DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ____ 345297 B. WING 12/13/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE SCOTIA VILLAGE-SNF LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Quality of Care F 684 F 684 12/29/17 CFR(s): 483.25 SS=D § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced bv: Based on staff interviews, Medical Director Based on staff interview, Medical Director interview and record review the facility failed to interview and record review the facility provide adequate care for one of two sampled failed to provide adequate care for one of residents who experienced urinary tract infections two sampled residents who experienced (UTI) which resulted in an unnecessary urinary tract infections (UTI) which hospitalization for an acute UTI with sepsis for resulted in an unnecessary hospitalization Resident #17. for an acute UTI with sepsis for Resident # 17. Findings included: Resident #17 was re-admitted to the facility on 12/04/17 after a short hospitalization for sepsis The statements made on this Plan of related to a urinary tract infection. Pertinent Correction are not an admission to and do diagnoses included recurrent urinary tract not constitute an agreement with the infections, cerebral vascular accident with left alleged deficiencies. To remain in hemiparesis, expressive aphasia, hypertension, compliance with all Federal and State and a seizure disorder. Regulations the facility has taken or will take the actions set forth in this Plan of Review of the comprehensive Minimum Data Set Correction. The Plan of Correction with an assessment reference date of 12/11/17 constitutes the facility's allegation of revealed that Resident #17 had intact long term compliance such that all alleged memory, no behaviors, required extensive deficiencies cited have been or will be assistance with activities of daily living, had an corrected by the date or dates indicated. impairment on one side, was frequently Address how corrective action will be incontinent of bowel and bladder, and had accomplished for the resident found to received Occupational Therapy for 5 days totaling have been affected by the deficient TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/03/2018

PRINTED: 01/23/2018

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.

Electronically Signed

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345297 B. WING 12/13/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE SCOTIA VILLAGE-SNF LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 1 F 684 232 minutes. practice. Example #1: In an interview conducted Review of the care plan for Resident #17 on 12/13/17 at 2:45pm with Nurse #1, he included: at risk for urinary tract infections with stated that the facility protocol was to call interventions to keep skin clean and dry, observe the laboratory for culture results forty-eight for confusion and behavior change, and to obtain hours after a urine sample was sent to a urinary analysis if needed. It also included determine the antibiotics in use were plans for rejection of care, fall risk, seizure activity sensitive and effective. He stated that he risk, pressure ulcer risk, and bowel and urinary had not contacted the laboratory for continence. results of the culture and sensitivity for resident # 17. Physician orders revealed that the resident had Nurse #1 who was involved in the been started on the antibiotic Ciprofloxacin on deficient practice was formally 11/14/17 after an assessment had been re-educated by the Director of Nursing completed at the hospital emergency room. immediately. See in-service training sheet Review of the medication administration record titled, Lab Test Results dated 12/13/2017. showed that Resident #17 received Ciprofloxacin Address how the facility will identify other 500 mg twice a day for the next 7 days. residents having the potential to be affected by the same deficient practice. Review of the urinalysis and urine culture dated In order to identify other residents having 11/14/17 and released 11/16/17 revealed the the potential to be affected by the same growth of >100,000 COL/ML Escherichia coli deficient practice, a 100% audit was which was resistant to Ciprofloxacin. conducted by a RN nurse mentor on each household for individuals diagnosed with a Record review of the hospital history and physical Urinary Tract Infection in the last 30 days. dated 11/27/17 revealed the following impression: The audit entailed reviewing if lab results "UTI-diagnosed 12 days ago, but not were received, if the MD had been appropriately treated until 2 days ago." notified, and if the antibiotic prescribed was correct. No other resident was In an interview conducted with the Medical affected by the deficient practice. See Director on 12/13/17 at 2:40 PM he revealed that audit sheets titled, Residents diagnosed if Resident #17 had been given the correct with UTI within last 30 days, dated antibiotics to treat the UTI the hospitalization 12/13/2017. would have been avoided. He said there was a complete lack of communication that occurred. Address what measures will be put in He stated that this case had "slipped through the place or system changes needed to cracks" and that he was not aware of the situation ensure that the deficient practice will not until after the fact. recur All nurses were verbally educated on

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AND PLAN OF CORRECTION Í IDENTIFICATION NUMBER: 345297		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		B. WING		12/13/2017		
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTIA VILLAGE-SNF				200 ELM DRIVE AURINBURG, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLET	
F 684	Continued From page 3		F 684	review and will continue until compliance is ensured. The monthly QA Meeting will be attended by the DON, RN Nurse Mentors, and the Administrator to ensure corrective actions are initiated as appropriate.		
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)		F 690			12/29/17
	resident who is contir admission receives s maintain continence	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is ain. esident with urinary				
	ensure that- (i) A resident who ent indwelling catheter is resident's clinical con catheterization was n (ii) A resident who en	ssment, the facility must ters the facility without an not catheterized unless the idition demonstrates that recessary; ters the facility with an subsequently receives one				
	is assessed for remover as possible unless the demonstrates that cand (iii) A resident who is	val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder				
		treatment and services to infections and to restore ent possible.				
	§483.25(e)(3) For a r incontinence, based of					

