

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/02/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>Bethany Woods Nursing and Rehabilitation Center</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  <b>33426 Old Salisbury Road BOX 1250, Albemarle, North Carolina, 28002</b>
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E0000	Initial Comments  An unannounced recertification and complaint investigation survey was conducted from 3/30/26 through 4/2/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22BC57-H1.	E0000		04/23/2026
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted from 3/30/26 through 4/2/26. Event ID #22BC57-H1. The following intakes were investigated: 2610839, 2809076, 2650326, 2691366, 2691426, 2720893, and 825512.  2 of the 10 complaint allegations resulted in deficiency.	F0000		04/23/2026
F0602 SS = E	Free from Misappropriation/Exploitation  CFR(s): 483.12  §483.12  The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  This REQUIREMENT is NOT MET as evidenced by:  Based on record reviews, and interviews with the police detective, pharmacy consultant, physician and staff, the facility failed to protect the residents' right to be free from misappropriation of multiple non-narcotic medications when Nurse #1 was found with a bag of prescribed medications during a traffic stop. This deficient practice affected 16 of 16 residents reviewed for misappropriation (Residents #2, #10, #31, #37, #60, #68, #78, #86, #88, #121, #122, #123, #124, #125, #126, and #127).  The findings included:	F0602	F-602 Free from Misappropriation/Exploitation  1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  Resident 121, 122, 123. 124, 125, 126, 127 no longer reside in the facility.  On 9/5/25, assessments (review of progress notes, vital signs, signs and symptoms of adverse reactions) associated with the medications in the nurse's possession which included non-narcotic pain relievers, antidepressant, antihypertensive, anti-nausea and inhalers were completed by the facility consultant for all identified residents currently residing in the facility with no adverse outcomes.  Additionally, on 9/5/25, the Administrator and DON completed interviews with the alert and oriented residents that were identified and remained in the facility as well as with nurses and medication aides. There were no concerns expressed regarding the nurses' practice of medication administration.	04/30/2026

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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F0602 SS = E	<p>Continued from page 1</p> <p>A review of the facility's policy entitled Abuse, Neglect, Misappropriation and Exploitation dated August 2019 read in part .... The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>Misappropriation of resident property is defined as the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without consent.</p> <p>A review of sheriff's office incident sheet dated 9/4/25 read that on 9/4/25 at 3:08 PM, a traffic stop was conducted with Nurse #1 due to a vehicle registration infraction. Nurse #1's vehicle was searched due to the smell of marijuana and multiple prescription medications were found inside a bag and under the passenger seat. Nurse #1 stated that she got them from the facility she had worked at, put them in her pocket and forgot to return them. The report indicated that the facility was made aware of the findings and confirmed that Nurse #1 was a former employee that had been terminated. The prescription medications were placed into evidence pending further investigation and Nurse #1 was taken into custody.</p> <p>A phone interview occurred on 3/31/26 at 1:09 PM with the Police Detective. He stated that he oversaw the narcotics division and special operations and was present at the traffic stop of Nurse #1 on 9/4/25. He recalled during the search of her vehicle finding multiple packs of single medications as well as medication cards in multiple areas of her vehicle. He stated that Nurse #1 expressed to them that she was a nurse and had forgotten the medications were in her pocket, inadvertently taking them home at the end of her shift. The Police Detective confirmed there were no narcotic medications found in Nurse #1's possession. The facility was notified of the findings. He stated that the Administrator came to the police station the following day to take an inventory of what had been found in Nurse #1's possession. The interview further revealed the medications were kept as evidence and not released back to the facility.</p> <p>An initial allegation report was submitted to the State by the prior Administrator on 9/5/25. The report read that the facility initially became aware of the incident on 9/4/25 at 4:00 PM, alleging that</p>	F0602	<p>Continued from page 1</p> <p>The DON notified the physician, the identified in-house alert and oriented residents, and responsible parties on 9/5/25 regarding the unauthorized removal of resident medications from the facility by Nurse #1.</p> <p>On 9/5/25, the Department of Health &amp; Human Services, and Adult Protective Services (APS) was notified by the Administrator.</p> <p>On 9/5/25, the DON notified pharmacy of the incident regarding each resident identified. Pharmacy assisted in providing resources such as delivery receipts, and signed delivery slips and credit for medication that was confiscated by nurse.</p> <p>On 9/5/25, the North Carolina Board of Nursing was notified by the Administrator of the Nurse #1's actions and police involvement.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>To ensure that all currently ordered medications were available in medication carts, administered per physician order, or returned to the pharmacy per protocol, the Director of Nursing conducted an audit on 9/5/25 of all ordered medications and medication administration records (MARS) for all residents, including those who are not alert and oriented, for the previous 30 days. No areas of concern were identified. On 4/23/26, Unit Managers re-initiated and completed an audit of all medications to MARS to ensure medications were available to administer per physician orders, medications returned to the pharmacy per protocol when indicated and to validate on-going compliance. There were no new concerns identified.