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 09/01/2023

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 8/28/23 through 8/31/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# Q24F11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted from 08/28/2023 through 08/31/2023. Event ID# Q24F11 Intakes NC00203367 and NC00202520 were investigated during the survey. 2 of the 4 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		9/29/23

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

Electronically Signed | 09/25/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to avoid the use of the term "feeder" when referring to a resident who required assistance with meals for 1 of 1 dining observations (Resident # 87). The reasonable person concept was applied as individuals have the expectation of being treated with dignity and not be referred to as "feeder". The findings included: Resident #87 was admitted 11/3/2022. The resident's quarterly Minimum Data Set (MDS) dated 7/27/2023 indicated the resident was severely cognitively impaired and required supervision and set up only during the	F 550	F550 Resident Rights/Exercise of Rights 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #87 remains in the facility and is having dignity maintained during mealtimes as evidenced by staff not referring to the resident as a “feeder”. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be	

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F 550	Continued From page 2 assessment period. Resident # 87's comprehensive care plan was last revised 8/3/2023 and included a focus for nutritional status due to inadequate intake. On 8/28/2023 at 12:37 PM Resident #87 was observed in the dining area. The Occupational Therapy Assistant (OTA) provided Resident #87 with assistance eating and drinking. On 8/29/2023 at 12:45 PM Resident #87 was observed in the dining area. OTA provided Resident #87 with assistance eating and drinking. On 8/30/2023 at 12:30 PM Resident #87 was observed sitting in the dining area with his lunch tray in front of him. He made several attempts to put a straw in the lid of a cup and was unsuccessful. He was observed making three attempts to grasp a piece of steamed broccoli and place it in his mouth with his fingers but dropped it in his lap before it reached his mouth. The resident was then observed attempting to place the straw into the lid of a cup again. After several attempts, Resident #87 lost his grip on the straw, and it fell to the floor. During the above observation, Nurse Assistant (NA) #3 was standing in the door of the dining room, directly behind Resident #87. NA #3 was not observed assisting Resident #87 with his meal. At 12:40 PM this writer asked NA#3 if Resident #87 needed assistance with meals. NA#3 stated, "I don't know. I don't usually work back here, I am the scheduler". NA#3 then walked to another dining area, stood in the door of the dining room	F 550	affected. On 9-20-2023, the Social Workers (SW) initiated resident care observations during mealtimes with current facility and/or agency staff to include NA #3 regarding dignity and respect. This audit is to ensure staff are treating residents with dignity at mealtimes to include but not limited to not referring to residents who require feeding assistance as “feeders”. The Director of Nursing (DON), Unit Managers (UM), and/or SDC will address any concerns identified during the audit to include addressing resident needs and/or education of staff. The audit will be completed by 9-29-2023. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • On 9-20-2023 , the Staff Development Coordinator (SDC) initiated an in-service with all nurses and nursing assistants to include NA #3 regarding Dignity and Respect with emphasis on treating each resident with dignity/respect to include but not limited to not referring to a resident who requires feeding assistance as a “feeder”. In-service will be completed by 9 -29-2023. After 9-29-2023, all contracted agency and/or facility staff that has not worked and received the education will complete upon their next scheduled shift. After 9-29-2023, the Staff Development Coordinator (SDC) will include this education regarding Dignity and Respect to contract agency/facility nursing staff in	

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F 550	Continued From page 3 and asked NA #4 if Resident #87 was a "feeder". NA#4 replied, yes. NA#3 then walked back to dining area #1, pulled up a chair and began to assist Resident #87 with his meal. On 8/31/2023 at 10:08AM and interview was conducted with NA#3. She stated she should not have referred to Resident #87 as a "feeder". She should have asked NA#4 if Resident #87 required assistance with his meal. 08/31/2023 1:17 PM and interview with Unit Manager #1 was conducted. She stated staff have been provided education on not referring to residents as "feeders".	F 550	general orientation. • Director of Nursing (DON), Unit Managers (UM), Social Workers (SW) or designee will observe 10 resident care interactions with nursing staff during mealtimes weekly x 4 weeks then monthly x 1 month using the Resident Interaction Audit Tool. This audit is to ensure residents requiring feeding assistance are being treated with respect and dignity to include but not limited to not referring to residents who require feeding assistance as “feeders”. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 9-29-2023	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		9/29/23

