

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  07/31/2025
NAME OF PROVIDER OR SUPPLIER  Saint Joseph of the Pines Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interviews, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment within the required time frame for 1 of 5 residents selected to be reviewed for submission of Resident Assessments within the required time frame (Resident #59). The findings included: Resident #59 was admitted to the facility on [DATE]. A review of Resident #59's most recent completed MDS was dated 5/7/25 and was coded as a discharge to home. The record indicated the assessment had been completed but not transmitted or accepted. During an interview with MDS Nurse #1 on 7/30/25 at 3:20 PM, she indicated the discharge assessment was completed on 5/7/25 but had not been submitted. She felt it was an oversight. On 7/31/25 at 8:21 AM, an interview occurred with the Director of Nursing who stated that she would expect all MDS assessments to be completed and submitted within the required timeframe.</p>

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, Nurse Practitioners and staff interviews, the facility failed to change the dressing to Resident #76's Peripherally Inserted Central Catheter (PICC) line. This occurred for 1 of 1 resident (Resident #76) reviewed for intravenous (IV) antibiotic therapy. The findings included: Resident #76 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (infection of the bone) and methicillin-resistant Staphylococcus aureus (MRSA). The 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact and was coded with IV access and antibiotics. Review of the active nurse practitioner orders dated 7/8/25 revealed orders to change the PICC dressing every seven days and as needed using sterile technique. On 7/28/25 at 2:35 PM an observation of Resident #76's PICC line, in the left upper arm, revealed a transparent dressing with rolled edges covering the insertion site dated 7/2/25. There was no redness, drainage, or signs of infection at the entry site. The resident denied itching or discomfort. Review of the treatment administration record (TAR) revealed an incomplete order entry on 7/8/25 under the heading PICC dressing change every seven days. The TAR did not have staff initials, or a scheduled timeframe available, for staff to document a dressing change had been completed. The Clinical Coordinator was interviewed on 7/29/25 at 11:29 AM and stated the dressing should be changed every seven days for any resident with a PICC line, and that the floor nurse assigned to the resident was responsible for completing the change. She further stated the date on the PICC line dressing was correct for the last dressing change. The Clinical Coordinator then assessed the PICC line and confirmed it was dated 7/2/25. She stated Resident #76 was getting ready to leave for an appointment with the Infectious Disease clinic, but she would change his dressing upon return to the facility since she was serving as the unit's nurse that day. On 7/29/25 at 12:27 PM the Director of Nursing (DON) was interviewed. She stated Resident #76 had an order to change his PICC line dressing every seven days, but it was not entered in the computer correctly. She stated due to the order not being entered correctly it did not show up on the TAR for the resident, so the nursing staff did not see an order to change the PICC line dressing. She confirmed the date on the PICC line dressing, 7/2/25, was correct for the last time the dressing was changed. On 7/30/25 at 4:26 PM the Infectious Disease clinic Nurse Practitioner (NP #2) was interviewed by phone. She stated she saw Resident #76 in the clinic on 7/29/25 and noted his PICC line dressing had not been changed since 7/2/25. She stated she assessed the site, and it did not appear to be infected, no redness, drainage, or pain at the site. She stated she had the clinic nurse change the PICC line dressing, called the facility, and requested they educate the staff on PICC line care. She further stated the clinic's PICC line dressing protocol for weekly dressing changes was sent with the resident at discharge from the hospital. A follow-up interview with the DON on 7/30/25 at 9:03 AM was completed. She stated she had received a phone call from the Infectious Disease clinic on 7/29/25 and was informed Resident #76's PICC line dressing was changed during his appointment. She stated the clinic asked the facility to educate the staff regarding PICC line care. She further stated she had entered the order for the PICC line dressing changes in Resident #76's chart, and it was now showing on the TAR. The DON stated she and the Clinical Coordinator had reviewed the order entry completed by the Clinical Coordinator, and they were uncertain how the computer system had allowed the order to advance without being completed correctly. Nurse Practitioner #1 was interviewed on 7/29/25 at 12:56 PM who stated Resident #76's PICC line dressing should be changed every seven days and as needed to prevent infection. She stated she had been regularly reviewing the resident's labs, and he had not shown any complications or signs of a new infection. She stated she had not been informed Resident #76's PICC line dressing had not been changed since 7/2/25.</p>		