</p> <p>On 9/5/25, the Director of Nursing completed an audit of all the medication carts to identify any discontinued or duplicate supply of medications in the medication cart. There was one resident identified that had been discharged with medication in the medication cart. The Director of Nursing ensured that the medication was removed and sent back to the pharmacy on 9/5/25. On 4/23/26, the Unit Managers re-initiated and completed an audit of all medication carts to identify any discontinued or duplicate supply of medications in the medication cart and to validate on-going compliance. There were no new concerns identified.</p> <p>On 9/5/25, the Minimum Data Set (MDS) Nurse</p>	04/30/2026

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F0602 SS = E	<p>Continued from page 2 Nurse #1 was detained during a traffic stop and was found with various medications belonging to facility residents. The facility investigation was initiated.</p> <p>Review of the facility investigation completed by the prior Administrator on 9/12/25 revealed that on 9/4/25, she was informed by the local law enforcement that Nurse #1 was stopped for a traffic violation and was observed with a zip lock bag of medications belonging to the facility. Nurse #1 was taken into custody and claimed the medications had been inadvertently taken home after being placed in her pocket. An inventory was taken of the medications in Nurse #1's possession on 9/5/25 with a total of 16 residents identified. Assessments associated with the medications in the nurse's possession were completed for all identified in-house residents with no adverse outcomes. The in-house identified residents' medication orders, Medication Administration Records (MARs) and progress notes were reviewed with no negative findings. Interviews were conducted with nursing staff and alert and oriented residents with no concerns expressed regarding the nurses' practice of medication administration. Nurse #1 had worked at the facility from 9/17/24 to 1/25/25 and again from 7/15/25 to 8/25/25. Both times she had been terminated for poor attendance. Nurse #1's personnel file was reviewed, including pre-hire background screening and licensure verification with no significant findings. She had received training on the policy of misappropriation upon her employment on 9/17/24 and 7/15/25. The facility investigation determined that, while the nurse was found in possession of resident medications as documented by law enforcement, there was no evidence to indicate that residents missed any prescribed doses or that their care was compromised. MARs indicated that medications were administered in accordance with physician orders. However, the way the medications were removed from the facility and when could not be determined. The facility substantiated the police report findings but had no prior knowledge of any unauthorized removal of medications by the nurse before being notified by law enforcement. The facility notified all alert and oriented residents, Responsible Parties (RPs), Adult Protective Services and the Board of Nursing. The residents involved were reimbursed for the medications identified by law enforcement. The facility report detailed the medications in Nurse #1's possession as follows:</p> <p>Belonging to Resident #2: A multidose medication card with six Gabapentin (a medication used to treat</p>	F0602	<p>Continued from page 2 completed assessments of all residents for pain including non-alert and oriented residents. During the assessments of pain, there were no residents visually observed with changes in condition including depression, confusion, fatigue, flushed face, nausea and shortness of breath related to not receiving prescribed medications. Additionally, there were no concerns of pain related to not receiving prescribed medications.</p> <p>On 9/5/25, the Social Worker completed interviews with all alert and oriented residents regarding (1) Do you have any concerns with medication administration, to include pain medication? A concern form was completed by the Social Worker and investigated through the grievance process for any identified area of concern voiced. On 4/24/26, the Social Workers re-initiated and completed resident questionnaires with all alert and oriented residents to identify any concerns related to medication administration and to validate on-going compliance, no new concerns identified.</p> <p>On 9/5/25, 100% of grievances completed in the previous 30 days to include from families of non-alert and oriented residents, was reviewed by the Social Worker to ensure all grievances including mishandling of medications were investigated and reported to the healthcare personnel investigator (HCPI) per facility protocol. There were no identified areas of concern. On 9/11/25, the grievance audit was expanded to the past 60 days and January 2025 by the Administrator for trends related to medications not being administered per the physician's order. There were no concerns identified. On 4/24/26 the Social Worker completed an audit of grievances for the past 30 days to include grievances from families of non-alert and oriented residents. This audit is to identify any grievances related to mishandling of medications and to validate on-going compliance. There were no new concerns identified.</p> <p>On 9/5/25, the Director of Nursing (DON) completed an audit of all incident reports for the past 30 days to identify trends, and identify any incident related to medication administration to ensure appropriate interventions were initiated. There were no identified areas of concern.</p> <p>On 9/8/25, the DON initiated staff questionnaires with all nursing staff to include nurses, nursing assistants, and med aides regarding (1) Do you have any concerns regarding nurses or medication aides not administering residents' prescribed medications and (2) Have any residents reported concerns to you</p>	04/30/2026