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F 554	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to assess Residebt #22 for self administration of medication for 1 of 1 resident observed to self-administer medication. Findings included: Resident #22 was admitted to the facility on 10/23/20. A review of Resident #22's current physician orders did not include an order for the resident to self-administer medications. The annual Minimum Data Set dated 7/1/23 documented Resident #22 had a moderately impaired cognition. The resident's active diagnoses were hypertension, arthritis, and osteoporosis. Resident #22's care plan dated 7/1/23 revealed the resident was not care planned to self-administer medications. On 08/28/23 at 9:55 am entry to Resident #22's room (Room 802), it was observed that the resident was holding a medication cup with 3 pills. The resident was taking a pill independently during entry into the room. Nurse #1 was not present. The remaining pills were red and orange in color. The resident continued to take her medication one at a time with water. The resident was slow and careful. During concurrent interview with Resident #22, she stated that sometimes the Nurse had not waited until "I take all my medication and left the room. I take long to	F 554	F554 Resident Self- Administration of Medications -Clinically Appropriate 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #22 remains in the facility. On 9-22-2023, the Unit Manager completed Medication Self Administration Assessment in the electronic health record. The findings of the assessment and physician has been deemed Resident # 22 to be clinically inappropriate for self-administration of medications. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: • Current residents have the potential to be affected. On 9-19-2023, the Administrator completed an audit of 100% of resident rooms. This audit is to ensure medications were not left at the resident bedside unless the resident had been assessed, deemed clinically appropriate for self-administration of medications, and physician order obtained. This audit revealed no concerns. • On 9-21-23, the RN Supervisor and Unit Managers (UM) initiated completion of the Medication Self Administration assessments for current residents with	

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F 554	Continued From page 5 swallow; it was difficult for me, and the staff left before I was finished." The resident stated she would prefer the staff stay in the room, "I think that was what they were supposed to do." An interview was conducted on 8/28/23 at 10:15 am of Nurse #1. Nurse #1 stated that she provided Resident #22 with her morning medication, handed her the cup with medication, and left the room. Nurse #1 stated she knew she was not supposed to leave the room while a resident took their medication independently, and I should not have left the room before the resident had taken her medication. Nurse #1 further stated Resident #22 was not independent with taking her medication. Nurse #1 had no further comments. On 8/31/22 at 1:55 pm an interview was conducted with the Administrator. She stated that the Director of Nursing (DON) was aware Nurse #1 had administered medication to Resident #22 unsupervised and staff would receive education. Nurse #1 had informed the DON. All medication administration was required to be supervised unless there was an order for self-administration.	F 554	BIMS score of 11 or greater to identify any residents clinically appropriate for self-administration of medications. The Director of Nursing (DON), Unit Managers (UM), and/or RN supervisors will address any identified concerns found during the audit. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • On 9-21-2023 , the Staff Development Coordinator (SDC) initiated an in-service with current facility and contract nurses including nurse #1 and medication aides regarding administering medications per physician order and not leaving medication at the bedside of a resident unless they have been assessed, noted to be clinically appropriate for self-administration of medication, and a physician order obtained. Inservice will be completed by 9-29-2023. After 9-29-23, any facility/contract nurse and medication aide that has not worked and received the education will complete upon their next scheduled shift. After 9-29-23, the Staff Development Coordinator (SDC) will include this same education to all new facility/contract nurses and medication aides in general facility orientation. • The Director of Nursing (DON), Unit Managers (UM), and RN Supervisors, will audit new Medication Self Administration assessments completed weekly x 4 weeks, then monthly x1 month. The audit is to identify residents clinically appropriate for self-administration who	

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F 554	Continued From page 6	F 554	desire to self-administer medications. The Director of Nursing (DON), Unit Managers (UM), and RN Supervisors will address and concerns identified during the audits. • The Director of Nursing (DON), Unit Managers (UM), Staff Development Coordinator, or designee will complete an audit of 100% of resident rooms 3 x week for 2 weeks, then weekly x 2 weeks and the monthly x one month is to ensure medications are not left at the resident beside unless the resident had been assessed, deemed clinically appropriate for self-administration of medications, and physician order obtained. The Director of Nursing (DON), Unit Managers (UM), Staff Development Coordinator, or designee will address any identified areas of concern noted during the audit. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 9-29-2023	

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F 584	Continued From page 7	F 584		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		9/29/23

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F 584	Continued From page 8 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to have a Packaged Terminal Air Conditioner (PTAC) unit in good repair (Room #314). This was for 1 of 6 rooms reviewed for comfortable, clean, and homelike environment. The findings included: On 8/28/23 at 12:30 PM, an observation of room 314 revealed the PTAC unit to have two broken vents and two missing sections of vent slats. Observations were conducted with the Maintenance Director on 8/31/23 at 8:50 AM. He observed the broken vent slats as well as the two sections of missing vents and indicated he was not aware of the damage to the PTAC unit. He acknowledged the area did require attention and would be repaired. The Administrator was interviewed on 8/31/23 at 1:45 PM and stated it was important for the environment to be well repaired and homelike.	F 584	F584 Safe Clean Comfortable Homelike Environment 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: No resident(s) were found to be affected. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: No residents have the potential to be affected. On 9-18-2023, the Maintenance Director completed an audit of 100% of rooms with Packaged Terminal Air Conditioner (PTAC) to include room #314. This audit is to identify any room that needs repair to include but not limited to the Packaged Terminal Air Conditioner (PTAC) units with broken vents or missing sections of vent slats. The Maintenance Director will address all concerns identified during the audit. 3. Measures to be put in place or systemic changes made to ensure	

