| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345375 | A. BUILDING ______ B. WING ______ | C 05/25/2023 |

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| ACCORDIUS HEALTH AT SCOTLAND MANOR | 920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 5/22/23 through 5/25/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1N7C11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 5/22/23 through 5/25/23. Event ID# 1N7C11. The following intakes were investigated NC00198954 and NC00195715.<br>8 of the 8 complaint allegations did not result in deficiencies. | F 000 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete a significant change assessment for a resident's admission to hospice services for 1 of 1 resident reviewed for hospice services. (Resident #151). | F 637 | 1.On Resident #151 had a significant change Minimum Data Set (MDS) assessment completed with an assessment reference date of 5/23/23 to reflect the change to Hospice services. | 6/9/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/08/2023

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 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.

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F 637

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The findings included:

Resident #151 was admitted to the facility on 10/12/17 with diagnoses which included stroke, depressive disorder, and anxiety.

The Minimum Data Set (MDS) quarterly assessment dated 4/12/23 revealed Resident #151 had moderately impaired cognition and was not on hospice services.

Review of the Hospice Admission record revealed Resident #151 was admitted to hospice services on 4/26/23 with a diagnosis of stroke.

Review of the Minimum Data Set (MDS) assessments revealed no significant change assessment was completed for Resident #151's admission to hospice services.

An interview was conducted on 5/23/23 at 2:42 pm with the MDS Nurse who revealed she was new in the position, and she was not aware of Resident #151's admission to hospice services. She stated she was not notified by nursing of the hospice admission for Resident #151. The MDS Nurse stated a significant change assessment was required for Resident #151's hospice admission but it was an oversight on her part.

During an interview on 5/24/23 at 12:30 pm the Social Worker revealed Resident #151's hospice admission was discussed in the morning meeting for all management staff, the clinical morning meeting, and was documented on the 24-hour report. The Social Worker stated that when there was a change in the payor source it was discussed in the next morning meeting and if the

F 637

2.Residents transitioning to Hospice services have the potential to be affected.

3.On 5/26/23 the MDS Coordinator was educated by the Director of Nursing on completing a comprehensive assessment after a significant change in condition per the Resident Assessment Instrument Manual. On 5/26/23 the Director of Nursing audited the other residents receiving Hospice services. No other residents were affected. To assure there is no recurrence, on 5/26/23 the Director of Nursing educated the MDS Coordinator and the Interdisciplinary Care Team that the Director of Nursing will send the MDS Coordinator and the Interdisciplinary Care Team an email when a resident is admitted to Hospice Care. Beginning 6/2/23, weekly for twelve weeks, when a resident is admitted to Hospice Services, the Director of Nursing will audit the resident□s MDS to validate a significant change in condition MDS is completed per the Resident Assessment Instrument Manual.

4.The Director of Nursing will present the audits to the Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audits monthly for three months and make any necessary recommendations to assure compliance is sustained ongoing.

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| F 637 | Continued From page 2<br>change affected the plan of care, it would be further discussed in the clinical morning meeting as well as written on the 24-hour report.<br><br>An interview was conducted on 5/25/23 at 8:52 am with the Director of Nursing (DON) who revealed all admissions, including hospice admissions, were discussed in the morning meeting. She stated Resident #151's admission would have been discussed during the morning meeting and the clinical meeting after signing onto hospice services. The DON stated the MDS Nurse was responsible to complete and submit an MDS significant change assessment for Resident #151's hospice admission.<br><br>An interview with the Administrator was conducted on 5/25/23 at 10:12 am who revealed hospice admissions were discussed in the morning meeting and the MDS Nurse participated in the meetings. She stated the MDS Nurse was responsible for the completion of the MDS significant change assessment for Resident #151's admission to hospice service. | F 637 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 4 of 24 sampled residents whose MDS were reviewed (Resident #3, Resident #18, Resident #23, and Resident #31). | F 641 | 1.The Minimum Data Set (MDS) assessment dated 4/11/23 for Resident #3 was modified on 06/06/23 to reflect the use of prescribed opioid medication. The Minimum Data Set (MDS) assessment dated 4/8/23 for Resident #18 was | 6/9/23 |

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F 641

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The findings included:

1. Resident # 3 was admitted to the facility on 11/19/20.

A physician order dated 8/31/23 for fentanyl patch (opioid medication for pain) 72 hour 50 micrograms/hour (mcg/hr). Apply 1 patch every 72 hours for pain remove per schedule.

