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 11/07/2024

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 recertification and complaint investigation survey was conducted on 11/04/2024 through 11/07/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OOWP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/04/2024 through 11/07/2024. Event ID# OOWP11. The following intake was investigated NC00223146. 1 of the 1 complaint allegation did not result in a deficiency.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to perform daily wound care treatments on a sacral wound for 1 of 1 resident (Resident #4) observed for pressure	F 686	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice	11/22/24

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

Electronically Signed | 11/19/2024

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F 686	Continued From page 1 ulcers. Findings included: Resident #4 was admitted to the facility on 11/04/22. Diagnoses included, in part, pressure ulcer of sacral region and myoneural disorder (spinal compression with paralysis to lower extremities). The quarterly Minimum Data Set assessment dated 09/20/24 revealed resident was cognitively intact with no behaviors, had impairment on both sides to upper and lower extremities, utilzed a wheelchair for mobility, was always incontinent of bowel and bladder and was coded as having a pressure ulcer stage III. A review of Resident #4's care plan updated on 09/20/24 revealed a plan of care for actual impairment to skin integrity with pressure ulcer to sacrum. The goal was that the skin injury would improve by the next review date with interventions to include, in part, daily treatment to affected area to promote wound healing. A review of the physician orders revealed an order written on 10/29/24 to cleanse sacral area with normal saline, apply silver collagen matrix cut to fit wound, cover with an absorbent silicone dressing daily. Review of the weekly observation tool dated 10/29/24 revealed Resident #4 acquired a stage II pressure ulcer on 09/04/24 which had increased to a stage III pressure ulcer on 10/23/24. The overall impression indicated the wound was improving with epithelial tissue and granulation tissue present (healthy tissue). The	F 686	"Infection Preventionist and Director of Nursing administered treatment per residents prescribed treatment orders the morning of 11/6/24. NP was made aware of omission of 11/5/24 dressing change the morning of 11/6/24. "TAR was reviewed showing completion of treatment on 11/5/24. Nurse who charted completion of treatment in error corrected documentation to reflect not completed for date of 11/5/24. Date of correction was 11/6/24. "Nurse who failed to complete wound treatment for resident on 11/5/24 was provided one on one education and counseling by the Director of Nursing on the importance of completing treatments timely per MD orders on 11/8/24. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: "A 100% audit was conducted of completion of dressing treatments compared to the electronic health record by the Nurse Mentors on 11/8/24 to ensure completion of treatments per MD orders. No issues identified. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur "All licensed nursing staff will be in-serviced by 11/22/24 by the Staff Development Coordinator or Designee on the importance of administering treatment orders timely per MD orders. If treatment not completed, reason should be	

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F 686	Continued From page 2 assessment noted there was serosanguinous (bloody serum) draining with moderate amounts with no odor. The measurement of the wound was 1.5 centimeters (cm) X 0.7 cm X no depth. An observation of wound care was conducted on 11/06/24 at 9:30 AM with Nurse #1 and the Director of Nursing (DON). Resident #4 was informed that the two nurses were going to change her dressing to her sacrum. Resident #4 was turned to her left side. Nurse #1 proceeded to remove the existing dressing to Resident #4's sacrum which was dated 11/04/24. The wound was noted to be opened with small amount of bloody serum with redness surrounding the wound. Nurse #1 cleansed the pressure ulcer with wound cleanser, patted dry, and applied a small wound size piece of silver collagen to the wound and covered it with an absorbent silicone dressing. An interview with Nurse #1 on 11/06/24 at 9:40 AM was conducted. Nurse #1 was asked about the date on the dressing being 11/04/24. Nurse #1 stated she did not notice the date and proceeded to then remove the dressing from the trash bag. Nurse #1 read the date on the dressing and confirmed the date was 11/04/24. Nurse #1 did not know if the dressing was changed on 11/05/24 as ordered. A phone interview was conducted with Nurse #2 on 11/06/24 at 9:45 AM. Nurse #2 revealed she worked 12 hour shifts from 7:00 AM to 7:00 PM and she had changed the dressing on 11/04/24 and it was removed around 7:00 PM when Resident #4 got a bath and another dressing was reapplied after her bath on 11/04/24. Nurse #2 stated she did not change it on 11/05/24 since it	F 686	documented in electronic health record with provider and POA notifications. "Education will be added to new hire orientation for all licensed nursing staff by the Staff Development Coordinator or Designee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained "An audit tool has been developed to monitor the completion of treatment orders by observation and documentation to ensure timeliness of completion per MD orders. Audits will include all residents with wounds to be conducted by the Nurse Mentors or designee 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 weeks to include some weekends and as needed to ensure compliance. "Audit Compliance and results will be discussed weekly by the DON or designee during morning administration meetings x 12 weeks, and as needed. "The Administrator or designee will bring the audit results to the QAPI meetings x 2 quarters and as needed for committee review and input. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DON or designee and monitoring to begin again at the weekly audits until compliance is met.	

