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 _____	09/14/2023

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

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E 000	Initial Comments An unannounced recertification investigation survey was conducted on 09/11/2023 through 09/14/2023. The facility was found in compliance with the requirement CFR. 483.73, Emergency Preparedness. Event ID# V58G11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 09/11/2023 through 09/14/2023. Event ID# V58G11.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Consultant Pharmacist, and Physician interviews the facility failed to protect a residents right to be free from misappropriation of a residents controlled medication (Oxycodone/Acetaminophen 5/325 milligrams (mg) , Hydrocodone/Acetaminophen 10/325 mg, Tramadol 50 mg, and Alprazolam 0.5 mg) which was prescribed by the physician for pain and anxiety. This resulted in a total of 42 doses of the medications that were not administered to 8 of 8 residents (Resident #51, #41, #2, #3,#4, #7, #8, #9) reviewed for misappropriation of medications.	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 10/02/2023

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 _____	09/14/2023

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F 602	Continued From page 1	F 602		

Findings included.

1a.)Resident #51 was admitted to the facility on 04/01/23 with diagnoses including fractured vertebra and sacrum, and Arthritis.

A physicians order dated 04/05/23 for Resident #51 revealed Oxycodone/Acetaminophen 5/325 mgs. Take one tablet every 8 hours as needed for pain.

Review of Resident #51's Controlled Drug Record initiated 04/05/23 revealed Oxycodone/Acetaminophen 5/325 mgs was signed out of the narcotic count by Nurse #1 on 04/11, 04/25, 04/27, and 04/28/23.

Review of Resident #51's Medication Administration Record (MAR) dated April 2023 revealed no documentation by Nurse #1 on 04/11, 04/25, 04/27, or 04/28 that the Oxycodone/Acetaminophen 5/325 mgs was administered to Resident #51.

Review of the nursing progress notes from 04/11/23 through 04/28/23 revealed no documentation by Nurse #1 that Oxycodone/Acetaminophen 5/325 mgs was administered to Resident #51. .

During an interview on 09/14/23 at 11:30 AM Resident #51 was observed sitting in a wheelchair in his room. He was alert and oriented. He stated he did not take any pain medication at this time. He stated he did not have complaints of pain and had never really had much pain. He stated he did not recall getting pain medication regularly or needing pain medication on a regular basis at any time since his admission

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 _____	09/14/2023

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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
F 602	Continued From page 2	F 602		

to the facility.

b.) Resident #41 was admitted to the facility on 06/09/21 with diagnoses including dementia, anxiety, and depression.

A physicians order dated 03/31/23 for Resident #41 revealed Alprazolam 0.5 mg. take one tablet by mouth as needed for anxiety.

Review of Resident #41's Controlled Drug Record initiated 03/31/23 revealed Alprazolam 0.5 mg was signed out of the narcotic count by Nurse #1 on 05/11/23 and 05/13/23.

Review of Resident #41's Medication Administration Record (MAR) dated May 2023 revealed no documentation by Nurse #1 on 05/11 or 05/13/23 that Alprazolam 0.5 mgs was administered.

Review of the nursing progress notes from 05/11/23 through 05/13/23 revealed no documentation by Nurse #1 that Alprazolam 0.5 mgs was administered to Resident #41.

During an observation on 05/11/23 at 11:00 AM Resident #41 was observed sitting in the locked memory unit dining area. She was calm with no signs of increased anxiety.

c.) Resident #2 was admitted to the facility on 03/24/23 with diagnoses including Respiratory failure and chronic pain.

A physicians order dated 04/05/23 for Resident #2 revealed Oxycodone/Acetaminophen 10/325 mgs. Take one tablet every 6 to 8 hours as needed for pain control.

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 _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 602	Continued From page 3	F 602		

Review of Resident #2's Controlled Drug Record initiated 04/06/23 revealed Oxycodone/Acetaminophen 10/325 mgs was signed out of the narcotic count by Nurse #1 on 04/07, 04/08, 04/09, 04/12, 04/13 at 8:30 AM and 2:00 PM and 04/18/23.

Review of Resident #2's Medication Administration Record (MAR) dated April 2023 revealed no documentation by Nurse #1 that Oxycodone/Acetaminophen 10/325 mgs was administered to Resident #2 on 04/07, 04/08, 04/09, 04/12, 04/13 at 8:30 AM and 2:00 PM and 04/18/23.

Review of the nursing progress notes from 04/07/23 through 04/18/23 revealed no documentation by Nurse #1 that Oxycodone/Acetaminophen 10/325 mgs was administered to Resident #2.