Review of the Medication Administration Record (MAR) for April 2023 revealed the fentanyl patch was administered as ordered.

The Minimum Data Set (MDS) annual assessment dated 4/11/23 revealed Resident #3 was not coded for opioid medication.

During an interview on 5/24/23 at 12:48 pm the MDS Nurse revealed she was new to the position and was still learning and it was an oversight of the medication when she completed the annual assessment for Resident #3.

An interview was conducted on 5/25/23 at 8:56 am with the Director of Nursing (DON) who revealed the MDS was responsible to accurately complete Resident #3's MDS assessments.

An interview with the Administrator on 5/25/23 at 10:12 am revealed the MDS Nurse was responsible to accurately code Resident #3's MDS assessments.

2. Resident #18 was admitted to the facility on 1/19/18 with a diagnosis which included dementia.

F 641

modified on 5/23/23 to reflect the use of the wander guard and to reflect the resident was not prescribed antipsychotic or anticoagulant medication. The Minimum Data Set (MDS) assessment dated 3/10/23 for Resident #23 was modified on 06/06/23 to reflect the resident was not prescribed anticoagulant medication. The Minimum Data Set (MDS) assessment dated 3/10/23 for Resident #31 was modified on 06/06/23 to reflect the resident did not have a pressure ulcer.

2.Residents requiring MDS Assessments have been identified as having the potential to be affected. On 06/06/23, the Director of Nursing and RN Unit Manager audited section 0P200 E, section M0210, section M0300, and section N of each current resident□s most recent MDS assessment. Modifications were completed, if indicated. The facility will protect other residents in similar situations through education to the Minimum Data Set Coordinator.

3.Measures and systems implemented to ensure the problem with Minimum Data Set coding does not recur include education of the Minimum Data Set Coordinator and auditing of the Minimum Data Sets. On 5/26/23, the Director of Nursing educated the MDS Coordinator on coding sections 0P200 E, M0210, M0300 and N of the MDS per the Resident Assessment Instrument (RAI) Manual. The Director of Nursing will randomly audit sections 0P200 E, M0210,

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a. A physician order dated 12/11/20 to check wander guard placement every day shift and night shift for wander guard placement.

The quarterly wandering assessment completed on 1/17/23 revealed Resident #18 was a high risk to wander.

The Minimum Data Set (MDS) quarterly assessment dated 4/8/23 revealed Resident #18 was not coded for wander/elopement alarm.

An interview on 5/23/23 at 2:39 pm with the MDS Nurse revealed she was new to the position and was not notified by nursing staff that Resident #18 had a wander guard in place. She stated it was an oversight.

An interview was conducted with the Director of Nursing (DON) on 5/25/23 at 9:05 am who revealed the MDS Nurse was responsible to accurately complete Resident #18's MDS assessments.

An interview with the Administrator on 5/25/23 at 10:12 am revealed the MDS Nurse was responsible for Resident #18's MDS assessments to be completed correctly.

b. The Minimum Data Set (MDS) quarterly assessment dated 4/8/23 revealed Resident #18 was coded for use of anticoagulant (used to prevent clotting) and antipsychotic (used to treat psychotic disorders) medications.

Review of the physician orders for April 2023 revealed Resident #18 did not have an order for an anticoagulant or an antipsychotic medication.

F 641

M0300 and N of three MDS Assessments per week for twelve weeks. Any inaccurate coding noted will be corrected and a one-to-one re-education will be provided by the Director of Nursing at that time.

4.The Director of Nursing will present the results of the audits for F641 to the Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audits and make recommendations, as needed, to assure compliance is sustained ongoing.

