 after she was notified that they were noted with	F 677	feed herself. She stadropped food on her not remove the cloth Resident #28's clothil lunch tray because s residents A joint interview with Administrator on 04/6 was their expectation after removing trays meals to promote dig ADL Care Provided f CFR(s): 483.24(a)(2) A resident activities of daily services to maintain personal and oral hy This REQUIREMENT by: Based on record revinterviews, the facility dependent resident's 3 residents reviewed (ADLs). The findings included Resident #35 was ad 12/30/22 with diagnod dementia, lack of cooweakness. Resident #35's active date of 12/30/22, inc self-care deficit asso	ted Resident #28 often clothing. She stated she did ing protector or the food from ng when she removed her he was busy assisting other the Director of Nursing and 05/23 at 2:49 PM revealed it in for the staff to come back and clean residents after gnity. or Dependent Residents dent who is unable to carry living receives the necessary good nutrition, grooming, and giene; Γ is not met as evidenced riew, observations and staff y failed to trim and clean a anails (Resident #35) for 1 of for Activities of Daily Living d: Imitted to the facility on isses that included Alzheimer's ordination and muscle et care plan, with an effective luded a problem area for ciated with the need for		This plan of correction constitutes a written allegation of compliance. Preparation and submission of this p correction does not constitute an admission or agreement by the provi the truth of the facts or alleged or the correctness of the conclusions set fo on the statement of deficiencies. The of correction is prepared and submitt solely because of the requirement ur state and federal law, and to demons the good faith attempts by the provid improve the quality of life of each res	der of erth e plan eed nder strate er to sident. were	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TION NI IMPED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345044	B. WING _			C 04/0		
NAME OF PR	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-7/	03/2023	
					03 GOSSMAN ROAD			
SAINT JOSEPH OF THE PINES HEALTH CENTER				INEHURST, NC 28374				
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	F 677 Continued From page 4		F6	677				
	decreased mobility as secondary to a fall wi	nd range of motion th fracture to the left femur			debris and jagged by the surveyor.			
	_	ventions included to provide			On 04/06/2023 Clinical Care Coordinators/Designee conducted a facility wide observation of all depende	nt		
	assessment dated 1/5/23 indicated Resident #35 had severely impaired cognition and displayed no behaviors or rejection of care. She required extensive assistance for personal hygiene and was dependent on staff for bathing tasks. A review of Resident #35's nursing progress notes from 12/30/22 through 4/4/23 revealed no refusals of nail care documented. On 4/3/23 at 9:50 AM, an observation of Resident #35 occurred while she was lying in bed with her hands resting on top of the covers. Her left thumb and fourth finger had a dark substance under them, and the third fingernail was broken and jagged. Her right first finger had a dark substance could have been affected by the deficient practice. No additional were identified through the obse have been affected. 3. Effective 04/24/2023 to 04/27/2027/2027/2027/2027/2027/2027/2027				residents, to identify other residents the could have been affected by the same			
			were identified through the observation					
					3. Effective 04/24/2023 to 04/27/2023 to Staff Development Coordinator/Design will in-service all nursing staff, to including high sand weekends, on the facilities practice of providing ADL care, specific	ee le		
			nail care, on resident shower days and during personal care daily, with nail car rendered as needed. Charge Nurses, during weekly skin observations, will observe resident nails to ensure nail ca has been rendered. Any nursing staff neducated by 04/27/23 will not be permi	re are				
	while sitting in her recunchanged from the				4. Effective 04/27/23 the Clinical Care Coordinators/Designee will conduct observations of random resident's nails post showers and daily personal care,			
	4/5/23 at 9:57 AM an should occur during s	d with Nurse Aide (NA) #1 on d explained that nail care showers and personal care ssigned to Resident #35.			ensure nail care has been rendered. 5 residents daily for 2 weeks Monday - Friday, then 10 resident weekly for 2 weeks, then 10 Residents monthly for 2 months. Any concern regarding nail car			
	AM while sitting up in	served on 4/5/23 at 10:03 her recliner. Her hands revealed her nails remained observations.			identified during the observation will be addressed promptly. Results of the observations to be reported at the risk meeting weekly and monthly at QAPI b the Director of Nursing Services or unti	e Py		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		CONSTRUCTION		DATE SURVEY COMPLETED	
		345044	B. WING _			04/0	05/2023	
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH OF THE PINES HEALTH CENTER				10	TREET ADDRESS, CITY, STATE, ZIP CODE 03 GOSSMAN ROAD INEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	10:41 AM. She was the Resident #35. She state completed when there shower or personal care occurred with NA #2 of #2 confirmed there with the left thumb and four finger as well as brok left third and right fifth she had not observed personal care that more rendered to them. The Director of Nursing 4/5/23 at 2:45 PM and of any refusals of nail that nail care was need would expect fingernal.	d with NA #2 on 4/5/23 at the NA assigned to care for ated nail care was e was a need during a are. An observation of Resident #35's nails. NA as a dark substance under urth finger and the right first en and jagged nails to the fingernails. NA #2 stated d Resident #35's nails during orning and care would be ng was interviewed on d stated she was not aware care from Resident #35 or eded. She added that she ails to be observed on ing personal care daily with	Fé	677	pattern of compliance is established. 5. Compliance date: 04/28/2023			