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 _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTLAND MANOR HEALTH CARE CENTER	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
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of medical records, the facility failed to accurately code the dental status on the Minimum Data Set (MDS) for 3 of 3 sampled residents (Residents #28, #36 and #68) reviewed for dental status, failed to accurately	F 278	Identified residents with dental status issues were re-assessed and a modification of the MDS was submitted to update the record. Modifications were made to the dental status on the MDS for Residents #28, #36, and #68 on 8/7/15.	9/9/15

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

Electronically Signed | 08/30/2015

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F 278	Continued From page 1 code the locomotion status for 1 of 2 sampled residents (Resident #14) reviewed for locomotion and failed to accurately code the continence status of 1 of 2 sampled residents (Resident #44) reviewed for incontinence. Findings included: 1. Resident #28 was admitted to the facility on 3/20/13 with diagnoses that included hypertension, seizure disorder and dementia. A Significant Change in Condition Minimum Data Set (MDS), dated 12/19/14 indicated Resident #28 was cognitively impaired. The resident was identified as being totally dependent on staff for hygiene. The resident was not identified as having no natural teeth, or tooth fragments, obvious or likely cavity or broken natural teeth or mouth/facial pain or difficulty chewing. A dental consult, dated 7/13/15, revealed the Resident #28 had no problem chewing and no oral pain. An observation was made on 8/3/15 at 11:24 AM. Resident #28 had some missing teeth. The Director of Nursing (DON) visualized the resident's mouth on 8/6/15 at 9:00 AM and stated the resident had no teeth. She stated the MDS was inaccurate. The DON stated she started in November 2014 and the resident had been edentulous the entire time. The MDS nurse was interviewed on 8/6/15 at 10:16 AM. The MDS nurse stated she gathered information for the completion of the MDS from the resident's chart, the nurse's notes, nursing assistant (NA) documentation and from observation and interview with the residents. The MDS nurse added a dental assessment, including observing the resident's oral cavity, was done for completion of the dental section of the MDS. The MDS nurse reviewed Resident #28's most recent full assessment, dated 12/19/14 and stated the	F 278	Modifications were also made on Resident #14 regarding her locomotion on and off the unit and on the MDS for Resident #44 to reflect accurate coding of continence. Modifications were completed on Resident #14 and #44 on September 8, 2015. Education was provided by the SDC starting on 8/07/15 to all CNAs that record ADL in the kiosk for services provided to each resident, as well as the MDS coordinator for appropriate assessment of each resident. Any resident that was admitted, has had an annual assessment or a significant change assessment completed since January 1, 2015, were reviewed for discrepancies for accurateness of dental status. Oral/Dental audits have been completed and modifications submitted on all residents that a discrepancy was found. A full house audit for locomotion and bowel and bladder were also initiated on August 8, 2015 and there were no further modifications found to be needed. The modification assessments prior to submission to the state were reviewed by the MDS coordinator with oversight from the regional clinical reimbursement specialist along with the DON. Dental reviews were completed by August 16, 2015. Bowel and Bladder and locomotion reviews were completed by August 31, 2015. ADL documentation has been reviewed on all assessments completed over the past 30 days and will continue to be a focus until accuracy is obtained. SDC will work with MDS nurse to insure proper education is provided to all certified	

