PRINTED: 10/05/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED					
		345297	B. WING _			09	/14/2023	
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF		•	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352			, 33		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000				
F 000	survey was conducte 09/14/2023. The faci		FC	000				
F 602 SS=E	09/11/2023 through (V58G11. Free from Misapprop	ey was conducted from 09/14/2023. Event ID# riation/Exploitation	Fé	802				
	neglect, misappropria and exploitation as d includes but is not lin corporal punishment, any physical or chem treat the resident's m This REQUIREMENT by: Based on observation Consultant Pharmacisthe facility failed to pure free from misappropric controlled medication (Oxycodone/Acetamia (mg), Hydrocodone/A maximum prescribed by the anxiety. This resulted medications that wer residents (Resident #	involuntary seclusion and ical restraint not required to edical symptoms. is not met as evidenced ons, record review, staff, st, and Physician interviews rotect a residents right to be iation of a residents			Past noncompliance: no plan of correction required.			
ADODATODY	DIDECTOR'S OR BROVINER	SLIPPLIER REPRESENTATIVE'S SIGNATUR	 DE		TITI F		(X6) DATE	

Electronically Signed 10/02/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345297	B. WING		09/14/2023
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352		, 3377	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 602	04/01/23 with diagnovertebra and sacrur A physicians order of the same sacrur A physicians order of the same sacrur #51 revealed Oxycomgs. Take one table pain. Review of Resident initiated 04/05/23 re Oxycodone/Acetam signed out of the national of the same sacretary of the sacr	as admitted to the facility on oses including fractured m, and Arthritis. dated 04/05/23 for Resident odone/Acetaminophen 5/325 et every 8 hours as needed for #51's Controlled Drug Record evealed inophen 5/325 mgs was arcotic count by Nurse #1 on , and 04/28/23. #51's Medication ord (MAR) dated April 2023 entation by Nurse #1 on 04/11, 1/28 that the inophen 5/325 mgs was sident #51. Ing progress notes from 1/28/23 revealed no Nurse #1 that inophen 5/325 mgs was sident #51. on 09/14/23 at 11:30 AM	F 602	DEFICIENCY)	
	wheelchair in his ro oriented. He stated medication at this ti complaints of pain a pain. He stated he of medication regularly	om. He was alert and he did not take any pain me. He stated he did not have and had never really had much did not recall getting pain y or needing pain medication at any time since his admission			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
345297 B. WING	09/14/2023
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF SCOTIA VILLAGE-SNF STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352	·
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRI PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 602 Continued From page 2 to the facility. b.) Resident #41 was admitted to the facility on 06/09/21 with diagnoses including dementia, anxiety, and depression. A physicians order dated 03/31/23 for Resident #41 revealed Alprazolam 0.5 mg. take one tablet by mouth as needed for anxiety. Review of Resident #41's Controlled Drug Record initiated 03/31/23 revealed Alprazolam 0.5 mg was signed out of the narcotic count by Nurse #1 on 05/11/23 and 05/13/23. Review of Resident #41's Medication Administration Record (MAR) dated May 2023 revealed no documentation by Nurse #1 on 05/11 or 05/13/23 that Alprazolam 0.5 mgs was administered. Review of the nursing progress notes from 05/11/23 through 05/13/23 revealed no documentation by Nurse #1 that Alprazolam 0.5 mgs was administered to Resident #41. During an observation on 05/11/23 at 11:00 AM Resident #41 was observed sitting in the locked memory unit dining area. She was calm with no signs of increased anxiety. c.) Resident #2 was admitted to the facility on 03/24/23 with diagnoses including Respiratory failure and chronic pain. A physicians order dated 04/05/23 for Resident #2 revealed Oxycodone/Acetaminophen 10/325 mgs. Take one tablet every 6 to 8 hours as needed for pain control.	

