| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345375 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/20/2025 |
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| **Scotland Manor Health and Rehabilitation Center** | **920 Jr High School Road , Scotland Neck, North Carolina, 27874** |

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| E0000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 11/17/25 through 11/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DB67C-H1. | E0000 | | 12/01/2025 |
| F0000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 11/17/25 through 11/20/25. Event ID# 1DB67C-H1.<br><br>The following intakes were investigated: NC837339 and NC837341.<br><br>6 of 6 complaint allegations did not result in a deficiency. | F0000 | | 12/01/2025 |
| F0685<br>SS = D | Treatment/Devices to Maintain Hearing/Vision<br><br>CFR(s): 483.25(a)(1)(2)<br><br>§483.25(a) Vision and hearing<br><br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and interviews with the resident, staff, and Medical Director, the facility failed to follow up with an audiologist's (a medical professional that specializes in the diagnosis, | F0685 | F685<br><br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>On 11/19/25 Resident #21 received physician's order for ear wax removal drops per recommendation from audiologist. Order was initiated on 11/19/25, completed on 11/23/25 and was documented on Resident #21 Medication Administration Record.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>On or before 12/8/25 the Director of Nursing or RN Supervisor performed a medical record review audit for residents who have physician orders for audiology consults to validate all follow-up recommendations have been reviewed and denied or approved by the attending physician. There were four residents who were identified from the audit as having the potential to be | 12/11/2025 |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0685 SS = D | Continued from page 1<br>evaluation and treatment of hearing disorders) recommendation for ear wax removal for 1 of 1 resident reviewed for hearing difficulties (Resident #21).<br><br>The findings included:<br><br>Resident #21 was admitted to the facility on 1/24/24 with diagnoses which included stroke.<br><br>The Minimum Data Set (MDS) quarterly assessment dated 10/23/25 revealed Resident #21 had moderate cognitive impairment. Resident #21 was coded for minimal hearing difficulty and no hearing aid.<br><br>The care plan, last reviewed on 10/30/25, revealed Resident #21 had a communication problem related to hearing deficit with interventions which included repeating as necessary, face the resident while speaking, and speaking clearly and slower than normal.<br><br>The Audiology (scientific study of hearing and balance) visit summary dated 12/12/24 revealed Resident #21 was seen for new verbal communication difficulties such as need to have commands repeated, not turning when spoken to, and having difficulty understanding speech. The visit summary further noted Resident #21 reported bilateral (both sides) ear pain and tinnitus (ringing, buzzing, or hissing in ears with no external source). The Audiology clinical findings included that the degree of hearing loss could not be established in the right and left ear due to too much ear wax present to conduct the test. The Audiologist noted that Resident #21 was evaluated at the bedside and was noted to have excessive hardened ear wax in both ears that was unable to be removed by curette (a surgical instrument used for scraping). The Audiologist recommendations for the attending physician and nurse was to contact Resident #21's physician for wax removal protocol for both ears.<br><br>The Audiology visit summary dated 11/07/25 revealed Resident #21 was seen by the Audiologist for reported bilateral tinnitus and ear pain. The clinical findings noted that the degree of hearing loss and discrimination (ability to understand speech) was unable to be established for both ears related to the amount of ear wax present. The Audiologist's additional comments noted that for the last two visits Resident #21's was noted to have hardened wax bilaterally that was unable to be removed with a curette, and the ear wax was still present at current visit. The Audiologist's recommendations for the attending physician and nursing staff were to contact Resident #21's physician for ear wax removal protocol. | F0685 | Continued from page 1<br>affected. Each of the four residents had the recommendations reviewed and approved by the attending physician with new orders implemented.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 12/8/2025 the Administrator in-serviced the Director of Nursing and RN Supervisor on reviewing recommendations from audiology summaries and providing any audiology recommendations to the attending physician for evaluation and determination of new physician orders.<br><br>Any newly hired nurse manager with assigned duties related to audiology visits summaries will be in-serviced by the Director of Nursing prior to provision of care.<br><br>`<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Monthly for three months during the Clinical Morning Meeting, the Director of Nursing or RN Supervisor will randomly audit five residents' charts to make sure all recommendations on visit summaries from audiology have been addressed and documented with initials. Results of the audit will be presented by the DON to the QAPI Committee monthly for three months. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.<br><br>Date of Compliance: 12/11/2025 | |

