STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345383	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scottish Pines Rehabilitation and Nursing Center	**620 Johns Road , Laurinburg, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 12/15/25 through 12/18/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # 1DE271-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted at this facility from 12/15/25 to 012/18/25. Event ID #1DE271-H1. The following intakes were investigated: 847718, 2564409, 2682175, 847719 and 2590496. 19 of the 19 complaint allegations did not result in deficiency.	F0000		
F0812 SS = E	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	F0812	1. On 12/15/2025, facility chef manager disposed of open bag of labeled diced potatoes, 98 eight-ounce containers of 2% milk in 2 racks, half full box of white mushrooms and an opened plastic bag labeled mozzarella cheese. 2. On 12/18/2025, 100% of dietary staff were in-serviced by the facility Food Service Director (FSD) on proper label and date standards for food items and the immediate removal of food items not properly stored and ready for use by the use by/expiration date. On 12/18/2025, 100% of dietary staff also in-serviced by the facility FSD on the procedure of discarding items that is to be completed at the closing of the kitchen daily. All newly hired dietary employees will be trained using employee training program, titled 'TLMS', which will ensure dietary employees are trained appropriately on proper dating, proper labeling and discarding of expired items.	01/09/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0812 SS = E	Continued from page 1 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to discard expired food and milk available for use and to label opened food items with the date opened and expiration date in 1 of 1 walk-in refrigerator in the kitchen. These practices had the potential to affect the food served to 73 of 77 residents. The findings included: An initial observation of the kitchen was conducted with the Cook on 12/15/25 at 10:34 AM. Observation of the walk-in refrigerator revealed an opened plastic bag labeled diced potatoes with an expiration date of 12/11/25, 98 eight ounce containers of 2% milk in 2 racks with an expiration date of 12/14/25, a half full box of white mushrooms with gray and white fuzz growing on top of them and with black parts with a received date of 11/11/25 and an opened plastic bag labeled mozzarella cheese with no opened or expiration date. An interview with the Cook was completed on 12/15/25 at 10:45 AM. The Cook stated that the opened plastic bag of diced potatoes and the mushrooms that were black with grayish white fuzz on them should have been discarded. He reported that the milk was supposed to have a “Do Not Use” tag on it because it was expired. The Cook indicated that it was the responsibility of all the staff working in the kitchen to label and date food items correctly. He stated the opened plastic bag of mozzarella cheese should have had an opened date and expiration date on it. An interview with the Dietary Manager occurred on 12/15/25 at 11:00 AM. The Dietary Manager stated that checking the walk-in refrigerator for expired food items was usually completed first thing in the morning. The Dietary Manager indicated that because she was not there early that morning, it was not done. She further stated there was not a sign off sheet for daily or weekly checking of the walk-in refrigerator. She explained that that she had instructed one of the dietary aides to attach a “Do Not Use” label to the 2% milk containers the night before and place it on the bottom shelf for pick up by the milk man on Wednesday. The Dietary Manager stated she didn’t know why the milk didn’t have the label on it and was not placed on the bottom shelf.	F0812	Continued from page 1 3. The facility dietary closing manager or designee will perform daily audits at the closing of the kitchen each day. The facility dietary closing manager or designee will utilize a monitoring tool named, “Closing Checklist” to document findings. Audits to begin 01/05/2026. The facility dietary cook supervisor or designee will perform daily audits at the start of the opening of the kitchen each day. Facility dietary cook supervisor will utilize a monitoring tool name, “F-812 Daily Check” to document findings. Audits to begin 01/05/2026 and identified concerns will be reported at the morning IDT meeting by the FSD or designee. 4. The facility Food Service Director (FSD) or designee will perform weekly audits to ensure compliance and accuracy of the “Closing Checklist” and “F-812 Daily Check” audit tools. The FSD will utilize a monitoring tool name, “Food Safety Audit Tool” to document findings and address issues of noncompliance. Audits will be conducted weekly times for four weeks, and then monthly for three months. Any area of concern identified with corrective action taken, will be reported in morning IDT meeting and documented by facility executive director or designee on morning IDT meeting minutes form. Results of compliance with plan will be discussed in the facility quality assurance and performance improvement (QAPI) meeting monthly times four months and adjustments to the plan will be made as determined by the facility QAPI team.	

