STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SCOTLAND MANOR	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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E 000	Initial Comments An unannounced Recertification survey was conducted on 06/24/19 through 06/27/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #W80V11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID #W8OV11.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident with a newly evident diagnosis of a serious mental illness for a	F 644	1. Resident # 32 was referred for Preadmission Screening and Resident Review(PASARR) on 6/25/2019 by	7/25/19

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

Electronically Signed | 07/18/2019

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F 644	Continued From page 1 Preadmission Screening and Resident Review (PASRR) level II for 1 of 4 residents reviewed for PASARR. (Resident #32). Findings included: Review of Resident #32 ' s PASARR Level I Determination Notification letter dated 2/19/19 revealed the resident was assessed to be level I. There were no further PASARR referrals for Resident #32 in the medical record. Resident #32 was admitted to the facility on 2/19/19 with diagnoses which included non-Alzheimer ' s dementia, depression, and psychotic disorder. The most recent significant change Data Set (MDS) assessment dated 5/22/19 indicated Resident #32 ' s cognition had been severely impaired. Resident #32 was not currently considered by the State Level II PASARR process to have a serious mental and/or intellectual disability or a related condition. His diagnoses included non-Alzheimer ' s dementia, depression and psychotic disorder. He was administered antipsychotic medication and antidepressant medication on 7 of 7 days during the assessment period. Resident #32 ' s plan of care included the focus of antidepressant medication use related to the diagnosis of depression and the use of antipsychotic medication use related to dementia. Review of Resident #32 ' s June 2019 Physician ' s Order Summary and Medication Administration Records indicated Resident #32 continued to receive antipsychotic medications and	F 644	Director of Social Services. Received PASSAR Level II determination for Resident # 32 on 6/27/2019. 2. Pharmacy Recommendations and Psychological Services Consultations for current residents will be audited to identify any new, severe mental illness diagnosis. Audit will be completed by Director of Nursing (DON) and Unit Manager (UM). Any resident identified with new diagnosis of severe mental illness will then have PASAAR audit completed by Anita Calhoun, Director of Social Services to ensure that referral for PASAAR Level II has been completed. Any resident identified as not having been referred for PASAAR Level II as required will be referred. 3. Interdisciplinary team will receive training and education for PASAAR Level II referral for new diagnosis of severe mental illness. Regional Director of Clinical Services will provide education to DON and UM who will then provide education and training to the Interdisciplinary team. Education will be completed by 7/23/2019. New diagnosis of mental illness will be reviewed by the Interdisciplinary Team as a part of the Clinical meeting and determination made as to need for referral for PASAAR Level II. If need for referral for PASAAR Level II is identified; Director of Social Services will complete the referral. 4. An audit of new diagnosis of severe mental illness will be completed weekly for four weeks and then monthly to ensure that referral for Preadmission Screening and Resident Review have been	

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F 644	Continued From page 2 antidepressant medications. During an interview with the MDS nurse on 6/25/19 at 11:00 AM, she revealed she had not done a new PASARR screen for Resident #32. During an interview with the Administrator on 6/26/19 at 08:42 AM, the Administrator stated the PASARR screen dated February 2019 was the last PASARR screen performed on Resident #32. She confirmed this was a PASARR Level I. The Administrator further stated Resident #32 had not been referred to have a new screening. She stated the added diagnosis for Resident #32 had been made during a pharmacy review and the new MDS nurse did not capture the information for referral. The Administrator indicated the staff was forwarding the new screening documents immediately and the facility would review all residents receiving antipsychotic medications.	F 644	completed. DON and/or UM will complete audits. Audits will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review. Any issues identified will be addressed by the QAPI committee and the plan revised to ensure continued and sustained compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		7/25/19