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| F0685 SS = D | Continued from page 2<br>Resident #21's physician orders were reviewed and revealed the Audiologist's recommendations for ear wax removal on 12/12/24 and 11/07/25 were not implemented.<br><br>An interview and observation of Resident #21 was conducted on 11/17/25 at 10:10 am. Resident #21 reported difficulty hearing, and he reported he did not have a hearing aid. This surveyor had to get close to Resident #21's left ear and speak slowly and at a slightly higher tone for the resident to be able to hear questions. Resident #21 stated he would like to have hearing aids if they were needed but he had not been able to get the test done. Resident #21 stated a doctor recently saw him but was not able to do anything about the hearing problem because he had too much ear wax in his ears. Resident #21 stated he did not recall if he had received any treatment for the ear wax.<br><br>An interview was conducted with Nurse #3 on 11/19/25 at 12:45 pm who was assigned to Resident #21. Nurse #3 stated Resident #21 did not have hearing aids and she stated she felt he could hear okay, sometimes better than others. She stated that she did not recall Resident #21 report ear pain or ringing in ears. Nurse #3 stated that typically the Audiology recommendations were reviewed by someone in nursing management, not the medication cart nurse assigned to the resident. Nurse #3 stated she received direction to enter an order for Resident #21's ear wax treatment today (11/19/25) by the Director of Nursing (DON).<br><br>An interview was conducted with the Social Worker on 11/20/25 at 11:21 am who revealed she was the person responsible to set up Audiology appointments. She stated she did receive the referral for Resident #21 to be seen by the Audiologist and she had the resident placed on the list to be seen. The Social Worker confirmed she was on the list to receive the visit summary email from the Audiologist along with the Director of Nursing, but she stated she only confirmed the appointment had been completed as scheduled and did not review for any nursing recommendations.<br><br>A telephone interview was conducted on 11/20/25 at 12:34 pm with the Medical Director who was the physician for Resident #21. The Medical Director stated that she saw Resident #21 in January 2025, and he did not report any ear pain or ringing in ears at that time. The Medical Director stated had the facility notified her of the Audiology recommendations from the two visits she would have ordered Resident #21's ear wax removal treatment. The Medical Director stated she was at the facility every Friday and was available by phone if anything was needed for a resident before her | F0685 | | |

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| F0685 SS = D | Continued from page 3<br>in-person visit to the facility.<br><br>During interviews with the DON on 11/19/25 at 1:31 pm and 11/20/25 at 11:40 am she confirmed that she did receive the Audiology visit notes from the provider, but she was unable to recall if she received them directly from the Audiologist or if they were forwarded from someone at the facility. The DON stated the 12/12/24 Audiology visit recommendations for Resident #21's ear wax removal should have been handled by the previous Assistant Director of Nursing when the recommendations were received, but she stated she did not follow up to make sure the provider was notified. The DON confirmed that she did receive the recommendations from the 11/07/25 Audiology visit for Resident #21's ear wax removal but she had not contacted the provider to get the order until 11/19/25. The DON stated the Audiology recommendation for Resident #21's ear wax removal should have been reviewed with the provider when they were received. An attempt to conduct a telephone interview with the previous Assistant Director of Nursing on 11/20/25 at 9:59 am was unsuccessful.<br><br>During an interview on 11/19/25 at 1:44 pm with the Regional Director of Clinical Services she revealed the physician should have been provided with the Audiologist recommendations for Resident #21's ear wax removal when the visit summary was received.<br><br>The previous Administrator was interviewed on 11/20/25 at 11:50 am and revealed the Director of Nursing or the previous Assistant Director of Nursing were responsible to ensure the Audiology recommendations for Resident #21's ear wax removal were reviewed with the provider to determine if orders were needed.<br><br>The Administrator was interviewed on 11/20/25 at 11:52 am and revealed the DON was responsible to ensure the recommendations were reviewed with the provider for Resident #21 when they were received. | F0685 | | |
| F0695 SS = D | Respiratory/Tracheostomy Care and Suctioning<br><br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br><br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' | F0695 | F695<br><br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Resident #21 had oxygen tubing changed and replaced on 11/17/25 by Licensed Nuse #4 and on 11/19/25 by the Director of Nursing. | 12/11/2025 |