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F0812 SS = E	Continued from page 2 An interview with the Administrator was conducted on 12/18/25 at 10:52 AM. The Administrator indicated all opened foods in the walk-in cooler were to be labeled and dated.	F0812		
F0880 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, 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: (A) The type and duration of the isolation, depending	F0880	1. C.N.A. #1 and C.N.A. #2 were in-serviced on the Infection Prevention and Control policy and procedures with an emphasis on the proper handling of linen (soiled and clean) and hand hygiene by the facility Director of Nursing Services (DNS) on 12/18/2025. Nurse #1 was in-serviced by the facility DNS on 12/17/2025 regarding the PPE requirements when performing tube feeding administration and other resident high contact activities as specified in the Enhanced Barrier Precaution policy. 2. On 01/01/2026, 100% of direct care staff were in-serviced by the facility Infection Control Preventionist Nurse (ICP) on facility policy and procedures for Infection Prevention and Control to include proper handling of clean and soiled linen, hand hygiene procedures, and enhanced barrier precautions (EBP) policies and procedures. Staff not in-serviced by 01/06/2026, will be in-serviced prior to their next scheduled working date by the facility ICP or designee. On 12/17/2025, 100% of licensed nursing staff also in-serviced by the ICP Nurse on the procedure of complying with Enhanced Barrier Precaution PPE requirements during medication administration via enteral tube and all other resident high-contact activities. Staff not in-serviced by 01/06/2026 will be in-serviced prior to their next scheduled working date by the ICP or designee. All newly hired direct care staff hired after 01/06/2026 will be trained during facility orientation by the Assistant Director of Nursing (ADON) on the Infection Prevention and Control policies and procedures and the EBP policies and procedures. 3. Facility Infection Control Preventionist (ICP) Nurse or designee will implement daily monitoring at random times at least three days per week with at least three staff members to ensure staff compliance with PPE during high contact activity for residents requiring EBP precautions and document findings on the “Enhanced Barrier Precautions (EBP) Audit Tool.” The ADON or designee will implement daily monitoring at random times with at least three staff members at least	01/09/2026

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F0880 SS = D	Continued from page 3 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, record review, and staff interviews the facility failed to; 1) implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to a resident (Resident #10) with a gastrostomy tube (a feeding tube placed through the abdominal wall into the stomach and used to provide essential nutrition); 2) and failed to properly dispose of soiled linens that were observed being put on the floor and failed to remove contaminated gloves and perform hand hygiene prior to transferring and touching a resident (Resident #51) and his belongings. This occurred for 3 of 4 staff members who were observed for infection control practices (Nurse #1, Nurse Aide #1 and Nurse Aide #2). Findings included: 1.) The Infection Control Policy dated 3/26/25	F0880	Continued from page 3 three days per week to ensure staff compliance with infection control practices, to include but not limited to handling linen and proper hand hygiene. Facility ADON or designee will document findings on the “Quality Audit: Observation of Care” audit form. Both audit tools will begin 01/05/2026 and identified concerns for both audit tools will be reported at the morning IDT meeting by the ICP nurse and/or ADON beginning 01/06/2026. 4. The Director of Nursing Services (DNS) or designee will monitor staff compliance with Infection Control policies and procedures and the EBP policies and procedures by completing a weekly audit entitled, “Weekly Infection Control and EBP Audit Tool”. Audits will be completed weekly for four weeks and then monthly for three months. Results of compliance with plan will be discussed in the facility Quality Assurance and Performance Improvement meeting monthly times four months and adjustments to the plan will be made as determined by the facility QAPI team.	

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F0880 SS = D	Continued from page 4 revealed “Enhanced Barrier Precautions” referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employed targeted gown and glove use during high contact resident care activities. During an observation on 12/17/25 at 10:00 AM Resident #10 was observed lying in bed. An “Enhanced Barrier Precaution” sign was observed by the door outside of Resident #10’s room. A PPE (personal protective equipment) supply cart was outside of the room with supplies including gloves and gown. Nurse #1 was observed administering medications through Resident #10’s gastrostomy tube. Nurse #1 set up the supplies on the bedside table, removed the blankets covering Resident #10. Nurse #1 checked the gastrostomy tube for placement by inserting a syringe into the tip of the gastrostomy tube. Nurse #1 then administered medications and water flushes through the tube and replaced the blankets over Resident #10. Nurse #1 was wearing gloves but did not don a gown prior to providing direct care to Resident #10. During an interview on 12/17/25 at 10:15 AM Nurse #1 stated she did not see the sign outside of Resident #10’s room and did not realize he was on enhanced barrier precautions. She stated she did not think to put on a gown before administering Resident #10’s medications through the gastrostomy tube. Nurse #1 stated she had received infection control training recently including training on enhanced barrier precautions and this was done in error. During an interview on 12/18/25 at 9:50 AM the Infection Control Preventionist Nurse stated staff had been trained on enhanced barrier precautions. He stated they provided in-service education on infection control including enhanced barrier precautions during each staff meeting, and he conducted random audits to ensure staff were adhering to PPE guidelines. He stated Nurse #1 should have donned a gown along with gloves when administering medications through a gastrostomy tube. He stated continued education would be provided to staff. During an interview on 12/18/25 at 2:00 PM the Director of Nursing (DON) stated staff received infection control training throughout the year. She stated staff should be following the infection control guidelines and wearing PPE when providing direct care to residents	F0880		

