STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	**3532 DUNN ROAD EASTOVER, NC 28301**

(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 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the resident ' s privacy by posting signs that indicated the type of diet, fluid restrictions and thickened liquids for 35 residents, on 1 of 1 supplement carts located in the hallway, the facility failed to provide privacy for 1 of 1	F 164	1. Resident #58,#28, and 35 resident names, diet, fluid restrictions, and thickened liquids that were displayed on the snack cart could have been effected by this deficient practice. The facility failed to protect the residents right to personal	10/15/15

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

Electronically Signed | 10/13/2015

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F 164	Continued From page 1 sampled residents (resident #58), by not pulling a privacy curtain between two residents during a gastrostomy medication administration observation, and by leaving a medication administration record unattended and open on the medication cart. Findings included: 1) During the initial tour on 9/21/15 at 4:15pm 1 supplement cart was observed sitting in the hallway by room 146. The cart had signs posted which displayed 35 resident names and room numbers, and the type of diet, fluid restriction and thickened liquids for each listed resident. During an observation on 09/24/2015 10:30:28 AM the dietary manager was observed pushing 1 supplement cart out of the dietary department, which is located near the entrance of the building, down the 100 hall, and onto the locked unit 200 hall, which is located near the back of the building. The cart had signs posted on the top of the cart with resident ' s names, room numbers, and types of diet, fluid restrictions and thickened liquids. 09/24/2015 10:33:28 AM During an interview with nursing assistant (NA) #2, she stated that the facility used the signs so the staff would know what type of diet residents are on. She stated that " it probably shouldn ' t be there because it ' s a HIPAA thing " . She stated that the signs " were always there " . 109/24/2015 10:45:23 AM During an interview with Nurse #2, she stated she did not even realize that the resident information was displayed on the supplement cart. Stated " I really don't	F 164	privacy and confidentiality of his or hers personal and clinical records. The facility will ensure that. A. resident #58 will have personal privacy by the staff pulling the privacy curtain closed when administering medications via gastrostomy tube and all other personal care. B. Resident #28 will have their private information protected by the nurse. The nurse will close the Medication Administration record (MAR) after using it and before leaving the medication cart at all times. C. The facility will protect the 35 resident names, room numbers, diets, fluid restrictions, and thickened liquids sign that was posted on the snack cart by removing the signs off the snack cart where they can be seen. 2. All residents could have been effected by this deficient practice. The facility will ensure that all residents personal privacy including accommodations, medical treatment, written telephone communications, personal care, visits, and meetings of family and resident groups, including but not limited to. A. Not displaying resident names, room numbers, type of diets, fluid restrictions, and thickened liquids on signs posted on the snack cart. B. By closing the curtain completely when a resident is receiving medication administration via gastrostomy tube by the nurse to provide privacy. C. By the nurse closing the MAR when leaving the medication cart, to protect the	

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F 164	Continued From page 2 remember seeing it up there before, but I do not usually pass the supplements out " . She stated the resident's private information should not be displayed for others to see. 09/24/2015 10:49:04 AM During an interview with the dietary manager, he stated that the resident information is not supposed to be displayed. Stated the reason we use it is " because we have had a recent turnover of nursing assistants and we want to make sure that the staff do not give the wrong supplements out to the wrong resident " . Stated " it's probably been about a week we have been using the sign, because the nursing assistants do not know the resident's diets, so we wanted to make sure they don't give out the wrong thing " . 09/24/2015 11:03:00 AM During a joint interview with the director of nursing (DON) and administrator (ADM), both stated they expect all resident private information to be covered and not prominently displayed for the public to view. The DON stated " we wanted to make sure everyone gets the right thing, but all the signs should be covered so the residents ' personal information is not displayed " . 2) 9/22/2015 4:44:19 PM During an observation of nurse #4 of medication administration, the nurse raised the head of the bed for resident #58, and pulled up the resident ' s gown, exposing her abdomen to begin to administer her medications via her gastrostomy tube. She did not pull the privacy curtain located between the residents during the medication administration. Upon completion of the medication administration, nurse #4 pulled the gown back down in place for resident #58 and exited the room.	F 164	residents name, diagnosis, and medications. 3. A.Donald Pickney, Dietary manger, will be in-serviced by Caroline Horne, Administrator that all residents has the right to personal privacy and confidentiality of his or her personal and clinical records, That resident names, room numbers, types of diets, fluid restrictions and thickened liquids can not be displayed on the snack cart. That all resident information must be protected and kept confidential. B. Pristina Blue, LPN, will be in serviced by Caroline Horne, Administrator that all residents has the right to privacy and she must provide privacy by always pulling the curtain completely closed when administering medications via Gastrostomy tube. C. Angela Leonard, LPN, medication nurse, will be in-serviced by Caroline Horne, Administrator that all resident information including but not limited to resident names, diagnosis, and medications must be protected and kept confidential by closing the MAR before leaving the medication cart. D. All staff will be in-serviced that every resident has the right to personal privacy and confidentiality of his or her personal and clinical record giving examples of, not displaying resident names, room numbers, diet, fluid restrictions and thickened liquids on snack carts, leaving a MAR open when walking away, and not pulling privacy curtains when receiving care. More examples given.	

