STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 02/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	620 JOHNS ROAD LAURINBURG, NC 28352

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E 000	Initial Comments An unannounced recertification/complaint investigation survey was conducted on 02/10/20 through 02/15/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# UYZ511.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint investigation was conducted 02/10/20 - 02/15/20. 5 of 5 complaint allegations were unsubstantiated. Event ID #UYZ511.	F 000		
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 observations, record review and staff and resident interviews the facility failed to accurately code bladder and bowel appliances, falls history, and nutritional approaches on the Minimum Data Sets (MDS) of 3 of 30 sampled residents (Resident #57, Resident #81, and Resident #34) whose MDS assessments were reviewed. Findings included: 1. Resident #57 was re-admitted to the facility on 07/11/19 and had diagnoses of urinary retention, dementia, and hypertension. The Urinary Catheter Order Clarification dated 07/11/19 revealed that Resident #57 was re-admitted to the facility with an indwelling catheter in place.	F 641	F641 Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. 1) On 2/15/2020, facility Minimum Data Sets (MDS) coordinator #1 made correction to resident #57 quarterly assessment for 12/12/2019 to indicate that resident had an indwelling catheter during assessment reference date period. 2) On 2/15/2020, facility MDS	3/5/20

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

Electronically Signed | 03/05/2020

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F 641	Continued From page 1 The December 2019 Medication Administration Record (MAR) revealed Resident #57 was provided care for an indwelling urinary catheter for the whole month. The quarterly MDS dated 12/12/19 specified that Resident #57 was always incontinent of bladder during the seven day look back period. Further review of this MDS revealed this section was completed by MDS Coordinator #1. In an interview on 02/15/20 at 11:55 AM MDS Coordinator #1 stated that she reviewed physician orders and the MAR to gather the information needed to complete the bowel and bladder section of the MDS. She verified that Resident #57 had an indwelling catheter at the time of the 12/12/19 quarterly MDS assessment and stated that she had incorrectly coded Resident #57 as being incontinent of bladder. She indicated that she had marked the wrong box on the assessment by mistake. In an interview on 02/15/20 at 12:06 PM the Director of Nursing Services (DNS) stated that an indwelling urinary catheter should always be coded on the MDS. She indicated that the MDS should accurately reflect what was going on with the resident. 2. Resident #81 was admitted to the facility on 06/05/15 with diagnoses including dementia with behavioral disturbance and falls. A fall report for Resident #81 dated 12/12/19 indicated she was found on the floor of her room. The most current Minimum Data Set (MDS)	F 641	coordinator #1 made correction to resident #81 quarterly assessment for 1/6/2020 to indicate that resident had a fall during assessment reference date period. 3) On 2/15/2020, facility MDS coordinator #1 made correction to resident #34 quarterly assessment for 11/15/2019 to indicate that resident had a mechanically altered diet during assessments reference date period. 4) On 3/3/2020, facility Administrator re-in serviced all staff who are assigned to complete a portion of the Minimum Data Sets (MDS) on expectation to ensure accurate assessment on resident is completed and coded/documented appropriately on Minimum Data Sets (MDS) prior to submission. 5) On 2/28/2020, facility RN MDS coordinator conducted 100% audit on all assessments transmitted since 2/15/2020 to ensure accurately reflects residents' current status. 6) Any inaccuracies identified on the assessments during the audit were corrected by the RN MDS coordinator or designee. 7) The MDS coordinator will participate in daily administrative nurse and IDT meetings to ensure that as interventions and changes are made, they are immediately transcribed to the careplan and updated on the next scheduled MDS assessment. 8) An audit tool titled, "MDS Coordination/Certification and Accuracy Audit" will be used to monitor performance. Audits will be conducted by	

