STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN ROAD 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 and complaint investigation was conducted on 04/03/23 through 04/05/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 6G6F11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was comducted 4/3/23 to 4/5/23. Four of the nine complaint allegations resulted in deficiencies (NC193977, NC00192004 and NC00187945). See Event # 6G6F11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		4/28/23

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

Electronically Signed | 04/21/2023

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to treat a resident with dignity and respect by not removing food debris from a resident's clothing and bed after meal trays were removed for 1 of 4 residents reviewed for dignity (Resident #28). The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity while in their home environment. The findings included: Resident #28 was admitted to the facility on 01/04/19 with multiple diagnoses which included Parkinson's Disease and Alzheimer's Disease. The quarterly Minimum Data Set (MDS) assessment dated 02/22/23 indicated Resident #28 had a severe cognitive impairment and required supervision with eating with 1 staff	F 550	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 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 04/05/23 after being notified by the surveyor that Resident # 28 had food debris on clothing, CNA #3 removed the food debris from resident #28.	

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F 550	Continued From page 2 member. Resident #28 was observed on 04/03/23 at 9:40 AM to be lying asleep in her bed. She had large pieces of brown food debris on her face, clothing, and clothing protector, an article worn around a resident's neck and drapes over the resident's torose to prevent food from soiling the resident's clothing. There was no meal tray located in the room. Resident #28 was observed on 04/04/23 at 11:00 AM to be lying awake in her bed. She was wearing a clothing protector around her chest with large pieces of brown food debris on her right side of her chest and a large brown piece of food debris on her bed sheet. There was no meal tray located in the room. Resident #28 was observed on 04/04/23 at 11:26 AM to be lying asleep in her bed with a clothing protector around her chest with what appeared to be the same large brown pieces of food debris on her face and in her bed. There was no meal tray located in her room. Resident #28 was observed on 04/05/23 at 1:05 PM. She was lying awake in her bed. She was wearing a clothing protector with large brown pieces of food debris on it. There was no meal tray located in her room. An observation and interview with Nurse Aide #3 occurred on 04/05/23 at 1:12 PM. She stated she was familiar with Resident #28's care needs and was assigned to work with Resident #28 on this day and stated she had not worked with Resident #28 the other two days. She stated Resident #28 required assistance with feeding but was able to	F 550	2. On 04/06/23 nursing staff conducted a facility wide observation during and after meal pass, to identify other residents that could have been affected by the same deficient practice. No additional residents were identified through the observation to have been affected. 3. Effective 04/24/23 to 04/27/2023 the Staff Development Coordinator will in-service all nursing staff, to include nights and weekends, to clean residents immediately after meal tray removal to ensure all residents are free from any remaining food particles to promote dignity. Any nursing staff not educated by 04/27/2023 will not be permitted to work. 4. Effective 04/28/23 the Clinical Care Coordinators/Designee will conduct random observations of residents during and after mealtimes to ensure residents are free from food particles and that dignity is maintained, 5 random residents will be observed daily for 2 weeks Monday-Friday, then 10 residents weekly for 2 weeks, then 10 residents monthly for 2 months. Any areas of concern identified will be addressed promptly. Results of the observations will be reported at the risk meeting weekly and monthly at QAPI by the Director of Nursing Services or until a pattern of compliance is established. 5. Compliance date: 04/28/2023	

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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 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, 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). The findings included: Resident #35 was admitted to the facility on 12/30/22 with diagnoses that included Alzheimer's dementia, lack of coordination and muscle weakness. 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,	F 677	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 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	4/28/23

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F 677	Continued From page 4 decreased mobility and range of motion secondary to a fall with fracture to the left femur (hip). One of the interventions included to provide assistance to complete ADL tasks. An admission Minimum Data Set (MDS) 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 under it and the fifth fingernail was broken and jagged. Resident #35 was observed on 4/4/23 at 2:24 PM while sitting in her recliner. Her fingernails were unchanged from the prior observation. An interview occurred with Nurse Aide (NA) #1 on 4/5/23 at 9:57 AM and explained that nail care should occur during showers and personal care tasks. She was not assigned to Resident #35. Resident #35 was observed on 4/5/23 at 10:03 AM while sitting up in her recliner. Her hands rested in her lap and revealed her nails remained the same from prior observations.	F 677	debris and jagged by the surveyor. 2. On 04/06/2023 Clinical Care Coordinators/Designee conducted a facility wide observation of all dependent residents, to identify other residents that could have been affected by the same deficient practice. No additional residents were identified through the observation to have been affected. 3. Effective 04/24/2023 to 04/27/2023 the Staff Development Coordinator/Designee will in-service all nursing staff, to include nights and weekends, on the facilities practice of providing ADL care, specifically nail care, on resident shower days and during personal care daily, with nail care rendered as needed. Charge Nurses, during weekly skin observations, will observe resident nails to ensure nail care has been rendered. Any nursing staff not educated by 04/27/23 will not be permitted to work. 4. Effective 04/27/23 the Clinical Care Coordinators/Designee will conduct observations of random resident's nails post showers and daily personal care, to 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 care identified during the observation will be addressed promptly. Results of the observations to be reported at the risk meeting weekly and monthly at QAPI by the Director of Nursing Services or until a	

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F 677	Continued From page 5 An interview occurred with NA #2 on 4/5/23 at 10:41 AM. She was the NA assigned to care for Resident #35. She stated nail care was completed when there was a need during a shower or personal care. An observation occurred with NA #2 of Resident #35's nails. NA #2 confirmed there was a dark substance under the left thumb and fourth finger and the right first finger as well as broken and jagged nails to the left third and right fifth fingernails. NA #2 stated she had not observed Resident #35's nails during personal care that morning and care would be rendered to them. The Director of Nursing was interviewed on 4/5/23 at 2:45 PM and stated she was not aware of any refusals of nail care from Resident #35 or that nail care was needed. She added that she would expect fingernails to be observed on shower days and during personal care daily with nail care rendered as needed.	F 677	pattern of compliance is established. 5. Compliance date: 04/28/2023	