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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345297 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/07/2024 |
| NAME OF PROVIDER OR SUPPLIER Scotia Village-Snf | | STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Elm Drive Laurinburg, NC 28352 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173</p> <p>Based on observations, record review, and staff interviews the facility failed to perform daily wound care treatments on a sacral wound for 1 of 1 resident (Resident #4) observed for pressure ulcers.</p> <p>Findings included:</p> <p>Resident #4 was admitted to the facility on [DATE]. Diagnoses included, in part, pressure ulcer of sacral region and myoneural disorder (spinal compression with paralysis to lower extremities).</p> <p>The quarterly Minimum Data Set assessment dated [DATE] revealed resident was cognitively intact with no behaviors, had impairment on both sides to upper and lower extremities, utilized a wheelchair for mobility, was always incontinent of bowel and bladder and was coded as having a pressure ulcer stage III.</p> <p>A review of Resident #4's care plan updated on 09/20/24 revealed a plan of care for actual impairment to skin integrity with pressure ulcer to sacrum. The goal was that the skin injury would improve by the next review date with interventions to include, in part, daily treatment to affected area to promote wound healing.</p> <p>A review of the physician orders revealed an order written on 10/29/24 to cleanse sacral area with normal saline, apply silver collagen matrix cut to fit wound, cover with an absorbent silicone dressing daily.</p> <p>Review of the weekly observation tool dated 10/29/24 revealed Resident #4 acquired a stage II pressure ulcer on 09/04/24 which had increased to a stage III pressure ulcer on 10/23/24. The overall impression indicated the wound was improving with epithelial tissue and granulation tissue present (healthy tissue). The assessment noted there was serosanguinous (bloody serum) draining with moderate amounts with no odor. The measurement of the wound was 1.5 centimeters (cm) X 0.7 cm X no depth.</p> <p>An observation of wound care was conducted on 11/06/24 at 9:30 AM with Nurse #1 and the Director of Nursing (DON). Resident #4 was informed that the two nurses were going to change her dressing to her sacrum. Resident #4 was turned to her left side. Nurse #1 proceeded to remove the existing dressing to Resident #4's sacrum which was dated 11/04/24. The wound was noted to be opened with small amount of bloody serum with redness surrounding the wound. Nurse #1 cleansed the pressure ulcer with wound cleanser, patted dry, and applied a small wound size piece of silver collagen to the wound and covered it with an absorbent silicone dressing.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview with Nurse #1 on 11/06/24 at 9:40 AM was conducted. Nurse #1 was asked about the date on the dressing being 11/04/24. Nurse #1 stated she did not notice the date and proceeded to then remove the dressing from the trash bag. Nurse #1 read the date on the dressing and confirmed the date was 11/04/24. Nurse #1 did not know if the dressing was changed on 11/05/24 as ordered.</p> <p>A phone interview was conducted with Nurse #2 on 11/06/24 at 9:45 AM. Nurse #2 revealed she worked 12 hour shifts from 7:00 AM to 7:00 PM and she had changed the dressing on 11/04/24 and it was removed around 7:00 PM when Resident #4 got a bath and another dressing was reapplied after her bath on 11/04/24. Nurse #2 stated she did not change it on 11/05/24 since it was changed twice on 11/04/24.</p> <p>An interview was conducted with the Director of Nursing on 11/06/24 at 10:30 AM. The DON reported Resident #4's pressure ulcer was a stage II when it was identified on 09/04/24 and had recently increased to a stage III wound. The DON reported Resident #4 requests to get out of bed daily and sit up in her wheelchair for prolonged periods which she believed contributed to the wound worsening. She stated she would have expected Nurse #2 to follow the physician's order and change the dressing daily in order to aide in healing.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173</p> <p>Based on observations, record review and staff interviews the facility failed to accurately document the completion of a wound treatment in the treatment administration record (TAR) for 1 of 1 residents (Resident #4) observed for pressure ulcers.</p> <p>Findings included:</p> <p>Resident #4 was admitted to the facility on [DATE]. Diagnoses included, in part, pressure ulcer of sacral region.