STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Health Care Facility	**3532 Dunn Road , Eastover, North Carolina, 28301**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/09/26 through 02/12/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1E3560-H1	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/09/26 through 02/12/26. Event ID# 1E3560-H1. The following intake was investigated: 2682986 7 of the 7 allegations did not result in a deficiency	F0000		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	The facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Diabetes and anxiety diagnoses for resident #5 The MDS assessment for resident #5 was modified to accurately code diabetes and anxiety disgnoses by the MDS coordinator An audit of all resident's diagnoses and section I of MDS compared to ensure the MDS is accurately coded and the MDS motified for all errors found Administrator educated MDS department that the MDS must accurately reflect the residents status and that the MDS assessment, resident diagnoses list in chart and Medical Director or other doctors progress notes/diagnoses list must all match to ensure that the MDS The QAPI coordinator will conduct a random audit of 3 resident 's MDS per week x's 4 weeks then bi monthly for 1 month and then monthly x's 3 mobths using new QAPI form titled "MDS diagnosis" to ensure that the MDS accurately reflects the residents current condition by coding the dx correctly in section I	03/12/2026

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 reverse for further 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.

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

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F0641 SS = D	Continued from page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of diabetes and anxiety diagnoses for 1 of 24 residents reviewed for MDS accuracy (Resident #5). Findings include: Resident #5 was admitted to the facility on 1/10/25 and most recently readmitted on 9/30/25. Her medical history was significant for type 2 diabetes mellitus and generalized anxiety disorder. Resident #5's care plan created 1/10/25 indicated Resident #5 had a diagnosis of diabetes. Anxiety was not included as a care focus area in Resident #5's care plan. A physician encounter note dated 10/28/25 indicated Resident #5 had a diagnosis of diet-controlled diabetes mellitus. Resident #5's physician order dated 11/19/25 indicated to administer 0.5 milligram Ativan (antianxiety medication) once a day in the evening for anxiety and unspecified mood disorder. Resident #5's annual MDS dated 12/23/25 coded Resident # 5 as cognitively severely impaired and as taking an antianxiety medication. The MDS did not indicate that Resident #5 had a diagnosis of diabetes or anxiety. During an interview with the MDS Nurse on 2/11/26 at 3:04 PM, she reported that Resident #5 had documented diagnoses of diabetes and generalized anxiety disorder, which should have been coded on the annual MDS. The MDS Nurse verbalized that she had missed coding the MDS to indicate that Resident #5 had diabetes and anxiety diagnoses when she completed the annual MDS on 12/23/25	F0641		

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F0641 SS = D	Continued from page 2 and that the omission was an oversight. During an interview on 2/12/26 at 10:22 AM, the facility Administrator stated that the MDS should include all of a resident's diagnoses, and that diabetes and anxiety should have been coded on Resident #5's annual MDS to accurately reflect her current condition.	F0641		
F0644 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 staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident with serious mental health diagnoses for 1 of 1 resident reviewed for PASRR (Resident #4). Findings included: Resident #4 was admitted to the facility on 10/31/2021 with diagnoses which included hypertension, hyperkalemia and hyperlipidemia. The PASRR history report dated 11/01/2021, provided by the facility, revealed Resident #4 had one Level I PASRR review, completed on 11/01/2021 and the review did not meet level II criteria. The PASRR review revealed Resident #4 was noted to have no mental health	F0644	The facility failed to submit a request for a level II Preadmission Screening and Resident Review (PASARR) evaluation for resident #4 with serious mental health diagnoses (dx). The MDS coordinator will ensure that the Business Office Manager (BOM) will be notified of all new mental health dx's. The BOM will request a PASARR) level II evaluation for all residents with new mental health dx. An audit of all mental health dx was completed by QAPI coordinator and DON to ensure that a request for a PASARR level II evaluation is done for all mental health dx's. Administrator educated the MDS department and BOM that with any new mental health dx a PASARR level II evaluation must be requested so that it can be determined from the residents assessment, care planning, and transitions of care that the resident is receiving the needed level of care. The QAPI coordinator will conduct random chart audits of three resident charts x's four weeksto review any new mental health dx. if any new mental health dx a PASARR level II evaluation will be requested then bi monthly x's one month and then monthly x's three months using new QAPI form titled "PASARR audit" to ensure a PASARR level II request is completed on any new mental health dx	03/12/2026

