STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	**620 JOHNS ROAD 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 08/07/23 through 08/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 4V2I11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/07/23 through 08/10/23. Event ID# 4V2I11. The following intake was investigated NC00204731. 1 of 1 complaint allegation did not result in deficiency	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code Minimum Data Set (MDS) assessments accurately for 4 of 22 residents whose MDS assessments were reviewed (Resident #59, Resident #19, Resident #5, and Resident #108). Findings included: 1. Resident #59 was admitted to the facility on 03/19/19 with a diagnosis of end stage renal disease. Review of a quarterly Minimum Data Set (MDS)	F 641	F641 Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. Address how corrective action will be accomplished for those residents found to have been affected by the deficient	8/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/31/2023

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 641 Continued From page 1

assessment dated 05/03/23 documented that Resident #59 had not received dialysis treatments.

In an interview with Resident #59 he stated he went to dialysis every Monday, Wednesday, and Friday morning at 6:00 AM.

In an interview with MDS Nurse #1 on 08/09/23 at 2:40 PM she stated Resident #59 had been going to dialysis every Monday, Wednesday, and Friday since his admission in 2019. She noted he was on dialysis and meant to indicate he was currently receiving dialysis on the assessment but had not. She stated she did not know why except that it was human error.

In an interview with the Administrator on 08/09/23 at 3:35 PM she stated she expected the MDS assessment to be accurate.

2. Resident #19 was readmitted to the facility on 05/22/23 with diagnoses that included, in part: gastrostomy (percutaneous endoscopic gastrostomy feeding tube or PEG tube) and dysphagia (difficulty swallowing).

Review of a Registered Dietician (RD) note written on 05/24/23 documented the following: "Resident is currently NPO (nothing by mouth) receiving enteral tube feeding of Vital 1.5 at 237 ML (8 oz) bolus feeding via gravity via PEG tube for every 6 hours with 100 ML water flush before and after of each bolus feeding ... Resident additionally receiving nutritional supplement of 30 ML via feeding tube twice a day ...to increase protein intake and skin integrity."

Review of a quarterly MDS assessment dated

F 641

practice.

1) On 8/9/2023, the facility MDS Coordinator submitted corrections to MDS assessment to correct coding inaccuracies for the following: a) Resident #59's assessment for 5/3/23 was corrected to show resident received dialysis during the assessment period b) Resident #19's assessment for 5/29/23 was corrected to accurately reflect her tube feeding status in which she received (51% or more of nutrition and 500 ML or more of fluids daily) by tube feeding c) Resident #5's assessment for 6/20/23 was corrected to accurately reflect that resident is dependent on feeding with one person assistance d) Resident #108's assessment for 7/30/23 was corrected to accurately reflect discharge status to the hospital.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

2) On 8/9/23 and 8/10/23, 100% audit was completed by the MDS Coordinators of all residents on dialysis, all residents who were tube fed, feeding assistance for tube feed residents, and all residents who were discharged in the last six months to check MDS assessment for accuracy. All inaccuracies noted on MDS assessment identified were corrected by the MDS Coordinator on 8/9/2023.

On 8/11/2023, facility MDS Coordinators(s) received re-in-service

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05/29/23 documented Resident #19 received 25% or less of her nutrition and 500 ML (Milliliters) or less of fluid daily by tube feeding.

In an interview with the facility RD on 08/09/23 at 2:00 PM she stated that the nutrition section of the MDS assessments were completed by the RD. She noted she was new at the facility and had not completed this assessment. She stated Resident #19 was and had been NPO. She commented the MDS assessment should have been coded to reflect that the resident received all her nutrition and hydration (51% or more of nutrition and 500 ML or more of fluids daily) by tube feeding.

In an interview with the administrator on 8/9/23 at 2:10 PM she stated the facility had not had consistent RD Consultants recently. She expected the MDS assessment to be completed correctly.

In an interview with MDS Nurse #1 on 2/9/23 at 2:45 PM she stated the RD fills out the nutrition section. She reviewed the MDS and commented the resident was NPO and received all her nourishment and fluids via tube feeding. She stated she would correct the nutrition section.

3. Resident #5 was admitted to the facility 03/20/2019 with diagnosis to include Alzheimer's disease.

The quarterly MDS assessment dated 06/20/2023 revealed Resident #5 was coded as having a feeding tube and receiving more than 51% of her nutrition from parenteral feeding. Resident #5 was coded as being totally dependent on the assistance of 2 staff members for eating.

