PRINTED: 12/07/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		345375	B. WING _		10	C 0/23/2017
	ROVIDER OR SUPPLIER US HEALTH AT SCOTLA	ND MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 157 SS=D	(INJURY/DECLINE/R CFR(s): 483.10(g)(14) (g)(14) Notification of (i) A facility must immonsult with the residual consistent with his or representative(s) where the consistent injury and his physician intervention. (B) A significant chan mental, or psychosocy deterioration in health status in either life-throclinical complications. (C) A need to alter treat a need to discontinue treatment due to advect the commence a new form the facility and the facility when the facility with the commence of	COOM, ETC) Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring t; ge in the resident's physical, ial status (that is, a ental, or psychosocial reatening conditions or o); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or	F 1	TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/06/2017 **Electronically Signed**

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.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345375	B. WING				23/2017
NAME OF P	ROVIDER OR SUPPLIER	0.00.0	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/.	23/2017
	10115211 011 001 1 2.2.1				20 JR HIGH SCHOOL ROAD		
ACCORDI	US HEALTH AT SCOTLA	AND MANOR			COTLAND NECK, NC 27874		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 157	Continued From page 1		F 1	157			
	(A) A change in room as specified in §483.	or roommate assignment 10(e)(6); or					
		ent rights under Federal or ons as specified in paragraph on.					
	update the address (in phone number of the This REQUIREMENT by:	record and periodically mailing and email) and resident representative(s). T is not met as evidenced iew and staff interviews the			Preparation and/or execution of this pl	an	
	Based on record review and staff interviews the facility failed to notify the physician for 1 of 3 sampled residents (Resident #1) who experienced a change in their physical condition. Resident #1 was admitted to the hospital intensive care unit with a blood glucose of 803 mg/dL, evidence of sepsis, urinary tract infection				of correction does not constitute admission or agreement by the provide the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared sole because it is required by the provisions Federal and State law.	er of ons s. ly	
	on December 2015, o	ed "Acute Condition otocol", and dated as revised			Resident #1 was discharged from th facility on 10/3/2017 and did not return 2. To assure a) residents have been properly assessed to ensure that change		
	#3. Direct care staff, will be trained to reco changes in the reside #6. Before contacting	including nursing assistants ognize subtle but significant ent. g a Physician about			in condition were identified, b) physicial were notified of all changes in condition c) documentation accurately reflects action taken, and that d) intervention were incompleted.	ns n vas	
	Nursing Staff will mal collect pertinent infor Physician.	te change of condition, the ce detailed observation and mation to report to the			timely and appropriate; residents requi emergency room visits and those who required hospitalization for the past 30 days will be reviewed in detail by	·	
	should be made by a who has collected an information, including symptoms and status	the resident's current			 11/10/2017. Reviews will be completed Director of Nursing (DON) and/or or Ur Manager. 3. Nurses are being in-serviced on a) proper and comprehensive physical assessment, b) recognizing an acute 	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345375	B. WING _				C 23/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	107	20/2017
					20 JR HIGH SCHOOL ROAD		
ACCORDI	US HEALTH AT SCOTL	AND MANOR			SCOTLAND NECK, NC 27874		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From pag	ge 2	F '	157			
		cy of the situation. For			change in condition, c) appropriate		
		Il call or page the Physician			notification of physician for orders to		
	and request a promp				intervene and respond to the acute		
					change, d) implementation of physician	1	
	Resident #1 was ad	mitted to the facility on			ordered response		
		noses to included stroke,			-A full return demonstration will be		
	_	gia, and dementia. Her			conducted with each nurse. Nurses will	il	
	quarterly Minimum [Data Set (MDS) assessment			receive in-service on and a copy of the		
	dated 7/29/2017 rev	ealed her cognition to be			NC Nursing Scope of Practice which		
		She required 2-person total			clearly delineate the requirement for a		
		f for bed mobility and			physician □s order prior to ordering		
		on total assistance for all			laboratory tests, x-rays, and other tests	as	
		ily living (ADLs). She			well as any treatment.		
	required a feeding to	ube for nutrition.			These in-services will be conducted by		
	A				clinical consultant. All licensed nurses v	WIII	
		s note dated 9/30/2017, at			be in-serviced by 11/20/2017.		