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F 641	Continued From page 2 assessment dated 01/06/2020 for Resident #81 indicated she was severely impaired for daily decision making, required the limited assistance of one person for bed mobility and transfers, had impaired lower extremity range of motion on both sides, was not steady but was able to stabilize without human assistance, received an anti-psychotic medication routinely seven (7) out of seven (7) days and had no falls during the assessment period. On 02/15/20 at 11:33 AM an interview with MDS coordinator #1 indicated she completed the falls section of Resident #81's MDS dated 01/06/2020. She further stated she was aware Resident #81 had a fall during the assessment period and should have noted the resident's 12/12/19 fall on the 01/06/20 MDS assessment, but just missed it. MDS coordinator #1 stated it was important for resident's MDS to accurately reflect their condition and Resident #81's did not. On 02/15/20 at 11:35 AM an interview with the Director of Nursing and the facility Administrator indicated Resident #81's MDS assessment dated 01/06/20 should have reflected the fall she had on 12/12/19 but it did not. They stated it was important for resident's MDS to be accurate and Resident #81's was not. 3. Resident #34 was admitted to the facility on 0706/17. The resident's diagnoses included anemia, vitamin D deficiency, and hypertension. A 10/30/19 physician's order started Resident #34 on a heart healthy diet with chopped meats. Resident #34's 11/15/19 quarterly minimum data set (MDS) documented the resident's cognition was severely impaired, she experienced an	F 641	the RN MDS coordinator or designee weekly x 4 weeks, monthly x 3 months and as needed to ensure compliance with accuracy. 9) Audit compliance will be discussed by the Executive Director or designee during morning administrative meetings where the Quality Assurance and Performance Improvement (QAPI) Committee members attend, x 4 weeks and as needed. 10) The Executive Director or designee will bring results of the “MDS Coordination/Certification and Accuracy Audit” at the facility monthly QAPI meeting for committee review. 11) Results of compliance with plan will be discussed and minutes recorded x 4 months during the facility’s monthly QAPI meeting, with adjustments to plan made as needed, followed by: 12) Results of audits and compliance with plan will be discussed and minutes recorded quarterly x 3 quarters during the facility’s quarterly QAPI committee meeting, with adjustments to plan made as needed followed by: 13) Should revisions be necessary, appropriate staff will be re-in-serviced by RN MDS coordinator or appropriate designee. 14) Any revisions to plan will require monitoring steps to begin again at step 11.	

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F 641	Continued From page 3	F 641		

unplanned significant weight loss, and she was on a therapeutic diet. The MDS assessment did not indicate that the resident received a mechanically altered diet.

During an observation on 02/11/20 at 12:33 PM Resident #34 received chopped smoked sausage, and her tray slip documented she was on a heart healthy diet with chopped meats.

During an observation on 02/12/20 at 8:30 AM Resident #34 received chopped breakfast sausage on her meal tray, and her tray slip documented she was on a heart healthy diet with chopped meats.

During an interview with Nursing Assistant (NA) #1 on 02/12/20 at 8:45 AM she stated Resident #34 had not had any chewing and swallowing problems since the kitchen had started chopping her meats.

During an interview with Nurse #1 on 02/12/20 at 11:08 AM she stated Resident #34 could eat regular texture vegetables and starchy foods, but needed her meats chopped because they were tougher and more difficult to swallow.

During an interview with Resident #34 on 02/12/20 at 12:35 PM she stated it was easier for her to swallow her meats now that they were being chopped.

During an interview with MDS Nurse #1 on 02/15/20 at 9:56 AM she stated section K (Swallowing/Nutritional Status) of MDS assessments was completed by the facility's Registered Dietitian (RD). She reported she reviewed the MDS assessments to make sure

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F 641	Continued From page 4 they were complete before she signed off on them, but the accuracy of the assessments was the responsibility of the staff members who completed each section of the assessments. During an interview with the facility's RD on 02/15/20 at 10:47 AM she stated when she completed the Nutritional Approaches portion of Section K on MDS assessments she referred to the resident diet orders, and talked with the direct care staff. After reviewing Resident #34's 10/30/19 diet order, she stated she should have coded the resident as receiving a mechanically altered diet since she was receiving chopped meats, and did not do so. She commented that she must not have seen the last part of the diet order before documenting only the therapeutic element in Resident #34's diet. According to the RD, it was her responsibility to code responses in Section K of MDS assessments correctly, and not coding that Resident #34 received a mechanically altered diet was an error.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		3/5/20

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F 761	Continued From page 5 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep a medication secured by leaving it on a beside table in a resident's room for 1 of 4 rooms observed during resident wound treatments. Findings included: During a treatment observation on 02/13/20 at 10:42 AM a syringe sealed in a transparent plastic wrapper was seen on the bedside table in room #809. The syringe was partially obscured by a pillow. On examination, the labeling of the syringe revealed it contained 500 units in 5 milliliters (ml) of heparin lock flush. The Treatment Nurse verified that the syringe contained heparin 500 units. On 02/13/20 at 11:22 AM following the treatment, the syringe was carried out of the room by Nurse #3 and handed to Nurse #4. Nurse #4 verified that the sealed package contained a syringe of 500 units of heparin. She stated that she had not left the syringe on the bedside table but knew that it had not been there the day before when she worked. Nurse #4 stated that medications should never be left unsecured at the bedside because	F 761	F761 Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. 1) On 2/13/2020, resident #282 was noted to have a sealed (unopened) Heparin syringe stored on resident's bedside table. Heparin syringe was immediately removed from resident's room by facility charge nurse and placed in appropriate storage within the facility. 2) On 2/14/2020, facility assistant director of nursing services conducted 1:1 re-training with nurses assigned to resident in room #282 on proper storage of medications and not leaving medications in resident rooms. 3) On 2/13/2020, 100% of resident	