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| F 641 | Continued From page 5<br>During an interview on 5/23/23 at 2:39 pm the MDS Nurse revealed she completed the medication section of the MDS assessment from Resident #18's physician orders. The MDS Nurse confirmed Resident #18 did not have an order for an anticoagulant or antipsychotic medications. The MDS Nurse stated it was an oversight and she incorrectly coded Resident #18 for an anticoagulant and antipsychotic medications.<br><br>An interview was conducted with the Director of Nursing (DON) on 5/25/23 at 9:05 am who revealed the MDS Nurse was responsible to accurately complete Resident #18's MDS assessments.<br><br>An interview with the Administrator on 5/25/23 at 10:12 am revealed the MDS Nurse was responsible to accurately complete the MDS assessments. The Administrator stated the MDS Nurse had multiple consultants available to her if she had any questions about how to complete the assessments correctly.<br><br>3. Resident # 23 was admitted to the facility on 12/09/22.<br><br>The Minimum Data Set (MDS) annual assessment dated 3/10/23 revealed Resident #23 was coded for an anticoagulant (used to prevent blood clotting) medication.<br><br>Review of the physician orders for the month of March 2023 revealed Resident #23 did not have an order for an anticoagulant medication.<br><br>During an interview on 5/23/23 at 2:39 pm the MDS Nurse confirmed Resident #23 did not have | F 641 | | |

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| F 641 | Continued From page 6 | F 641 | | |

an order for an anticoagulant medication during the period the MDS assessment was completed. The MDS Nurse stated she incorrectly coded Resident #23 for an anticoagulant medication.

An interview was conducted with the Director of Nursing (DON) on 5/25/23 at 9:05 am who revealed the MDS Nurse was responsible to accurately complete the MDS assessments for Resident #23.

An interview with the Administrator on 5/25/23 at 10:12 am revealed the MDS Nurse was responsible to accurately complete the MDS assessments and she had multiple consultants available if she had any questions regarding Resident #23's medications.

4. Resident #31 was admitted to the facility on 7/01/20.

Review of the Minimum Data Set (MDS) quarterly assessment dated 5/04/23 revealed Resident #31 was coded for a stage 3 pressure ulcer which was not present upon admission.

Review of Resident #31's physician orders revealed there were no orders for treatment of a stage 3 pressure ulcer.

Resident #31 had a care plan which was last reviewed 5/19/23 for potential for pressure ulcer development related to decreased mobility and incontinence.

During an interview on 5/23/23 at 2:40 pm the MDS Nurse stated she thought she saw a note in Resident #31's record regarding a stage 3 pressure ulcer so she coded him for a pressure

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| F 641 | Continued From page 7<br>ulcer. The MDS Nurse stated she was not provided with a list of residents from the nursing department of those residents that have pressure ulcers, so she reviewed the progress notes.<br><br>During an interview on 5/23/23 at 1:43 pm Nurse #1 revealed Resident #31 did not have a pressure ulcer and did not have an order for pressure ulcer treatment.<br><br>An interview was conducted on 5/23/23 at 3:05 pm with the Director of Nursing (DON) who revealed Resident #31 did not have a stage 3 pressure ulcer.<br><br>An observation on 5/24/23 of personal care revealed Resident #31 did not have a pressure ulcer.<br><br>During an interview on 5/25/23 at 10:16 am the Administrator revealed the MDS Nurse was able to reach out to nursing staff or her consultant when she had questions about completing an MDS assessment. The Administrator stated the MDS Nurse was required to ensure the assessments were completed accurately. | F 641 | | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an | F 645 | | 6/6/23 |

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| F 645 | Continued From page 8 | F 645 | | |

independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the

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| F 645 | Continued From page 9<br>condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) after the initial approval for nursing home placement expired for 3 of 3 residents reviewed for PASRR (Resident #16, Resident #36, and Resident #35).<br><br>The findings included:<br><br>1. Resident #16 was admitted to the facility on 12/28/22 with diagnoses that included metabolic encephalopathy (a disorder in the brain caused by a chemical imbalance in the blood).<br>The quarterly Minimum Data Set (MDS) assessment dated 5/17/23 revealed Resident #16 had moderately impaired cognition. The MDS further revealed the Resident required extensive assistance from 2 staff members to complete activities of daily living and exhibited no behaviors during the assessment period. | F 645 | 1.Residents #16, 36 and 35 had their respective Preadmission Screening and Resident Review (PASRR) level II requested on 5/24/23 � 5/25/23 and were received on 6/2/23.<br><br>2.Residents with a temporary PASRR have been identified as having the potential to be affected. The Director of Nursing completed a house-wide audit on 5/25/23 to validate each resident�s PASRR status. Two additional residents were identified with an expired PASRR. The PASRR have been requested and were received on 6/2/23.<br><br>3.On 5/30/23 the Director of Nursing educated the Social Worker on PASRR process after the initial approval for nursing home placement. The Social | |

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A review of the PASRR Level II Determination Notification document dated 12/28/22 revealed nursing facility placement was appropriate for a limited stay of no more than 30 days. The notification further explained if the resident was expected to extend beyond that 30-day period (1/27/23) further approval and screening must be obtained within 5 days of the PASRR expiration date. No additional PASRR Level II Determination Notifications were found the medical record.