		lurse #1 was called to the			Niverse will be in consisted an and reserve		
	-	the nursing assistant (NA #4) sident was alert but not			Nurses will be in-serviced on and received	ve	
		signs were taken with the			copies of pertinent policies(to include change of condition, appropriate		
	-	1, the blood pressure was			notification of physician/family,		
		nd respirations 24. A blood			implementation of physician orders, etc	•)	
	• •	vith the result of 486mg/dL			and sign for that receipt indicating their	•	
	•	iter). The tube feeding was			understanding and agreement to follow		
		lent was a little more			the policies as written. In-service will b		
		tube feeding had been			conducted by DON and/or Unit Manage		
		e indicated she would			All nurses will be in-serviced by		
		and make the 7:00 PM shift			11/10/2017. Any nurse not completing		
	aware of the situation				in-service by this time will be in-service	d	
	documentation of ca	Illing the Physician.			prior to next shift worked.		
	A review of a nurse's	s note dated 10/1/2017 at					
	6:22 PM by Nurse #	1, revealed the resident's					
	_	rning (no time given) was 486			4. A comprehensive review of resident		
		eding was turned off and the			records pertaining to all emergency visit		
	•	ted (no time given), and a			and hospitalizations will be completed to		
		L was obtained. The tube			the DON and/or Unit Manager to ensur	е	
	_	back on and the labs			all aspects of the above systemic		
		ork) were ordered. Nurse #1			corrective action are complete. This		
	would report to the r	night nurse and continue to			review will be recorded on the audit too)l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345375	B. WING _				C 10/23/2017
	ROVIDER OR SUPPLIER US HEALTH AT SCOTL	AND MANOR		920 JR	FADDRESS, CITY, STATE, ZIP CODE HIGH SCHOOL ROAD LAND NECK, NC 27874	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	the Physician. A Physician telepho 10/2/2017 (not times blood count), CMP (panel), Hemoglobin #2. Chest x-ray 2 vis Manager. Laboratory results of and reported on 10/blood glucose of 58 deciliter), with norm to 105 mg/dL. A so (milliequivalents per value of 136 to 145 125 mEq/L, with a nmEq/L: and a hemonormal value of 4.0 A radiology report of electronically signed the time of 8:35 PM slight left lower lobe A review of a nurse' 7:30 AM, revealed the results were reported Nurse #4, who also slight left lower lobe signs and symptoms Physician's orders were sident to the hosp ambulance was call of 10/3/2017. A review of the hosp physical dated 10/3, had a blood glucose sepsis, findings con	ne order was reviewed, dated d) for #1. CBC (complete (comprehensive metabolic A1C (test for diabetes), and ews, written by the Nurse lated 10/2/2017 at 3:09 PM, 3/2017, included an abnormal 2 mg/dL (milligrams per al blood glucose value of 70 dium result of 174 mEq/L liter, with a normal sodium mEq/L; a chloride result of iormal chloride value of 125 globin A1C of 11.0%, with a to 6.0%. ated 10/2/2017, and d by the reading Physician at concluded the resident had pneumonia. In the abnormal laboratory do to the on-call Physician, by reported the x-ray showed pneumonia. There were no so of respiratory distress. Were received to send the ital emergency room. The ed at 12:10 AM, the morning loital admission history and (2017 revealed Resident #1 et of 803 mg/dL, evidence of sistent with urinary tractionia. The resident was	F	retrof points of	ached for the next 60 days with raining and reinforcement of stap practice for any findings suggestinued need for re-education of sciplinary action of staff. The Quality Assurance and Performent (QAPI) team will revolve to the search of the next of the search of the next of every 3 emergency visits or spitalizations for the purpose of suring sustained compliance with rective action.	andards sting a or ormance view e tt 60 hudit will r f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345375	B. WING			1	23/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 .0.	
				9	20 JR HIGH SCHOOL ROAD		
ACCORDI	US HEALTH AT SCOT	TLAND MANOR		5	SCOTLAND NECK, NC 27874		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF	PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			COMPLETION DATE
F 157	Continued From pa	age 4	F	157			
	An interview was o	conducted on 10/16/2017 at					
		e #1, who stated on 9/30/2017,					
		right before shift change and					
		nt had been sleepier than					
		ert, but not responding. The					
		e resident, got her vital signs,					
	and then asked Nu	urse #2 what she advised.					