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| F0695 SS = D | Continued from page 4<br>goals and preferences, and 483.65 of this subpart.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and staff interviews, the facility failed to follow physician orders to change oxygen supplies, which included the nasal cannula, for 1 of 1 resident reviewed for respiratory care (Resident #21).<br><br>The findings included:<br><br>Resident #21 was admitted to the facility on 1/24/24 with diagnoses which included chronic obstructive pulmonary disease (COPD).<br><br>The Minimum Data Set (MDS) quarterly assessment dated 10/23/25 revealed Resident #21 had moderate cognitive impairment. Resident #21 was coded for supplemental oxygen use.<br><br>The care plan last reviewed on 10/30/25, revealed Resident #21 was at risk for shortness of breath related to COPD with interventions which included to administer oxygen as ordered.<br><br>Resident #21 had a physician order dated 10/08/25 to change oxygen supplies (nasal canula tubing, humidifier bottles) every 7 days when oxygen is in use. Every night shift, every Wednesday for oxygen cannula.<br><br>Review of the Medication Administration Record (MAR) for November 2025 revealed Resident #21's oxygen nasal cannula tubing was documented as changed on 11/05/25 and 11/12/25 by Nurse #4.<br><br>An observation was conducted on 11/17/25 at 10:10 am of Resident #21. Resident #21 was observed in bed with oxygen at 2 liters via nasal cannula in place. The oxygen cannula tubing had a white piece of tape on the tubing with the date of 10/31/25 handwritten in black ink.<br><br>An interview was conducted with Nurse #2 on 11/17/25 at 10:20 am who confirmed the date on Resident #21's oxygen nasal cannula was 10/31/25. Nurse #2 stated she believed the oxygen nasal cannula was ordered to be | F0695 | Continued from page 4<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>Residents who are receiving oxygen have been identified as having the potential to be affected. On 11/19/25 the Director of Nursing (DON) completed an audit of physician orders and identified three additional residents with physician orders for oxygen. On 11/19/25 the DON completed a visual inspection of the additional three resident's oxygen tubing with no concerns noted with oxygen tubing set up or with date change in the last seven day. On 11/19/25 the DON reviewed the additional three residents Medication Administration Records with no concerns for documentation of oxygen tubing set change.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 11/20/25 the Director of Nursing (DON) provided Licensed Nurse #4 one to one education on following physician's orders for changing oxygen tubing and accurately documenting the changing of the oxygen tubing in the Medication Administration Record. On 12/8/2025 the Director of Nursing initiated education to each Licensed Nurse or Certified Medication Aid on following physician's orders for changing oxygen supplies. Any Licensed Nurse or Certified Medication Aid who did not receive the education by 12/10/2025 will not be permitted to work without first receiving the education prior to the start of their next scheduled shift. No Licensed Nurse or RN will be permitted to work without receiving the education.<br><br>Any newly hired License Nurse or Certified Medication Aid and newly contracted agency nurse will receive the education from the Director of Nursing or Nurse Supervisor in Charge on following physician orders when to change oxygen supplies, prior to provision of care.<br><br>`<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Once a week for twelve weeks during the Clinical | |

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| F0695 SS = D | Continued from page 5<br>changed weekly during the night shift.<br><br>A telephone interview was conducted on 11/18/25 at 2:38 pm with Nurse #4 who confirmed he was assigned to Resident #21 on 11/05/25 and 11/12/25 during the 11:00 pm to 7:00 am shift when the nasal cannula was ordered to be changed. Nurse #4 stated he normally changed the oxygen nasal cannula at the end of the shift before he left the facility, but it must have slipped his mind. Nurse #4 stated he must have signed the physician order as completed before he put the new oxygen supplies in place for Resident #21.<br><br>During an interview with the Director of Nursing (DON) on 11/19/25 at 1:25 pm she revealed oxygen supplies were changed weekly during the night shift and typically would be changed by the night nurse assigned to the resident. The DON stated Nurse #4 was responsible for changing Resident #21's oxygen supplies on 11/05/25 and 11/12/25.<br><br>An interview was conducted with the Administrator on 11/20/25 at 12:00 pm who revealed the nurse assigned to Resident #21 at the time the oxygen supplies were to be changed was responsible to ensure the physician order was completed. | F0695 | Continued from page 5<br>Morning Meeting, the Director of Nursing or Nurse Supervisor in Charge will randomly audit two residents who are ordered oxygen by the physician to validate oxygen tubing is changed and documented per physicians' orders. Results of the audits and will be presented by the DON to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months.<br><br>The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.<br><br>Date of Compliance 12/11/2025 | |
| F0842 SS = D | Resident Records - Identifiable Information<br><br>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br><br>(i) A facility may not release information that is resident-identifiable to the public.<br><br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(h) Medical records.<br><br>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete; | F0842 | F842<br><br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Resident #21 had his oxygen tubing set up changed and documented per physician order on 11/17/25. Resident #21 is currently on oxygen via nasal cannula. On 11/19/25 Licensed Nurse #4 clarified in the medical record the documentation of the changing of the oxygen tubing set up for 11/5/25 and 11/12/25 was documented inaccurately. A facility Risk Report was completed by Licensed Nurse #2 for the inaccurate documentation of the changing of the oxygen tubing set up for 11/5/25 and 11/12/25.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice: | 12/11/2025 |