During an interview on 09/14/23 at 1:00 PM the Director of Nursing stated Resident #2 expired on 04/20/23 due to respiratory disease.

d.) Resident #3 was admitted to the facility on 02/27/15 with diagnoses including Cerebral Palsy, Quadriplegia, and Non-Alzheimer's dementia.

A physicians order dated 04/05/23 for Resident #3 revealed Hydrocodone/Acetaminophen 10/325 mgs. Take one tablet every 6 hours as needed for pain control.

Review of Resident #3's Controlled Drug Record initiated 03/24/23 revealed Hydrocodone /acetaminophen 10/325 mgs was signed out of the narcotic count by Nurse #1 on 04/07, 04/08 at

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 _____	09/14/2023

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

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F 602	Continued From page 4	F 602		

7:45 AM and 6:22 PM, 04/09, 04/13, 04/18, 04/21 at 7:15 AM and 1:15 PM, 04/22 at 7:15 AM, and 1:30 PM, 04/23, 04/25 at 2:00 PM, 04/26, 04/27 at 7:15 AM and 5:30 PM, 04/28, 05/01 at 8:00 AM, 05/02 at 8:00 AM and 5:30 PM, 05/05, 05/06 at 7:25 AM and 6:26 PM, 05/07 at 7:30 AM and 6:00 PM, and 05/11/23.

Review of Resident #3's Medication Administration Record (MAR) dated April 2023 and May 2023 revealed no documentation by Nurse #1 that Hydrocodone/Acetaminophen 10/325 mgs was administered to Resident #3 on 04/07, 04/08 at 7:45 AM and 6:22 PM, 04/09, 04/13, 04/18, 04/21 at 7:15 AM and 1:15 PM, 04/22 at 7:15 AM, and 1:30 PM, 04/23, 04/25 at 2:00 PM, 04/26, 04/27 at 7:15 AM and 5:30 PM, 04/28, 05/01 at 8:00 AM, 05/02 at 8:00 AM and 5:30 PM, 05/05, 05/06 at 7:25 AM and 6:26 PM, 05/07 at 7:30 AM and 6:00 PM, and on 05/11/23.

Review of the nursing progress notes from 04/07/23 through 05/11/23 revealed no documentation by Nurse #1 that Hydrocodone/Acetaminophen 10/325 mgs was administered to Resident #3.

e.) Resident #4 was admitted to the facility on 03/21/23 with diagnoses including Diabetes and left below knee amputation.

A physicians order dated 03/22/23 for Resident #4 revealed Oxycodone/Acetaminophen 5/325 mgs. Take one tablet every 4 hours as needed for pain.

Review of Resident #4's Controlled Drug Record initiated 03/23/23 revealed

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 _____	09/14/2023

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
F 602	Continued From page 5	F 602		

Oxycodone/Acetaminophen 5/325 mgs was signed out of the narcotic count by Nurse #1 on 03/26/23.

Review of Resident #4's Medication Administration Record (MAR) dated March 2023 revealed no documentation by Nurse #1 on 03/26/23 that the Oxycodone/Acetaminophen 5/325 mgs was administered to Resident #4.

Review of the nursing progress notes on 03/26/23 revealed no documentation by Nurse #1 that Oxycodone/Acetaminophen 5/325 mgs was administered to Resident #4.

Resident #4 was discharged from the facility on 04/05/23.

f.) Resident #7 was admitted to the facility on 09/04/20 with diagnoses including Congestive heart failure, Non-Alzheimer's dementia, and pain.

A physicians order dated 05/03/23 for Resident #7 revealed Tramadol 50 mgs. Take one tablet by mouth three times a day as needed for pain.

Review of Resident #7's Controlled Drug Record initiated 05/11/23 revealed Tramadol 50 mgs was signed out of the narcotic count by Nurse #1 on 05/11/23.

Review of Resident #7's Medication Administration Record (MAR) dated May 2023 revealed no documentation by Nurse #1 on 05/11/23 that Tramadol 50 mgs was administered to Resident #7.

Review of the nursing progress notes on 05/11/23

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 _____	09/14/2023

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
F 602	Continued From page 6	F 602		

revealed no documentation by Nurse #1 that Tramadol 50 mgs was administered to Resident #7.

Resident #7 was discharged from the facility on 07/16/23.

g.) Resident #8 was admitted to the facility on 04/10/23 with diagnoses including Diabetes, and hip and knee replacement.