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F 164	Continued From page 3 9/24/15 12:05 PM During a phone interview with nurse #4 she stated she realized after the medication observation that she had forgotten to pull the privacy curtain between resident #58 and resident #38 during her medication administration. She stated that she " knew better than that, but had just gotten nervous " during the observation. 09/24/2015 10:57:36 AM During an interview with the DON, Assistant director of nursing (ADON) and ADM. They jointly stated that the expectation is to provide the resident with privacy during any medication administration that may expose the resident. The DON stated " the curtain should have been pulled when she administered the medications " . 3) 9/23/15 9:35:16 AM During an observation of nurse #3 of medication observation, she left the the medication administration record (MAR) open on top of her medication cart, exposing the resident ' s name, diagnosis and medications while she went into resident #28 room, shut the door, and administered the medications to resident #28. 09/24/15 10:25:50AM During an interview with nurse #3 she did not recall leaving MAR open while she was in the resident ' s room. 09/24/2015 10:57:36AM During an interview with DON she stated that all private information, including the MAR, should be covered at all times. 09/24/2015 10:57:36 AM During an interview with ADM, she agrees that resident private information	F 164	4. LaDean Hair, RN, QA, will ensure that all residents rights to personal privacy and confidentiality of his or her personal and clinical records are protected by using new QA form titled "resident privacy" to be done weekly X's 90 days then monthly on an ongoing basis. Making sure resident privacy curtains are closed completely when receiving all care, no signs present on snack cart or anywhere in public view with any resident information on it, and that MAR's must be closed when not using or leaving the medication cart. 1. to be completed by 09/21/2015 2. to be completed by 09/21/2015 3. to be completed by10/05/2015 4. to be completed by 10/15/2015	

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F 164	Continued From page 4 is to remain confidential at all times.	F 164		
F 278 SS=D	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 record review and staff interviews, the facility failed to accurately code section A of the Minimum Data Set (MDS) to reflect the Level II	F 278	1. Resident #5 could have been effected by this deficient practice. The facility will ensure that the MDS is coded accurately	10/23/15

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F 278	Continued From page 5 Preadmission Screening and Resident Review (PASRR) determination for one of one resident reviewed as Level II PASRR resident. (Resident #5). Findings included: Resident #5 was initially admitted to the facility on 03/31/2014 with diagnoses including depression and psychotic disorder. A review of section A1500 (Preadmission Screening and Resident Review (PASRR)) of Resident #5's annual Minimum Data Set (MDS) dated 04/01/2015 was conducted. Section A1500 indicated the resident was evaluated by Level II PASRR and determined not to have a serious mental illness and/or intellectual disability. The results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #5 was included among the residents named on the list. During an interview on 09/24/2015 at 8:51 AM, the facility Office Manager confirmed Resident #5 did indeed have a Level II PASRR status. The review of Resident ' s PASRR II form revealed that Resident #5 had Level II PASRR status. The MDS Coordinator was interviewed on 09/24/2015 at 10:05 AM, regarding the accuracy of Resident #5's annual MDS. When it was revealed the MDS did not reflect the Level II PASRR determination for this resident, the MDS	F 278	under section A1500 to reflect the level II preadmission screening and resident review (PASRR) determination to ensure the results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individual plan of care are used. 2. All residents could have been effected b this deficient practice. The facility will ensure all the MDS's are coded accurately under section A1500 to reflect the level II preadmission screening and resident review (PASRR) determination to ensure the results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individualized plan of care. 3. LaDean Hair, RN, MDS will be in-serviced by Caroline Horne, Administrator that all MDS's section A1500 must be coded correctly to reflect the level II preadmission screening and resident review (PASRR) determination to ensure the results of this screening and review are used to determine needs, appropriate care setting, and a set of recommendations for services to help develop an individualized plan of care are used. 4. LaDean Hair RN,QA will ensure that all MDS section A1500 are coded correctly using new QA form titled "MDS section A1500, form 1" to check all current MDS	