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F 584	Continued From page 9	F 584	practice will not re-occur: • On 9-21-2023, the Administrator completed an in-service with the Maintenance Director regarding Maintaining a Homelike Environment with emphasis on timely repair of Packaged Terminal Air Conditioner (PTAC) units with broken vents or missing sections of vent slats to maintain a safe and homelike environment and not resolving work orders in Technology Enabled Life Safety system (TELS) until repairs are completed. • On 9-21-2023, the Staff Development Coordinator (SDC) initiated an in-service with all nurses, nursing assistants, therapy staff, housekeeping staff, maintenance staff, accounts payable, accounts receivable, social worker, activity staff, receptionist, scheduler, and medical records director regarding Safe and Homelike Environment. Emphasis is the process for prompt reporting of any area in the facility in need of repair to maintain a safe and homelike environment including but not limited to the Packaged Terminal Air Conditioner (PTAC) units. In-service will be completed by 09-29-2023. • The Maintenance Director will complete audit of 10 rooms weekly x 4 weeks then monthly x 1 month utilizing the Environmental Rounds Audit Tool to identify any room that need repair to include but not limited to the Packaged Terminal Air Conditioner (PTAC) units with broken vents or missing sections of vent slats.	

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F 584	Continued From page 10	F 584	4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 09-29-2023	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications (Resident #13 and Resident #42) for 2 of 22 residents reviewed. The findings included: 1. Resident #13 was admitted to the facility on 11/8/10 with diagnoses that included type 2 diabetes.	F 641	F641 Accuracy of Assessments 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident # 13 remains in the facility. On 9-19-2023, the Minimum Data Set (MDS) Coordinator completed a modification of the annual assessment dated 5-12-2023 and the quarterly assessment dated	9/29/23

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F 641	Continued From page 11 A review of Resident #13's physician orders included an order for Humalog Solution (insulin to treat diabetes) 100 units per milliliter (ml). Inject as per sliding scale subcutaneously with meals. If blood glucose levels measure: 0-200= then administer 0 units; 201-250= 1 unit; 251-300= 2 units; 301-350= 3 units; 351-400= 4 units. a. An annual Minimum Data Set (MDS) assessment dated 5/12/23 indicated Resident #13 had received 7 days of an insulin injection. A review of the May 2023 Medication Administration Record (MAR) indicated Resident #13 received Humalog Solution as per sliding scale five days during the 7-day look back period for the 5/12/23 MDS assessment (5/6/23, 5/9/23, 5/10/23, 5/11/23 and 5/12/23). b. A quarterly MDS assessment dated 8/11/23 indicated Resident #13 was not coded as receiving any insulin injections. A review of the August 2023 MAR indicated that Resident #13 received Humalog Solution as per the sliding scale four days during the 7-day look back period for the 8/11/23 MDS assessment (8/5/23, 8/8/23, 8/10/23 and 8/11/23). On 8/31/23 at 11:10 AM, an interview occurred with MDS Nurses #1 and #2, who reviewed the MDS assessments dated 5/12/23 and 8/11/23, as well as reviewed Resident #13's medical record. MDS Nurse #2 stated she coded the MDS assessments incorrectly for the insulin injections received and felt it was an oversight. Both MDS Nurse #1 and #2 stated the MARs should be reviewed carefully in order to code the insulin injections accurately on the MDS assessment.	F 641	8-11-2023 for resident #13 to reflect accurate coding of medication use to include diabetic medications. Resident #42 remains in the facility. On 9-19-2023, the Minimum Data Set (MDS) Coordinator completed a modification of the quarterly assessment dated 8-2-2023 for resident #14 to reflect accurate coding of medication use to include diabetic and anticoagulation medications. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. On 09-03-2023, the Regional Minimal Data Set (MDS) Consultant initiated an audit of the most recent MDS assessment section “N” from for all residents prescribed diabetic and anticoagulant medications to include Resident #13 and #42 to ensure all MDS’s assessments completed are coded accurately to include but not limited to the use of diabetic and anticoagulant medications. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from DON. The audit will be completed by 9-29-2023. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • On 9-18-2023, the Regional Minimal	

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	345146	A. BUILDING _____ B. WING _____	C 09/01/2023