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F 686	Continued From page 3 was changed twice on 11/04/24. An interview was conducted with the Director of Nursing on 11/06/24 at 10:30 AM. The DON reported Resident #4's pressure ulcer was a stage II when it was identified on 09/04/24 and had recently increased to a stage III wound. The DON reported Resident #4 requests to get out of bed daily and sit up in her wheelchair for prolonged periods which she believed contributed to the wound worsening. She stated she would have expected Nurse #2 to follow the physician's order and change the dressing daily in order to aide in healing.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(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(h)(2) The facility must keep confidential	F 842		11/22/24

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F 842	Continued From page 4	F 842		

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;
(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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(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(h)(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;

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F 842	Continued From page 5 (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 observations, record review and staff interviews the facility failed to accurately document the completion of a wound treatment in the treatment administration record (TAR) for 1 of 1 residents (Resident #4) observed for pressure ulcers. Findings included: Resident #4 was admitted to the facility on 11/04/22. Diagnoses included, in part, pressure ulcer of sacral region. A review of the physician orders revealed an order written on 10/29/24 to cleanse sacral area with normal saline, apply silver collagen matrix (antimicrobial barrier to prevent infections) cut to fit wound, cover with an absorbent silicone (a dressing that absorbs drainage) daily. Review of the Treatment Administration Record (TAR) revealed the wound treatment for Resident #4 was signed off on the TAR as evidenced by a check mark with Nurse #2's initials on 11/05/24. A phone interview was conducted with Nurse #2 on 11/06/24 at 9:45 AM. Nurse #2 revealed she had changed the dressing on 11/04/24 and it was removed around 7:00 PM when Resident #4 got a bath and another dressing was reapplied after her bath on 11/04/24. Nurse #2 stated she did not change it on 11/05/24 since it was changed twice on 11/04/24. Nurse #2 stated she should not	F 842	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice "Nurse who charted completion of treatment in error corrected documentation to reflect not completed for date of 11/5/24. Date of correction was 11/6/24. "Nurse who charted inaccurately was provided one on one education and counseling by the Director of Nursing on the importance of documenting accurately in residents health records on 11/8/24. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: "An 100% audit was conducted of completion of dressing treatments compared to the electronic health record by the Nurse Mentors on 11/8/24 to ensure accurate documentation of records. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur "All licensed nursing staff will be in-serviced by 11/22/24 by the Staff Development Coordinator or Designee on the importance of documenting accurately	

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F 842	Continued From page 6 have signed off in the treatment administration record that she did the dressing change on 11/05/24 as that was inaccurate documentation. An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 10:30 AM. The DON reported she expected her nursing staff to accurately document in the treatment administration record to reflect the care that was provided. The DON stated Nurse #2 should not have signed off on a treatment that she did not provide.	F 842	in residents health records to reflect residents current status. "Education will be added by the Staff Development Coordinator or Designee to the new hire orientation for all licensed nursing staff. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained "An audit tool has been developed to monitor the completion of treatment orders compared to the documentation in the electronic health record for accuracy. Audits of all residents with wounds will be conducted by the Nurse Mentors or designee 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 weeks to include some weekends and as needed to ensure compliance with accuracy. "Audit Compliance will be discussed weekly by the DON or designee during morning administration meetings x 12 weeks, and as needed. "The Administrator or designee will bring the audit results to the QAPI meetings x 2 quarters and as needed for committee review and input. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DON or designee and monitoring to begin again at the weekly audits until compliance is met.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		11/22/24

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F 880	Continued From page 7 §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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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:	F 880		