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F 656	Continued From page 3 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop comprehensive plans of care in the area of hospice (Resident # 22). The findings included: Resident # 22 was admitted to the facility on 5/2/2019 with diagnoses that included protein malnutrition, diabetes and malignant neoplasm of tongue. The admission Minimum Data Set (MDS)	F 656	1. Resident # 22 is no longer a resident of Accordius Health at Scotland Manor; thus, his care plan was not adjusted to include hospice. 2. Review of current resident□s charts has been conducted to ensure all hospice residents are identified. Accordius Health at Scotland Manor does not currently have any residents receiving Hospice services. 3. Education and training will be provided to the Interdisciplinary Team on implementation of Hospice Care Plans for	

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F 656	Continued From page 4 assessment dated 5/9/2019 indicated Resident # 22 as severely cognitively impaired and was a hospice patient at the facility. A review of Resident # 22's comprehensive plan of care indicated a care plan related to hospice services was not initiated on 5/8/2019. Review of the nurse note dated 6/20/2019 revealed the resident passed away at the facility and was under the care of hospice. An interview was conducted with the MDS Coordinator on 6/26/2019 at 1:29 PM. She confirmed Resident # 22 was admitted to hospice care and the services were ongoing. The MDS Coordinator indicated she will review all hospice residents admitted at the facility and make sure their care plans are completed. She reported a care plan related to hospice should have been initiated promptly following Resident # 22's admission to hospice. An interview was conducted with the Director of Nursing on 6/27/2019 at 11:12 AM. She indicated she expected hospice care plans to have been completed for Resident # 22. The Administrator stated in an interview on 6/27/2019 at 12:50 PM she expected hospice to be careplanned as soon as a resident becomes a hospice patient.	F 656	residents receiving Hospice by the Regional Director of Clinical Reimbursement on 7/22 and 7/23/2019. New orders for Hospice will be reviewed in clinical meeting by Interdisciplinary Team and Care Plan reviewed to ensure that a Hospice care plan has been initiated. 4. An audit of hospice charts will be conducted weekly to ensure that care plan is in place for Hospice weekly times 4 weeks, and then monthly until continued and sustained compliance is determined. Audits will be completed by MDS Coordinator. Administrator will oversee this process. Audits will be taken to the monthly QAPI meeting for review. Any issues identified will be addressed by the committee, and the plan will be revised to ensure that continued and sustained compliance is achieved.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		7/25/19

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F 867	Continued From page 5 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee previously put in place. This failure was related to non-compliance at the regulatory grouping of 483.21: Comprehensive Care Plans, on four consecutive annual recertification surveys, which was recited on the current 6/27/2019 annual recertification/complaint investigation survey. The facility's continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: 1.This tag is cross referenced to: 483.21 Develop/Implement Comprehensive Care Plan: Based on record review and staff interviews, the facility failed to develop comprehensive care plan for hospice care 1 of 1 sampled resident. (Resident #22) During an interview with the Administrator on 06/27/19 at 12:22 PM, the Administrator stated she has recently hired a new Minimum Data Set (MDS) coordinator. The MDS Coordinator has been provided with education through our corporate VP of Clinical Reimbursement, regional and sister facilities to provide her with the education and support to assure the	F 867	1. Resident #22 is no longer a resident of Accordius Health at Scotland Manor; thus, the care plan was not adjusted to include hospice. 2. An audit of MDS triggers for residents is being conducted to ensure that triggered items have been care planned appropriately. Audit is being completed by MDS Coordinator, DON, UM, Director of Social Services and Administrator. Care Plans will be developed for any issue identified. 3. Education and training on development of appropriate care plans will be provided to the interdisciplinary team by the Regional Director of Clinical Reimbursement on 7/22 and 7/23/2019. Audits of triggers for MDS for four random residents will be completed weekly for four weeks and then monthly to ensure that care plans are developed appropriately. Audits will be completed by the MDS Coordinator. 4. Audits will be taken to the monthly QAPI committee meeting to be reviewed. Any issues identified will be addressed by the committee and plan will be revised to ensure continue and sustained compliance. Regional Director of Clinical Reimbursement will participate in the monthly QAPI meeting at least quarterly to ensure that compliance is achieved and maintained.	

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F 867	Continued From page 6 comprehensive care plans are being completed properly. The Administrator also stated there has been ongoing audits to assure the care plans are being completed thoroughly.	F 867		