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F0602 SS = E	<p>Continued from page 3 nerve pain and seizures) 300 milligrams (mg) tablets.</p> <p>Belonging to Resident #10: A multidose medication card with three Gabapentin 400 mg tablets.</p> <p>Belonging to Resident #31: A single dose smart pack of one Carvedilol (a medication used to treat high blood pressure)12.5 mg tablet and a single dose smart pack of two and half Paroxetine (an antidepressant medication) 20 mg tablets.</p> <p>Belonging to Resident #37: A single dose smart pack of two Gabapentin 100mg tablets, a single dose smart pack of one Carbamazepine (a medication used to treat pain and seizures) 200 mg tablet, a single dose smart pack of one Meloxicam (a medication used to treat joint pain) 15 mg tablet and a single dose smart pack of one Xifaxin (an antibiotic) 550 mg tablet.</p> <p>Belonging to Resident #60: A multidose medication card with 14 Zofran (an antinausea medication) 4 mg tablets.</p> <p>Belonging to Resident #68: A multidose medication card with 10 Trazodone (an antidepressant) 50 mg tablets and a multidose medication card with one Trazodone 50 mg tablet.</p> <p>Belonging to Resident #78: A multidose medication card with 13 Simethicone (a medication used to treat gas) 125 mg tablets.</p> <p>Belonging to Resident #86: A single dose smart pack with one Gabapentin 300 mg tablet, a single dose smart pack with one Lisinopril (a medication used to treat high blood pressure) 20 mg tablet, a single dose smart pack with three Divalproex (a medication used to treat seizures and mood) 125 mg tablets, a single dose smart pack of one Vitamin B12 1000 micrograms (mcg) tablet, and a single dose smart pack of one Paliperidone (an antipsychotic medication) 6 mg tablet.</p> <p>Belonging to Resident #88: A multidose medication card with one Levaquin (an antibiotic) 500 mg, a multidose medication card with seven Prednisone 10 mg tablets, a multidose medication card with two Vitamin B12 1000 mcg tablets, and a multidose medication card with eight Gabapentin 300 mg tablets.</p> <p>Belonging to Resident #121: A multidose medication card with 16 Guaifenesin (a medication used to treat cough) 400 mg tablets.</p>	F0602	<p>Continued from page 3 regarding not receiving their prescribed medications? The staff questionnaires were completed by 9/8/25. The DON monitored staff completion of the staff questionnaires. Any staff member who had not completed the staff questionnaire by 9/8/25 completed it during their next scheduled shift. DON immediately initiated an investigation into all concerns identified. On 4/24/26, the Staff Development Coordinator/scheduler re-initiated staff questionnaires regarding medication administration concerns with all nurses and medication aides no administering residents' prescribed medications and to ensure any concerns were reported and investigated per facility protocol. The Director of Nursing will initiate an investigation for all concerns identified. The questionnaires will be completed by 4/29/26. After 4/29/26, any nurse or medication aide who has not worked or completed the questionnaire will complete it upon the next scheduled work shift.</p> <p>On 9/11/25, the DON audited residents who were discharged within the last 30 days to ensure that all medications were returned to the pharmacy or sent with the resident at discharge per physicians' order and not stored in the medication cart. Any medications found were returned to the pharmacy per facility protocol. On 4/24/26, the Unit Managers initiated a review of all residents discharged in the past 30 days to ensure all medications were returned to pharmacy or sent with the resident at discharge per physician's orders and not stored on the medication cart. The Unit Managers will address all concerns identified during the audit. The audit will be completed by 4/29/26.</p> <p>On 9/12/25, the Administrator made the decision to post the procedure for return of drug in the medication room for nurses to use as a guide for returning medications and included this in the education with all nurses. Medication aides are not responsible for returning medications to the pharmacy.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 9/5/25, all employee files were audited by the Business Office Manager to ensure the files had background checks, reference checks, healthcare personnel registry checks on hire, and misappropriation education on hire. There were no</p>	04/30/2026

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F0602 SS = E	<p>Continued from page 4</p> <p>Belonging to Resident #122: A single dose smart pack of one Sertraline (an antidepressant) 0.25 mg tablet and one single dose smart pack of a Xarelto (a blood thinner) 10 mg tablet.</p> <p>Belonging to Resident #123: One multidose Albuterol inhaler (a medication used to treat wheezing) 108 mcg.</p> <p>Belonging to Resident #124: A multidose medication card with six Prilosec 20 mg tablets and one tube of Voltaren Gel.</p> <p>Belonging to Resident #125: A multidose medication card with two Gabapentin 300 mg tablets.</p> <p>Belonging to Resident #126: A multidose medication card with 16 Phenergan (an antinausea medication) 12.5 mg tablets.</p> <p>Belonging to Resident #127: A multidose medication card with 16 Benzonate (a medication used to treat cough and congestion) 200 mg.</p> <p>Belonging to an unknown resident: One Albuterol inhaler 108 mcg.</p> <p>Belonging to an unknown resident: One Levalbuterol inhaler.</p> <p>Belonging to an unknown resident: A multidose medication card of seven oval shaped white tablets with the marking "F" on one side the "91" on the other. Per pharmacy verification the tablet was identified as Zofran.</p> <p>Multiple attempts to contact Nurse #1 from 3/31/26 to 4/2/26, were unsuccessful.