	Nurse #2 told her t	o check the blood sugar, even					
	though the residen	it did not have diabetes. When					
		ar result was found, Nurse #1					
	•	irse #2 to turn off the tube					
	_	. The Nurse stated that since it					
		hange she did not turn the					
	•	ut informed the night nurse to					
		r 20 minutes. When Nurse #1					
		the next day on 10/1/2017,					
	_	I the Resident #1's blood sugar					
		tion pass, about 8:00 AM. The was 486 mg/dL, so she turned					
	_	g for about 2 ½ hours. The					
		est was done after lunch and					
		7mg/dL. The Nurse again					
	_	hat to do, and was told Nurse					
		Director of Nursing (DON) and					
		urse #1 stated she did not call					
		ne blood sugar readings, as					
	,	se #2 was going to. Nurse #1					
	stated she did not	have a Physician's order to					
	turn off the tube fee	eding, but it was a nursing					
	judgement call if th	ne tube feeding was not off for					
		d of time. The Nurse stated					
		e feeding off for 2.5 hours, and					
		er than that she would have					
	called the physicia						
		conducted with Nurse #4 on					
		PM. The Nurse stated she					
	-	ne DON to look for an arriving					
		o reports for Resident #1, on					
	the night shift of 10	0/2/2017. The Nurse indicated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG _		Ι,	С
		345375	B. WING				23/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	IIIS HEALTH AT SCOT	TI AND MANOR		92	20 JR HIGH SCHOOL ROAD		
ACCORD	IUS HEALTH AT SCOT	LAND MANOR		S	COTLAND NECK, NC 27874		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	she saw the lab re on-call Physician to the emergency roccalled the Emerge transport to the horesponsible party (resident was trans AM on 10/3/2017. On 10/17/2017 at conducted with Nuwas not working on had given advice to indicated she called was told it would be so she informed N did not call the Physician, as sewould call the Physician, as sewould call the Physician work, but she had morning meeting to for Resident #1. Physician's office at they determined a ordered, and that Nurse Manager star Physician's nurse of the vital secretions. She dinurse of the vital secretions. She dinurse of the vital secretions of 10/2/20 responded back to the secretion of the vital secretion of 10/2/20 responded back to the secretion of the vital secretion of 10/2/20 responded back to	ify the on-call Physician when ports arrive to the facility. The old her to send Resident #1 to om. The Nurse stated she ncy Medical Service (EMS) for spital, and called Resident #1's RP). Nurse #4 indicated the ferred to the hospital at 12:10 8:36 AM, an interview was rese #2. The Nurse stated she in the hall with the resident, but to Nurse #1. The Nurse id the DON on 10/1/2017 and id e okay to order some lab work, urse #1. Nurse #2 stated she ysician, or tell Nurse #1 to call she just assumed Nurse #1	F	157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ', '		` '	(X3) DATE SURVEY COMPLETED	
		345375	B. WING _			C 0/23/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	0/23/2017	
ACCORDI	US HEALTH AT SCO	TLAND MANOR		920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 2787	4		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 157	Manager stated it practice to order la order. On 10/17/2017 at conducted with the was called by Nur that Resident #1 v sugars and the nur feedings for a while sugar. The DON on call should be ordered. The DON nurse to call the publood sugar to see ordered. The DON nurse Manager has Later that evening critical results wer Resident #1. The her to look for a facritical values, and the Physician and hospital. The DON a specific policy the continuous tube for DON stated it was practice to order la order. On 10/17/2017, at	age 6 that morning. The Nurse was not in the nursing scope of ab work without a Physician's 9:55 AM an interview was a DON. The DON stated she se #2 on 10/1/2017 and told was having some high blood rses had stopped the tube le and that had helped the blood told Nurse #2 that the Physician contacted so lab work could be N stated she expected the floor hysician, and inform him of the e what lab work should be N indicated on 10/2/2017, the ad checked on Resident #1. I, the DON received a page that le being faxed to the facility, for DON called Nurse #4 and told ax that would be arriving with that was when Nurse #4 called sent the resident to the N stated the facility did not have leat addressed the time a seeding could be turned off. The sent within the nursing scope of ab work without a Physician's	F	157	IENCY)		