F 641

training by the Director of Clinical Reimbursement on the MDS Coordinators role and responsibilities to ensure compliance with MDS accuracy. Special emphasis was placed on accuracy in the sections regarding dialysis, tube feeding, and discharges. Any change or new hires in the MDS Coordinator role will be trained if hired after 8/11/23 or thereafter.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

3) On 8/14/23, Facility MDS Coordinators will begin active participation in daily administrative nurse and IDT meetings to monitor changes in condition or change, discharge/transfer status that would warrant changes in the MDS assessment. The MDS assessment calendar will be used to denote changes and this information will be used to update or correct any MDS assessments to ensure accuracy.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

4) An audit tool titled “MDS Coordination/Certification and Accuracy Audit” will be completed on 100% of the assessments completed for the week by the Director of Clinical Reimbursement and/or designee to monitor for accuracy and compliance. Audits will be conducted weekly X 4 weeks for Section A, G, K, O

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F 641	Continued From page 3	F 641		

A progress note written by the Registered Dietician dated 08/03/2023 read in part, " Resident is NPO (nothing by mouth) and is receiving tube feeding of 237 milliliters (ml) bolus feeding, 4 times a day with 75 ml of free water flush before and after each bolus."

An interview was conducted with MDS Nurse #1 on 08/09/2023 at 09:10 AM. MDS Nurse #1 stated that on the worksheet she used to code the MDS she had crossed out eating assistance of 2 staff members. She further stated that it was just an entry error that she had coded wrong. MDS Nurse #1 stated that she was going to correct the MDS and resubmit it.

An interview was conducted with the DON on 08/09/2023 at 2:39 PM. The DON stated that MDS Nurse #1 had made a human error. She further stated that the MDS assessments should be coded accurately and submitted to the state on time.

4. Resident #108 was admitted to the facility on 03/25/2022 with diagnoses to include hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease. He was discharged to the hospital on 07/30/2023 and readmitted on 08/02/2023.
Resident #108's discharge MDS assessment dated 07/30/2023 was coded as discharged to the community.

An interview was conducted with MDS Nurse #1 on 08/09/2023 at 09:06 AM. MDS Nurse #1 stated that Resident #108's MDS was coded wrong. She further stated that he was not discharged to the community, he was discharged

Provider's Plan of Correction (F 641):

and then randomly of 10% of the resident population monthly for all areas coded on the MDS times 3 months and quarterly thereafter to ensure compliance with accuracy beginning 8/14/23 and thereafter.

Audit compliance will be discussed weekly x4 by the Executive Director of designee during morning clinical meets where the Quality Assurance Performance Improvement (QAPI) Committee members attend. Results of audit compliance will be discussed monthly x 3 by the facility’s QAPI team members at the QAPI meeting and quarterly thereafter. Revisions will be made to plan made as needed to ensure on-going quality and improvement.

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F 641	Continued From page 4 to the hospital. MDS Nurse #1 stated that she was going to correct the MDS assessment and resubmit it to the state. An interview with the DON was competed on 08/09/2023 at 2:39 PM. The DON stated that Resident #108 was still residing in the facility and had not been discharged to the community. She further stated that MDS Nurse #1 had made a human error and was going to correct it. The DON indicated that the MDS assessments should be coded accurately and submitted to the state on time.	F 641		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		8/31/23

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package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and staff interviews the facility failed to store medications securely when 1. a cognitively impaired resident's (Resident #65) medications were observed on her bedside table, and 2. controlled substances were not stored in a permanently affixed compartment of the refrigerator in the only refrigerator used to store controlled medications (100, 200, 300 Hall medication storage room).

Findings included:

1. Resident #65 was admitted to the facility on 05/09/2019 with diagnoses to include hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side, and vascular dementia.

The quarterly Minimum Data Set (MDS) assessment dated 07/01/2023 revealed Resident #65 was severely cognitively impaired.
An observation of a Resident #65's room was completed on 08/07/2023 at 11:59 AM. The resident was lying in bed with her eyes closed. A plastic medication cup containing crushed medications and applesauce and a plastic cup of white liquid was noted to be sitting on the bedside table. There were no staff members observed in Resident #65's room.

An observation of the hallway on 08/07/2023 at 12:00 PM revealed Nurse #1 was standing at the

F 761

F761

Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and the provision of quality care to residents.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

1) On 8/7/2023, resident #65 medications were reported to be at resident bedside and nurse noted to have exited the room to obtain help to reposition resident in bed so that resident could safely take medication, leaving the medications unsecured. No negative outcome to the resident, pills were inspected and accounted for upon return to the room. On 8/7/2023, resident #65 received scheduled doses per physician order.

