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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scotland Manor Health and Rehabilitation Center	920 Jr High School Road Scotland Neck, NC 27874

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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. (continued on next page)

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.

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

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scotland Manor Health and Rehabilitation Center	920 Jr High School Road Scotland Neck, NC 27874

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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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, evaluation and treatment of hearing disorders) recommendation for ear wax removal for 1 of 1 resident reviewed for hearing difficulties (Resident #21).The findings included:Resident #21 was admitted to the facility on [DATE] with diagnoses which included stroke. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #21 had moderate cognitive impairment. Resident #21 was coded for minimal hearing difficulty and no hearing aid.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. 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.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. 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.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. 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). 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. 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 in-person visit to the facility. During

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scotland Manor Health and Rehabilitation Center	920 Jr High School Road Scotland Neck, NC 27874

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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included:Resident #21 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #21 had moderate cognitive impairment. Resident #21 was coded for supplemental oxygen use. 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. 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. 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.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. 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 changed weekly during the night shift.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.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. 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.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scotland Manor Health and Rehabilitation Center	920 Jr High School Road Scotland Neck, NC 27874

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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included:Resident #21 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). 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. 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.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.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 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. 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. 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.