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F 641	Continued From page 12 2. Resident #42 was admitted to the facility on 5/9/17 with diagnoses Diabetes and quadriplegia. Review of Resident #42' August 2023 Physician orders included the following orders: *Eliquis (anticoagulant) 2.5 milligrams (mg) by mouth twice a day for deep vein thrombosis prevention with the order date 6/2/23. *Levemir (insulin) 25 injected units daily for Diabetes with the order date 5/29/23. Review of Resident #42's July 2023 and August 2023 Medication Administration Record (MAR) indicated the following: *Eliquis refused on 7/27/23, 7/28/23, 7/29/23, 7/30/23 and 8/1/23 *Levemir refused on 7/30/23 Review of Resident #42 quarterly Minimum Data Set (MDS) dated 8/2/23 indicated he received 7 days of an anticoagulant and 7 days of an insulin injection. A telephone interview was completed on 9/1/23 at 1:25 PM with MDS Nurse #3. She stated the 7 day look back for Resident #42's quarterly MDS dated 8/2/23 would have been from 7/27/23 to 8/1/23. She stated she mistakenly coded the MDS for 7 of 7 days of insulin injections and 7 of 7 days of an anticoagulant. An interview was completed on 8/31/23 at 1:35 PM with the Administrator. She stated she expected the MDS to be coded accurately in the area of medications.	F 641	Data Set (MDS) Consultant initiated an in-service with all Minimum Data Set Nurses (MDS) regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on ensuring assessments are coded accurately on the MDS assessment to include but not limited to resident medications. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. • The Minimum Data Set (MDS) nurses will audit of 10% of completed MDS assessments, to include assessments for resident # 13, and resident #42 utilizing the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include residents that are receiving diabetic and anticoagulant medications. All identified areas of concern will be addressed immediately by the DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance	

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F 641	Continued From page 13	F 641	Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 09-29-2023	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to request a level II Preadmission Screening and Resident Review (PASRR) for a resident (Resident #81) newly diagnosed mental illness for 1of 1 residents reviewed for PASRR. The findings included: Resident #81 was admitted from another facility	F 644	F644 Coordination of PASRR and Assessments 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice:	9/29/23

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F 644	Continued From page 14 on 6/7/22 with diagnoses of Diabetes, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. He was admitted with a level 1 PASRR as of 6/1/20 and no further screening was required unless a significant change occurred to suggest a diagnosis of mental illness. Resident #81 was seen by Psychiatry on 12/14/22 due to anger, aggression and mood instability. Resident #81 was newly diagnosed with Borderline Personality Disorder, Bipolar Disorder and Narcissistic Personality Disorder. Resident #81's annual Minimum Data Set dated 2/5/23 indicated he was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. An interview was completed with Social Worker #1 on 8/29/23 at 1:50 PM. She stated she completed the requested for Resident #81 to be screened for a PASRR level 2 earlier on 8/29/23. Social Worker #1 stated she was not aware that a PASRR level 2 screen was required when a resident was newly diagnosed with a serious mental illness and/or intellectual disability or related condition. An interview was completed on 8/31/23 at 1:35 PM with the Administrator. She stated a PASRR level 2 screening request should have been sent at the time Resident #81 was newly diagnosed with Borderline Personality Disorder, Bipolar Disorder and Narcissistic Personality Disorder on 12/14/22.	F 644	Resident #81 remains in the facility. On 8-29-2023, a PASRR screening was completed for resident #81 and returned as Level II effective 9-19-2023. On 09-19-2023, the Business Office Manager updated resident medical record to reflect Level II PASRR. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. On 9-18-2023, the Social Workers (SW) initiated an audit of diagnosis for all residents with a Level I PASRR. This audit is to identify any resident with a newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation. The Social Workers (SW) will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation. The audit will be completed by 9-29-2023. On 9-22-2023, the Social Workers (SW) initiated an audit of all newly admitted residents, readmitted residents or residents transferring from another facility to ensure residents were screened for a PASRR level per facility protocol. The Social Workers (SW) will address all concerns identified during the audit to include submitting a PASRR through the North Carolina Medicaid Uniform Screening tool and updated resident	

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F 644	Continued From page 15	F 644		

medical record when indicated. The Audit will be completed by 9-29-2023.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

• On 9-20-2023, the Administrator initiated an in-service on Level II PASRRs with the Admission Director, Social Workers, Minimum Data Set Nurse (MDS), Director of Nursing and administrative nurses with emphasis on referral for evaluation/re-evaluation of PASRR on admission to include transfer from another facility, following changes in mental health status or new Level II qualifying diagnosis. In-service will be completed by 9-29-2023. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), administrative nurses, and Director of Nursing will be in-service during orientation on PASRRs with emphasis on PASRR screening on admission to include transfer from another facility and/or with changes in mental health status or new Level II qualifying diagnoses.
• The Social Workers (SW) will review all visit notes from psychiatric Nurse Practitioner to identify new mental health diagnoses to include resident #81 weekly x 4 weeks then monthly x 1 month. This audit is to ensure any newly identified PASRR qualifying diagnosis is reviewed to determine the need for re-submission of PASRR information. The Social Workers (SW) will address all concerns identified during the audit to include completing a

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F 644	Continued From page 16	F 644	new PASRR review. • The Admission Director will audit all newly admitted residents to include residents admitted from another facility to ensure residents were screened for a PASRR level per facility protocol. The Admission Director will address all concerns identified during the audit to include submitting a PASRR through the North Carolina Medicaid Uniform Screening tool, updating resident medical record when indicated and/or re-training of staff. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 09-29-2023	

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F 656	Continued From page 17	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		9/29/23