On 8/8/2023, facility Director of Nursing Services secured the medication until facility Director of Maintenance placed a lock on facility refrigerator. On 8/8/23, the Director of Maintenance placed a locked

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medication cart 4 rooms down on the opposite side of the hallway.

An interview was completed with Nurse #1 on 08/07/2023 at 12:01 PM. Nurse #1 stated that she left the medications on Resident #65's bedside table because she was asleep, and she needed to be pulled up in the bed, before taking the medications. Nurse #1 indicated that she went to find someone to help pull Resident #65 up in bed and she forgot to take the medications with her. Nurse #1 stated the medication cup contained Resident #65's 9:00 AM medications which included lisinopril, vitamin D3, hydrochlorothiazide, donepezil, sertraline hydrochloride, and mirtazapine, and the cup of liquid was 120ml of weight support liquid.

An interview with the Director of Nursing (DON) was completed on 08/08/2023 at 11:10 AM. The DON stated that Nurse #1 should not have left the cup of medications in Resident #65's room. She stated that Nurse #1 went to find someone to help her pull Resident #65 up in bed and just forgot to pick up the cup of medications. She further stated it was just a human error.

An interview was conducted with the Administrator and the Director of Operations on 08/10/2023 at 10:23 AM. The Administrator stated she thought the breakdown in the process was caused by distractions and nerves.

2. An observation of the locked 100, 200, 300 hall medication storage room was completed with the DON on 08/08/2023 at 11:09 AM. The refrigerator designed for medication storage did not have a lock on it and contained a small metal box with a key lock on it and it was not permanently affixed

box in the refrigerator and secured it to the refrigerator under double lock and key. All medication was accounted for, no negative findings.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

2) On 8/8/2023, 100% of all resident rooms were inspected by the facility Department Heads to ensure that no medications were left unattended or stored at the bedside. There were no other residents affected.

On 8/9/2023, 100% of all facility medication storage rooms and medication carts were inspected by facility Director of Nursing Services to ensure that medications requiring a double lock were locked and stored properly. No negative findings.

On 8/8/2023, 100% of all facility licensed nursing staff and medication aides were re-in-serviced on facility protocol regarding medication storage and security. All licensed nursing staff and medication aides not re-in-serviced by 8/14/2023 will be re-in-serviced prior to their next scheduled shift. All facility new hires after 8/14/23 will be in-serviced during facility new hire orientation by the facility Assistant Director of Nursing Services and/or designee.

Address what measures will be put into place or systemic changes made to

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to the refrigerator. The metal box contained 18 foil packages of dronabinol (dronabinol is one of the psychoactive compounds present in cannabis and is abusable and controlled Schedule III under the Controlled Substance Act). The DON stated the dronabinol was for a specific resident on the 100 hall, and it had to be kept in the refrigerator. She further stated that it was probably better to be safe than sorry because someone could remove the metal box.

An interview was completed with the DON on 08/08/2023 at 2:17 PM. The DON stated that the old refrigerator in the 100. 200, 300 hall medication storage room broke a few weeks ago and that no one put a lock on the new refrigerator. She stated that maintenance had put a padlock on the refrigerator door and the metal box was now secured to the refrigerator.

F 761

ensure that the deficient practice will not recur.

3) An audit tool titled “Resident and Room Audit” will be implemented and utilized by the facility department heads to monitor for medication storage. An audit tool titled “Medication Room and Medication Cart Audit” will be implemented and utilized by the Director of Nursing Services and/or designee to monitor for medication storage in the medication rooms. These forms will be used beginning 8/14/23.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

4) On 8/14/23, weekly audits of all resident rooms and all medication storage rooms will be conducted weekly x four weeks and then monthly thereafter. Findings will be documented on the designated “Resident Room Audit Tool” and the “Medication Room and Medication Cart Audit” tool by the facility department heads. Findings with be corrected immediately and audit tools will be brought to the Executive Director weekly for review.

Beginning 8/14/2023, audit compliance will be discussed by the Executive Director monthly x3 and quarterly thereafter by the Executive Director at the monthly Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI team will make revisions to the

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F 761	Continued From page 8	F 761	plan as needed and the Executive Director and/or designee will provide re-education to reflect revisions.	