An interview was completed on 5/25/23 at 10:44am with the Social Worker. The Social Worker stated she was new to the position and did not understand the PASRR process. She revealed she was not aware PASRR level II's were at times issued with an expiration date.

An interview was completed 5/25/23 10:22am with the Administrator. She indicated the Social Worker was responsible for ensuring the PASRR's were reviewed and updated as needed. The Administrator stated the Social Worker or Admissions were expected to discuss during the facility's clinical meeting but was unable to recall if PASRR's were discussed.

An interview was completed on 5/25/23 at 10:51am with the Director of Nursing (DON). The DON verified the PASRR level II had expired for Residents #16. She indicated it was the Social Worker's responsibility to review and update PASSR's. The DON stated the Social Worker was new to the position and did not understand the PASSR level 2 process.

2. Resident #36 was admitted to the facility on

F 645

Worker will audit the status of the temporary PASRRs weekly for twelve weeks and update the Interdisciplinary Care Team in the Morning Meeting weekly on Wednesdays.

4.The Social Worker will present the audits to the Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations to assure compliance is sustained ongoing.

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7/19/21 with diagnoses that included adjustment disorder with anxiety and depression.
The annual MDS dated 4/6/23 revealed Resident #36 was cognitively intact.

A review of the PASRR Level II Determination Notification document dated 7/13/21 revealed nursing facility placement was appropriate for a limited stay of no more than 30 days. The notification further explained if the resident was expected to extend beyond that 30-day period (8/12/21) further approval and screening must be obtained within 5 days of the PASRR expiration date. No additional PASRR Level II Determination Notifications were found the medical record.

An interview was completed on 5/25/23 at 10:44am with the Social Worker. The Social Worker stated she was new to the position and did not understand the PASRR process. She revealed she was not aware PASRR level II's were at times issued with an expiration date.

An interview was completed 5/25/23 10:22am with the Administrator. She indicated the Social Worker was responsible for ensuring the PASRR's were reviewed and updated as needed. The Administrator stated the Social Worker or Admissions were expected to discuss during the facility's clinical meeting but was unable to recall if PASRR's were discussed.

An interview was completed on 5/25/23 at 10:51am with the Director of Nursing (DON). The DON verified the PASRR level II had expired for Residents #36. She indicated it was the Social Worker's responsibility to review and update PASSR's. The DON stated the Social Worker was

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| F 645 | Continued From page 12 | F 645 | | |

new to the position and did not understand the PASSR level 2 process.

3. Resident # 35 was admitted to the facility on 6/17/21 with diagnoses which included bipolar II disorder and borderline personality disorder.

The PASRR Level II Determination Notification dated 7/14/21 revealed Resident #35's nursing facility placement was appropriate for a 60-day period. The PASRR Level II expiration date was 9/12/21. No additional PASRR Level II Determination Notification was found in the medical record.

During an interview on 5/24/23 at 4:45 pm the Director of Nursing (DON) and the Vice President of Clinical Services revealed the PASRR Level II re-evaluation for Resident #35 had not been sent.

An interview was conducted on 5/25/23 at 10:03 am with the DON who revealed the Social Worker was responsible to monitor the PASRR's and send the required information for re-evaluation when it was needed. The DON was unable to state why the PASRR Level II re-evaluation for Resident #35 was not completed.

During an interview on 5/25/23 at 10:44 am the Social Worker revealed she did not understand the PASRR process and did not realize Resident #35's PASRR Level II had expired and she was required to be re-evaluated.

An interview with the Administrator on 5/25/23 at 10:22 am revealed the Social Worker was to ensure Resident #35's PASRR Level II was re-evaluated as required.