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F 761	Continued From page 6 residents could get them and take them. In an interview on 02/13/20 at 2:27 PM the Registered Pharmacist stated that heparin was a blood thinner and if it was ingested it could be a potential problem. She stated that medications should not be left on bedside tables in resident rooms and that they should always be secured. In an interview on 02/14/20 at 9:35 AM Nurse #5 stated that on the evening of 02/12/20 she had gone into room #809 with a syringe of heparin to flush the PICC (peripherally inserted central catheter) line of one of the resident's but that the infusion had not finished. She indicated that the other resident in the room was trying to get out of bed, so she placed the syringe on the bedside table and went to assist the resident. Nurse #5 indicated that after helping the resident, she forgot that she had left the syringe on the bedside table and did not remove it from the room. She stated that medications should always be kept locked on the medication cart for safety because if left out residents could take the medications and harm themselves. In an interview on 02/14/20 at 3:50 PM the Director of Nursing Services (DNS) stated that she expected medications to be secured in the medication carts and not left at the bedside. She indicated that the facility had residents that wandered and that leaving medications at the bedside could be harmful if a resident got ahold of them.	F 761	rooms within the facility were inspected to ensure that medications were not left or being stored at the bedside. No other residents were affected. 4) On 2/13/2020, 100% of all licensed nursing staff and medication aides were re in-serviced by facility assistant director of nursing on facility protocol regarding medication storage and security. 5) All new hires will be in-serviced upon facility orientation by facility assistant director of nursing services or designee on the facility protocol regarding medication storage and security. 6) On 2/13/2020 and ongoing, room rounds will be conducted by facility department heads daily times seven days, then weekly times six weeks, to ensure that no medications are being stored or left unsecured in resident rooms or on medication carts. Findings will be documented on the “Resident Room/Med Cart Audit Tool” and reported to the facility director of nursing services or designee. 7) Results of compliance with plan will be discussed and minutes recorded times four months during the facility’s monthly QAPI meeting, with adjustments to plan made as needed, followed by: 8) Results of audits and compliance with plan will be discussed and minutes recorded quarterly times three quarters during the facility’s quarterly QAPI committee meeting, with adjustments to plan made as needed followed by: 9) Should revisions be necessary, appropriate staff will be re-in-serviced by director of nursing services or appropriate designee.	

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F 761	Continued From page 7	F 761	10) Any revisions to plan will require monitoring steps to begin again at step 7.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to clean vents in the kitchen ceiling and filters above the oven/stove system, failed to discard abraded kitchenware, and failed to cover the tea canister in the presence of pests in the kitchen. Findings included: 1. During initial tour of the kitchen, beginning at 11:30 AM on 02/10/20, four vents in the kitchen ceiling had grated coverings which were coated with dust and dirt, and there were strands of dust hanging from the vents. These vents were above	F 812	F812 Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. 1) On 02/10/2020, facility Food Service	3/5/20