	level he would hav sliding scale insuli wouldn't have pre- have decreased that the hospital. The remember when h	nown of the high blood sugar ve started the resident on a n order, and although it vented a hospital visit, it might ne magnitude of the blood sugar ne Physician stated he could not be was contacted about ny details of orders for the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		OMPLETED
		345375	B. WING			C 10/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874	I	10/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	comment on the recould have made it had many patients remember the deta On 10/17/2017 at 1 conducted with the Administrator state nursing staff to use thought that would the Physician. On 10/23/2017 at 1 was conducted with Medical Assistant (received a phone of 10/2/2017, and at the Resident #1's blood that labs had been had made a note in office, for the docto the Nurse Manager also indicated for the nurse sident. On 10/23/2017 at 4 was conducted with it was possible she Assistant (PA) oncremember for sure indicated she called residents and it was about Resident #1. the PA ordered the otherwise she would blood work for the I stated it was possible stated it was possible stated it was possible stated it was possible she would blood work for the I stated it was possible stated it was poss	sician stated he could not sident's condition or if anything better or worse because he to care for and could not	F1	57		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	١ , ,	TE SURVEY MPLETED
		345375	B. WING			C 0/23/2017
	ROVIDER OR SUPPLIER US HEALTH AT SCOTLA	AND MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309 SS=D	him about stopping the unresponsiveness, or other vital signs, becar known that. She state order was needed to extended period, any stated she did not tell. Physician because she already know she new Nurse #2 could not sometified, only the post did not call the Physician because she already know she new Nurse #2 could not sometified, only the post did not call the Physician because she weekend and all photoperson. PROVIDE CARE/SEI WELL BEING CFR(s): 483.24, 483. 483.24 Quality of life Quality of life is a fun applies to all care and residents. Each reside facility must provide the services to attain or in practicable physical, well-being, consistent comprehensive assessing that residents. Bas assessment of a residents received accordance with profit.	It have known that ted she would not have told he tube feeding, her of the low-grade temp and ause she would not have ed she was aware that an stop a tube feeding for an authing over an hour. She have a sumed Nurse #1 would eded to call the Physician. And directly if the PA was sibility of a call. The Nurse cian's CMA because it was a mes calls went to an on-call expression of the provided to facility dent must receive and the he necessary care and maintain the highest mental, and psychosocial to with the resident's essment and plan of care.	F 15			11/20/17

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		COMPLETED
		345375	B. WING _			C 10/23/2017
	ROVIDER OR SUPPLIER	LAND MANOR		STREET ADDRESS, CITY, STATE, ZIP CO 920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874	I	10/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 309	but not limited to the (k) Pain Management The facility must en provided to resident consistent with profit the comprehensive and the residents' go (I) Dialysis. The fact residents who requiservices, consistent of practice, the compartice, the compartic	residents' choices, including e following: ent. Issure that pain management is ts who require such services, fessional standards of practice, person-centered care plan, goals and preferences. Cility must ensure that ire dialysis receive such the with professional standards in prehensive person-centered residents' goals and NT is not met as evidenced eview and staff interviews the engize changes in condition for dents (Resident #1) reviewed days. Resident #1 was pital intensive care unit with a 103 mg/dL, evidence of sepsis, on and pneumonia. ed: titled "Acute Condition Protocol", and dated as revised in documented under ecognition, the following: ff, including nursing assistants cognize subtle but significant	F	Preparation and/or execution of correction does not constitute admission or agreement by the truth of the fact alleged of set forth in the statement of the plan of correction is presecuse it is required by the Federal and State law. 1. Resident #1 was discharge facility on 10/3/2017 and did 2. To assure a) residents has properly assessed to ensure in condition were identified, were notified of all changes c) documentation accurately action taken, and that d) into timely and appropriate; residence mergency room visits and required hospitalization for the days will be reviewed in details.	