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| F 758 | Continued From page 13 | F 758 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) | F 758 | | 6/9/23 |

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or

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| F 758 | Continued From page 14<br>prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and Pharmacy Consultant interview, the facility failed to ensure Physician orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 1 resident reviewed for hospice services (Resident #151).<br><br>The findings included:<br><br>Resident #151 was admitted to the facility on 10/12/17 with diagnoses which included stroke, anxiety, and major depressive disorder. Resident #151 was discharged to the hospital on 4/17/23 and returned to the facility on 4/25/23 and was placed on hospice services.<br><br>A physician order dated 4/25/23 for lorazepam (a medication used to treat anxiety) 1 milligram (mg) every four hours as needed (PRN) for agitation without a stop date.<br><br>Record review of the Medication Administration Record (MAR) for April 2023 and May 2023 revealed Resident #151 had not been administered the lorazepam PRN. | F 758 | 1.Resident #151 was discharged from the facility on 5/27/23.<br><br>2.Residents with orders for as needed psychotropic medication have been identified as having the potential to be affected. In order to protect residents in similar situations, auditing of physician□s orders and education was conducted. On 5/26/23 the Director of Nursing and RN Unit Manager audited each resident□s physician□s orders to determine other residents identified on psychotropic as needed prescribed medication without 14-day time limited stop date. No other residents were identified.<br><br>3.To protect residents in similar situations to ensure the concern does not recur, on 5/26/23 the Director of Nursing initiated education with the Licensed Nurses to request a 14-day stop date and re-evaluation for any prescribed as needed psychotropic medications. After 06/09/23 no Licensed Nurse will be permitted to work without first receiving | |

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An interview was conducted on 5/23/23 at 3:06 pm with the Nurse Unit Manager who revealed she entered the lorazepam PRN order for Resident #151. She stated the lorazepam PRN order required a stop date but stated the Physician Assistant or the Pharmacy Consultant would normally find the error and the order would be changed. The Nurse Unit Manager stated new orders were to be checked the next day by another nurse for accuracy, but she was unable to state how the lorazepam PRN order without a stop date was missed for Resident #151.

During an interview on 5/25/23 at 8:49 am the Director of Nursing (DON) revealed Resident #151's lorazepam PRN order required a 14-day stop date unless otherwise directed for a longer stop date by the doctor, but it required a stop date. The DON stated new orders were checked in the morning meeting with nursing management and was unable to state how the lorazepam PRN order without a stop date was missed for Resident #151.

An attempt to interview the Physician Assistant on 5/25/23 at 10:00 am was unsuccessful.

An interview on 5/25/23 at 10:10 am with the Administrator revealed physician orders were reviewed in the clinical meetings and it as the nursing management teams responsibility to ensure the 14-day stop date was in place for Resident #151's lorazepam PRN order.

A telephone interview with the Pharmacy Consultant was conducted on 5/25/23 at 10:28 am who revealed he had not completed the monthly medication review for the facility and had not yet reviewed the new orders for Resident

F 758

the education. During the Morning Clinical Meeting Monday  Friday ongoing, the Director of Nursing or Nursing Supervisor will review all newly prescribed psychotropic medications to validate 14-day time limited stop date is ordered, if appropriate. Weekly for 12 weeks, the Director of Nursing will audit three residents prescribed as needed psychotropic medications to validate the residents have a 14-day time limited stop date, as appropriate. If there are any improvement opportunities noted from the audits, the Director of Nursing will provide one-to-one re-education for the Licensed Nurse.

4.The Director of Nursing will report the audits to the Quality Assurance and Performance Improvement Committee for recommendations. The Quality Assurance and Performance Improvement Committee will review the audits in the monthly meeting for three months to assure compliance is sustained ongoing.

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| F 758 | Continued From page 16<br>#151. The Pharmacy Consultant stated his normal practice was when he completed the monthly review of medications, he notified the facility of the need for a stop date for as needed psychotropic medications if found. The Pharmacy Consultant stated Resident #151's lorazepam as needed medication was required to have a stop date.<br><br>An attempt to interview the Medical Director on 5/25/23 at 10:48 am was unsuccessful. | F 758 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to 1) label and date opened items in 2 kitchen refrigerators (refrigerator #1 located in | F 812 | 1.On 5/25/23 open, undated, and expired food items were discarded in the dietary department, nutrition storage areas and | 6/9/23 |

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F 812

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the stock room, and refrigerator #2 located near the tray line counter) and the kitchen wall freezer located in the stock room and 2) failed to remove expired items from the residents' refrigerator, failed to label and date food items in the residents' refrigerator, and keep 1 of 1 freezer used for residents' personal food items, free from ice build-up.