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F 656	Continued From page 18 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to develop a comprehensive care plan in the areas of personal and incontinence care refusal (Resident #32) and nutrition and weight loss (Resident #50) for 2 of 22 residents reviewed for care plan. Findings included: 1. Resident #32 was admitted to the facility on 9/24/19 with the diagnosis of schizophrenia. A review of Resident #32's electronic medical records from 6/1/23 to 8/31/23 documented the resident refused care, including incontinence care when needed at least once a week. Resident #32's care plan dated 7/26/23 documented she was totally dependent of 2 staff for bathing and was incontinent of bowel and bladder. There was no mention of care refusal. Resident #32's quarterly Minimum Data Set (MDS) dated 7/26/23 documented the resident had an intact cognition. The resident had feelings of being down and refused care 3 to 5 times a week. No other behaviors were coded. The resident was dependent for bathing and required	F 656	F656 Develop/Implement Comprehensive Care Plan 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #32 remains in the facility. On 8-31-2023, the Minimum Data Set (MDS) Nurse updated the care plan for resident #32 to accurately reflect refusal of care to include but not limited to refusal of incontinent care. Resident #50 remains in the facility. On 9-6-2023, the Minimum Data Set (MDS) Nurse updated the care plan for resident #50 to accurately reflect weight loss and nutritional interventions. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. On 9-22-23, the Facility Nurse	

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F 656	Continued From page 19 assistance of 1 staff for dressing and incontinence care. On 8/30/21 at 2:40 pm an interview was conducted with Resident #32. The resident stated she did not like to get out of bed and staff provided care and she had no concerns (the resident had not recalled refusing care). On 8/31/23 at 11:50 am an interview was conducted with MDS Coordinator #1. She stated Resident #32 had a care plan for manipulative behaviors but not for refusal of care. A care plan for refusal of care would be added. On 8/31/23 at 2:40 pm an interview was conducted with the Administrator. The Administrator stated she was not aware Resident #32 had no care plan for refusal of care and she would follow up with the MDS Coordinator. 2. Resident #50 was admitted to the facility on 12/5/17 with dementia. Resident #50's quarterly Minimum Data Set (MDS) dated 7/20/23 documented the resident had cognition that was severely impaired. The diagnoses were dementia and gastric reflux disease. The resident had weight loss, an undetermined amount. A review of Resident #50's electronic medical record for the month of August 2023 documented she ate between 25 to 50% of her meals. The resident had weight loss of 11.2% in 3 months. The dietician notes documented she was following and requested weekly weights. The resident was receiving a protein supplement and	F 656	Consultant initiated an audit of all resident care plans to ensure the care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to refusal of care, weight loss and nutritional interventions. The Minimum Data Set (MDS) Nurses will address all concerns identified during the audit to include updating care plan when indicated and/or education of staff. The audit will be completed by 9-29-23. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • On 9-20-2023, the Staff Development Coordinator (SDC) initiated an in-service with all facility and contract/agency nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to resident refusals of care, weight loss and nutritional interventions. In-service will be completed by 9-29-2023. After 9-29-2023, all facility and contract/agency nurses that has not worked and received the education will complete upon their next scheduled shift. After 9-29-2023, the Staff Development Coordinator (SDC) will include this education regarding Care Plans to facility	

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F 656	Continued From page 20 multivitamin for weight gain. The Registered Dietician (RD) note dated 8/8/23 documented Resident #50 had continued weight loss for the past 30 days. The RD evaluated and prescribed nutritional supplement to prevent weight loss. The resident would be weighed weekly for 4 weeks or until weight was stable (no further weight loss). Resident #50 had a physician order dated 8/13/23 for Mirtazapine each day (appetite stimulant). On 8/31/23 at 11:50 am interview was conducted with MDS Coordinator #1. She stated Resident #50 had no care plan for nutrition and weight loss. A nutrition and weight loss care plan area would be added. On 8/31/23 at 2:40 pm an interview was conducted with the Administrator. The Administrator was not aware Resident #50 had no care plan for weight loss. The resident's weight loss was discussed in morning meetings and the Dietary Manager was addressing the issue.	F 656	and contract/agency nurses during general facility orientation. • The Director of Nursing (DON), Unit Managers (UM), RN supervisor, or designee will review 15 resident care plans to include resident #32 and resident #50 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure residents with documented ADL care refusals and weight loss have person centered care plans with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs through implementation of behavioral and nutritional interventions. The Director of Nursing (DON), Unit Managers (UM), and/or RN supervisor will address all concerns identified during the audit to include updating care plan when indicated and re-education of staff. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 09-29-2023	

