STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	C 09/11/2024

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

(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 9/09/24 through 9/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #YZ8V11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/09/24 through 9/11/24. Event ID# YZ8V11. The following intakes were investigated NC00208768 and NC00207562. 3 of the 3 complaint allegations did not result in deficiencies.	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Dialysis Charge Nurse interviews, the facility failed to maintain ongoing communication with the dialysis treatment center for 1 of 1 resident reviewed for dialysis (Resident #18). The findings included: Resident #18 was admitted to the facility on 5/12/17 with diagnoses which included end stage renal disease (ESRD) and dependence on	F 698	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility staff and dialysis staff are currently communicating regarding Resident #18 with use of dialysis communication document. Address how the facility will identify other	10/2/24

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

Electronically Signed | 09/26/2024

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F 698	Continued From page 1 dialysis (treatment to filter wastes and water from the blood). Resident #18 had an active physician order dated 2/22/21 for dialysis on Monday, Wednesday, and Friday. Review of Resident #18's care plan last reviewed 7/09/24 revealed the need for dialysis related to renal failure with an intervention to communicate with the dialysis center by the dialysis communication form. Review of Resident #18's dialysis communication forms, located in the dialysis communication notebook at the nursing station, dated 8/01/24 through 9/09/24 revealed 8 of the 17 dialysis communications forms were not completed by the facility staff prior to dialysis for Resident #18. The reviewed dialysis communication forms did not have the following information noted from the facility: medications administered prior to dialysis, arteriovenous (catheter access area for delivery of hemodialysis) access site type, dialysis access type observation including signs or symptoms of infection, access site assessment including bruit (a whooshing sound heard at the fistula site with a stethoscope) and thrill (vibration caused by blood flow felt with fingers), resident pain, and time of transfer to dialysis center. A telephone interview was conducted on 9/10/24 at 1:46 pm with Medication Aide #1, who was assigned to Resident #18 on the dates the dialysis communication forms were not completed, revealed the only information she entered prior to Resident #18 leaving for dialysis were the vital signs (blood pressure, pulse, temperature, and respiratory rate), resident	F 698	residents having the potential to be affected by the same deficient practice: Residents residing in the facility, who receive dialysis care, have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 9/10/24 the Director of Nursing initiated education to the Licensed Nurses on dialysis communication to include the completion of communication document before and after dialysis treatment. After 09/30/24 no Licensed Nurse will be permitted to work without first receiving the education from the Director of Nursing. The Director of Nursing will audit for completion of dialysis communication document for three random residents weekly for a minimum of four weeks, then monthly for a minimum of two months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An Ad Hoc QAPI meeting was held on 09/16/24 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director and Medical Director. Results of the audits will be presented by the DON in the monthly	

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F 698	Continued From page 2 name, resident room number, the date, and the name of the physician. Medication Aide #1 stated she was not aware of any other information that was needed on the dialysis communication form for Resident #18 prior to the dialysis appointment. An attempt to conduct a telephone interview on 9/11/24 at 1:33 pm with Nurse #2, who was the nurse assigned to oversee Medication Aide #1 on the dates the dialysis communication forms were not completed, was unsuccessful. A telephone interview was conducted on 9/11/24 at 8:57 am with the Dialysis Charge Nurse who revealed the dialysis communication forms were sent with the resident from the facility. The Dialysis Charge Nurse stated the facility was to complete their portion of the form before the resident left the facility with information that included vital signs, any medications that were administered, any issues or concerns with the dialysis access site, and if any pain was reported. The Dialysis Charge Nurse stated the dialysis communication form was reviewed by staff at the dialysis center in the event there was a concern that needed to be addressed prior to starting treatment. The Dialysis Charge Nurse stated if any concerns were identified when Resident #18 arrived at the dialysis center a call would be placed to the facility for any additional information that was needed. An interview was conducted with the Director of Nursing (DON) on 9/10/24 at 1:08 pm who revealed the facility was responsible to complete the dialysis communication form prior to the resident being sent to dialysis center. The DON stated Medication Aide #1 was able to complete the non-assessment portions but was unable to	F 698	Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 698	Continued From page 3 complete the assessment portion of the form because Medication Aide #1 was not a licensed nurse. The DON stated Nurse #2, who was assigned to Medication Aide #1 should have completed the assessment portion of Resident #18's dialysis communication forms and made sure the forms were completed prior to dialysis. The DON stated she conducted random audits of the dialysis communication forms to ensure they were being completed, but she stated she just missed Resident #18's incomplete dialysis communication forms. During an interview on 9/11/24 at 10:33 am the Administrator reported the dialysis communication forms for Resident #18 should have been completed prior to his dialysis appointments. The Administrator stated the DON was responsible to ensure the dialysis communication forms for Resident #18 were completed.	F 698		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10/2/24