itute the provider of or conclusions deficiencies. pared solely provisions of ged from the not return. Expense that changes b) physicians in condition reflects ervention was dents requiring those who he past 30	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345375	B. WING _			C 10/23/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 0	•	10/20/2017	
				920 JR HIGH SCHOOL ROAD			
ACCORDI	US HEALTH AT SCOTL	AND MANOR		SCOTLAND NECK, NC 27874			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From pag	ne 10	F3	009			
L 208	should be made by a who has collected an information, includin symptoms and statu #7. The nursing staff based on the urgence emergencies, the wi and request a promp. Resident #1 was add 3/26/2014 with diagr hemiplegia, dysphage quarterly Minimum Edated 7/29/2017 rev severely impaired. Sassistance from staff transfer, and 1 person their activities of da required a feeding to A review of a nurse's 6:45 PM, revealed N. Resident's room by the who indicated the reresponding. Vitals as temperature of 100.110/70, pulse 105 and glucose was taken we (milligrams per decil turned off. The resid responsive after the stopped. The Nurse continue to monitor a ware of the situation documentation of call A review of a nurse's 6:22 PM by Nurse #	an adequately prepared nurse and prepared pertinent g the resident's current s. f will contact the Physician by of the situation. For all call or page the Physician by the response. mitted to the facility on the response of the second of		11/10/2017. Reviews will be Director of Nursing (DON) Manager. 3. Nurses are being in-ser proper and comprehensive assessment, b) recognizin change in condition, c) approbation of physician for intervene and respond to the change, d) implementation ordered response. A full return demonstration conducted with each nurse receive in-service on and a NC Nursing Scope of Practicearly delineate the require physician's order prior to collaboratory tests, x-rays, ar well as any treatment. These in-services will be collinical consultant. All licer be in-serviced by 11/20/20. Nurses will be in-serviced copies of pertinent policies change of condition, appronotification of physician/fai implementation of physician and sign for that receipt in understanding and agreen the policies as written. Inconducted by DON and/or All nurses will be in-service 11/10/2017. Any nurse not in-service by this time will prior to next shift worked.	and/or or Unit viced on a) e physical g an acute propriate r orders to the acute n of physician In will be e. Nurses will a copy of the ctice which rement for a predering and other tests as conducted by ased nurses will prize sito include priate milly, an orders, etc.) dicating their ment to follow service will be Unit Manager. ed by t completing		
	continue to monitor a aware of the situatio documentation of ca A review of a nurse's 6:22 PM by Nurse # blood sugar that mon	and make the 7:00 PM shift n. There was no Iling the Physician. s note dated 10/1/2017 at		All nurses will be in-service 11/10/2017. Any nurse not in-service by this time will	ed by t completing be in-serviced		

1 '	PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI F	CONSTRUCTION	(X3) DATE	CLID//EV
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	` '			` '	LETED
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	345375	B. WING			10/	23/2017
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH AT SCOTLAND N	MANOR			20 JR HIGH SCHOOL ROAD		