345297 B. WING 09/1 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	14/2023
SCOTIA VILLAGE-SNF 2200 ELM DRIVE LAURINBURG, NC 28352	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602 Continued From page 3 F 602	
Review of Resident #2's Controlled Drug Record initiated 04/06/23 revealed Oxycodone/Acetaminophen 10/325 mgs was signed out of the narcotic count by Nurse #1 on 04/07, 04/08, 04/09, 04/12, 04/13 at 8:30 AM and 2:00 PM and 04/18/23. Review of Resident #2's Medication Administration Record (MAR) dated April 2023 revealed no documentation by Nurse #1 that Oxycodone/Acetaminophen 10/325 mgs was administered to Resident #2 on 04/07, 04/08, 04/09, 04/12, 04/13 at 8:30 AM and 2:00 PM and 04/18/23. Review of the nursing progress notes from 04/07/23 through 04/18/23 revealed no documentation by Nurse #1 that Oxycodone/Acetaminophen 10/325 mgs was administered to Resident #2 that Oxycodone/Acetaminophen 10/325 mgs was administered to Resident #2. During an interview on 09/14/23 at 1:00 PM the Director of Nursing stated Resident #2 expired on 04/20/23 due to respiratory disease. d.) Resident #3 was admitted to the facility on 02/27/15 with diagnoses including Cerebral Palsy, Quadriplegia, and Non-Alzheimer's dementia. A physicians order dated 04/05/23 for Resident #3 revealed Hydrocodone/Acetaminophen 10/325 mgs. Take one tablet every 6 hours as needed for pain control. Review of Resident #3's Controlled Drug Record initiated 03/24/23 revealed Hydrocodone/Acetaminophen 10/325 mgs was as signed out of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345297	B. WING		09/14/2023
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF		22	REET ADDRESS, CITY, STATE, ZIP CODE 00 ELM DRIVE AURINBURG, NC 28352	, 337.1.222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 602	at 7:15 AM and 1:15 1:30 PM, 04/23, 04/ at 7:15 AM and 5:30 AM, 05/02 at 8:00 A	PM, 04/09, 04/13, 04/18, 04/21 5 PM, 04/22 at 7:15 AM, and 25 at 2:00 PM, 04/26, 04/27 D PM, 04/28, 05/01 at 8:00 M and 5:30 PM, 05/05, 05/06 6 PM, 05/07 at 7:30 AM and	F 602		
	and May 2023 reve Nurse #1 that Hydro 10/325 mgs was ad 04/07, 04/08 at 7:45 04/13, 04/18, 04/21 04/22 at 7:15 AM, a 2:00 PM, 04/26, 04/ 04/28, 05/01 at 8:00 5:30 PM, 05/05, 05/	#3's Medication ord (MAR) dated April 2023 aled no documentation by ocodone/Acetaminophen ministered to Resident #3 on 5 AM and 6:22 PM, 04/09, at 7:15 AM and 1:15 PM, and 1:30 PM, 04/23, 04/25 at 127 at 7:15 AM and 5:30 PM, 0 AM, 05/02 at 8:00 AM and 106 at 7:25 AM and 6:26 PM, and 6:00 PM, and on 05/11/23.			
	04/07/23 through 08 documentation by N Hydrocodone/Aceta administered to Res	lurse #1 that minophen 10/325 mgs was sident #3.			
	03/21/23 with diagn left below knee amp A physicians order of #4 revealed Oxycoo	s admitted to the facility on oses including Diabetes and outation. dated 03/22/23 for Resident done/Acetaminophen 5/325 et every 4 hours as needed for			
	Review of Resident initiated 03/23/23 re	#4's Controlled Drug Record			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345297	B. WING			9/14/2023
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF		STREET ADDRESS, CITY, STATE, ZIP CODI 2200 ELM DRIVE LAURINBURG, NC 28352		•	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 602	signed out of the name 03/26/23. Review of Resident # Administration Recorrevealed no documer 03/26/23 that the Oxy 5/325 mgs was admi Review of the nursing revealed no documer Oxycodone/Acetamir administered to Resident #4 was disc 04/05/23. f.) Resident #7 was a 09/04/20 with diagno heart failure, Non-Alz pain. A physicians order da #7 revealed Tramado mouth three times a company of Resident #4 initiated 05/11/23 revealed out of the name 05/11/23. Review of Resident # Administration Recorrections and the signed out of the name 05/11/23.	rophen 5/325 mgs was cotic count by Nurse #1 on 44's Medication d (MAR) dated March 2023 attation by Nurse #1 on ycodone/Acetaminophen nistered to Resident #4. If progress notes on 03/26/23 attation by Nurse #1 that nophen 5/325 mgs was dent #4. It charged from the facility on sees including Congestive theimer's dementia, and atted 05/03/23 for Resident by day as needed for pain. If 's Controlled Drug Record ealed Tramadol 50 mgs was cotic count by Nurse #1 on	F 60			
	to Resident #7.	lol 50 mgs was administered g progress notes on 05/11/23				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		, ,			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345297	B. WING	B. WING		09/	14/2023
	ROVIDER OR SUPPLIER		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 ELM DRIVE LAURINBURG, NC 28352	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	Tramadol 50 mgs war #7. Resident #7 was disc 07/16/23. g.) Resident #8 was a 04/10/23 with diagnoship and knee replaced. A physicians order dar #8 revealed Tramado mouth every 6 hours. Review of Resident # initiated 04/11/23 revesigned out of the narc 04/13/23. Review of Resident # Administration Record revealed no documer 04/13/23 that Tramado to Resident #8. Review of the nursing revealed no documer Tramadol 50 mgs war #8. Resident #7 was disc 05/19/23. h.) Resident #9 was a factor of the narce of the nursing revealed no documer than 100 mgs war #8.	station by Nurse #1 that is administered to Resident sharged from the facility on admitted to the facility on ses including Diabetes, and ment. Seted 04/10/23 for Resident of 150 mgs. Take one tablet by as needed for pain. Setes Controlled Drug Record and Tramadol 50 mgs was actic count by Nurse #1 on the facility of the facility on the facility on the facility of the facility on the facility of the facility on the facility of the facility of the facility of the facility on the facility of the facility	F	602			