</p> <p>A phone interview was conducted on 3/31/26 at 2:00 PM with the prior Administrator. She recalled being notified by the local law enforcement that Nurse #1 had been stopped for a traffic violation and was found to have multiple residents' medications that belonged to the facility. She stated that both she and the Director of Nursing (DON) went to the police station the following morning to take an inventory of what was found in Nurse #1's possession. There was a total of 16 residents that were identified and 3 medications that were unidentified. The Administrator stated that once the resident medications were identified, the physician, pharmacy, alert and oriented residents and responsible parties were notified. She stated that</p>	F0602	<p>Continued from page 4</p> <p>areas of concern identified during the audit.</p> <p>On 9/5/25, the Business Office Manager completed a current check of the health care personnel registry for all employees to ensure there were no substantial findings including misappropriation and drug diversion. There were no areas of concern identified during the audit.</p> <p>On 9/5/25, the Staff Development Coordinator (SDC) initiated 100% medication pass observations with all nurses and medication aides including agency utilizing the Medication Pass Audit Tool. This observation was to ensure all medications were being administered per the physician orders and medications were documented on the medication administration record (MAR) after the medication administration. All nurses and medication aides will be retrained during the observation for any identified areas of concern. The medication pass observations were completed by 9/5/25 for all nurses and medication aides who had worked. Any nurse or medication aide who does not successfully pass the medication pass observation after the 1st attempt will remain under observation until successful demonstration is observed. After 9/5/25, any nurse or medication aide who had not completed the medication pass observation completed it during their next scheduled shift.</p> <p>On 9/5/25, the DON received education and guidance from the Nurse Consultant regarding responsibilities for monitoring medication management processes, including ensuring discontinued medications are promptly returned to the pharmacy and preventing duplicate or excess medications from being maintained in medication carts.</p> <p>On 9/5/25, education was completed with all alert and oriented residents by the Social Worker regarding misappropriation, including the definitions, misappropriation of resident property, and how to report misappropriation.</p> <p>On 9/5/25, the SDC Nurse initiated an in-service with all nurses and medication aides including agency regarding (1) Drug Diversion to include: the definition, implications, misappropriation, immediately reporting concerns for medication administration to the Director of Nursing, and the process for returning medications and (2) 5 rights of Medication Administration to include reading the MAR and accurately administering medications per physician orders and documentation. The education was completed by 9/12/25. The SDC monitored staff</p>	04/30/2026

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F0602 SS = E	<p>Continued from page 5 both she and the DON investigated how or when Nurse #1 misappropriated the medications but was difficult to determine as she worked at the facility two separate times and some of the residents she was not assigned to care for. It was thought that the discontinued medications may have still been on the medication cart or in the medication room waiting for pharmacy return. The prior Administrator stated that Nurse #1 had been terminated from the facility for poor attendance prior to the traffic stop. The interview further revealed all identified residents were reimbursed for the medications that had been misappropriated.</p> <p>The DON was interviewed on 4/1/26 at 10:44 AM and stated that she had been employed at the facility for approximately 3 weeks with the misappropriation incident occurred involving Nurse #1. She recalled it was difficult to determine when the medications had been removed from the facility as Nurse #1 had been employed twice at the facility. She stated that she and the prior Administrator went to the police station the day after being notified to take an inventory of the medications in Nurse #1's possession. The pharmacy was notified and assisted with when the medications had been dispensed and the reimbursement rate.</p> <p>An interview occurred with the Medical Director on 4/1/26 at 12:09 PM and stated that he had been notified of the incident in September 2025 and was aware of each resident that could have potentially been affected. He stated that he and his Nurse Practitioner (NP) assessed the residents' that were affected and found no negative effects.</p> <p>A phone interview was completed with the Pharmacy Consultant on 4/1/26 at 1:12 PM and verified she had been made aware of the misappropriation incident in September 2025. She stated the pharmacy assisted the Administrator to identify when the medications had been dispensed and the reimbursement rates for refund. The Pharmacy Consultant stated that she was at the facility monthly and completed a medication pass with a nurse as well as reviewed medication carts for expired medications. She stated that she would not have been able to determine from the medication cart audits if a medication had been discontinued or if a resident who no longer resided in the facility had medications on the medication carts.</p>	F0602	<p>Continued from page 5 for completion of the in-services. After 9/12/25, any staff, including agency staff who have not received the in-services, will complete it upon their next scheduled shift. Any newly hired staff will receive the in-services training upon hire by SDC.