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F 658 SS=B	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation, and staff interviews, the facility failed to clarify a consultation note and discontinue an order to flush an abscess drain (Resident #25). This was for 1 of 1 resident reviewed for well-being. The findings included: Resident #25 was originally admitted to the facility on 2/14/12. He was recently readmitted from the hospital on 8/2/23 with a diagnosis of a liver abscess with a drain present. A quarterly Minimum Data Set (MDS) assessment dated 8/7/23 indicated Resident #25 had severely impaired decision-making skills and was coded with surgical wounds. A review of Resident #25's active physician orders included an order dated 8/9/23 to use 5 milliliters (ml) of sterile saline solution via irrigation twice a day for the abscess tube for six weeks. Keep the drain to gravity drainage. Review of a Report of Consultation from a radiology specialist, dated 8/10/23, indicated the abscess had resolved and the drain was removed. Resident #25's August 2023 Medication	F 658	F658 Services Provided Meet Professional Standards 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #25 remains in the facility. On 8-28-2023, the physician gave an order to discontinue active order for flushing of abscess drain. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. On 9-25-2023, an audit of all consult recommendations for the past 60 days was initiated by Director of Nursing. The Director of Nursing (DON), Unit Managers, and/or RN Supervisors will address any concerns identified during the audit to include but not limited to obtaining physician orders and/ education to staff. This audit will be completed by 9-29-2023. 3. Measures to be put in place or	9/29/23

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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 658	Continued From page 22 Administration Record (MAR) was reviewed and indicated the order to use 5 ml of sterile saline solution via irrigation twice a day for the abscess tube was still active from 8/9/23 to 8/28/23. Unit Manager #1 was interviewed on 8/30/23 at 11:12 AM. She indicated when a resident returned from an appointment the paperwork was reviewed and provided to the Nurse Practitioner or physician to approve any recommendations. She reviewed the Report of Consultation dated 8/10/23 and stated she was unsure why the order to flush the abscess drain had not been discontinued and removed from the MAR as the drain had been removed on 8/10/23 at the appointment. Unit Manager #1 stated a clarification order should have been obtained to discontinue the flush to the abscess drain. On 8/30/23 at 1:53 PM, an observation was made with the wound care nurse of Resident #25's right abdomen. A scab was present where the abscess drain had been removed on 8/10/23. On 8/30/23 at 3:20 PM, the Director of Nursing stated he would have expected a clarification order to be obtained to discontinue the flushes to the abscess drain when it was removed on 8/10/23.	F 658	systemic changes made to ensure practice will not re-occur: • On 9-25-2023, the Staff Development Coordinator (SDC) initiated an in-service with current facility and contract/agency nurses noting it is the nurse's responsibility to review consult sheets/paperwork upon the resident's return to the facility from an appointment to identify new and discontinued orders, follow the orders as written, document orders in the electronic health record. In-service will be completed by 9-29-2023. After 9-29-2023, all facility and contracted/agency nurses that have not worked and received the education will complete upon their next scheduled shift. After 9-29-2023, the Staff Development Coordinator (SDC) will include this education to facility and contract/agency nurses during general facility orientation. • On 9-25-2023, Director of Nursing (DON) initiated an in-service with the Unit Managers (UM) and RN Supervisors noting they are to provide oversight as a second check system to ensure consult orders are followed as written and transcribed to the electronic health record through review of consult sheets/paperwork, and progress notes. • The Director of Nursing (DON), Unit Managers (UM), RN Supervisors, and/or designee review 10% of all residents' consult visit sheets/paperwork weekly x 4 weeks, monthly x 1 month. The audit is to ensure orders from consulting providers have been followed as written and transcribed to the electronic health record.	

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F 658	Continued From page 23	F 658	The Director of Nursing (DON), Unit Managers (UM), Staff Development Coordinator, or designee will address any identified areas of concern noted during the audit. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 09-29-2023	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate	F 676		9/29/23

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F 676	Continued From page 24 treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide assistance with eating to maintain a resident's ability to feed himself for 1 of 1 residents (Resident #87) reviewed for activities of daily living (ADL). The findings included: Resident #87 was admitted 11/3/2023 with diagnoses that included dementia.	F 676	F676 Activities of Daily Living/ Maintain Abilities 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #87 remains in the facility and continues to receive assistance during mealtimes.	

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F 676	Continued From page 25 The resident's quarterly Minimum Data Set (MDS) dated 7/27/2023 indicated the resident required supervision and set up only during the assessment period. Resident # 87's care plan was last revised 8/3/2023 and included a focus for activities of daily living and personal care deficit. Interventions included provide supervision with minimal set up or assistance with cutting food, verbal cues and/or assist to complete meals as needed. Resident #87's medical record also contained an Occupational Therapy (OT) Plan of Care dated 8/4/2023. The OT care plan indicated the resident's current level of function required total assist for completion of meals. On 8/28/2023 at 12:37 PM Resident #87 was observed in the dining area. The Occupational Therapy Assistant (OTA) provided Resident #87 with assistance putting straw in cup lid and getting cup to his mouth. Additionally, the OTA was observed putting food on the utensils and assisting Resident #87 with getting the food up to his mouth. On 8/29/2023 at 12:45 PM Resident #87 was observed in the dining area. The OTA provided Resident #87 with assistance eating and drinking. On 8/30/2023 at 12:30 PM Resident #87 was observed sitting in the dining area with his lunch tray in front of him. The OTA was not present. Resident #87 made several attempts to put a straw in the lid of a cup and was unsuccessful. He was observed making three attempts to grasp a piece of steamed broccoli with his fingers and place it in his mouth but dropped it in his lap	F 676	2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. On 9-20-2023, the Social Workers (SW) initiated resident care/ feeding assistance observations during mealtimes with current facility and/or agency staff to include NA #3 to audit eating assistance provided. This audit is to ensure staff are assisting residents needing assistance at mealtimes as needed. The Director of Nursing (DON), Unit Managers (UM), and/or SDC will address any concerns identified during the audit to include addressing resident needs and/or education of staff. The audit will be completed by 9-29-2023. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • On 9-20-2023, the Staff Development Coordinator (SDC) initiated an in-service with all facility and contract/agency nursing staff regarding resident care with emphasis on ensuring residents are receiving assistance as appropriate at mealtimes. In-service will be completed by 9-29-2023. After 9-29-2023, all facility and contract/agency nurses that has not worked and received the education will complete upon their next scheduled shift. After 9-29-2023, the Staff Development Coordinator (SDC) will include this education regarding mealtime assistance	