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F 278	Continued From page 2 resident was coded as having no dental issues. She stated if Resident #28 had no teeth, the assessment was inaccurate. The MDS nurse stated she was unsure why she had inaccurately coded the resident's dental status. 2. Resident #68 was admitted to the facility on 3/30/15 and readmitted on 5/19/15 with diagnoses that included pressure ulcers, neurological disease and hypertension. The 4/7/15 Admission Minimum Data Set (MDS) revealed Resident #68 was cognitively intact. The resident was not identified as having tooth fragments, obvious or likely cavities or broken natural teeth. An observation was made of Resident #68's teeth on 8/3/15 at 3:47 PM. Missing and broken teeth were observed in Resident #68's oral cavity. An interview with the resident was held on 8/5/15 at 12:00 PM. Resident #68 revealed her teeth had been broken during a childhood accident. The DON observed Resident #68 on 8/6/15 at 9:00 AM and then reviewed the MDS. The DON stated the resident had broken teeth, so therefore, the MDS was inaccurate. The MDS nurse was interviewed on 8/6/15 at 10:16 AM. The MDS nurse stated she gathered information for the completion of the MDS from the resident's chart, the nurse's notes, nursing assistant (NA) documentation and from observation and interview with the residents. The MDS nurse added a dental assessment, including observing the resident's oral cavity, was done for completion of the dental section of the MDS. The MDS nurse reviewed the last full assessment for Resident #68, an Admission assessment, dated 4/7/15. She stated she had coded dental as none of the above. The MDS nurse assessed the resident at this time and reported the resident had missing teeth on the bottom and broken teeth on	F 278	nursing assistants. MDS nurse has received education regarding process of how to assess residents appropriately by the clinical reimbursement specialist. This education was completed by 8/26/14. In addition to the education provided for the MDS coordinator, education was also provided to the Administrator, DON, ADON, and SDC on how to properly read and code the MDS for the sections regarding locomotion, bowel and bladder, as well as dental status. This education was completed on 8/26/15. Audits will be conducted by the clinical reimbursement specialist for the next three months to insure compliance with education provided as well as the accuracy of all MDS that are prepared and submitted. The facility will audit no less than 10% of the patient population with each audit. There will be a full review of all MDS assessments by the clinical reimbursement specialist prior to submissions for the first 30 days of the assessment window. In house audits will be ongoing by the Administrator, DON or ADON with assistance from clinical reimbursement specialist to insure accuracy of provision of ADLs. MDS that are in the ARD window are reviewed on week days in clinical white board meeting to assist in decreasing incorrect data entry on the MDS as well as to validate accurate ADL coding in the electronic system. Audit information will be collected on a spreadsheet and will be added to the POC book as a part of the annual state	

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F 278	Continued From page 3 top. The MDS nurse acknowledged Resident #68's dental assessment was inaccurate. She stated she thought she must have completed the assessment quickly and clicked the wrong choice. 3. Resident #36 was admitted to the facility on 3/26/14 with hypertension and dementia. A Significant Change in Status Minimum Data Set (MDS), dated 1/27/15 indicated Resident #36 was moderately cognitively impaired. Loose, broken or missing teeth were not identified on the MDS for Resident #36. An observation was completed on 8/3/15 at 11:12 AM. The resident had broken teeth and missing teeth. On 8/6/15 at 9:00 AM, the Director of Nursing (DON) assessed the resident's oral cavity and stated Resident #36 had missing and broken teeth. The DON reviewed the 1/27/15 MDS for Resident #36 and stated the dental status for the resident was inaccurate. The DON stated she had started in November 2015 and the resident ' s teeth were in poor condition at that time. The MDS nurse was interviewed on 8/6/15 at 10:16 AM. The MDS nurse stated she gathered information for the completion of the MDS from the resident's chart, the nurse's notes, nursing assistant (NA) documentation and from observation and interview with the residents. The MDS nurse added a dental assessment, including observing the resident's oral cavity, was done for completion of the dental section of the MDS. At this time, the MDS nurse assessed Resident #36's dental status and reported the resident had broken teeth. She stated the MDS for Resident #36's dental status was not accurate. The MDS nurse stated she could not say why the dental assessment for Resident #36 was not accurate.	F 278	survey. Ongoing audits by licensed nurses for observation and documentation of proper dental status, proper ADL coding related to both incontinence and mobility on and off the unit. These audits will be weekly for one month, then monthly for three months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 278	Continued From page 4	F 278		

#4. Resident #14 was admitted to the facility on 5/11/2011, with diagnosis to include dementia and stroke.
Her most recent Minimum Data Set (MDS) assessment on 7/24/2015 indicated her cognition was severely impaired. She required extensive assistance with locomotion on the unit, and supervision only with locomotion off the unit.
On 8/4/2015 at 10:29 AM, an observation of Resident #14 was conducted in the resident's room. The resident independently propelled herself in her wheelchair (w/c) from the side of the bed to the television, and then turned her chair and propelled back to the bed.
An interview was conducted with the nursing assistant (NA) #2 on 8/4/2015 at 2:41 PM. The NA stated the resident could propel herself in her w/c, after she was assisted into chair. She indicated the resident could not take direction, so she was pushed to the dining room and back, for meals and activities. The NA stated she coded the locomotion as limited assistance.
An interview was conducted with NA #3 on 8/4/2015 at 2:57 PM. The NA stated the resident required extensive assistance with activities of daily living (ADL's), but could propel herself in the hallways once she was assisted into her w/c. The NA indicated the resident needed assistance with eating and needed to be pushed to the dining room, because she would not understand to go there on her own. The NA stated she coded locomotion as one person limited assistance.
On 8/5/2015 at 1:04 PM, an interview was conducted with the nurse (nurse #1). The nurse

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F 278	Continued From page 5	F 278		

stated the resident got around the facility using her feet to propel her w/c. She indicated the resident didn't go anywhere with a purpose, so the staff had to push her w/c to take her to dining room or lobby.