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F 880	Continued From page 4 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 5 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when Nurse Aide (NA) #1 failed to perform hand hygiene after performing bathing and incontinence care for 1 of 2 residents observed for incontinence care (Resident #26). The findings included: The facility policy titled "Infection Control", no date noted, revealed the purpose of the policy was to provide guidelines for the prevention of infection control in the facility. The policy stated in part that gloves were worn by all staff when providing care such as suctioning, bathing, care of perineal area, and wound care to prevent cross-contamination of infectious waste to hands. The facility policy titled "Handwashing/Hand Hygiene" dated 11/02/21 revealed hand hygiene was the primary means to prevent the spread of infections and that all staff shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: NA # 1 completed a return demonstration of proper hand hygiene before and after activities of daily living for resident #26 on September 16, 2024 with the Director of Nursing with no issues identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Certified nursing assistants will be educated by the Director of Nursing by 10/1/2024 on performing hand hygiene before and after completing activities of daily living. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Director of Nursing will audit five	

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F 880	Continued From page 6 further stated that hand hygiene was to be performed before moving from a contaminated body site to a clean body site during resident care. A continuous observation on 9/09/24 at 1:25 pm through 1:34 pm revealed NA #1 prepared to provide bathing and incontinence care to Resident #26. NA #1 performed hand hygiene and donned clean gloves and prepared a wash basin and wash cloth and proceeded to clean Resident #26's front side of her body including the perineal area (pelvic area located between the legs), placed Resident #26's gown on, without removing her gloves and performing hand hygiene, and assisted Resident #26 to turn onto her left side. NA #1 then removed the urine soiled incontinence brief from under Resident #26 and continued to wash Resident #26's back side and in between her buttocks. NA #1 removed the urine soiled bed pad from under Resident #26 and, without removing her gloves and performing hand hygiene, placed a new incontinence brief and clean sheet under Resident #26. NA #1 removed her gloves, performed hand hygiene and exited the Resident #26's room with the soiled linen and trash bags. An interview was conducted with NA #1 on 9/09/24 at 1:55 pm who revealed she did not change her gloves during the incontinence care and bathing that was performed for Resident #26. NA #1 stated she always used the same gloves for entire process of bathing and incontinence care without putting on new gloves. NA #1 stated she did not know she had to take off the gloves before putting on the clean sheet and clothes for Resident #26.	F 880	nursing assistants during and after performing ADL care to validate compliance with appropriate hand hygiene weekly for a minimum of four weeks, then monthly for a minimum of two months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An Ad Hoc QAPI meeting was held on 09/16/24 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director and Medical Director. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 880	Continued From page 7 During an interview on 9/10/24 at 1:04 pm with the Infection Preventionist she revealed gloves were to be removed and hand hygiene performed before moving from dirty to clean tasks during resident care. The Infection Preventionist stated NA #1 should have removed her gloves and performed hand hygiene before putting on the clean brief and linens for Resident #26. An interview was conducted on 9/11/24 at 1:12 pm with the Administrator who revealed NA #1 should have removed her gloves and performed hand hygiene before touching the clean brief and linens during Resident #26's bathing and incontinence care.	F 880		