

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/28/2020
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BETHANY WOODS NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 08/25/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# E15X11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 08/25/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		

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

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.