An interview was conducted with the MDS nurse on 8/6/2015 at 11:42 AM. The MDS nurse stated she had to code what the NA's documented for ADL's. She indicated the information she reviewed to complete the MDS came from the resident's chart, the ADL documentation, the nurses notes, and for certain areas, the residents themselves. The MDS nurse indicated locomotion on the unit meant in the area around the resident's room, and locomotion off the unit meant the area of lobby or dining room. While reviewing the 7 day look back period for the MDS dated 7/24/2015, the MDS nurse indicated that the NA's had coded 2 episodes of independent and 1 extensive assistance for off unit locomotion. The on unit locomotion was coded with 2 independent episodes, 2 limited assistance, 2 extensive assistance, and 1 total assistance. She stated extensive assistance for locomotion on the unit, and supervision off the unit was the correct coding for this resident. She stated the NA's were coding accurately since she had given them instructions on how to code. She stated some days the resident rolled herself up and down the hall, but if she was supposed to go to the dining room the staff would have to take her.

On 8/6/2015 at 11:15 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that it was hard for her to understand that on the unit, which would be in the area of the resident's room, she was coded as an extensive assistance and off the unit, which would be the area of dining room, she was coded

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F 278	Continued From page 6 as supervision. The DON indicated the resident would need to be taken to the dining room, so off unit should have been coded extensive assistance and not supervision. She indicated she expected the MDS nurse to educate the NA's on coding the care trackers correctly, and to correct mistakes that were made in the care tracker. #5. Resident #44 was re-admitted to the facility on 5/13/2015, with diagnoses to include stroke, and end stage renal disease, receiving dialysis. His admission MDS assessment dated 4/20/2015 revealed his cognition was intact and he was occasionally incontinent. The most recent MDS assessment dated 7/21/2015 revealed a decline in his urinary incontinence to frequently incontinent, and his cognition remained intact. On 8/4/2015 at 2:52 PM an interview was conducted with the resident. The resident stated he took himself to the bathroom, and he had never had an accident with toileting. He indicated that he knew when he had to go to the bathroom, and he could take himself. An interview was conducted with the MDS nurse on 8/4/2015 at 3:39 PM. The MDS nurse stated that she had to code what was in the CNA tracker guide. She stated that she sometimes talked to the NA's if she knew for a fact that a resident had not had incontinent episodes, but she thought this resident must have had incontinent episodes. She indicated the information she reviewed to complete the MDS came from the resident's chart, the ADL documentation, the nurses notes, and for certain areas, the residents themselves. On 8/4/2015 at 4:24 PM, an interview was conducted with NA #2. The NA stated the resident was alert and oriented and was not	F 278		

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F 278	Continued From page 7 incontinent. She indicated he was independent with his own care. She stated if she coded the resident as incontinent, then that was a mistake, because he could go to the bathroom by himself, and she had never known him to be incontinent. An interview was conducted on 8/5/2015 at 11:11 AM with NA # 1. The NA stated the resident was continent of both bowel and bladder when she had worked with him. She indicated she had never known him to be incontinent. On 8/5/2015 at 1:08 PM an interview was conducted with Nurse #1. The nurse stated the resident was alert and oriented and he had no incontinence. An interview was conducted with the DON on 8/6/2015 at 11:39 AM. The DON stated she has only known that the resident was continent, and it appeared that mistakes were made on the CNA care tracker. She expected the MDS nurse to educate the NA's on coding the care trackers correctly, and to correct mistakes that were made in the care tracker.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide incontinent care for 1 of 1 sampled residents (Resident #74) that was observed during the provision of care.	F 312	ADL Care was provided to Resident #74 by NA #1 to remove the soiled brief and soiled bedding. Education was provided to NA #1 on 8/6/15 by the DON following	9/9/15