A physicians order dated 04/10/23 for Resident #8 revealed Tramadol 50 mgs. Take one tablet by mouth every 6 hours as needed for pain.

Review of Resident #8's Controlled Drug Record initiated 04/11/23 revealed Tramadol 50 mgs was signed out of the narcotic count by Nurse #1 on 04/13/23.

Review of Resident #8's Medication Administration Record (MAR) dated April 2023 revealed no documentation by Nurse #1 on 04/13/23 that Tramadol 50 mgs was administered to Resident #8.

Review of the nursing progress notes on 04/13/23 revealed no documentation by Nurse #1 that Tramadol 50 mgs was administered to Resident #8.

Resident #7 was discharged from the facility on 05/19/23.

h.) Resident #9 was admitted to the facility on 12/24/18 with diagnoses including right femur fracture, dementia, and chronic pain.

A physicians order dated 03/28/23 for Resident

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 _____	09/14/2023

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
F 602	Continued From page 7	F 602		

#9 revealed Hydrocodone/Acetaminophen 10/325 mgs. Take one tablet every 12 hours as needed for pain control.

Review of Resident #9's Controlled Drug Record initiated 03/29/23 revealed Hydrocodone/acetaminophen 10/325 mgs was signed out of the narcotic count by Nurse #1 on 05/01/23, 05/02/23 at 12:31 PM, and 05/11/23.

Review of Resident #9's Medication Administration Record (MAR) dated May 2023 revealed no documentation by Nurse #1 on 05/01/23, 05/02/23 at 12:31 PM, and 05/11/23 that Hydrocodone/Acetaminophen 10/325 mgs was administered to Resident #9.

Review of the nursing progress notes from 05/01/23 through 05/11/23 revealed no documentation by Nurse #1 that Hydrocodone/Acetaminophen 10/325 mgs was administered to Resident #9.

Resident #9 was discharged from the facility on 07/31/23.

Review of the facility investigation initiated on 05/15/23 revealed: On 5/15/23 at approximately 11:30 AM Nurse #2 reported that Nurse #3 had suspicions that Nurse #1 was taking resident's medications and not administering the medications to the residents. She stated that one specific resident had an order for a narcotic as needed pain medication, but the resident never complained of pain. She stated that Nurse #1 was the only nurse signing out this narcotic for this specific resident. She stated that over a month ago another resident complained that Nurse #1 crushed her medications although there was no

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 _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 602	Continued From page 8	F 602		

indication or need for the medications to be crushed. Nurse #3 stated that the resident complained and she didn't think the nurse was giving her pain medication. She stated she felt that it was also suspicious that Nurse #1 picked up additional shifts on households that she generally did not work and thought this could be to gain access to medications. Nurse #3 reported that other nurses were suspicious as well and provided a list of nurses and medication aides with concerns.

An interview was conducted on 09/13/23 at 10:00 AM with the Director of Nursing (DON) along with the Administrator. The DON stated she was made aware of the allegation of possible drug diversion regarding Nurse #1 on 05/15/23 and a full investigation was initiated. She stated she reviewed the narcotic book containing all controlled drug records from the household that Nurse #1 worked on and identified a Resident (#51) that had an order for Oxycodone/Acetaminophen 5/325mg as needed every 8 hours for pain. The order stood out to her because Nurse #1 was the only nurse that signed out this medication for Resident #51 since 04/20/23. She stated from 04/20/23 through 05/15/23 Nurse #1 signed out the medication 13 times. She stated she reviewed Resident #51's MAR to reconcile with the Controlled Drug Record and found where Nurse #1 failed to document that she administered the medication on the medication administration record on several occasions. She stated Resident #51 rarely complained of pain. She reviewed more resident records and found several other residents that had controlled medication orders and Nurse #1 signed them out on the Controlled Drug Record but didn't sign them out on the MAR

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 _____	09/14/2023

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
F 602	Continued From page 9	F 602		

as being administered to the residents. She stated she then notified the Administrator, and they interviewed Nurse #1 who denied taking any of the residents medications. The DON stated Nurse #1 stated she always documented on the MAR and didn't understand why the documentation on the MAR didn't show up and she probably just forgot to sign them out on the MAR. The Administrator added that the audits conducted and the interviews with other nurses indicated drug diversion. He stated Nurse #1 had been employed with the facility for 18 years and was terminated at that time. The DON added that she informed Nurse #1 that she would be reported to the Board of Nursing. She stated Nurse #1 did not want to review the audits that were done. The DON stated the Board of Nursing submitted their findings to the facility following their investigation. The Board of Nursing findings revealed Nurse #1 admitted that she had been diverting controlled medications from the facility for a period of time. Her nursing license was suspended.