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F 676	Continued From page 26 before it reached his mouth. The resident was then observed attempting to place the straw into the lid of a cup again. After several attempts, Resident #87 lost his grip on the straw, and it fell to the floor. During the above observation, Nurse Assistant (NA) #3 was standing in the door of the dining room, directly behind Resident #87. NA #3 was not observed assisting Resident #87 with his meal. When Resident #87 moved his wheelchair back to look for the straw he dropped, the wheelchair contacted NA#3. NA#3 picked up the straw, placed it in the trash, and placed a clean straw in the resident's cup. She then went back to standing in the door of the dining area. At 12:40 PM on 8/30/2023 this writer asked NA#3 if Resident #87 needed assistance with meals. NA#3 stated, "I don't know. I don't usually work back here; I am the scheduler". NA#3 then walked to another dining area, stood in the door of the dining area and asked NA #4 (who was seated assisting another resident) if Resident #87 was a "feeder". NA#4 replied, yes. NA#3 then walked back to dining area where Resident #87 was sitting, pulled up a chair, and assisted Resident #87 with his meal. On 8/31/2023 at 10:08AM and interview was conducted with NA#3. She stated she did not work in the unit very often. She was not aware Resident #87 received assistance with his meals. On 8/31/2023 at 10:18 AM an interview was conducted with the Occupational Therapist (OT). He stated Resident #87 was on OT case load and receiving therapy services. The OT stated Resident #87 had a global functional decline over	F 676	to facility and contract/agency nurses during general facility orientation. • The Director of Nursing (DON), Unit Managers (UM), Social Workers (SW) or designee will observe resident care/assistance provided during mealtimes for 10 residents weekly x 4 weeks then monthly x 1 month using the Resident Interaction Audit Tool. This audit is to ensure residents requiring feeding assistance are receiving the required assistance during mealtimes. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 09-29-2023	

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F 676	Continued From page 27 the previous 4 weeks. He further stated the staff had noticed Resident #87 needed assistance with meals. The OT stated he communicated with the unit staff frequently since 8/4/2023 and the staff were aware of the resident's decline. He stated the resident may have "fallen through the cracks" on 8/30/2023 because the staff working in the unit that day were not familiar with the residents. 08/31/2023 1:17 PM and interview with Unit Manager #1 was conducted. She stated NA#3 did not work in the unit routinely and was not aware Resident #87 required assistance with his meal.	F 676		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 812	F812 Food Procurement,	9/29/23

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F 812	Continued From page 28 facility failed to maintain a clean floor and walls in the dry food storage room for 1 of 2 dry food storage rooms observed (the emergency dry food storage area). Findings included: On 08/28/23 at 9:34 am an initial observation of the kitchen, including the emergency dry food storage room was conducted. The dry food storage room floor and walls had black soiling all over them (entire floor and wall without shelves) as well as the front of the ice machine. The inside of the ice machine was clean and had ice. Concurrent interview with the Dietary Manager was conducted. He stated the floor had not been cleaned in "a couple of days" and the black was soil not aging of the floor tile and the front of the ice machine had splatter. The Dietary Manager stated that a couple of weeks ago the Maintenance staff had serviced the ice machine and caused the splatter which had not been cleaned. On 8/31/23 at 1:40 pm the Administrator was interviewed. The Administrator stated she was not aware the emergency dry food storage room floor and walls were dirty and would follow up with the Dietary Manager.	F 812	Store/Prepare/Serve- Sanitary 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: On 08-28-2023, the Dietary Manager and Dietary Staff cleaned the black soiling on the floor and walls in the dry food storage room (the emergency dry food storage area) as well as the front of the ice machine. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: On 8-28-2023, the Administrator completed an audit of all areas of the kitchen to ensure floors and walls were clean and in good repair. The Dietary Manager will address all concerns identified during the audit to include but not limited to cleaning of all areas of concern and the education of staff. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • On 08-28-2023, the Dietary Manager initiated an in-service with all dietary staff regarding Cleaning Kitchen Areas with emphasis on routine cleaning schedule of floors, walls and storage areas and immediately cleaning spills/splatters to ensure food service safety. In-service will	

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F 812	Continued From page 29	F 812		

be completed by 9-29-23. After 9-29-23, any dietary staff who has not completed the in-service will complete upon next scheduled work shift. All newly hired dietary staff will be in-service during orientation regarding Cleaning Kitchen Areas.

