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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Joseph of the Pines Health Center	103 Gossman Road Pinehurst, NC 28374

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46725 Based on staff interviews and record review, the facility failed to issue a Centers for Medicare and Medicaid Services (CMS), CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) to 1 of 3 residents reviewed for SNF Beneficiary Protection Notification Review (Resident # 50). Findings included: Resident #50 was admitted to the facility under part A Medicare services on 5/22/24. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed by telephone with Resident #50's responsible party on 6/17/24. The notice indicated that Medicare coverage for skilled services was to end 6/19/24 and the resident would remain in the facility. A review of the medical record revealed a CMS-10055 SNF ABN (ABN) was not provided to the resident or responsible party. An interview was conducted with the Social Worker on 7/10/24 at 12:26 PM and he revealed that Residents # 50 planned to remain in the facility and the social worker made the resident and family aware that there would be a private pay cost. The social worker further revealed the SNF ABN form was not issued because the family had appealed the Notice of Medicare Non-Coverage (NOMNC) and he thought he had to wait to issue the SNF ABN notice until after the NOMNC appeal decision had been received. An interview was conducted with the Administrator on 7/11/24 at 9:56 AM revealed the social worker had not yet issued the SNF ABN to Resident #50 because he did not want to confuse the family member by issuing the SNF ABN notice before the NOMNC appeal decision had been finalized.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Saint Joseph of the Pines Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Gossman Road Pinehurst, NC 28374	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46725 Based on record review and staff interviews, the facility failed to report allegations of abuse to Adult Protective Services (APS). This deficient practice was for 4 of 4 residents reviewed for abuse. (Resident # 41, Resident #324, Resident #72 and Resident #223). Finding included: 1. A review of the Initial Allegation Report for an allegation of misappropriation of property submitted on 6/18/24 at 3:47 PM indicated the facility became aware of the alleged incident on 6/18/24 at 1:00 PM for Resident #41. The allegation details revealed Resident #41 alleged that someone stole $100 from her pocketbook. The initial report indicated local law enforcement was notified on 6/18/24 at 2:30 PM. The initial report did not indicate APS was notified. The Investigation Report completed on 6/24/24 for the 6/18/24 incident concerning Resident #41 indicated APS was not notified of the allegation of misappropriation of resident property. During an interview with the Director of Clinical Services 7/11/24 9:52 AM he indicated that he did not contact APS and that he was not aware APS needed to be notified an allegation of misappropriation of resident property During an interview with the Administrator on 7/11/24 at 10:08 AM he indicated that he did not know APS needed to be notified of an allegation of misappropriation of resident property. 2. A review of the Initial Allegation Report for an allegation of misappropriation of property submitted on 6/18/24 at 3:47 PM indicated the facility became aware of the alleged incident on 6/18/24 at 1:00 PM for Resident #72. The allegation details revealed Resident #41 alleged that someone stole $20 from her pocketbook. The initial report indicated local law enforcement was notified on 6/18/24 at 2:30 PM. The initial report did not indicate APS was notified. The Investigation Report completed on 6/24/24 for the 6/18/24 incident concerning Resident #72 indicated APS was not notified of the allegation of misappropriation of resident property. During an interview with the Director of Clinical Services 7/11/24 9:52 AM he indicated that he did not contact APS and that he was not aware APS needed to be notified of the allegation of misappropriation of resident property During an interview with the Administrator on 7/11/24 at 10:08 AM he indicated that he did not know APS needed to be notified of the allegation of misappropriation of resident property. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of the Initial Allegation Report for an allegation of resident abuse submitted on 7/2/24 at 3:57 PM indicated the facility became aware of the alleged incident on 7/2/24 at 12:00 AM for Resident #324. The allegation details revealed Resident # 324 alleged the accused pushed resident #324 into the shower, shut the door to the shower and did not come back when Resident #324 yelled for help. Resident #324 also alledged the accused told Resident #324 to shut up, and to go to bed. The initial report indicated no injuries occurred and local law enforcement was notified on 7/2/24 at 2:06 AM. The initial report did not indicate whether APS was notified. The Investigation Report completed on 7/9/24 for the 7/2/24 incident concerning Resident #324 indicated the allegation was not substantiated and APS was not notified of the allegation of resident abuse. During an interview with the Director of Clinical Services 7/11/24 9:52 AM he indicated that he did not contact APS and that he was not aware APS needed to be notified of the allegation of resident abuse. During an interview with the Administrator on 7/11/24 at 10:08 AM he indicated that he did not know APS needed to be notified of the allegation of resident abuse. 40197 4) A review of the Initial Allegation Report for an allegation of abuse with no serious bodily injury was submitted on 6/7/24. The report indicated the facility became aware of the incident on 6/7/24 at 10:00 AM for Resident #223. The allegation details read Resident #223 alleged that another resident hit her in the hip. The initial report indicated law enforcement was notified on 6/7/24 at 11:06 AM. The initial report did not indicate that APS was notified. The Investigation Report completed on 6/14/24 for the 6/7/24 incident concerning Resident #223 revealed that APS was not notified for an allegation of abuse. On 7/11/24 at 9:43 AM, an interview occurred with the Administrator and the Director of Clinical Services. They stated they were not aware that APS had to be notified regarding an allegation of abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46095 Based on record reviews, observations, and staff interviews, the facility failed to ensure the daily nurse staffing sheets were completed and posted for 1 of 30 days reviewed (07/08/24) for staffing. Findings included: On 07/08/24 at 09:51 AM the daily nurse staff sheets observed in the lobby of the facility was dated 06/28/24 through 07/01/24. An interview was conducted on 07/08/24 at 09:52 AM with the Administrator. He stated that he had been at the facility about six weeks, and they had a change in the staffing position. He stated the Director of Nursing (DON) had been posting the daily nurse staff postings however she was on vacation and the postings had not been updated since 07/01/24. He then stated he would get it updated right now. An interview was conducted on 07/09/24 at 3:30 PM with the Staff Coordinator. She stated she had been in her current position since 07/07/24 and she was still learning her duties. She indicated she did not post nurse staffing in the lobby for 07/08/24. She explained that the Director of Nursing (DON) had been handling some things but was currently on vacation. An interview was conducted on 07/11/24 at 10:03 AM with the Administrator. He stated his expectation was for the daily nurse staff sheets to be completed and posted 7 days a week.