	A physicians order da	ated 03/28/23 for Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345297	B. WING			09/	14/2023
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 200 ELM DRIVE AURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	mgs. Take one tablet for pain control. Review of Resident # initiated 03/29/23 revelled type of the narco 05/01/23, 05/02/23 at the control of the narco 05/01/23 through 05/01/23 thr	done/Acetaminophen 10/325 every 12 hours as needed 9's Controlled Drug Record ealed inophen 10/325 mgs was cotic count by Nurse #1 on 12:31 PM, and 05/11/23. 9's Medication d (MAR) dated May 2023 ntation by Nurse #1 on 12:31 PM, and 05/11/23 etaminophen 10/325 mgs Resident #9. g progress notes from 11/23 revealed no rse #1 that ninophen 10/325 mgs was dent #9. harged from the facility on investigation initiated on n 5/15/23 at approximately eported that Nurse #3 had e #1 was taking resident's	F	602			
	ago another resident	stated that over a month complained that Nurse #1 ons although there was no					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		345297	B. WING _			09/14/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 602	crushed. Nurse #3 st complained and she giving her pain medic that it was also suspi up additional shifts o generally did not wor to gain access to me that other nurses well provided a list of nurse with concerns. An interview was corn AM with the Director the Administrator. The aware of the allegation regarding Nurse #1 controlled drug recorn Nurse #1 worked on #51) that had an order Oxycodone/Acetamine every 8 hours for paid because Nurse #1 wout this medication for 04/20/23. She stated 05/15/23 Nurse #1 si times. She stated she MAR to reconcile with Record and found with document that she are on the medication and several occasions. So rarely complained of resident records and residents that had count and Nurse #1 signed	the medications to be ated that the resident didn't think the nurse was cation. She stated she felt cious that Nurse #1 picked in households that she k and thought this could be dications. Nurse #3 reported re suspicious as well and ses and medication aides and medication aides and medication aides are suspicious as well and ses and medication aides and medication aides are suspicious as well and ses and medication aides are suspicious as well and ses and medication aides are suspicious as well and ses and medication aides are suspicious as well and ses and medication aides are suspicious as well and ses and medication aides are suspicious as well and ses and medication all did from the household that and identified a Resident (ser for nophen 5/325mg as needed in. The order stood out to her as the only nurse that signed or Resident #51 since from 04/20/23 through gned out the medication 13 are reviewed Resident #51's in the Controlled Drug nere Nurse #1 failed to diministered the medication ministration record on the stated Resident #51 pain. She reviewed more	F6	502		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED	
		345297	B. WING			09/14/2023
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352	03/14/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 602	stated she then not they interviewed Nu of the residents men Nurse #1 stated she MAR and didn't und documentation on the probably just for MAR. The Administ conducted and the indicated drug diverbeen employed with was terminated at the informed Nurse reported to the Boan Nurse #1 did not was were done. The DO submitted their finditheir investigation. Trevealed Nurse #1 adiverting controlled for a period of time. Suspended. During an interview Nurse #4 stated she of drug diversion are interviewed during the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated for example complained of pain, medications for him stated there were of the stated she of the stated sh	ed to the residents. She fied the Administrator, and firse #1 who denied taking any dications. The DON stated e always documented on the lerstand why the he MAR didn't show up and rgot to sign them out on the rator added that the audits interviews with other nurses rsion. He stated Nurse #1 had he the facility for 18 years and hat time. The DON added that hat that she would be rd of Nursing. She stated and to review the audits that N stated the Board of Nursing high stated that she had been medications from the facility Her nursing license was on 09/13/23 at 11:00 AM e was aware of the allegations and was one of the nurses he investigation of Nurse #1. 1 was suspected of not giving eir pain medications. She	F 6			
	regarding drug dive	vice training during that time rsion. erview on 09/13/23 at 4:10 PM				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED		
	345297	B. WING _			09/14/2023		
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF		•	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352		1 03/14/2020		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFI) TAG	X (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