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F 312	Continued From page 8 Findings included: Resident #74 was admitted on 7/22/15 with diagnoses that included: amputation of the right arm, hypertension, diabetes, seizure disorder and coronary artery disease. The Admission Minimum Data Set (MDS), with a date of 7/29/15, coded the resident as having short and long term memory impairment and severely impaired cognitive skills for daily decision making. There was no rejection of care noted. The MDS coded the resident as requiring extensive assistance with toilet use and personal hygiene. An observation was made on 8/5/15 at 3:10 PM of Nursing Assistant (NA) #1 bathing the resident. On removal of Resident #74's brief, it was observed the brief was saturated with urine and a strong urine smell was noted. Also observed was the doubled turn sheet and the bottom sheet were saturated to the point the color of the mattress was visualized through the sheet. The wet area extended from just under the resident's breast area to below her groin. NA #1 stated with the sheets so wet, most likely the mattress was also wet. The NA added Resident #74 was a "heavy wetter". The treatment nurse who was assisting with the care acknowledged the sheets were wet. A wound was visualized on the resident's left buttock. The treatment nurse identified this wound as a moisture related wound and added the wet brief and sheets did not help. The Treatment Nurse was again interviewed on 8/5/15 at 3:37 PM. She stated the left buttock wound was a moisture related wound. The	F 312	care provided to insure she understood the importance of timely ADL provisions, where she could find care card with information related to each resident, as well as expectations of what the NA should do if she found herself behind in rounding and/or providing care. The LN, wound nurse, and all other NA that were assigned to this unit were instructed to round on Resident #74 every hour to hour and a half due to her potential for heavy wetting. Facility rounds by the DON, ADON, and SDC were completed to insure that no other residents in the center were affected by this deficient practice on 8/6/15. It was found that no other residents were found in this manner. ADL Care education has been completed by 8/7/15 by the SDC and DON to all Licensed nurses and certified nursing assistants. Monitoring has been executed daily at varied times on all shifts by the DON, SDC or ADON to insure ADL care is accurately and adequately provided for residents within the center. These rounds are to include any residents that are not able to provide their own ADL care, make their needs known or one that has the potential for skin breakdown. Any concerns were immediately addressed and corrected by the observing nurse manager that was executing the rounds. These audits will include no less than 10% of the facility population and will be recorded in POC audits as part of the annual survey. Education to all Certified Nursing	

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F 312	Continued From page 9 treatment nurse added if a resident was identified as as one that voided large amounts, then checking every 2 hours was probably not enough. NA #1 was interviewed on 8/5/15 at 4:14 PM. NA #1 stated she had been assigned to care for Resident #74. The NA added she arrived for work around 7:00 AM and completed rounds before breakfast;adding she had provided incontinent care for Resident #74 around 7:30 AM, but because she had been really busy, she had not had a chance to provide care again. The NA added she knew she should check on residents at least every 2 hours and provide care if needed. The NA stated Resident #74 was a new resident, had been identified as a heavy wetter, added the assignment was not her normal assignment and she was not a full time employee and because she had been really busy she had not had time to provide incontinent care for Resident #74 since 7:30 AM. On 8/5/15 at 4:35 PM the Director of Nursing (DON) was interviewed. The DON stated the expectation was for NAs to check residents for incontinence every 2 hours and as needed. She added if a NA was really busy and falling behind and thought they could not complete their tasks, they were expected to notify their supervisor. She stated each staff member was instructed to notify their supervisors when help was needed during orientation. The DON added NA #1 had not reported she needed help to care for her residents and had not been able to provide incontinent care for Resident #74 since 7:30 AM. The DON stated the danger of being wet for prolonged periods of time was poor skin integrity with potential skin breakdown.	F 312	Assistants and Licensed Nurses was provided by the DON, SDC, or ADON; this education was complete by 08/26/15. This training will also be provided to all nurse assistants upon hire during orientation and at least annually through a skills review. Ongoing audits by the DON, SDC, or ADON for observation and review of proper ADL care provided to residents of the facility. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. These audits will also include no less than 10% of the population of the center. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 431	Continued From page 10	F 431		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 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:	F 431		9/9/15