• The Dietary Manager will complete an audit of all areas of the kitchen 2 times a week x 4 weeks then weekly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure staff complete routine cleaning of all kitchen areas and all spills/splatters are immediately cleaned for food service safety. The Dietary Manager will address all concerns identified during the audit to include but not limited to cleaning of all areas of concern and re-training of staff.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator is responsible for the plan of correction and monitoring of audits. The results of the audits will be reviewed weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits to determine trends and/or further problem resolution if needed.

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F 867	Continued From page 30	F 867		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		9/29/23

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facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and

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F 867	Continued From page 32 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain	F 867	F867 QAPI/QAA Improvement Activities 1. What corrective action will be	

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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 867	Continued From page 33 implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint survey conducted on 2/3/2022. This was for 5 deficiencies in the areas of resident rights, safe/clean/comfortable homelike environment, accuracy of assessments, care plans, and services to meet professional standards, previously cited on 2/3/2022 and recited on the current recertification and complaint survey of 8/31/23. The duplicate citations during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F550- Based on observations, record reviews, and staff interviews, the facility failed to avoid the use of the term "feeder" when referring to a resident who required assistance with meals for 1 of 1 dining observations (Resident # 87). The reasonable person concept was applied as individuals have the expectation of being treated with dignity and not be referred to as "feeder". During the facility's recertification survey of 2/3/2022 the facility failed to promote a dignified dining experience by serving meals on disposable plates and utensils. The facility also failed to provide dignity by allowing a resident to eat in a room with a strong urine odor. 2. F584- Based on observations and staff interviews, the facility failed to have a Packaged Terminal Air Conditioner (PTAC) unit in good repair (Room #314). This was for 1 of 6 rooms reviewed for comfortable, clean, and homelike	F 867	accomplished for each resident found to have been affected by the deficient practice: No residents were affected 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: No residents have the potential to be affected. On 9/12/22, The Facility Consultant initiated an audit of previous citations and action plans within the past year to include resident rights, safe/clean/comfortable homelike environment, accuracy of assessments, care plans, and services to meet professional standards to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Administrator and Director of Nursing (DON) will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 9-29-2023. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: On 09-25-2023, the Facility Nurse Consultant initiated an in-service with the	

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F 867	Continued From page 34 environment. During the facility's recertification survey of 2/3/2023 the facility failed to maintain a clean environment as evidenced by dirty toilets and strong urine smells in bathrooms and failed to provide clean bed linens for 2 of 2 residents. 3. F641-Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications (Resident #13 and Resident #42) for 2 of 22 residents reviewed. During the facility's recertification survey of 2/3/2022 the facility failed to accurately code the MDS assessment in the areas of nutrition, falls, pressure ulcers, dental status, and urinary catheters. 4.F656-Based on record review and staff and resident interviews, the facility failed to develop a comprehensive care plan in the areas of personal and incontinence care refusal (Resident #32) and nutrition and weight loss (Resident #50) for 2 of 22 residents reviewed for care plan. During the facility's recertification survey 2/3/2022 the facility failed to develop a comprehensive care plan for Activities of Daily Living (ADL) assistance, for the use of a prophylactic antibiotic, and for a right-hand contracture. 5. F658- Based on record reviews, observation, and staff interviews, the facility failed to clarify a consultation note and discontinue an order to flush an abscess drain (Resident #25). This was for 1 of 1 resident reviewed for well-being.	F 867	Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers, Minimum Data Set (MDS) nurses, Social Workers, Dietary Manager Maintenance Director, and Environmental Services Manager process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 9-29-2023. All newly hired Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers, Minimum Data Set (MDS) nurses, Social Workers, Dietary Manager Maintenance Director, and Environmental Services Manager will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include resident rights, safe/clean/comfortable homelike environment, accuracy of assessments, care plans, and services to meet professional standards will be taken to the Quality Assurance committee for review monthly x 6 months by the Administrator. The Quality Assurance committee will review the data and determine if plan of corrections is being followed, if changes in plans of action are required to improve	

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F 867	Continued From page 35 During the facility's recertification survey of 2/3/2022 the facility failed to follow physician's order by not holding the Lantus and Lispro insulin (used to treat diabetes mellitus) for blood sugar of 150 or less.	F 867	outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Administrator. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing Quarterly QA meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include resident rights, safe/clean/comfortable homelike environment, accuracy of assessments, care plans, and services to meet professional standards and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers, Minimum Data Set (MDS) nurses, Social Workers, Dietary Manager Maintenance Director, and Environmental Services Manager for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be	

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F 867	Continued From page 36	F 867	presented by the Administrator to the Quality Assurance Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. Date of compliance: 09-29-2023	