the Consultant Phai monthly record revies she was made award diversion in May 20 stated she was not problems with narcount of the stated during the reviewed prn (as nearly and did not see on a medications were befrequently. She stated that time with medications were befrequently. She stated that time with medication of the Medical Director of the medication did the facility on the dataware. He stated he weekly at the facility any of the residents all of the affected refound no negative of concerns with the facility and audit results we meeting which was the audits were complemented to include and audit results were meeting which was the audits were complemented to include and audit results were complemented to include audits were complement	remacist stated she conducted lews at the facility. She stated re of the allegation of 23 regarding Nurse #1. She aware until that time of any office medications at the facility. The monthly record reviews she needed) use of medications the residents MAR that the residents MAR that the residents make the had no concerns since the stated he was made aware version. He stated he was at any the facility was made remade rounds with the nurses of and there was no harm to and there was no harm to and the stated he had evaluated residents during that time and not recome. He stated he had no recility staff. Interview on 09/14/23 at 3:00 a full plan of correction was unde in-service training, audits, are discussed in the last QA held on 07/25/23. She stated appleted in August 2023 and growld be held the week of the for the noncompliance as follows:	F	502				
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From parthe Consultant Pharmonthly record revies he was made awardiversion in May 20 stated she was not problems with narconstant She stated during the reviewed prn (as neand did not see on medications were befrequently. She stated that time with medical facility. During a phone intended the facility on the deaware. He stated he weekly at the facility any of the residents all of the affected refound no negative of concerns with the facility any of the residents all of the affected refound no negative of concerns with the facility any of the residents all of the affected refound no negative of concerns with the facility and the pool of the medication of the medication of the affected refound no negative of concerns with the facility and the pool of the medication of the affected refound no negative of concerns with the facility and the pool of the medication of the affected refound no negative of concerns with the facility and the pool of the medication of the affected refound no negative of concerns with the facility and the pool of the medication of the affected refound no negative of concerns with the facility and the pool of the affected refound no negative of concerns with the facility and the pool of the medication of the affected refound of the affecte	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 the Consultant Pharmacist stated she conducted monthly record reviews at the facility. She stated she was made aware of the allegation of diversion in May 2023 regarding Nurse #1. She stated she was not aware until that time of any problems with narcotic medications at the facility. She stated during the monthly record reviews she reviewed prn (as needed) use of medications and did not see on the residents MAR that the medications were being administered or used frequently. She stated she had no concerns since that time with medication administration at the facility. During a phone interview on 09/13/23 at 4:31 PM the Medical Director stated he was made aware of the medication diversion. He stated he was at the facility on the day the facility was made aware. He stated he made rounds with the nurses weekly at the facility and there was no harm to any of the residents. He stated he had evaluated all of the affected residents during that time and found no negative outcome. He stated he had no concerns with the facility staff. During a follow up interview on 09/14/23 at 3:00 PM the DON stated a full plan of correction was implemented to include in-service training, audits, and audit results were discussed in the last QA meeting which was held on 07/25/23. She stated the audits were completed in August 2023 and the next QA meeting would be held the week of	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 the Consultant Pharmacist stated she conducted monthly record reviews at the facility. She stated she was made aware of the allegation of diversion in May 2023 regarding Nurse #1. She stated she was not aware until that time of any problems with narcotic medications at the facility. She stated during the monthly record reviews she reviewed prn (as needed) use of medications and did not see on the residents MAR that the medications were being administered or used frequently. She stated she had no concerns since that time with medication administration at the facility on the day the facility was made aware of the medication diversion. He stated he was at the facility on the day the facility was made aware. He stated he made rounds with the nurses weekly at the facility and there was no harm to any of the residents. He stated he had evaluated all of the affected residents during that time and found no negative outcome. He stated he had no concerns with the facility staff. During a follow up interview on 09/14/23 at 3:00 PM the DON stated a full plan of correction was implemented to include in-service training, audits, and audit results were discussed in the last OA meeting which was held on 07/25/23. She stated the audits were completed in August 2023 and the next QA meeting would be held the week of 09/18/23. The corrective action for the noncompliance dated 05/15/23 was as follows: On 05/15/23 the Director of Nursing and the	ROUIDER OR SUPPLIER ILLAGE-SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQUILATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 10 the Consultant Pharmacist stated she conducted monthly record reviews at the facility. She stated she was made aware of the allegation of diversion in May 2023 regarding Nurse #1. She stated dhe had on concerns since that time