			S	COTLAND NECK, NC 27874		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 Continued From page 11 blood sugar rechecked (not reading of 377 mg/dL was feeding was turned back of (laboratory blood work) we would report to the night in monitor. There was no do the Physician. A Physician telephone ord 10/2/2017 (not timed) for a blood count), CMP (compipanel), Hemoglobin A1C (#2. Chest x-ray 2 views, with Manager. Laboratory results dated 1 and reported on 10/3/2017 blood glucose of 582 mg/d deciliter), with normal blood to 105 mg/dL. A sodium in (milliequivalents per liter, value of 136 to 145 mEq/L 125 mEq/L, with a normal mEq/L: and a hemoglobin normal value of 4.0 to 6.00 A radiology report dated 1 electronically signed by the the time of 8:35 PM conclusing telf lower lobe pneur A review of a nurse's note 7:30 AM, revealed the aboresults were reported to the Nurse #4, who also report slight left lower lobe pneur signs and symptoms of results were reported to the Nurse #4, who also report slight left lower lobe pneur signs and symptoms of results were reported to the Nurse #4, who also report slight left lower lobe pneur signs and symptoms of results were reported to the Nurse was called at a for 10/3/2017. A review of the hospital acquired to the hospital emanbulance was called at a for 10/3/2017. A review of the hospital acquired the specific physical dated 10/3/2017.	s obtained. The tube on and the labs ere ordered. Nurse #1 nurse and continue to ocumentation of calling der was reviewed, dated #1. CBC (complete rehensive metabolic (test for diabetes), and written by the Nurse 10/2/2017 at 3:09 PM, 7, included an abnormal dL (milligrams per od glucose value of 70 result of 174 mEq/L with a normal sodium; a chloride result of chloride value of 125 A1C of 11.0%, with a %. 10/2/2017, and re reading Physician at uded the resident had monia. It dated 10/3/2017 at normal laboratory ne on-call Physician, by the det he x-ray showed monia. There were no spiratory distress. Received to send the nergency room. The 12:10 AM, the morning dimission history and	F	309	records pertaining to all emergency vis and hospitalizations will be completed the DON and/or Unit Manager to ensur all aspects of the above systemic corrective action are complete. This review will be recorded on the audit too attached for the next 60 days with retraining and reinforcement of standar of practice for any findings suggesting continued need for re-education or disciplinary action of staff. -The Quality Assurance and Performan Improvement(QAPI) team will review findings on these audit tools at the monthly team meeting for the next 60 days. On an ongoing basis, the audit who be completed on a random selection of out of every 3 emergency visits or hospitalizations for the purpose of assuring sustained compliance with this corrective action.	oy e ol ds a ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345375	B. WING				00/0047	
NAME OF PROVIDER OR SUPPLIER				5	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	23/2017	
					20 JR HIGH SCHOOL ROAD			
ACCORDI	US HEALTH AT SCOTLA	ND MANOR			COTLAND NECK, NC 27874			
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From page 12		F3	309				
	sepsis, findings consi	of 803 mg/dL, evidence of stent with urinary tract onia. The resident was sive care unit.						
	3:29 PM with Nurse # NA #4 came to her rig told her the resident h	ducted on 10/16/2017 at 11, who stated on 9/30/2017, ght before shift change and had been sleepier than						
	Nurse checked the reand then asked Nurse	but not responding. The sident, got her vital signs, e #2 what she advised. Sheck the blood sugar, even						
	though the resident d the high blood sugar	id not have diabetes. When result was found, Nurse #1 e #2 to turn off the tube						
	was right at shift char	The Nurse stated that since it nge she did not turn the nformed the night nurse to						
	turn it back on after 2 came back to work th	0 minutes. When Nurse #1 e next day on 10/1/2017,						
	at morning medicatio	e Resident #1's blood sugar n pass, about 8:00 AM. The s 486 mg/dL, so she turned						
	off the tube feeding for next blood sugar test	or about 2 ½ hours. The was done after lunch and						
	asked Nurse #2 what	g/dL. The Nurse again to do, and was told Nurse ector of Nursing (DON) and						
	take care of it. Nurse the Physician for the	e #1 stated she did not call blood sugar readings, as						
	stated she did not ha	#2 was going to. Nurse #1 we a Physician's order to ng, but it was a nursing						
	judgement call if the tan extended period o	ube feeding was not off for f time. The Nurse stated						
		eeding off for 2.5 hours, and han that she would have or an order.						