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F0644 SS = D	Continued from page 3 diagnosis at the time of the review. A review of the active diagnosis list revealed Resident #4 had a diagnosis of generalized anxiety disorder and depressive disorder both noted as active on 03/26/2025. Review of the Psychiatrist note dated 01/20/2026 indicated Resident#4 had a chief complaint/ nature of presenting problem as mood disorder with psychosis/bipolar. The note documented medication prescribed for mood disorder with psychosis /bipolar was Zyprexa 5 milligrams one tablet by mouth (po) every bedtime. Review of Resident #4's electronic and paper medical record revealed no evidence a request was submitted for an evaluation for level II PASRR determination. The Minimum Data Set (MDS) assessment dated 09/25/25 revealed Resident #4 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS indicated the resident had a diagnosis of bipolar disorder. During an interview on 02/11/2026 at 11:01 AM, MDS Coordinator stated that her usual practice was to notify the Business Office Manager (BOM) of the resident's new mental illness diagnoses and the BOM was responsible for sending the request to the state agency for evaluation for the level II PASRR. The MDS Coordinator stated that when the provider added the new mental illness diagnoses for Resident#4 in March 2025 she failed to notify the BOM so she could submit request for level II PASRR evaluation. During an interview on 02/12/2026 at 8:44 AM, the Business Office Manager (BOM) confirmed she was responsible for requesting level II PASRR evaluations for residents at the facility. She stated the MDS Coordinator did not notify her of the new mental health diagnoses of anxiety disorder, and depressive disorder for Resident #4 in March 2025. The BOM also stated she was not made aware of the bipolar disorder diagnosis in January 2026. She further stated that she would continue to communicate with the MDS Coordinator about the new mental health diagnoses and request level II PASRR evaluations. An interview was conducted with the Administrator on 02/12/26 at 8:57 AM who revealed the facility received Resident #4's level I PASRR information after his	F0644		

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F0644 SS = D	Continued from page 4 admission to the facility on 11/01/2021 indicating she did not have any mental illness. She added the MDS Coordinator was responsible for notifying the BOM of Resident #4's new mental health diagnoses in March 2025 and the BOM would have requested a level II PASRR evaluation. She added Resident #4's level II PASRR evaluation should have been completed in March 2025 when the new mental illness diagnoses were added in the medical records.	F0644		
F0812 SS = D	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 observations and staff interviews, the facility failed to discard expired food items and food items with signs of spoilage and failed to label and date resident's personal food items stored in 2 of 2 nourishment room refrigerators (Main Unit and Locked Unit). This practice had the potential to cause foodborne illnesses. Findings included: a. Observation of the Main Unit nourishment room refrigerator with the facility's Dietary Manager (DM)	F0812	The facility failed to discard expired food items and food items with signs of spoilage and failed to label and date residents personal food items. The refrigerator in the main unit nourishment room and in the Alzheimer's unit nourishment room was cleaned and all expired food items were discarded to prevent any food borne illnesses. An audit of all refrigerators in the facility was completed by QAPI coordinator, charge nurse, and housekeeping supervisor to ensure that no expired food items and no items with signs of spoilage were in refrigerators and opened food had labels with open dates Administrator will educate all nursing staff the policy and procedure for food brought in by family, expiration dates, labeling food, and food borne illnesses. QAPI will audit refrigerators in main unit nourishment room and in the Alzheimer's room to ensure no expired food or open food with signs of spoilage are present and that all food is properly labeled and dated by using new QAPI form titled "expired food" weekly x's 4 weeks and then monthly x's 3 months	03/12/2026

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F0812 SS = D	Continued from page 5 on 2/11/26 at 2:05 PM revealed the following: - A jar of strawberry preserves that was approximately a third full with a use by date of 1/19/26; - An unopened 8 ounces bottle of high protein milkshake with a best if used by date of 1/30/26; - Three unopened bottles of nutritional energy drink with a use by date of 10/9/25; - A 2-liter soft drink bottle that was half full of an orange liquid that was not labeled or dated; - A 500-milliliter disposable water bottle with a purplish liquid that was not labeled or dated; - A 500-milliliter soft drink bottle that was approximately half full of a brownish liquid that was not labeled or dated. The Unit Manager who came into the nourishment room during the observation placed the above food items in the trash can. The Unit Manager stated that nursing staff were supposed to ensure that all food items in the nourishment refrigerator were dated and labeled and that expired food items were discarded. b. Observation of the Locked Unit nourishment room refrigerator with the DM on 2/11/26 at 2:20 PM revealed the following: - A cup of yogurt with an expiration date of 1/9/26; - A pack of 3 prepackaged apples with an opened by date of 12/15/25 and best by date of 1/29/26. Two apples in the packet were observed to have grayish fuzz. The Locked Unit Charge Nurse who was present during the observation placed the items in the trash can. The Locked Unit Charge Nurse indicated that nurses were responsible for labeling the food items and checking the expiry dates and that she should have checked the refrigerator at the beginning of her shift at 7:00 am and ensured that expired food items were discarded to prevent food borne illnesses. During an interview on 2/11/26 at 2:40 PM with the Director of Nursing (DON), she stated that she expected nursing staff to inspect the nourishment room refrigerators to ensure expired food items were not left in the refrigerator and that all food items were labeled and dated.	F0812		

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F0812 SS = D	Continued from page 6 During an interview with the facility Administrator on 2/11/26 at 2:45 PM, she indicated that her expectation was to have all food items in the nourishment room refrigerators dated and labeled, have no outdated food items in the refrigerator and that any expired food items should have been thrown out by nursing staff.	F0812		