with medication administration at the facility. Buring a phone interview on 09/13/23 at 4:31 PM the Medical Director stated he was made aware of the medication diversion. He stated he was at the facility and there was no harm to any of the residents. He stated he had evaluated all of the affected residents during that time and found no negative outcome. He stated he had no concerns since ware. He stated he made rounds with the nurses weekly at the facility and there was no harm to any of the residents. He stated he had evaluated all of the affected residents during that time and found no negative outcome. He stated he had no concerns with the facility saff. During a follow up interview on 09/14/23 at 3:00 PM the DON stated a full plan of correction was implemented to include in-service training, audits, and audit results were discussed in the last QA meeting which was held on 07/25/23. She stated the audits were completed in August 2023 and the next QA meeting would be held the week of 09/18/23. The corrective action for the noncompliance dated 05/15/23 was as follows: On 05/15/23 the Director of Nursing and the	A BULDING 345297 A BULDING B WINNE REGULATORY OR ISC DENTIFYING INFORMATION) Continued From page 10 the Consultant Pharmacist stated she conducted monthly record reviews at the facility. She stated she was nade aware of the melications are of the facility. She stated during the monthly record reviews she reviewed pri (as needed) use of medications and did not see on the residents MAR that the medication administration at the facility on the day the facility was made aware of the medication administration at the facility. The Medical Director stated he was an the facility was made aware of the facility was made aware of the medication administration at the facility on the day the facility was made aware of the facility was made aware of the medication diversion. He stated he was at the facility on the day the facility was made aware. He stated he made rounds with the nurses weekly at the facility and there was no harm to any of the residents. He stated he had no concerns with the facility staff. During a follow up interview on 09/14/23 at 3:00 PM the DON stated a full plan of correction was implemented to include in-service training, audits, and audit results were discussed in the last QA meeting which was held on 07/25/23. She stated the audits were completed in August 2023 and the next QA meeting would be held the week of 09/18/23 was as follows: On 05/15/23 the Director of Nursing and the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345297	B. WING _			09/	14/2023
	ROVIDER OR SUPPLIER			2200	ET ADDRESS, CITY, STATE, ZIP CODE ELM DRIVE RINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 602	On 05/15/23 the DON the Medication Admir and Controlled Drug received Controlled rust residents correspondiscrepancies. The amedication was signed Controlled Drug Received Entertain the residents identified Drug Received Entertain the MAR that administered. The outlook residents identified On 05/15/23 Nurse #On 05/15/23 the Mediaware of the possible Drug On 05/15/23 the Politof the possible drug of the possible drug of the facility were as clinical condition. Interested residents or to identify any conceived receiving as needed There were no issues with as needed medial interviews were conditions.	tial investigation. e Agency was notified. N initiated a 100% audit of nistration Records (MARs) Records of all residents who nedications and compared to onding MAR to identify udit was to ensure the ed out on the residents ord and to ensure staff the narcotic was atcome of the audit revealed d as being affected. 1 was terminated. Itical Director was made a drug diversion. The Department was notified diversion. The residents that still remained sessed for changes in erviews were conducted with their Responsible Party (RP) and with residents not medications upon request.	F	602			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345297	B. WING _			09/14/2023	
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 602	initiated with all nurs the Staff Developmer regarding signs of nurs prevention, reporting diversion, and medicensuring that controus the MAR. In-service 05/26/23. After 05/2 received the in-service diversion aides we consume the medication aides we consume that each controlled drug reconsumer that each co	in-service training was sees and medication aides by ent Coordinator (SDC) arcotic diversion and grequirements of suspected cation policy and procedures lled drug records matched s were to be completed by 6/23, any staff who had not ce training would not be If they completed the all newly hired nurses and culd be in-serviced during The nurse mentors will review escribed as needed narcotics narcotic is signed out on the rd with a corresponding donce weekly x 4 weeks, reeks x 1 month, then monthly sing will forward the results of fality Assurance (QA) monthly until resolved. Reeting was held 07/25/23 the investigation and audits rective action was completed cluded staff interviews nt, and in-service training that ure understanding and lining provided. Observations the medication carts; the counts were conducted with	F6	02			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345297	B. WING			09/14/2023	
NAME OF PROVIDER OR SUPPLIER SCOTIA VILLAGE-SNF				STREET ADDRESS, CITY, STATE, Z 2200 ELM DRIVE LAURINBURG, NC 28352	IP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			(X5) COMPLETION DATE	
F 602	Records were review QA meeting was hel results were discuss	ontrolled Substance Count wed. Audits were verified. A d on 07/25/23 where audit sed.	F	602			