</p> <p>On 9/5/25, an in-service was initiated with all staff including agency on Misappropriation Policy with emphasis on the definition, examples, and reporting by the SDC Nurse. The education was completed by 9/12/25. The SDC monitored staff for completion of the in-services. After 9/12/25, any staff including agency staff who have not worked and received the in-services will complete it upon their next scheduled shift. Any newly hired staff will receive the in-services training upon hire by SDC. On 4/24/26, the Staff Development Coordinator re-initiated the education with all staff including agency on Misappropriation Policy with emphasis on the definition, examples to include unauthorized removing of resident medications from the facility, and reporting concerns. The education will be completed by 4/29/26. After 4/29/26, any staff who has not completed the education will complete it at the next scheduled work shift. Education continues to be completed with all newly hired staff during orientation.</p> <p>On 9/10/25, an in-service was initiated by the SDC Nurse for all nurses and medication aides including agency regarding (1) immediately remove discontinued medications or unused/duplicate medications from the medication cart when a medication is discontinued or when there is duplicate supply of medication such as card and smart pack, (2) instructed on how to dispose of single-dose discontinued medications, (3) how to properly return discontinued multi-dose medications to the pharmacy, (4) what to do with medications when residents are discharged. The education was completed by 9/12/25. The SDC monitored staff for completion of the in-services. After 9/12/25, any staff including agency staff who have not worked and received the in-services will complete it upon their next scheduled shift. Any newly hired staff will receive the in-services training upon hire by SDC. On 4/24/26, the Staff Development Coordinator re-initiated the education with all nurses and medication aides on removing discontinued medications, duplicate or unused medications from the medication cart when a medication is discontinued or when a duplicate supply is identified, how to return medications to the pharmacy and what to do with medications when residents are discharged. The education will be completed by 4/29/26. After 4/29/26, any nurse or</p>	04/30/2026

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F0602 SS = E	Continued from page 6 The Administrator was interviewed on 4/2/26 at 11:22 AM and stated that efforts were still ongoing to prevent misappropriation of resident medications.  The facility provided a plan of correction that was not acceptable to the State Agency as the facility did not include a systemic approach to prevent future incidents of misappropriation of resident property.	F0602	Continued from page 6 medication aide who has not completed the education will complete it at the next scheduled work shift. Education continues to be completed with all newly hired staff during orientation.  On 4/24/26, the Director of Nursing contacted pharmacy vendor to arrange additional education with all available nurses and medication aides on Medication Administration with emphasis on process for removing and returning medications to the pharmacy, and preventative measure to prevent misappropriation. Education will be completed on 5/15/26, any nurse or medication aide who cannot attend the training will be educated by the Staff Development Coordinator upon the next scheduled work shift.  On 9/12/25, the SDC Nurse initiated an in-service with all staff including agency regarding the Code of Conduct Policy to include Fraud and Theft. The education was completed by 9/12/25. The SDC monitored staff for completion of the in-services. After 9/12/25, any staff including agency staff who have not worked and received the in-services will complete it upon their next scheduled shift. Any newly hired staff will receive the in-services training upon hire by SDC. On 4/24/26, the Staff Development Coordinator re-initiated the education with all staff including agency on Code of Conduct with emphasis on the definition, examples to include unauthorized removing of resident medications from the facility, and reporting concerns. The education will be completed by 4/29/26. After 4/29/26, any staff who has not completed the education will complete it at the next scheduled work shift. Education continues to be completed with all newly hired staff during orientation.  On 9/12/25, the Administrator made the decision to post the procedure for return of drug in the medication room for nurses to use as a guide for returning medications and included this in the education with all nurses.  On 9/5/25, as an initial system change the DON ensured the unit managers' task list was reviewed with all current unit managers and will ensure it will be reviewed with all newly hired unit managers. The task list includes the responsibility of monitoring medication carts weekly for removal of discontinued/duplicate supply of medications and oversight of return of medication to pharmacy per facility protocol. The purpose of this task list is to ensure the unit managers check medication carts weekly to reduce the risk of misappropriation and unauthorized removal of medications from the	04/30/2026

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NAME OF PROVIDER OR SUPPLIER  <b>Bethany Woods Nursing and Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>33426 Old Salisbury Road BOX 1250, Albemarle, North Carolina, 28002</b>	
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F0602 SS = E		F0602	<p>Continued from page 7 facility.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>As a system change, the DON has implemented enhanced oversight including routine medication cart audits, reconciliation of discontinued and returned medications, and monitoring for duplicate medications. The DON is responsible for ongoing supervision of these processes to ensure compliance with facility policy and prevention of medication diversion.