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F 278	Continued From page 6 Coordinator reported the information on the Level II PASRR was read wrong and the MDS was not coded correctly. On 09/24/2015 at 10:50 AM, the Director of Nursing indicated it was her expectation that the Level II PASRR determination would be coded accurately on each resident's MDS.	F 278	sections A1500. Then to use new QA form titled "MDS section A1500, form 2" to be done on all new admissions, and to be done on all quarterly and annual assessments on an ongoing basis.to ensure that MDS section A1500 is coded accurately to reflect the level II preadmission screening and resident review (PASRR) determination to ensure the results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individualized plan of care are used.	
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, record review and staff interviews, the facility failed to provide nail care for one of four residents sampled for Activities of Daily Living (ADLs). (Resident #64). Findings included: Resident #64 was admitted to the facility on 5/08/2012. The resident's diagnoses included adult failure to thrive and dementia. The Minimum Data Set (MDS) dated 4/02/2015	F 312	1. Resident #64 could have been effected by this deficient practice. The facility will ensure that this resident receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene by cleaning resident #64 nails thoroughly making sure they are cleaned and trimmed neatly. 2. All residents could have been effected by this deficient practice. The facility will	10/23/15

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F 312	Continued From page 7 noted Resident #64 was severely cognitively impaired and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one or two persons. On 9/22/2015 at 5:00 PM, Resident #64 was observed in her wheelchair. All of Resident #64's nails were long on both hands and had black matter underneath the nails. At 11:03 AM on 9/23/2015, in an interview, Nurse Aide (NA) #2 stated residents received showers or bed baths according to their schedule. ADL care, including washing hair and trimming nails, was provided during that time to residents. NA #2 stated Resident #64 was scheduled for a shower during 3-11 PM shift. On 9/23/2015 at 11:48 AM, Resident #64 was observed with untrimmed fingernails with black matter underneath. On 9/23/2015 at 2:51 PM, Resident #64 was observed again with Nurse #1. The resident had untrimmed fingernails with black matter underneath. Nurse #1 reported the resident was scheduled for shower on Mondays and Fridays for 3-11 PM shift, and nail care should be provided during shower or as needed. Nurse #1 also reported NAs were responsible for the resident ' s nail care as needed as somedays the resident needed set up only help with eating. At 3:23 PM on 9/23/2015, in an interview, the Director of Nursing (DON) stated her expectation was ADL care including nail care would be provided as scheduled and as needed.	F 312	ensure that all residents receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene by checking all the residents nails in the facility to ensure all resident nails are clean and trimmed neatly. 3. All nursing staff including nurses and certified nursing assistants will be in-serviced by Caroline Horne, Administrator on proper nail care including the policy and procedure to ensure all residents are receiving necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 4. A. LaDean Hair, RN, QA, will ensure that all residents receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene related to nail care by using new QA form titled "nail care(now)" checking all residents now. B. LaDean Hair, RN, QA, will ensure that all residents receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene related to nail care on an ongoing basis using new QA form titled "nail care" to be done monthly on an ongoing basis.	

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F 431	Continued From page 8	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		10/23/15

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F 431	Continued From page 9 Based on observation, staff interview and the medication storage policy review, the facility failed to discard expired medications for 1 of 2 medication rooms (100 hall medication room), the facility failed to properly store medications to be administered to the residents for 2 of 3 nurses administering medications, and failed to date multidose tuberculin vial for 1 of 2 refrigerators. Findings included: The facility ' s medication policy, (no date provided) was reviewed. Page #48 of medication policy under " discontinued drugs " states " contrary to the instruction on the drug returned to pharmacy or released to the patient form, the nurse must list all controlled substances on the form along with other medications. The pharmacy complete the form supplied by the State Drug Authority " . #4 states " return medications and forms to the pharmacy " , and #5 states " if medications are to be discharged with the resident, have the responsible party sign the form then forward to the pharmacy " . A review of the manufacturer ' s instruction for storage and use dated November 2013 indicated that Tuberculin vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. 1) 09/24/2015 9:03:40 AM observation of 100 hall medication room revealed outdated medications of Warfarin 7.5mg filled on 11/18/2013 & Warfarin 7.5 mg filled on 9/4/2014 stored in a cabinet. 09/24/2015 9:07:30 AM During an interview with nurse #1 regarding the facility policy of	F 431	1. All residents could have been effected by this deficient practice. The facility will ensure that A. no medications are left unattended on the medication cart or in a residents room. B. That all medications are inspected for expiration dates and that all medications are dated when opened including but limited to Tuberculin (TB) vials. C. That all expired medications are sent promptly to the pharmacy per our facility policy and procedure to be destroyed. This is to ensure all Drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, and the expiration date when applicable. 2. All residents could have been effected by this deficient practice. The facility will ensure that A. No medications are left unattended on the medication cart or in a residents room. B. That all medications are inspected for expiration dates and that all medications are dated when opened including but not limited to Tuberculin (TB) vials. C. That all expired medications are sent promptly to the pharmacy per our facility policy and procedure to be destroyed. This is to ensure all Drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, and includes the appropriate accessory and cautionary	