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F0880 SS = D	Continued from page 5 on enhanced barrier precautions. 2) The Infection Prevention and Control Program policy dated 12/2010 and revised on 10/28/2020 revealed in part, for standard precautions that all staff shall assume that all residents are potentially infectious or colonized with an organism that could be transmitted during the course of providing resident care services; and soiled linens shall be collected at the bedside and placed and secured in a linen bag; and hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures. An observation of incontinence care was conducted with Resident #51 on 12/15/25 at 11:50 AM with Nurse Aide #1 and Nurse Aide #2. Resident #51 was noted to be lying in bed. His shirt was wet up to his naval, his sheets and his brief were noted to be saturated with urine. Nurse Aide #2 entered the room and observed Resident #51's wet clothes, brief, and his sheets and stated she would provide his care now. Nurse Aide #1 entered the room with clean linens and towels to assist Nurse Aide #2. Nurse Aide #1 and Nurse Aide #2 were noted to apply gloves before starting resident care. There was a rolling dispenser of linen bags noted to be secured to the wall of Resident #51's room. Nurse Aide #2 removed Resident #51's soiled shirt and tossed it on the floor. The urine-soaked brief was removed by Nurse Aide #2 and placed in the trash can. Nurse Aide #1 and Nurse Aide #2 proceeded to remove the urine-soaked sheets and give Resident #51 his bed bath. Nurse Aide #2 was observed using clean linens to bathe Resident #51 and after cleansing the resident, tossed the soiled wash clothes, towels and soiled sheets onto the floor. When the bath was completed and the bed was changed, Resident #51 was assisted with getting dressed by the nurse aides without removing their contaminated gloves. Nurse Aide #2 went to the wall by the door entrance and obtained a linen bag from the rolling dispenser. She did not remove her contaminated gloves. Nurse Aide #2 proceeded to put all the soiled linens, towels and personal clothes in the linen bag and secured the bag. Nurse Aide #1 and Nurse Aide #2 were observed transferring Resident #51 after providing care. The nurse aides did not remove their gloves or wash their hands before transferring Resident #51 out of bed to his wheelchair. Once Resident #51 was in his wheelchair, Nurse Aide #2 moved Resident #51's bedside table, phone, and walker within Resident #51's reach and did not remove her contaminated gloves until she was ready to leave the room. Nurse Aide #1 and Nurse Aide #2 removed their gloves before exiting the room and used sanitizer to	F0880		

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F0880 SS = D	Continued from page 6 cleanse their hands. An interview was conducted with Nurse Aide #2 on 12/15/25 at 12:22 PM. Nurse Aide #2 stated she should not have put the soiled clothes, towels and linens on the floor. She stated she was educated to put soiled items in a plastic linen bag which were available to her in each resident's room. She stated she just was not thinking and was trying to get the bath done before lunch. Nurse Aide #2 also stated she should have removed her gloves and washed her hands after all the soiled items were secured in a bag and before touching Resident #51 and his personal belongings. Nurse Aide #2 stated she had received education on hand hygiene upon hire in April 2025. An interview was conducted with Nurse Aide #1 on 12/15/25 at 12:30 PM. Nurse Aide #1 stated she realized halfway through the bed bath that the towels and linens were being put on the floor and she should have said something when she realized it. Nurse Aide #1 stated she had received education on handling soiled linens and hand hygiene, and she should have removed her gloves and washed her hands after handling the soiled linens and she should not have assisted with transferring Resident #51 with her contaminated gloves still on. An interview was conducted with the Infection Preventionist on 12/18/25 at 10:20 AM. The Infection Preventionist stated he would have expected the nurse aides to follow the infection control procedures. He stated he provided education to all the staff regarding infection control and handling and disposing of dirty linens. He stated the plastic linen bags were placed in the rolling dispenser in every room to enable the staff to be compliant with placing the dirty/soiled linens in the bag when they were providing care. The Infection Preventionist stated he provided education to all the staff regarding infection control and hand hygiene. He stated hand hygiene should be done before staff enter the room, before staff touch a resident, after staff touch a resident, after the staff provide care, and after the staff touch surfaces in the room. He stated the moment Nurse Aide #1 and #2 were done with care and everything was placed in bags; he would have expected them to remove their contaminated gloves and perform hand hygiene before touching the resident and setting up his personal items in his room to prevent potential contamination. The Infection Preventionist stated education was provided to all new hires during orientation and if he saw a trend in infections in	F0880		

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F0880 SS = D	Continued from page 7 service education would be completed. An interview was conducted with the Administrator on 12/18/25 at 1:00 PM. The Administrator stated she expected all the staff to adhere to the infection control policy and utilize the provided linen bags to place soiled linen in. The Administrator stated the staff also needed to ensure they were removing contaminated gloves prior to touching a clean resident and their personal belongings in order to prevent contamination.	F0880		