The findings included:

1. During an observation of the kitchen on 5/22/23 at 10:14 am with the cook the following items were observed:

a. The kitchen refrigerator #1, located in the stock room, was observed to have the following: 2 one-gallon containers of mayonnaise open and without a date, a container of tartar sauce open and without a date, a half empty jar of maraschino cherries open and without a date, and an open container of ranch dressing without a date.

b. The kitchen wall freezer, located in the stock room, was observed to have 1 large clear plastic bag of frozen pizza slices with multiple holes in the bag and tied at the top without a date, and a clear zipper storage bag of pork chops (as determined by the Cook) without a label or date.

c. The kitchen refrigerator #2, located near the tray line counter, was observed to have the following: 1/2 box of blueberry muffins partially covered with plastic wrap that was not dated, and 2 large meal serving trays with peanut butter and jelly sandwiches in individual bags without a date.

An interview was conducted on 5/22/23 at 10:16

F 812

the resident refrigerator. The resident freezer was defrosted on 5/25/23.

2.Residents who eat food prepared in the kitchen and residents who store food in the resident freezer have been identified as having the potential to be affected. On 5/26/23 the new Dietary Manager performed an observation walk through in the dietary department and in any nutrition storage areas to include the resident refrigerator, to identify any open, undated, and expired food items as well as observing any freezers that need defrosting. No additional concerns were noted.

3.To ensure there is no recurrence, on 5/26/23 the Nursing Home Administrator educated the new Dietary Manager and dietary employees on dating and labeling food items upon opening, discarding expired food items on or before the expiration date, in the dietary department and any nutrition storage areas to include the resident refrigerator, and provided education on defrosting the resident freezer as needed, in order to protect residents in similar situations. In order to sustain solutions ongoing, beginning 6/2/23 for twelve weeks, the new Dietary Manager will perform weekly rounds in the dietary department and nutrition storage areas to include the resident refrigerator, to validate dating and labeling food items upon opening, discarding expired food items on or before the expiration date and on defrosting the resident freezer as needed. The Dietary Manager will validate

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| F 812 | Continued From page 18<br>am with the Cook who revealed all staff were educated to place a date on anything open in the refrigerators or freezers, but she was unable to state why the open items were not dated. The Cook stated she thought the peanut butter and jelly sandwiches were made the day prior but since there was not a date on them, she would remove them from the refrigerator.<br><br>During an interview on 5/23/23 at 2:55 pm the Dietary Consultant revealed all open items, premade sandwiches, and unused items placed in freezer were required to have a date they were made or placed for storage. She stated she had provided education in the past to all staff regarding labeling and dating all open items in the refrigerator or freezers and she would re-educate all staff immediately.<br><br>An interview was conducted with the Dietary Manager on 5/24/23 at 11:30 am who revealed she was new to the facility but stated any item that was opened was required to be labeled with the date of opening, leftovers must be labeled and dated before going into the refrigerator or freezer, and the premade sandwiches were to be dated when they were made.<br><br>During an interview on 5/25/23 at 10:19 am the Administrator revealed it was the Dietary Managers responsibility to ensure items in the kitchen refrigerator and kitchen freezer were labeled and dated as required.<br><br>2. During an observation on 5/24/23 at 2:05 pm of the residents' refrigerator/freezer, which was in the break room and used for residents' personal food items, with the Director of Nursing (DON) and Administrator #2 the following was observed: | F 812 | any identified areas are addressed and corrected and will re-educate the dietary staff if any concerns are identified.<br><br>4.The Dietary Manager will report the weekly audits to the Quality Assurance and Performance Improvement Committee for recommendations. The Quality Assurance and Performance Improvement Committee will review the audits in the monthly meeting for three months to assure compliance is sustained ongoing. | |

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| F 812 | Continued From page 19 | F 812 | | |

a. The freezer compartment was opened and observed to have freezer frost throughout the entire freezer which was unable to be penetrated by DON's hand or the surveyor's pen. No visualization of the interior of the freezer was possible due to the freezer frost buildup which filled the entire freezer compartment.

b. The refrigerator compartment was opened and observed to have the following: 2 individual cartons of white milk unopened with expiration date of 2/13/23, 1 half-gallon bottle of orange juice open and not dated, 1 plastic bag with grapes without a resident name or date, 1 food plate covered with aluminum foil with date of 2/8/23, 1 white paper bag of homemade cookies with date of 2/8/23, 1 plastic bag with plate inside of leftover food dated 4/18/23, and 2 plastic bags with open food items without a resident name or date.