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		345375	B. WING	B. WING			10/23/2017	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				9:	20 JR HIGH SCHOOL ROAD			
ACCORDI	US HEALTH AT SCOTL	AND MANOR		SCOTLAND NECK, NC 27874				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	OULD BE COMPLET		
F 309	F 309 Continued From page 13 An interview was conducted with Nurse #4 on 10/16/2017 at 3:43 PM. The Nurse stated she was informed by the DON to look for an arriving fax of abnormal lab reports for Resident #1, on the night shift of 10/2/2017. The Nurse indicated she decided to notify the on-call Physician when she saw the lab reports arrive to the facility. The		F	309				
	the emergency room called the Emergency transport to the hosp	d her to send Resident #1 to i. The Nurse stated she by Medical Service (EMS) for bital, and called Resident #1's						
	resident was transfe AM on 10/3/2017.	P). Nurse #4 indicated the rred to the hospital at 12:10						
	On 10/17/2017 at 8:36 AM, an interview was conducted with Nurse #2. The Nurse stated she was not working on the hall with the resident, but had given advice to Nurse #1. The Nurse							
	indicated she called	the DON on 10/1/2017 and okay to order some lab work,						
	did not call the Phys	se #1. Nurse #2 stated she ician, or tell Nurse #1 to call						
	would call the Physic	e just assumed Nurse #1 cian. 45 AM, an interview was						
	conducted with the Non 10/2/2017 she did	Nurse Manager, who stated d not see an order written for						
	morning meeting tha	d been informed in the It lab work had been ordered e Nurse Manager called the						
	Physician's office an	d spoke with his nurse, and nest x-ray should also be						
	Nurse Manager state							
	blood sugars, but no secretions. She did	at Resident #1 had high t the values, and had not inform the Physician's						
		ns, the unresponsiveness on ube feedings had been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345375	B. WING		C 10/23/2017
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT SCOTLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874	1 10/20/2011
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 309	Continued From pag	ge 14	F 30	9	
	stated she had spok morning of 10/2/201 responded back to hand that was norma appear in distress the Manager stated it was practice to order laborder. On 10/17/2017 at 9: conducted with the laws called by Nurse that Resident #1 was ugars and the nurse feedings for a while sugar. The DON toleon call should be coordered. The DON nurse to call the phyblood sugar to see wordered. The DON Nurse Manager had Later that evening, to critical results were Resident #1. The Desident physician and set the Physici	imes. The Nurse Manager ten with Resident #1 on the 7 and the resident had the with a head nod or a word, I for her, and so she did not that morning. The Nurse as not in the nursing scope of work without a Physician's 55 AM an interview was DON. The DON stated she #2 on 10/1/2017 and told is having some high blood es had stopped the tube and that had helped the blood indicated so lab work could be stated she expected the floor escician, and inform him of the what lab work should be indicated on 10/2/2017, the checked on Resident #1. The DON received a page that being faxed to the facility, for ON called Nurse #4 and told that would be arriving with that was when Nurse #4 called that would be arriving with that was when Nurse #4 called that would be turned off. The ot within the nursing scope of work without a Physician's 0:04 AM, an interview was Physician. The Physician wn of the high blood sugar started the resident on a order, and although it			

		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	23/2017	
				92	20 JR HIGH SCHOOL ROAD			
ACCORDI	US HEALTH AT SCOTL	AND MANOR		S	COTLAND NECK, NC 27874			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 309	have decreased the at the hospital. The remember when he resident #1, or any resident. The Physic comment on the resicould have made it that many patients to remember the details On 10/17/2017 at 12 conducted with the Administrator stated nursing staff to use thought that would have physician. On 10/23/2017 at 10 was conducted with Medical Assistant (Creceived a phone ca 10/2/2017, and at the Resident #1's blood that labs had been on had made a note in the office, for the doctor, the Nurse Manager of also indicated for the on 10/2/2017. The Creceived in the on 10/2/2017 at 4.2 was conducted with it was possible she to Assistant (PA) on-caremember for sure sindicated she called	nted a hospital visit, it might magnitude of the blood sugar Physician stated he could not was contacted about details of orders for the cian stated he could not dent's condition or if anything better or worse because he o care for and could not so of this one case.	F3	309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345375	B. WING _			10/	23/2017
NAME OF PROVIDER OR SUPPLIER				STREET	TADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT SCOTLA	ND MANOR		920 JR	HIGH SCHOOL ROAD		
ACCORDI	US REALIN AT SCOTEA	IND WANCK		SCOTI	LAND NECK, NC 27874		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 309	Continued From page	: 16	F3	809			
	otherwise she would i	o work for the resident, not have written out the					
	stated it was possible						
	value, as she wouldn'	blood sugar, but not the t have known that ed she would not have told					
	him about stopping th						
	other vital signs, beca	nuse she would not have ed she was aware that an					
	extended period, any	stop a tube feeding for an thing over an hour. She					
		ne assumed Nurse #1 would					
	Nurse #2 could not sa	eded to call the Physician. By directly if the PA was Sibility of a call. The Nurse					
	did not call the Physic	cian's CMA because it was a nes calls went to an on-call					
	person.						