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F 812	Continued From page 8 racks where sanitized kitchenware was stored and the three-compartment sink where kitchenware was washed, rinsed, and sanitized. During an interview with the Dietary Manager (DM) on 02/12/20 at 3:07 PM she stated the maintenance department was supposed to check the ceiling vents in the kitchen weekly to make sure they were clean. However, she reported she was unsure of the last time maintenance had actually made a visual inspection. The DM commented that dusty and dirty vents in the kitchen ceiling could contaminate sanitized kitchenware and food which was being prepared and/or served. During an interview with Dietary Aide #1 on 02/12/20 at 3:22 PM she stated the maintenance department wiped down the ceiling vents monthly. She reported it was important to keep the vents clean so dust, dirt, bacteria, mold, and germs did not get blown all over kitchenware and food. During an interview with the Maintenance Manager (MM) on 02/14/20 at 9:02 AM he stated the vents in the kitchen ceiling were currently being cleaned every three months. He reported he thought it was possible the vents with the grated coverings got overlooked the last time kitchen vents were cleaned because vents of another style in the kitchen ceiling were clean and free of any dust and dirt. However, the MM commented there had been some discussion recently that the frequency of kitchen vent cleaning needed to be adjusted due to all the steam and oils present in the kitchen. He explained that this revised cleaning schedule was in the process of being finalized.	F 812	Director notified Maintenance Director of four vents in ceiling that needed to be cleaned after lunch that day in the kitchen. On 2/10/2020, the vents were thoroughly cleaned by the maintenance department and no additional dust nor dirt was noted. 2) On 02/10/2020, facility Food Service Director, removed four filter vents from above the oven/ stove system and cleaned them appropriately. 3) On 02/12/2020, facility Food Service Director, disposed of eight pieces of kitchenware (plastic bowls) that had some abraded surfaces on them. 4) On 2/12/2020, facility Food Service Director, placed the tea canister lid on the tea canister. 5) On 02/10/2020, 100% of dietary staff was re-in-serviced on proper cleaning and monitoring of the ceiling vents and hood vents per regulatory guidelines. 6) On 02/12/2020, 100% of dietary staff were re-in-serviced on the importance of keeping the tea canister / beverage dispensers covered at all times 7) On 02/12/2020, 100% of dietary staff were re-in-serviced on the importance of checking and disposing of any kitchenware that has noticeable abraded surfaces. 8) Facility Food Service Director or designee will monitor the compliance of the proper cleaning of vents in ceiling and the hood vents. Facility Food Service Director or designee will conduct a checklist to monitor these areas daily for four weeks, weekly for two weeks and monthly thereafter. Facility Food Service Director or designee will utilize a	

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F 812	Continued From page 9 2. During initial tour of the kitchen, beginning at 11:30 AM on 02/10/20, 4 of the 8 filters above the oven/stove system had a very heavy coating of oil and grease on them with particles of dust beginning to stick to them. During an interview with the Dietary Manager (DM) on 02/12/20 at 3:07 PM she stated the filters above the stove and ovens were supposed to be cleaned by the dietary department bi-weekly and as needed when grease and oil built up on them. She reported if the cooks observed a build-up of grease and oil on the filters it was their responsibility to make sure they were cleaned immediately. The DM commented greasy filters were a fire hazard, and because dust and dirt collected on oily surfaces, the filters were a possible source of cross contamination. She explained dust and dirt on the filters could fall into or onto the foods being prepared in this section of the kitchen. During an interview with Dietary Aide #1 on 02/12/20 at 3:22 PM she stated the filters above the stove and ovens were cleaned by the night cooks who soaked them in a sanitizing solution. She reported she was not sure if these filters were routinely cleaned at a specific time interval, but thought that the expectation was just to clean them when they were observed to have a build-up of grease and oil on them. She commented greasy, oily surfaces attracted dust and dirt which could contaminate the foods being prepared on the stove or foods placed in and on top of the ovens. During an interview with the Maintenance Manager (MM) on 02/14/20 at 9:02 AM he stated the filters above the stove and ovens were	F 812	monitoring tool named, “Unit Audit” to document findings. 9) On 2/29/2020 and monthly thereafter, Facility Maintenance Director or designee will take down, clean and paint (if necessary) ceiling air vents in the kitchen/dietary area on an ongoing monthly basis. This will be monitored by using our facility “TELS” system that has been set up to notify maintenance department of this task due on a monthly basis. At the completion of each month, facility Maintenance Director or designee will monitor any “overdue” tasks within the “TELS” system to ensure tasks (to include that related to air vents in kitchen) are being completed properly as assigned. 10) Facility Food Service Director or designee will monitor the compliance of proper covering of the tea canister and beverage dispensers. Facility Food Service Director or designee will conduct a checklist to monitor daily for four weeks, weekly for two weeks and monthly thereafter. Facility Food Service Director or designee will utilize a monitoring tool named, “Unit Audit” to document findings. 11) Facility Food Service Director or designee will monitor the compliance of the proper disposal of kitchenware with abraded surfaces. Facility Food Service Director or designee will conduct a checklist to monitor daily for four weeks, weekly for two weeks and monthly thereafter. Facility Food Service Director or designee will utilize a monitoring tool named, “Unit Audit” to document findings. 12) Facility Cook Manager or designee will perform daily audits at the time of	