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F 431	Continued From page 10 medication storage, states " we usually give the meds back to the family, we can't use them because they are mixed pills in one bottle of meds " . She stated that another " evening shift nurse is responsible for checking the medication rooms for expired medications " . 09/24/2015 10:19:14 AM During an interview with DON regarding the facility policy of expired medications and medications brought from the resident ' s home, she stated that is the facility expectation to send back any expired medications to the pharmacy, and unidentified medications brought from the residents home back should be sent back home with the residents family. The DON stated that two weeks is too long of a time frame to return the medications; the medications should be sent back immediately. 09/24/2015 10:19:14 AM During an interview with the Administrator (ADM) regarding the facility policy of expired medication and medications brought from the resident ' s home, she stated that it was her expectation that expired medications should be discarded and medications brought from the resident ' s home should be returned to the resident ' s family. 2a) On 9/22/2015 4:44:19 PM During an observation of nurse #4 of medication administration, she pulled the medications from medication cart for resident #58, prepared medications by diluting them in water for gastrostomy tube administration, locked cart, and then went to another residents room, turning her back on the cart and leaving the medications on top of the cart unattended. She came back to the cart, gathered the medications she had prepared	F 431	instructions, and the expiration date when applicable. 3. All nurses will be in-serviced by Caroline Horne, Administrator to ensure that they are trained and know that all drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. in-service including but not limited to: A. no medications should be left unattended on the medication cart or in a residents room. B. That all medications are to be inspected for expiration dates and that all medications are to be dated when opened. C. That all expired medications are to be sent promptly to the pharmacy per our facility policy and procedure to be destroyed. 4. LaDean Hair, RN, QA, will ensure that: A. No medications are left unattended on the medication cart or in a residents room. B. That all medications are inspected for expiration dates and that all medications are dated when opened including but limited to TB vials. C. That all expired medications are sent promptly to the pharmacy per our facility policy and procedure to be destroyed. by using new QA form titled " Medication QA" to be done weekly X's 90 days then monthly on an ongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	**3532 DUNN ROAD EASTOVER, NC 28301**

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F 431	Continued From page 11	F 431		

for resident #58 and then entered the semi-private room for resident #58 and resident #38, and shut the door. She was preparing to begin to administer her medications via her gastrostomy tube, but stated she " forgot something " , so she left the medications on the bedside table, exited the room and shut the door. Upon returning to the room, she began to administer the medications.

9/24/15 12:05 PM During a phone interview with nurse #4 stated she would not normally leave medications unattended on the cart or in the resident ' s room.

2b) 9/23/15 9:35:16 AM During an observation of nurse #3 of medication administration, she pulled out a bag containing topical medications of Voltaren gel from the medication cart, 1 Voltaren gel that was opened and 1 that had not been opened, and placed them on top of her cart for resident #28. She collected the medications for resident #28, including 1 opened vial of the Voltaren gel, but left the second unopened vial of Voltaren gel on top of her medication cart unattended while she went into resident #28 room, shut the door, and administered the medications to resident #28, the medications were not in her view.

09/24/15 10:25:50AM During an interview with nurse #3 regarding medications left unattended on her cart. She stated that " I can totally remember the 2 tubes of Voltaren, one tube was new and the other was old, I completely forgot about leaving them on the medication cart " . States it is not okay to leave medications unattended and you should never leave medications on top of the medication cart

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	345212	A. BUILDING _____ B. WING _____	C 09/24/2015

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F 431	Continued From page 12 unattended. States " I open the MAR to check for medications that are due, go through my meds, pull them out and verify the orders, and then I lock up my cart when I go into the resident ' s room " . 09/24/2015 10:57:36AM During an interview with DON regarding unattended medications. The DON states that " the nurse is to have their eyes on the medication cart at all times " , the cart should be locked when the nurse is not within reach and medications should never be left unattended at any time. 09/24/2015 10:57:36 AM During an interview with ADM regarding unattended medications. She stated that it is her expectation that medications should never be left unattended and should be kept locked on the medication cart. 3) On 9/24/15 9:16 AM During an observation of medication storage on the locked unit (200 hall), an open multidose vial of Tuberculin 5TU/0.1ml was found with no date of opening. 09/24/2015 9:16 AM Staff interview with Nurse #2 on the unit revealed that it was missed. Stated she would discard it. 09/24/2015 10:21 AM Interview with DON/ADON stated, it was expected that staff would date when opening multidose vials.	F 431		