</p> <p>A review of the physician orders revealed an order written on 10/29/24 to cleanse sacral area with normal saline, apply silver collagen matrix (antimicrobial barrier to prevent infections) cut to fit wound, cover with an absorbent silicone (a dressing that absorbs drainage) daily.</p> <p>Review of the Treatment Administration Record (TAR) revealed the wound treatment for Resident #4 was signed off on the TAR as evidenced by a check mark with Nurse #2's initials on 11/05/24.</p> <p>A phone interview was conducted with Nurse #2 on 11/06/24 at 9:45 AM. Nurse #2 revealed she had changed the dressing on 11/04/24 and it was removed around 7:00 PM when Resident #4 got a bath and another dressing was reapplied after her bath on 11/04/24. Nurse #2 stated she did not change it on 11/05/24 since it was changed twice on 11/04/24. Nurse #2 stated she should not have signed off in the treatment administration record that she did the dressing change on 11/05/24 as that was inaccurate documentation.</p> <p>An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 10:30 AM. The DON reported she expected her nursing staff to accurately document in the treatment administration record to reflect the care that was provided. The DON stated Nurse #2 should not have signed off on a treatment that she did not provide.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>32968</p> <p>Based on observations and staff interviews, facility staff failed to implement infection control policy and procedures when Nurse Aide (NA) #1 and NA #2 did not don Protective Equipment (PPE) to include a gown when providing high-contact resident care activities for Resident #49 who had an indwelling medical device. Resident #49 had a lower back indwelling pleural catheter which was used for draining fluid from the pleural space (fluid filled space that surrounds the lungs) to help with breathing. The deficient practice was identified for 2 of 2 staff members reviewed for infection control practices (NA #1 and NA #2).</p> <p>The findings included:</p> <p>Review of the facility's the facility's Enhanced Barrier Precautions (EBP) signage for long term care facilities (LTCF) dated 07/26/22 read: All residents with any of the following: Wounds (skin opening that requires a dressing) and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of multi-drug-resistant-organism (MDRO) colonization status. All healthcare personnel must: wear gloves and gowns for the following high-contact resident care activities: Handling linen, transferring resident, and changing linen.</p> <p>During an observation on 11/06/24 at 11:25 AM a sign was posted by Resident #49's room door that read in part: Enhanced barrier precautions, and providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care or use of a central line, urinary catheters, feeding tubes, and wound care.</p> <p>During an observation from the hall on 11/06/24 at 11:30 AM Nurse Aide (NA #2) and NA #1 were observed in Resident #49's room changing the bed linens. Resident #49 was sitting at the bedside in her recliner. Nurse Aide #2 and Nurse Aide #1 had on gloves when changing the bed linens but were not wearing gowns. A hanging door bin with PPE (personal protective equipment) supplies was on the door, including one time use disposable gowns.</p> <p>An interview was conducted on 11/06/24 at 11:30 AM with Nurse Aide #1 and #2. They stated they did not put on gowns when they transferred Resident #49 to the recliner or when they changed the bed linens. They both knew Resident #49 was on Enhanced Barrier Precautions and acknowledged that they should have worn a gown and gloves when providing direct care, such as the transfer, and should have also worn a gown and gloves when changing bed linens.</p> <p>An interview was conducted on 11/07/24 at 8:55 AM with NA #1. She revealed on 11/06/24 at 11:30 AM when she was helping transfer Resident #49 from bed to Recliner, she went to put on a gown with her gloves, when NA #2 stated she didn't need to don a gown, so she didn't. NA #1 said looking back, she and NA #2 should have worn gowns.</p> <p>An interview was conducted on 11/07/24 at 9:05 AM with NA #2. She revealed she changed Resident #49's bed linens and was aware that the donning gown and gloves were required during high contact resident care activities. She stated they just got in a hurry when transferring Resident #49 and changing her linen.</p> <p>(continued on next page)</p> | | |

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