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F 812	Continued From page 10 cleaned professionally every six months when the entire hood system was serviced. He reported in between this professional service the dietary department was responsible for visual inspections to prevent the build-up of grease and oil which could pose a fire hazard. 3. During an inspection of kitchenware on 02/12/20 at 10:21 AM a rack containing twelve plastic soup and cereal bowls was inspected. This rack contained kitchenware that was observed being used by residents at the breakfast meal, and observed being run through the dish machine afterwards. 8 of 12 plastic bowls had heavy abrasions inside of them which were rough to the touch. During an interview with the Dietary Manager (DM) on 02/12/20 at 3:07 PM she stated the dietary staff was taught to dispose of pieces of kitchenware compromised by cracks, chips, and abraded surfaces as they found them. She reported food and bacteria could build up in the abraded surfaces with the potential of making residents sick. The DM commented she had cases of new bowls in storage, but apparently the dietary staff had not had a chance to sort out compromised bowls that needed to be replaced. During an interview with Dietary Aide #1 on 02/12/20 at 3:22 PM she stated dietary staff were supposed to pull pieces of kitchenware damaged by chips, cracks, and abrasions as they found them. She reported the process was to present the compromised kitchenware to the DM so she could verify the damage and make sure replacement kitchenware was on order. She commented she was unable to explain why so many soup and cereal bowls were still being used	F 812	opening and closing the kitchen each day to check all ceiling vents to make sure they are free of debris, check all hood vents to make sure they are free of debris, check all tea canister/ beverage dispensers are covered with lid and inspect all kitchenware to ensure they are free of abraded surfaces. Facility Cook Manager of designee will complete this audit twice a day. Facility Cook Manager or designee will utilize a monitoring tool named, “Supervisor Closing and Opening Checklist” to document findings. 13) All newly hired dietary employees will be trained using Employee Training Program (TLMS)which will ensure dietary employees are trained appropriately on proper cleaning of vents, lid covering of tea canister/ beverage dispensers and proper monitoring of kitchenware to ensure the disposal of any kitchenware with abraded surfaces per regulatory guidelines. Upon completion of Employee Training Program, new hire competency checklist will be completed by new hire and Food Service Director, Area Director or designee. 14) All dietary employees will be re-in-serviced annually through dietary workstation modules on proper cleaning of vents, proper covering of tea canisters/ beverage dispensers and disposal of kitchenware with abraded surfaces per regulatory guidelines. 15) Results of compliance with plan will be discussed and minutes recorded x 4 months during the facility’s monthly QAPI meeting, with adjustments to plan made as needed, followed by:	

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	345383	A. BUILDING _____ B. WING _____	C 02/15/2020

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F 812	Continued From page 11 with abraded interior surfaces. According to Dietary Aide #1, pieces of plastic could slough off the bowls and get into resident food with the potential of residents swallowing the plastic. She also stated the abrasions could harbor germs and bacteria which could make residents sick. 4. During initial tour of the kitchen, beginning at 11:30 AM on 02/10/20 and concluding at 11:58 AM on 02/10/20, a canister containing tea was not covered. The canister was not warm to the touch. During a follow-up inspection of the kitchen, beginning at 9:33 AM on 02/12/20 and concluding at 10:36 AM on 02/12/20, a canister containing tea was not covered. The canister was not warm to the touch. At 10:16 AM on 02/12/20 multiple gnats were observed in the kitchen. During a 02/12/20 observation of the kitchen, beginning at 11:30 AM and concluding at 11:48 AM, a canister containing tea was not covered. The canister was not warm to the touch. At 11:43 AM on 02/12/20 a fly was observed in the kitchen. During an interview with the Dietary Manager (DM) on 02/12/20 at 3:07 PM she stated the facility had a top for the tea canister which was supposed to be covering the tea to prevent dust/dirt and pests from contaminating the tea. She reported she thought the top was being cleaned during part of the kitchen survey, but was unsure why it would have taken so long to put it back into use.	F 812	16) Results of audits and compliance with plan will be discussed and minutes recorded quarterly x three quarters during the facility's quarterly QAPI committee meeting, with adjustments to plan made as needed followed by: 17) Should revisions be necessary, appropriate staff will be re-in-serviced by Food Services Manager or appropriate designee. 18) Any revisions to plan will require monitoring steps to begin again at step 14.	