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					OMB NO. 0938-03	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345297			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		12/13/2017		
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		D BE COMPLETIO	
F 690	ensure that a residen	ssment, the facility must t who is incontinent of bowel treatment and services to	F 690			
	by: Based on staff interv interview and record provide adequate car residents who did not for a urinary tract infe (Resident #17).	is not met as evidenced iews, Medical Director review the facility failed to re for one of two sampled treceive adequate treatment action resulting in sepsis		Based on staff interview, Medical Director interview and record review the facility failed to provide adequate care for one of two sampled residents who did not receive adequate treatment for urinary tract infection resulting in sepsis (Resident #17).		
	Findings included: Resident #17 was re-admitted to the facility on 12/04/17 after a short hospitalization for sepsis related to a urinary tract infection. Pertinent diagnoses included recurrent urinary tract infections, cerebral vascular accident with left hemiparesis, expressive aphasia, hypertension, and a seizure disorder. Review of the comprehensive Minimum Data Set with an assessment reference date of 12/11/17 revealed that Resident #17 had intact long term memory, no behaviors, required extensive assistance with activities of daily living, had an impairment on one side, was frequently incontinent of bowel and bladder, and had received Occupational Therapy for 5 days totaling 232 minutes.			The statements made on this Plan of Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Sta Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indica Address how corrective action will b accomplished for the resident found have been affected by the deficient practice.	and do e te will n of f be ated. he l to	
	interventions to keep for confusion and beh	an for Resident #17 Irinary tract infections with skin clean and dry, observe navior change, and to obtain eeded. It also included		Example #1: In an interview condu on 12/13/17 at 2:45pm with Nurse # stated that the facility protocol was t the laboratory for culture results fort hours after a urine sample was sent determine the antibiotics in use wer	t1, he to call ty-eight t to	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345297 B. WING 12/13/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE SCOTIA VILLAGE-SNF LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 690 Continued From page 5 F 690 plans for rejection of care, fall risk, seizure activity sensitive and effective. He stated that he risk, pressure ulcer risk, and bowel and urinary had not contacted the laboratory for continence. results of the culture and sensitivity for resident # 17. Physician orders revealed that the resident had Nurse #1 who was involved in the been started on the antibiotic Ciprofloxacin on deficient practice was formally 11/14/17 after an assessment had been re-educated by the Director of Nursing completed at the hospital emergency room. immediately. See in-service training sheet Review of the medication administration record titled, Lab Test Results dated 12/13/2017. showed that Resident #17 received Ciprofloxacin 2. Address how the facility will identify 500 mg twice a day for the next 7 days. other residents having the potential to be affected by the same deficient Review of the urinalysis and urine culture dated practice. 11/14/17 and released 11/16/17 revealed the In order to identify other residents having growth of >100,000 COL/ML Escherichia coli the potential to be affected by the same which was resistant to Ciprofloxacin. deficient practice, a 100% audit was conducted by a RN nurse mentor on each Record review of the hospital history and physical household for individuals diagnosed with a dated 11/27/17 revealed the following impression: Urinary Tract Infection in the last 30 days. "UTI-diagnosed 12 days ago, but not The audit entailed reviewing if lab results appropriately treated until 2 days ago." were received, if the MD had been notified, and if the antibiotic prescribed was correct. No other resident was In an interview conducted with the Medical Director on 12/13/17 at 2:40 PM he revealed that affected by the deficient practice. See Resident #17 had been given an antibiotic that audit sheets titled, Residents diagnosed was not effective. He said there was a complete with UTI within last 30 days, dated 12/13/2017. lack of communication that occurred. He stated that this case had "slipped through the cracks" 3. Address what measures will be put in and that he was not aware of the situation until place or system changes needed to after the fact. ensure that the deficient practice will not recur. In an interview conducted on 12/13/17 at 2:45 PM All nurses were verbally educated on with Nurse #1 he stated that the facility protocol 12/13/2017 by a RN nurse mentor was to call the laboratory for culture results regarding facility policies on Urinary Tract Infections/Bacteriuria-Clinical Protocol, forty-eight hours after a urine sample was sent to determine that antibiotics in use were sensitive Antimicrobial Stewardship Program, and and effective. He stated that he had not Lab and Diagnostic Test Results-Clinical contacted the laboratory for results of the culture Protocol to include review of the proper and sensitivity for Resident #17. procedures of using the facility Lab

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345297		()	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		12/13/2017			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SCOTIA V	ILLAGE-SNF			2200 ELM DRIVE			
				LAURINBURG, NC 28352			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 690	with the Director of N Resident #17 had be to which the organism that the facility failed results performed at room which showed given to the resident (Ciprofloxacin). She laboratory results for sensitivity to be follow forty-eight hours afte	Licted on 12/13/17 at 3:30 PM Jursing she revealed that then treated with an antibiotic m was resistant. She stated to follow up on the laboratory the hospital emergency that the antibiotic that was was not effective said that she expected	F 69	 Follow-up form. Formal in-service trainings of all nurses were completed in a service training service to make service the solutions are sustained. The RN nurse mentors of each how will audit all Lab Follow-up forms of completion and appropriateness we ensure follow-up of all labs orderer residents are completed in a timel manner by shift nurses. Compliant be monitored and ongoing. The wauditing program will be reviewed discussed by the DON at a weekly meeting. This will be done weekly month or until resolved by the Quar Assurance Committee. The weekly Meeting will be attended by the DON nurse Mentors, and the Administrate ensure corrective actions are initiated appropriate. First weekly meeting. This will be done by DON x 3 months, to include quarter review and will continue until complis ensured. The monthly QA Meeting be attended by the DON, RN Nurse Mentors, and the Administrator to corrective actions are initiated as appropriate. 	eted by (17- sheets t to ure usehold or veekly to d on y ceekly and v QA for one ality y QA DN, RN ator to ted as The ewed onthly the erly QA bliance cing will se		

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