STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345297	A. BUILDING _____ B. WING _____	C 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTIA VILLAGE-SNF	2200 ELM DRIVE LAURINBURG, NC 28352

(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 COVID-19 Focused Survey was conducted on 12/22/2020 to 12/23/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# PV4M11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control and Complaint Investigation Survey was conducted on 12/22/2020 to 12/23/2020. The facility was found not in compliance with 42 CFR §483.80 infection control regulations. Please see event# PV4M11. 1 of the 1 complaint allegation was not substantiated.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		1/12/21

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

Electronically Signed | 01/14/2021

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F 880	Continued From page 1 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 2 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement their policies and procedures related to personal protective equipment (PPE) and hand hygiene for 1 of 5 sampled residents (Resident #1) who was on enhanced droplet isolation. These failures occurred during COVID-19 pandemic. The findings included: Record review of facility policy and procedure titled "Handwashing/Hand Hygiene" revised August 2015 revealed personnel were to use alcohol-based hand rub or soap and water before and after entering isolation precaution settings. Record review of facility policy titled, "Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (Covid-19)" revealed staff were to wear full personal protective equipment when working with individuals with known or suspected COVID-19. Residents admitted/readmitted to facility were to be isolated in their rooms for 14 days. Resident #1 was in isolation for COVID-19 observation for 14 days after readmission with an enhanced droplet isolation signage at the door. The signage indicated staff were required to perform hand hygiene, don mask, eye protection,	F 880	F-880- Infection Prevention and Control Program Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. NA #1 was educated about entering resident rooms with proper PPE and handwashing by Infection Control Nurse & Director of Nursing. Also, Infection Control Nurse encouraged employee to focus on having awareness for all residents on enhanced droplet isolation precautions. This meeting occurred on 12/23/2020. Staff Development/ Infection Control Nurse was able to complete required in-service to all nursing staff. information was base on our policy and procedures on the implementation of hand hygiene and proper use of PPE. Also, discussed was the implementation of our facilities policy on infection Control Policy for suspected	

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F 880	Continued From page 3 gown and gloves before entering the room. On 12/22/20 at 11:25 AM, Nurse Aide (NA) #1 was observed entering Resident #1's room without a gown or gloves. She did not perform hand hygiene before entering the room as well as when she exited the room. She walked into the room and talked to the resident then exited the room and walked down the hallway and was not observed performing hand hygiene. The enhanced droplet isolation signage was on the door when she entered the room. During an interview on 12/22/20 at 12:05 PM, NA #1 revealed she had been trained regarding infection control practices, hand hygiene and use of PPE when entering isolation rooms. She indicated she was aware that she should have performed hand hygiene and don PPE according to the signage on the door but missed to do it when she entered and exited Resident # 1's room. An interview with Nurse #1 on 12/22/20 at 11:30 AM revealed Resident #1 was on isolation due to readmission from another healthcare facility. Nurse #1 indicated residents placed on isolation had a signage and PPE supplies outside their doors for staff to utilize prior to entering the room. She indicated nursing staff had been trained on hand hygiene and the use of PPE when caring for residents in isolation to prevent infection transmission. She indicated she always donned PPE prior to entering the room and performed hand hygiene when entering and exiting residents' rooms. An interview with Director of Nursing (DON) on 12/22/20 at 11:45 AM revealed she was also the	F 880	or confirmed Coronavirus. In-service commenced on 12/30/2021 and was completed on 1/12/2021. Any new employee starting employment in skilled nursing will be in-serviced of these policies prior to providing resident care. Staff Development Coordinator will audit all doors where enhanced droplet precautions signage is posted to make sure there is no clutter on door and signage is visible to employees providing care. The Staff Development Coordinator or Director of Nursing will complete observational audits for both hand hygiene and proper use of PPE for ALL enhanced droplet precautions for 12 weeks to monitor and ensure that all staff are complying with infection control protocols. The first Audit being completed by 12/30/2020. Any identified issues will be corrected immediately upon discovery and the Director of Nursing will ensure the Associate Director is notified for corrective action. The results of this audit will be presented to and reviewed by the Staff Development Coordinator or Director of Nursing Services to the Quality Assessment Performance Improvement Committee Meeting for a minimum of three consecutive meetings. Any issues, trends or concerns identified will be addressed and the plan will be updated to ensure continued compliance.	

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F 880	Continued From page 4 Infection Prevention Nurse (IPN). She indicated all staff had been trained regarding infection control practices, policies and procedures including enhanced droplet precaution requirements. She stated staff were to perform hand hygiene before and after every resident encounter as well as don PPE as per signage on the resident's door. She indicated Resident #1 was on 14 days isolation following readmission on 12/18/20 and had an enhanced droplet isolation signage as well as PPE supply outside her door that staff were required to use prior to entering the room. An interview with the Administrator on 12/22/2020 at 12:25 PM revealed all staff were to perform hand hygiene and don PPE as per signage on the door prior to entering the room of residents on isolation	F 880		