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F 812	Continued From page 12 During an interview with Dietary Aide #1 on 02/12/20 at 3:22 PM she stated there was supposed to be a lid on the tea canister at all times. She reported this was important to keep flies, gnats, dust/dirt, and bacteria out of the tea which all posed risks to the health of the residents.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		3/5/20

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F 842	Continued From page 13 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the	F 842	F842	

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F 842	Continued From page 14 facility failed to accurately code the reason why wound treatments did not get completed for 1 of 4 sampled residents (Resident #64) who was reviewed for pressure ulcers. Findings included: Record review revealed Resident #64 was admitted to the facility on 12/11/19. Her diagnoses included pressure ulcers, venous insufficiency, and lymphedema. The resident's care plan identified "Resident is at risk for skin impairment d/t (due to) decreased mobility/incontinence/advanced age with fragile skin, fluctuating appetite, altered sensation, edema, and overall compromised health status" as a problem on 12/11/19. Interventions to this problem included skin assessments and treatments per facility protocol. The resident's 12/17/19 admission minimum data set (MDS) documented the resident's cognition was severely impaired, and she had two stage II pressure ulcers. Review of Resident #64's December 2019 Treatment Administration Record (TAR) revealed on 12/19/19, 12/25/19, and 12/27/19 treatments to the resident's sacral pressure ulcer and the abrasion/pressure ulcer to the mid lower back were not provided. Treatment Aide #1 documented the reason the treatments were not completed was that the resident was not available. Review of progress notes and the sign out notebook at the front desk in the lobby revealed Resident #64 was present in the facility all day on 12/19/19, 12/25/19, and 12/27/19.	F 842	Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. 1) On 2/15/2020, resident #64 treatment administration record (TAR) was reviewed and it was revealed that on 12/19/19, 12/25/19 and 12/27/19 resident's treatments were documented that the reason the treatments were not completed was due to the resident was "not available." Instead, it was determined that the resident treatment was not completed due to the resident refusal to allow staff to perform the task. 2) On 2/17/2020, facility treatment nurse conducted one on one re-training with treatment aides on accuracy of treatment documentation. 3) On 3/4/2020, all licensed nursing staff and medication aides were re-educated by facility director of nursing services to ensure accurately coding the reason why treatments are not administered (i.e. "not available", "refused" or "held"). 4) On 2/17/2020, all active residents with treatment physician orders in place were audited to ensure no additional documentation inaccuracies were identified. 5) All new hires will be in-serviced upon facility orientation on accurately documenting in resident medical record.	

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F 842	Continued From page 15 During an interview with the facility's Treatment Nurse on 02/13/20 at 5:10 PM she stated she was informed by her Treatment Aides that Resident #64 periodically refused to have her wound treatments done even though they reapproached her multiple times, and this had been communicated to the resident's primary physician. During a telephone interview with Treatment Aide #1 on 02/14/20 at 11:57 AM she stated Resident #64 was refusing wound treatments on an average of twice a month, but she could not remember for sure what transpired with the resident on 12/19/19, 12/25/19, and 12/27/19 in regard to her wound treatments. She reported Resident #64 did not leave the facility because of her debilitated state, and she always reapproached residents if they were not in their rooms the first time she entered to provide wound treatments. According to Treatment Aide #1, she could not recall any time that she was unable to provide a wound treatment unless the resident refused to allow her to perform the task. She commented therefore it seemed likely that Resident #64 refused wound treatments on 12/19/19, 12/25/19, and 12/27/19. During an interview with the facility's Treatment Nurse and Administrator on 02/15/20 at 9:16 AM they stated upon reviewing documentation made by Treatment Aide #1 they realized she was coding the reason for not administering wound treatments to all residents, many of whom had a history of refusing treatments, as "N" for "not available." They reported this was incorrect, and many of those missed treatments, including Resident #64's 12/19/19, 12/25/19, and 12/27/19 treatments, should have been coded as "R" for	F 842	6) On 3/3/2020 and ongoing, audits of the facility treatment administration record will be conducted weekly times eight weeks, then monthly times four months, to ensure that no documentation inaccuracies noted. Findings will be documented on the “Audit for Accurately Documenting on TAR” and reported to the facility director of nursing services or designee. 7) Results of compliance with plan will be discussed and minutes recorded times four months during the facility’s monthly QAPI meeting, with adjustments to plan made as needed, followed by: 8) Results of audits and compliance with plan will be discussed and minutes recorded quarterly times three quarters during the facility’s quarterly QAPI committee meeting, with adjustments to plan made as needed followed by: 9) Should revisions be necessary, appropriate staff will be re-in-serviced by director of nursing services or appropriate designee. 10) Any revisions to plan will require monitoring steps to begin again at step 7.	

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F 842	Continued From page 16 "refused". They also commented there was a third code which could be entered to justify wound treatments not being completed which was "H" for "held."	F 842		