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F 880	Continued From page 8 (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. §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 observations and staff interviews, facility staff failed to implement infection control policy and procedures when Nurse Aide (NA) #1 and NA #2 did not don Protective Equipment (PPE) to include a gown when providing high-contact resident care activities for Resident #49 who had an indwelling medical device. Resident #49 had a lower back indwelling pleural catheter which was used for draining fluid from the pleural space (fluid filled space that surrounds the lungs) to help with breathing. The deficient	F 880	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice "The two CNA□s involved in deficient practice were immediately re-educated by Director of Nursing on infection control practices to include protocol for Enhanced Barrier Precautions. 2) Address the facility will identify other	

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F 880	Continued From page 9 practice was identified for 2 of 2 staff members reviewed for infection control practices (NA #1 and NA #2). The findings included: Review of the facility's the facility's Enhanced Barrier Precautions (EBP) signage for long term care facilities (LTCF) dated 07/26/22 read: All residents with any of the following: Wounds (skin opening that requires a dressing) and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of multi-drug-resistant-organism (MDRO) colonization status. All healthcare personnel must: wear gloves and gowns for the following high-contact resident care activities: Handling linen, transferring resident, and changing linen. During an observation on 11/06/24 at 11:25 AM a sign was posted by Resident #49's room door that read in part: Enhanced barrier precautions, and providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care or use of a central line, urinary catheters, feeding tubes, and wound care. During an observation from the hall on 11/06/24 at 11:30 AM Nurse Aide (NA #2) and NA #1 were observed in Resident #49's room changing the bed linens. Resident #49 was sitting at the bedside in her recliner. Nurse Aide #2 and Nurse Aide #1 had on gloves when changing the bed linens but were not wearing gowns. A hanging door bin with PPE (personal protective	F 880	residents having the potential to be affected by the same deficient practice: "100% re-education provided by Staff Development Coordinator or designee to all nursing staff by 11/22/24 regarding infection control policy and procedure related to Enhanced Barrier Precautions. "Infection Control Committee initiated to meet weekly to discuss policies/procedures and review of audits. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur "100% re-education provided by Staff Development Coordinator or designee to all nursing staff by 11/22/24 regarding infection control policy and procedure related to Enhanced Barrier Precautions. "Infection Control Committee initiated to meet weekly discuss policies/procedures and review of daily/weekly audits. "Policy and Procedure for Enhanced Barrier Precautions will continue to be reviewed in new hire orientation for all nursing staff and will be added to be reviewed in the Annual Skills Fair by the Staff Development Coordinator or Designee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained "An audit tool has been developed to monitor performance of PPE usage with identified Enhanced Barrier Precaution rooms. Audits of a minimum of 5 observations per week will be conducted	

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F 880	Continued From page 10 equipment) supplies was on the door, including one time use disposable gowns. An interview was conducted on 11/06/24 at 11:30 AM with Nurse Aide #1 and #2. They stated they did not put on gowns when they transferred Resident #49 to the recliner or when they changed the bed linens. They both knew Resident #49 was on Enhanced Barrier Precautions and acknowledged that they should have worn a gown and gloves when providing direct care, such as the transfer, and should have also worn a gown and gloves when changing bed linens. An interview was conducted on 11/07/24 at 8:55 AM with NA #1. She revealed on 11/06/24 at 11:30 AM when she was helping transfer Resident #49 from bed to Recliner, she went to put on a gown with her gloves, when NA #2 stated she didn't need to don a gown, so she didn't. NA #1 said looking back, she and NA #2 should have worn gowns. An interview was conducted on 11/07/24 at 9:05 AM with NA #2. She revealed she changed Resident #49's bed linens and was aware that the donning gown and gloves were required during high contact resident care activities. She stated they just got in a hurry when transferring Resident #49 and changing her linen. An interview was conducted on 11/07/24 at 9:20 AM with the Director of Nursing (DON). She stated staff should wear the appropriate personal protective equipment PPE when providing direct care to residents on enhanced barrier precautions. She also stated regardless, all the staff knew to abide by the different types of	F 880	by members of the infection control committee 5 times a week x 4 weeks, then weekly x 4 weeks, to include some weekends and night shifts and as needed to ensure compliance. "Audit Compliance and results will be discussed weekly by the DON or designee during Infection Control Committee Meetings x 8 weeks, and as needed. "The Administrator or designee will bring results of audits to the QAPI meetings for committee review and input X 2 quarters, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DON/designee and monitoring to begin again at the daily audits until compliance is met.	

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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 880	Continued From page 11 precautions posted on the residents' door and to follow the assigned personal protective equipment (PPE). She stated education would be provided to NA #1 and NA #2.	F 880		