During an interview on 09/13/23 at 11:00 AM Nurse #4 stated she was aware of the allegations of drug diversion and was one of the nurses interviewed during the investigation of Nurse #1. She stated Nurse #1 was suspected of not giving certain residents their pain medications. She stated for example Resident #51 never complained of pain, but Nurse #1 signed out pain medications for him on many occasions. She stated there were other residents identified during the investigation that were affected. She stated she received in-service training during that time regarding drug diversion.

During a phone interview on 09/13/23 at 4:10 PM

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 _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 602	Continued From page 10	F 602		

the Consultant Pharmacist stated she conducted monthly record reviews at the facility. She stated she was made aware of the allegation of diversion in May 2023 regarding Nurse #1. She stated she was not aware until that time of any problems with narcotic medications at the facility. She stated during the monthly record reviews she reviewed prn (as needed) use of medications and did not see on the residents MAR that the medications were being administered or used frequently. She stated she had no concerns since that time with medication administration at the facility.

During a phone interview on 09/13/23 at 4:31 PM the Medical Director stated he was made aware of the medication diversion. He stated he was at the facility on the day the facility was made aware. He stated he made rounds with the nurses weekly at the facility and there was no harm to any of the residents. He stated he had evaluated all of the affected residents during that time and found no negative outcome. He stated he had no concerns with the facility staff.

During a follow up interview on 09/14/23 at 3:00 PM the DON stated a full plan of correction was implemented to include in-service training, audits, and audit results were discussed in the last QA meeting which was held on 07/25/23. She stated the audits were completed in August 2023 and the next QA meeting would be held the week of 09/18/23.

The corrective action for the noncompliance dated 05/15/23 was as follows:

On 05/15/23 the Director of Nursing and the Administrator were made aware of the allegation

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 _____	09/14/2023

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
F 602	Continued From page 11	F 602		

and conducted an initial investigation.

On 05/15/23 the State Agency was notified.

On 05/15/23 the DON initiated a 100% audit of the Medication Administration Records (MARs) and Controlled Drug Records of all residents who received Controlled medications and compared to the residents corresponding MAR to identify discrepancies. The audit was to ensure the medication was signed out on the residents Controlled Drug Record and to ensure staff signed the MAR that the narcotic was administered. The outcome of the audit revealed 10 residents identified as being affected.

On 05/15/23 Nurse #1 was terminated.

On 05/15/23 the Medical Director was made aware of the possible drug diversion.

On 05/15/23 the Police Department was notified of the possible drug diversion.

On 05/18/23 affected residents that still remained in the facility were assessed for changes in clinical condition. Interviews were conducted with affected residents or their Responsible Party (RP) to identify any concerns with residents not receiving as needed medications upon request. There were no issues identified.

On 05/18/23 residents with the potential to be affected were assessed to identify any concerns with as needed medications being administered. Interviews were conducted with the residents or their Responsible Party (RP). There were no issues identified.

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 _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 602	Continued From page 12	F 602		

On 05/22/23, 100% in-service training was initiated with all nurses and medication aides by the Staff Development Coordinator (SDC) regarding signs of narcotic diversion and prevention, reporting requirements of suspected diversion, and medication policy and procedures ensuring that controlled drug records matched the MAR. In-services were to be completed by 05/26/23. After 05/26/23, any staff who had not received the in-service training would not be allowed to work until they completed the in-service training. All newly hired nurses and medication aides would be in-serviced during orientation.

Beginning 05/16/23, the nurse mentors will review all residents with prescribed as needed narcotics to ensure that each narcotic is signed out on the controlled drug record with a corresponding administration record once weekly x 4 weeks, then once every 2 weeks x 1 month, then monthly x 1.

The Director of Nursing will forward the results of the audits to the Quality Assurance (QA) Committee Meeting monthly until resolved.

The quarterly QA meeting was held 07/25/23 where the results of the investigation and audits were discussed.

Validation of the corrective action was completed on 09/14/23. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. Observations were conducted of the medication carts; controlled substance counts were conducted with nursing staff of narcotics stored on the

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 _____	09/14/2023

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
F 602	Continued From page 13 medication carts. Controlled Substance Count Records were reviewed. Audits were verified. A QA meeting was held on 07/25/23 where audit results were discussed. The facility alleged compliance with the corrective action plan on 05/27/23.	F 602		