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| F0842 SS = D | Continued from page 6<br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records,<br><br>regardless of the form or storage method of the records, except when release is-<br><br>(i) To the individual, or their resident representative where permitted by applicable law;<br><br>(ii) Required by Law;<br><br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br><br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(h)(4) Medical records must be retained for-<br><br>(i) The period of time required by State law; or<br><br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br><br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(h)(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments; | F0842 | Continued from page 6<br><br>On 11/19/25 the Director of Nursing (DON) completed an audit of physician orders and identified three additional residents with physician orders for oxygen. On 11/19/25 the DON completed a visual inspection of the additional three resident's oxygen tubing with no concerns noted with oxygen tubing set up or with date change in the last seven days. On 11/19/25 the DON reviewed the additional three residents Medication Administration Records with no concerns for documentation of oxygen tubing set change. Residents who have physicians' orders for nasal cannula changes have been identified as having the potential to be affected.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 11/20/25 the Director of Nursing provided Licensed Nurse #4 one to one education on following physician's orders for changing oxygen tubing and accurately documenting the changing of the oxygen tubing in the Medication Administration Record. On 12/8/2025 the Director of Nursing, (DON) RN Supervisor, or Nursing Home Administrator (NHA), initiated education to each Licensed Nurse and Certified Medication Aid on following physician's orders for nasal cannula changes with documentation in the Medication Administration Record (MAR). Any Licensed Nurse or Certified Medication Aid who did not receive the education by 12/10/2025 will not be permitted to work without first receiving the education by the DON, RN Supervisor, or NHA, prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work without receiving the education.<br><br>Any newly hired License Nurse, newly contracted agency nurse, or newly hired Certified Medication Aid will receive the education from the Director of Nursing, NHA, or Nurse Supervisor in Charge on nasal cannula changes documentation on MAR prior to provision of care.<br><br>`<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Once a week for twelve weeks during the Clinical | |

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| F0842 SS = D | Continued from page 7<br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and staff interviews, the facility failed to ensure a medical record was accurate regarding oxygen nasal cannula changes. This was for 1 of 23 sampled residents whose medical records were reviewed (Resident #21).<br><br>The findings included:<br><br>Resident #21 was admitted to the facility on 1/24/24 with diagnoses which included chronic obstructive pulmonary disease (COPD).<br><br>A physician order dated 10/08/25 to change oxygen supplies every 7 days when oxygen is in use. Initial and date supplies. Every night shift, every Wednesday for oxygen cannula.<br><br>Review of the Medication Administration Record (MAR) for November 2025 revealed Resident #21's oxygen was used every shift as ordered by the physician. Further review of the MAR revealed Resident #21's oxygen nasal cannula tubing was documented as changed on 11/05/25 and 11/12/25 by Nurse #4.<br><br>An observation was conducted on 11/17/25 at 10:10 am of Resident #21. Resident #21 was observed in bed with oxygen at 2 liters via nasal cannula in place. The oxygen cannula tubing had a white piece of tape on the tubing with the date of 10/31/25 handwritten in black ink.<br><br>A telephone interview was conducted on 11/18/25 at 2:38 pm with Nurse #4 who confirmed he was assigned to Resident #21 on 11/05/25 and 11/12/25 during the 11:00 pm-7:00 am shift when the nasal cannula was ordered to be changed. Nurse #4 stated he normally documented the | F0842 | Continued from page 7<br>Morning Meeting, the Director of Nursing or Nurse Supervisor in Charge will randomly audit three residents nasal cannula tubing date against the residents' medication administration records to validate accurate documentation Results of the audits will be presented by the DON to the QAPI Committee monthly for three months. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.<br><br>Date of Compliance 12/11/2025 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345375 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/20/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Scotland Manor Health and Rehabilitation Center** | **920 Jr High School Road , Scotland Neck, North Carolina, 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 |
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| F0842 SS = D | Continued from page 8<br>nasal cannula tubing was changed sometime during the shift but not necessarily at the time it was changed. Nurse #4 stated he changed the oxygen tubing at the end of the shift, but it must have slipped his mind on 11/05/25 and 11/12/25.<br><br>During an interview with the Director of Nursing (DON) on 11/19/25 at 1:25 pm she revealed Nurse #4 should not have documented that Resident #21's oxygen tubing was changed if he did not change it.<br><br>An interview was conducted with the Administrator on 11/20/25 at 12:00 pm who revealed the nurse that was assigned to Resident #21 should not have documented the oxygen tubing was changed if not completed as ordered. | F0842 | | |