An interview was completed on 5/24/23 at 2:10 pm with Administrator #2 in the presence of the DON who revealed all open food items in the residents' refrigerator were to be dated and labeled with the residents' name and were to be removed after 3 days. Administrator #2 stated the dietary department was responsible to monitor and remove expired foods from the residents' personal refrigerator.

During an interview on 5/25/23 at 9:02 am the DON stated the cart nurse had the key to the residents' refrigerator/freezer, but any staff member was able to put the residents' items in the refrigerator. She stated staff were educated to label with resident name and date when items were placed in the refrigerator/freezer, but she

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| F 812 | Continued From page 20 | F 812 | | |

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was unable to state why this did not occur. The DON stated the dietary department was required to clean the refrigerator.

During an interview on 5/25/23 at 11:32 am the Dietary Consultant revealed she was not notified of the responsibility to manage the resident refrigerator/freezer. She stated she covered the facility as an interim Dietary Manager and had not cleaned out the resident refrigerator/freezer or monitored the residents' refrigerator during her time at the facility.

During an interview on 5/25/23 at 11:34 am the Dietary Manager revealed she was new to the facility but reported she was not notified she was responsible for the monitoring of the resident refrigerator/freezer. The Dietary Manager stated she had not monitored the resident refrigerator/freezer during her time at the facility.

An interview was conducted on 5/25/23 at 11:38 am with the Maintenance Director who revealed he had not been instructed that he was responsible to defrost the resident freezer. He stated he was instructed to put a lock on both the refrigerator and freezer before but had not been informed he was responsible for monitoring or defrosting the freezer.

An interview was conducted on 5/25/23 at 10:08 am with the Administrator who revealed she failed to notify the correct department of the requirement to monitor the resident refrigerator/freezer. She stated the Maintenance Director was responsible for defrosting the freezer when needed and the dietary department was responsible for disposal of the expired food items. The Administrator was unable to state

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| F 812 | Continued From page 21<br>when the resident refrigerator/freezer was last checked. | F 812 | | |
| F 867<br>SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, | F 867 | | 6/6/23 |

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| ACCORDIUS HEALTH AT SCOTLAND MANOR | 920 JR HIGH SCHOOL ROAD<br>SCOTLAND NECK, NC 27874 |

| (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 |
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| F 867 | Continued From page 22<br>analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement | F 867 | | |

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|---|---|---|---|
| | 345375 | A. BUILDING ______ B. WING ______ | C 05/25/2023 |

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| F 867 | Continued From page 23<br>activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the | F 867 | 1.August Healthcare Vice President, | |

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facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification survey conducted on 1/07/22. This was for a recited deficiency on the current recertification and complaint survey in the area of food procurement, store, prepare, and serve in a sanitary manner. The continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:
This tag is cross referenced to:

F812: Based on observations and staff interviews, the facility failed to 1) label and date opened items in 2 kitchen refrigerators (refrigerator #1 located in the stock room, and refrigerator #2 located near the tray line counter) and the kitchen wall freezer located in the stock room and 2) failed to remove expired items from the residents' refrigerator, failed to label and date food items in the residents' refrigerator, and keep 1 of 1 freezer used for residents' personal food items, free from ice build-up.

An interview was completed on 5/25/23 at 12:04 pm with the Administrator. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The Administrator indicated there were no current monitoring plans in place for the area the food procurement, store, prepare, and serve in a sanitary manner. The Administrator indicated it was her expectation the facility continued to follow the QAA process and monitor those issues within the facility so they would not receive a recited deficiency.

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Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC).

2.Residents residing in the facility have the potential to be affected.

3.On 5/25/23 the Regional Vice President of Clinical Services provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 5/25/23, under the direction and supervision of the Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff Development and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited.

4.An Ad Hoc QAPI meeting was held on 6/1/2023 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, RN Unit Manager,

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| F 867 | Continued From page 25 | F 867 | Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, the Medical Director, and the Regional Vice President of Clinical Services. The QAPI Committee will meet weekly for four weeks starting on 6/1/23, then monthly until substantial compliance is obtained, to monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits / reports. The Administrator is responsible for ensuring this plan of correction is implemented. | |