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 02/13/2020

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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, facility staff interviews, interviews with the oncologist, and facility nurse practitioner (NP), the facility failed to secure an appointment with an interventional radiologist, as ordered by the facility's nurse practitioner in 1 of 3 residents (Resident #2) sampled for abscess wound care. Findings included: Resident #2 was admitted to the facility on 11/22/2019 with diagnoses that included retrocolic abscess. The resident's readmission Minimum Data Set dated 1/6/2020 indicated the resident was cognitively intact, required assistance with all activities of daily living including personal hygiene and transfers. She was coded as receiving antibiotics 7 of 7 days during the assessment period. Facility's records revealed a progress note on 1/13/2020 that indicated the resident was seen by the facility NP on 1/13/2020 around 3:00pm. Documentation by the NP indicated the resident needed to be seen by interventional radiology for	F 684	Identified 1. Identified resident # 2 medical record was reviewed with no other negative findings on 2/17/2020 by the Director of Nurses Potential 1. Audit of all appointment orders were reviewed for the last 14 days to ensure they were scheduled as ordered by nursing administration on 2/27/2020. No negative findings noted. Training 1. Re-education provided to licensed nurses, including agency, on reviewing doctors orders and notes to ensure appointments are secured appropriately and notify the physician if an appointment cannot be scheduled per order by the director of nursing (DON) and staff development coordinator by 2/28/2020. Any licensed nurse not completing this education by 2/28/2019 will not be allowed to work until in-service is complete. This in-service will be provided to new licensed	2/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2020

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F 684	Continued From page 1 follow up as soon as possible for a possible clogged drain that was leaking in a resident with leukocytosis. She further noted there might be a need to change the resident's antibiotics to avoid rehospitalization in the presence of a low grade fever. NP noted the resident's vitals were: blood pressure, 106/72, heart rate 74, respiratory rate 18, and temperature- 99.5 degrees Fahrenheit. Review of resident's record revealed a written order dated 1/13/2020 which read, "patient to follow up with Interventional Radiology as soon as possible for clogged drain with leakage and leukocytosis". On 2/4/2020 at 12:50pm an interview was conducted with the facility's NP in which she stated she followed Resident #1 closely because she was concerned about the resident's overall health status and the many comorbidities that the resident had. She stated the resident had very little drainage from the time she returned from the hospital until the time she left the facility. She did recall there being drainage or leakage around the drain at the insertion site on 1/13/2020 and was suspicious that it was clogged. She further stated the resident had begun to run a low grade fever and that was when she ordered the follow up with interventional radiology. The NP was concerned that the resident's WBC was 14.2 on 1/8 and 16.6 on 1/10/2020 despite being on antibiotic therapy and thought the resident might need to be seen sooner than her original appointment that was scheduled on 1/15/2020, to avoid rehospitalization. An interview was conducted with the DON on 2/5/2020 at 10:55am in which she explained how an order for an appointment is first	F 684	nurses during orientation. 2. Re-education provided to Appointment Scheduler to notify the nurse when an appointment cannot be made per the order on 2/27/2020 by Director of nurses. Audits 1. Nursing management will complete 10 random resident audits (to include all halls) for 4 weeks and then monthly for 2 months to ensure appointments are secured and followed. This audit will be documented on the consultation audit tool. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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F 684	Continued From page 2	F 684		

communicated by written order and/or verbally to the nursing staff who then make the appointment scheduler/transportation aide aware. The transportation aide then, calls and makes the appointment. Once the appointment is made, the scheduler makes the nursing staff aware of the date and time.

In an interview with the appointment scheduler/facility transportation aide on 2/5/2020 11:05am she stated she called the office of the interventional radiologist on 1/13/2020 at 5:38pm and again at 5:39pm, and left a message stating she needed a call back regarding Resident #2. She stated the medical office did not call her back. The scheduler/transporter then stated she did not recall making a follow up call on 1/14/2020 and the resident had an appointment already scheduled on 1/15/2020. She further stated she did not recall if she made the NP aware she was unable to secure an appointment for the resident to be seen before 1/15/2020.

Facility documentation by Nurse #2 indicated the resident had an appointment with oncology on the morning of 1/15/2020 and left the facility around 10:00am.

On 2/13/2020 at 11:15am a phone interview was conducted with the oncologist in which he stated he conducted a brief exam on Resident #2 and contacted the facility's NP for an update. After speaking with the NP, he decided it was in the resident's best interest to be seen in the Emergency Department at the local hospital.