</p> <p>Beginning 4/30/26, The DON/SDC Nurse will audit 10 residents medication orders to ensure (1) the medications were in the medication cart as ordered, administered, or returned to the pharmacy/disposed (if discontinued) (2) duplicate medications are not stored in the medication cart, (3) discharge residents medications were sent with the resident or back to pharmacy (4) return of drug sheets were completed for medications in the tote processed to be sent back to pharmacy, or already sent back weekly x 4 weeks then monthly x1 month and document on a Medication Order audit tool. The DON/SDC will initiate an investigation for any identified areas of concern, retrain the nurse or medication aides, and ensure medications are immediately sent back to pharmacy per protocol. The MD will be notified of any potential medication omissions identified during the audit.</p> <p>Beginning 4/30/26, The DON/SDC will complete medication pass audits with 10 nurses and/or medication aides including agency weekly for 4 weeks, then monthly for 1 month to ensure medications are being administered per physician order and documented on the MAR after the administration of medications utilizing a Medication Pass Audit Tool. The medication pass audits will be completed on various days, shifts, and times. Any areas of concern will be immediately addressed during the observation including staff retraining. DON was notified of this responsibility by the facility consultant on 4/24/26</p> <p>The DON will review and initial the audits weekly for 4 weeks, then monthly for 1 month to ensure all areas of concern are addressed appropriately.</p> <p>The Administrator or DON will present the findings of the Audit Tools to the QAPI committee monthly</p>	04/30/2026

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F0602 SS = E		F0602	<p>Continued from page 8 for 2 months. The QAPI committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring.</p> <p>Beginning 12/1/2025, as an additional system change following the initial monitoring, the DON initiated ongoing oversight of removal and return of discontinued/ duplicate supply of medications to the pharmacy per facility protocol by reviewing the discontinued medications, resident discharges and return of drug forms weekly. The purpose of this monitoring is to reduce the risk of misappropriation and the risk of unauthorized removal of medications from the facility.</p>	04/30/2026
F0761 SS = E	<p>Label/Store Drugs and Biologicals</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to secure medications left on top of and in an unattended unlocked medication cart (400 hall medication cart) and failed to remove one (1)</p>	F0761	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 4/1/26, the Director of Nursing removed all medications from the 800-hall medication cart that was not labeled with an "open" or "use by" date per facility protocol.</p> <p>On 4/1/26, the Director of Nursing educated medication aide #2 regarding medication labeling and storage with emphasis on ensuring medications have an "open" or "use by" date per facility protocol and removing expired medications from the medication cart.</p> <p>On 4/2/26, the Director of Nursing immediately secured medications and medication cart on the 400-hall.</p> <p>On 4/2/26, the Director of Nursing educated nurse #2 regarding medication storage with emphasis on securing medications/medication cart when not under the direct supervision of the nurse.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 04/23/2026, the unit managers initiated an audit of all medication carts and medication storage rooms. This audit is to ensure all medications were labeled with an "open" or "use by" date when indicated by pharmacy protocol, medications were not expired and to ensure that medications and medication carts are secured when not in the direct supervision of the nurse or medication aide. The unit</p>	04/30/2026

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F0761 SS = E	<p>Continued from page 9 bottle of expired eye drops, label an Ozempic insulin pen with the name of the specific resident for whom it was prescribed and the date it was opened, and stored an unopened insulin pen in the medication cart (800 hall medication cart). This was for 2 of 3 medication carts observed for medication storage (400 hall and 800 hall medication cart).</p> <p>The findings included:</p> <p>1. A continuous observation of an unattended medication cart on the 400 hall was made on 4/2/26 from 12:35 PM until 12:38 PM. The medication cart was observed to be unlocked (a red dot is visible on the lock mechanism when in the unlocked position), the narcotic medication drawer was pulled out and open, allowing the medications in the narcotic drawer to be exposed. In addition, a cup of crushed white pills and a small white bottle of medication containing a red liquid were observed on top of the medication cart. The medication cart was parked in the hallway between rooms 409 and 411. There were no observed residents, staff or visitors around the location of the medication cart. Nurse #2 walked up to the medication cart and stated she didn't mean to leave the narcotic drawer open, the medication cart unlocked or the medications on top of the cart.</p> <p>During an interview on 4/2/26 at 12:38 PM, Nurse #2 indicated she was assigned to the 400-hall medication cart and stated she had stepped into a resident's room and forgot to close the narcotic drawer, secure the medications on top of the medication cart as well as secure the medication cart. She verified that the medication left on top of the medication cart was a bottle of liquid Morphine (an opioid) and the crushed medications in the medication cup were Fluoxetine (an antidepressant) and Gabapentin (a non-narcotic medication used for pain). She added that medications should never be left unattended and the medication carts were to be locked when unattended.</p> <p>In an interview on 4/2/26 at 1:11 PM, the Director of Nursing (DON) stated that medications should not be left unattended on top of the medication carts and medication carts should be secured. She indicated that a resident could have come up and removed the medication from the cart and swallowed it.</p> <p>2. On 4/1/26 at 10:16 AM an observation was conducted of the 800-hall medication cart in the</p>	F0761	<p>Continued from page 9 managers will address all concerns identified during the audit to include but not limited to removing medications not labeled per facility protocol, securing medications/medication carts when not under the direct supervision of the nurse/medication aide and education of staff. The audit will be completed by 04/29/2026.