STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	**33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002**

(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 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		10/1/18

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

Electronically Signed | 09/26/2018

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.

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the resident's representative of a fall and transport to the emergency department for 1 of 3 sampled residents (Resident # 2). Findings included: Resident #2 was admitted to the facility on 1/13/2014 with diagnoses that included dementia, Alzheimer's Disease, anxiety, psychotic other than schizophrenia and mixed lipidemia (a genetic disorder of high levels of blood fat). A review of the significant change in status Minimum Data Set (MDS) assessment dated 8/13/2018 revealed Resident #2 had moderate impaired cognition. The MDS further revealed Resident #2 required limited assistance with transfers, did not have steady balance but was able to stabilize without staff assistance and did not have any functional limitations to her arms of legs. Additionally, Resident #2 was coded for one fall since reentry with no injury, acquired Hospice care within the last 14 days, received 3 days of physical therapy and used a wander/elopement alarm daily.	F 580	Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation Centers response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The facility interdisciplinary team including the administrator, the director of nursing, the quality improvement nurse, and the	

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F 580	Continued From page 2 A review of Resident #2's care plan dated 8/3/2018 revealed a focus for risk for falls related to unsteady gait and included a goal to remain free from injury as evidence by no falls or accidents through next review, 11/23/2018. Interventions included assist during transfer and mobility, encourage resident to wear glasses, ensure environment was free of clutter, have commonly used articles within easy reach, low bed, observe for potential medication side effects that may increase risk for falls, i.e. blurred vision, orthostatic hypotension, dizziness, etc., resident to wear proper non-slip footwear, toilet resident frequently and as needed, Geri chair when out of bed. The goal was not met. Further review of the care plan revealed the focus was updated on 8/27/2018 after eight falls. The updated focus revealed a risk for falls related to unsteady gait included a goal to not sustain serious injury through next review date 11/23/18. A review of the nurse's notes revealed Resident #2 fell on 6/15/2018, 7/2/2018, 8/11/2018, 8/12/2018, 8/14/2018, 8/15/2018, 8/22/208, 8/23/2018, 8/24/2018 and 8/26/2018. Further review revealed that Resident #2's responsible party was notified on 8/24/2018 of a fall but not notified of a fall on 8/26/2018 and subsequent emergency department visit on 8/26/2018. Additionally, the nurse's note dated 8/26/2018 revealed that Hospice was notified. Further review revealed an order was obtained on 8/26/2018 from Hospice, to transport Resident #2 to the emergency department for evaluation of her externally rotated left foot. A review of the emergency department visit dated 8/26/2018 revealed Resident #2 was discharged with a contusion (bruise) of the left hip region.	F 580	social worker identified that the procedure for notifying family and physician of significant events had not been followed. The incident report for resident #2 was reviewed on 8/27/18 in the morning interdisciplinary meeting by the director of nursing, the quality improvement nurse, the administrator, and the social worker. It was noted by the quality improvement nurse that the resident representative had not been notified in a timely manner of the resident's fall and emergency room visit per facility policy. The nurse on duty at the time of the fall and the first shift registered nurse supervisor on duty 8/26/18 received education and a consultation/counseling session by the Director of Nursing. The consultation included reeducation for the nurses on facility policy for notification of changes in condition and counseling regarding the nurse's role in notification of families for changes in condition. A record of the consultation was included in each nurse's employment file. Actions were completed 8/31/18. In order to ensure that all residents are free from the deficient practice and to ensure compliance with facility policy, all incident reports for the past three months were audited by the quality improvement nurse to verify that notifications were given for all incidents for all affected residents. No evidence of lack of notification was found. This audit was completed 9/25/18. As further protection for all residents in the facility, the registered nurse staff	

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F 580	Continued From page 3 Further review of the emergency department final report dated 8/26/2018 revealed Resident #2's x-rays were reviewed and negative for fracture. A review of the Hospice records dated 8/26/2018 did not indicate Resident #2's responsible party was notified of the fall or emergency department visit. A called was placed on 9/6/2018 at 2:18 PM to the nurse who provided care to Resident #2 on 8/26/2018. A detailed message was left to contact the surveyor including the contact information. A follow-up call was placed on 9/6/2018 at 5:40 PM to the nurse who provided care to Resident #2 on 8/26/2018. A message was left to contact the surveyor including the contact information. An interview with the Quality Improvement Nurse on 9/6/2018 at 3:11 PM revealed that the nurse for Resident #2 on 8/26/2018 did not notify the responsible party of the fall or of the transport to the emergency department. An interview with the Director of Nursing (DON) on 9/6/2018 at 6:00 PM revealed she expected all nurses to complete an incident report for incidents and injuries. The DON further revealed she expected nurses to notify the responsible parties and the medical provider when a resident is injured. An interview with the Administrator on 9/6/2018 at 6:46 PM revealed that a facility concern form was completed on behalf of Resident #2. The DON further revealed she expected nurses to complete incident reports, implement the emergency interventions and notify responsible parties when	F 580	facilitator educated 100% of the nurses regarding facility policy for notification of family and physician of accidents and changes in condition. Education was completed 9/24/18. To ensure that the deficient practice does not reoccur, all incident reports and progress notes will be reviewed for appropriate notifications during the morning interdisciplinary meeting by the quality improvement nurse. Any exceptions to the notification policy will be noted and corrected by the quality improvement nurse. To monitor continued compliance, the Quality Improvement nurse will audit all incident reports and progress notes on a daily basis and share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee monthly times three months. If any reoccurrence of failure to notify is noted the reoccurrence issues will be addressed immediately and corrective action taken by the quality improvement nurse. This process began on 9/26/18. The Quality Assurance Performance Improvement Committee will review the results of the daily audit monthly x3 months. The committee will make recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further Quality Improvement monitoring. This process began 9/26/18. The Director of Nursing will be responsible for implementation of this plan	

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F 580	Continued From page 4 a resident experienced an incident and transferred out the facility.	F 580	of correction.	