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 _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTLAND MANOR HEALTH CARE CENTER	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
F 431	Continued From page 11 Based on observation, staff interview and facility policy, the facility failed to date insulin when opened on 1 of 2 medication carts (South Hall cart), discard expired medications on 2 of 2 medication carts (North Hall and South Hall carts) and discard an unlabeled bottle of liquid medication on 1 of 2 medication carts (North Hall cart). The findings included: The facility policy entitled "Medication Storage" dated 2007 read in part, "Note the date on the label for insulin vials and pens when first used." "Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and re-ordered from the pharmacy." 1. Observation of the South Hall medication cart on 8/5/15 at 3:45 PM revealed 1 vial of Humalog Insulin opened and undated; one bottle of Dulcolax tablets and one bottle of Liquid Iron expired 6/2015 and one bottle of acetaminophen with an illegible expiration date but a hand written date of "6/18" . During an interview on 8/5/15 at 3:45 PM, Nurse #2 indicated insulin should be dated when opened and expired medications should be discarded. The nurse stated she could not read the expiration date on the acetaminophen bottle, and added she did not know what the date "6/18" meant. The Director of Nursing (DON) was interviewed	F 431	Education was started with Licensed Nurses and Medication aides that are employed by the center on appropriate medication storage. This education was provided by the SDC and DON. Medications noted were OTC meds that were replaced with current dated bottles, a vial of Humalog insulin that was immediately removed from the cart, and a bottle of clear liquid assumed to be eye drops that were discarded as well. Education was provided to all LN (including LN #1 and LN #2) on medication storage on 8/07/15. Medications out of date or not correctly labeled were immediately removed from the med cart by the licensed nurse. Med cart and storage areas have been inspected and reviewed by the DON or ADON on 8/10/15 to insure all medications were within date range for administration. Any concerns were addressed and corrected by the licensed nurse immediately. Likewise, any outdated or unlabeled medications were immediately removed from the medication carts. Audits will be completed for each medication cart and storage areas by the DON, ADON, or SDC at various times on all shifts to insure med cart compliance is met. These audits will be ongoing weekly for one month and then monthly for three months. In addition, pharmacy staff will do a monthly unannounced audit of each med cart and storage area for three months. These audits will be documented on a POC audit form as part of the annual survey.	

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F 431	Continued From page 12 on 8/6/15. She stated insulin should be dated when opened and expired medications should be discarded. The DON also indicated there was a known problem with the manufacturer's expiration date rubbing off from some acetaminophen bottles, and any bottles without legible expiration dates should be discarded. 2. On 8/5/15 at 5:00 PM an observation was made of the North Hall medication cart. Inside the cart in the drawer for stock medications were found the following expired medications. Zinc Sulfate with a use by date of 4/15 Bisacodyl with an expiration date of 11/14 Bisacodyl with an expiration date of 6/15 Calcium Carbonate with an expiration date of 2/15 Senior Tabs with a use by date of 1/15 Vitamin D with a use by date of 1/15 Additionally in the cart was found an unlabeled bottle of a clear liquid. Nurse #1, who was using the cart to pass medications to residents, identified the bottle as an eye medication. Along with no identifying label, the bottle was not labeled with a resident's name. Nurse #1 added it was the responsibility of each nurse to make sure all medications were labeled correctly and all expired medications were removed from the cart. She added the consultant pharmacist also audited the cart monthly for expired medications. The Director of Nursing (DON) was interviewed on 8/6/15 at 11:26 AM. The DON stated the nurse accepting the medication cart at the beginning of a shift was responsible to make sure there were no expired medications or unlabeled	F 431	All licensed nurses and mediation aides have been educated by the SDC or DON regarding proper storage, dating, and labeling of medications on the medication cart. This education was completed by 8/28/15. This training will also be provided to all licensed nurses upon hire during orientation and at least annually through a skills review. Ongoing audits will be performed by the DON, SDC, or ADON to insure compliance with proper storage, dating, and labeling of medications on the medication carts and storage areas. These audits will be weekly for one month, then monthly for three months. In addition, pharmacy staff will conduct at least one audit per month on each medication cart to insure accuracy as well. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise	

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F 431	Continued From page 13 medications in the cart. The DON added the pharmacy consultant did a monthly review of the medication cart and gave her feedback on what was found. She added last month when the North Cart was audited, the pharmacist had found one medication.	F 431		