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 04/23/2026, the Staff Development Coordinator initiated an in-service with all nurses/medication aides to include agency regarding Medication Storage with emphasis on medication storage, labeling, how to identify the expiration date, and that medication should never be left unattended and medication carts should be locked when not under the direct supervision of the nurse/medication aide. The in-service will be completed by 04/29/2026. After 04/29/2026, any nurse/medication aide to include agency who have not worked and received the in-service will complete education prior to their next scheduled shift. All newly hired nurses/medication aide to include agency will be educated during orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The unit managers will audit all medication carts and medication storage rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. The audit is to ensure (1) medications were labeled with an "open" or "use by" date when indicated by pharmacy protocol and there were no expired medications on the cart or medication rooms and (2) medications and medication carts were secured when not in under the direct supervision of the nurse or medication aide. All identified areas of concern will be addressed by the Director of Nursing during the audit to include discarding any medications found to be expired or not labeled per facility protocol, replacing medication when indicated, securing medications/medication carts and re-training of staff. The Director of Nursing will review the Medication Audit Tool weekly x 4 weeks then monthly x 1 month.</p>	04/30/2026

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F0761 SS = E	<p>Continued from page 10 presence of Medication Aide (MA) #2. The following medications were noted stored in the medication cart:</p> <p>One (1) Ozempic pen open in use and not labeled.</p> <p>One (1) Lantus Solostar pen not in use and not refrigerated as the label directed.</p> <p>One (1) bottle of latanoprost eye drops opened and dated 2/4/26 with an expiration date of 6 weeks after opening as the label directed.</p> <p>One (1) bottle of geritussin opened and undated.</p> <p>One (1) bottle of guaifenesin liquid opened and undated.</p> <p>One (1) bottle of milk of magnesia opened and undated.</p> <p>On 4/1/26 at 10:20 AM, MA #2 was interviewed and stated she was unaware the Ozempic pen was unlabeled. MA #2 explained the Lantus insulin pen should have been refrigerated since it was not in use, and the latanoprost eye drops should have been discarded 6 weeks after opening. MA #2 stated the stock medications of geritussin, guaifenesin, and milk of magnesia should have been labeled with the date they were opened. She was not sure why the medications were not labeled with resident identifier or dated. MA #2 removed the medications from the medication cart to be disposed.</p> <p>Unit Manager #1 was interviewed on 4/1/26 at 2:45 PM and stated staff assigned to the medication cart should have checked the labels of all medications for resident identifiers as well as open and expiration dates. UM #1 indicated all insulin pens should have been labeled with the resident's identifiers, as well as the open date, and refrigerated if not in use, and all expired medications should have been discarded.</p> <p>On 4/2/26 at 2:01 PM the Director of Nursing (DON) was interviewed and stated the Unit Managers had been auditing the medication carts weekly to make sure the medications were labeled and dated correctly as well as all expired medications were disposed of. She indicated the Lantus Solostar pen on the 800-hall medication cart must have been delivered during the night shift on 3/31/26 and placed on the cart instead of stored in the refrigerator as the label instructed. She further explained that all medication bottles and insulin pens should be labeled with resident identifiers and</p>	F0761	<p>Continued from page 10 The Director of Nursing will forward the results of the Medication Audit Tool to the Quality Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.</p>	04/30/2026

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F0761 SS = E	Continued from page 11 dates when opened. The DON stated the eye drops should have been discarded as the label directed 6 weeks after opening.	F0761		04/30/2026
F0550 SS = D	<p>Resident Rights/Exercise of Rights</p> <p>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights.</p> <p>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.</p> <p>§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.</p> <p>§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 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> <p>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.</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:  Based on record review and resident and staff</p>	F0550	<p>F-550 Resident Rights/Exercise of Rights</p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 3/19/26, the unit manager immediately removed NA #8 from resident care area/schedule pending investigation and provided verbal education regarding Dignity and Respect with emphasis on effective communication to include professional verbal interaction with a resident and not using profanity to promote dignity and respect. NA #8 is no longer employed at the facility.</p> <p>On 03/19/26, the unit manager assessed resident #7 with no negative findings</p> <p>On 4/23/26, the social worker completed a trauma assessment for resident #7 with no negative findings.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 04/23/2026, the treatment nurse initiated 15 random observations to include all shifts. This audit is to ensure all staff treat residents, including non-alert and oriented residents with dignity and respect. This audit will include using professional verbal interactions and not using profanity. There were no additional concerns identified.</p> <p>On 4/24/26, the Social Worker initiated questionnaires with all residents with a Brief Interview Mental Status (BIMS) of 13 or higher to validate that residents had no concerns related to dignity/respect. There were no additional concerns identified.</p> <p>On 4/24/26 the unit managers-completed skin checks on all non-alert residents for signs and symptoms of abuse. There were no negative findings.</p> <p>On 4/24/26, the Staff Development Coordinator/scheduler-initiated staff questionnaires with all staff regarding Dignity and Respect. This questionnaire is to identify any concerns regarding staff to residents (including non-alert and oriented residents) interactions to include but not limited to</p>	04/30/2026

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F0550 SS = D	<p>Continued from page 12 interviews, the facility failed to ensure that residents were treated in a dignified and respectful manner. This was evidenced by staff arguing with a resident and using profanity in the resident's presence for 1 of 4 residents reviewed for dignity (Resident #7).</p> <p>Findings included:</p> <p>Resident #7 was admitted to the facility on 1/19/21 with diagnoses that included unspecified mood affective disorder and anxiety disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 2/20/26 showed that Resident #7 was cognitively intact.</p> <p>Resident #7's active care plan, last reviewed on 3/2/26, indicated that he exhibits problematic behaviors related to ineffective coping, including verbal aggression and expressions of anger. These behaviors include use of profanity towards others, making threats toward staff, and making false accusations regarding his care. Interventions included avoid arguments with the resident.</p> <p>A review of the investigation report dated 3/23/26, completed by the Administrator, revealed that on 3/19/26, two nursing assistants (NA) #3 and NA #8, were having a discussion in the hallway. Resident #7 heard them from his bed and disagreed with the topic they were discussing. Resident #7 yelled out to NA #3 and NA #8 and shared his opinion. NA #8 responded, and a verbal exchange occurred between her and Resident #7 from the hallway. During this exchange, both Resident #7 and NA #8 used profanity. Unit Manager (UM) #2 removed NA #8 from the hallway and spoke with Resident #7 about the incident. Resident #7 stated that he and NA #8 had been arguing because she was talking about another staff member (NA #6), and he felt what she said was untrue.</p> <p>During an interview conducted with Resident #7 on 3/30/26 at 12:44 PM, he reported that on 3/19/26 NA #8 and NA #3, were in the hallway talking about NA #6, who also worked in the facility. He said he told them to stop talking about NA #6 because he felt NA #6 did a good job. He explained that NA #8 was disrespectful and had no business arguing with him. He stated the exchange made him angry primarily because they were talking about NA #6.</p> <p>During an interview on 4/1/26 at 8:17 PM, NA #3 stated that she and NA #8 were in the hallway talking about another employee. She stated that Resident #7 heard them and began yelling and</p>	F0550	<p>Continued from page 12 verbal interaction or use of profanity. The Director of Nursing will address all concerns identified during the audit to include education of staff. The questionnaires will be completed by 4/29/26. After 4/29/26, any staff who have not worked and completed the questionnaires will complete it at the next scheduled work shift.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 03/19/2026 the Staff Development Coordinator (SDC) initiated an in-service with all staff to include NA #3 and agency staff regarding Resident Rights/Effective Communication with emphasis on professional verbal interaction with residents and not using profanity. In-service will be completed by 04/29/2026. After 04/29/2026, any staff to include agency who has not received the in-service will complete it upon next scheduled work shift. All newly hired staff, to include agency, will be in-serviced during orientation regarding Resident Rights/Effective Communication.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The department managers will complete 10 resident care observations to include all shifts weekly x 4 weeks then monthly x 1 month utilizing the Resident Rights Audit Tool. This audit is to ensure staff treat residents with dignity and respect to include using professional verbal interaction and not using profanity. The Director of Nursing will address all concerns identified during the audit to include retraining of staff. The Director of Nursing (DON) will review the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.</p> <p>The DON will forward the results of the Resident Rights Audit Tool to the Quality Assurance Performance Improvement Committee monthly x 2 months to review the Resident Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.</p> <p>The Director of Nursing will present the observations to the Quality Assurance Committee monthly x 2 months for review and determine trends and/or issues that may need further interventions and the need for additional monitoring. One-to-one</p>	04/30/2026

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F0550 SS = D	<p>Continued from page 13 cursing, telling them to stop talking about the employee. NA #3 explained that at this point, NA #8 began arguing back with the resident. She stated that both Resident #7 and NA #8 used profanity during the verbal exchange.</p> <p>Attempts to speak with NA #8 by phone on 4/1/26 and 4/2/26 were unsuccessful.</p> <p>During an interview conducted with the Director of Nursing (DON) on 4/2/26 at 11:16 AM, she explained that the verbal exchange between Resident #7 and NA #8 should not have occurred. The DON confirmed that NA #8 admitted to her that she used profanity in the hallway during the verbal exchange with Resident #7. She stated that NA #8 should not have engaged or argued with Resident #7 and should not have used profanity in the hallway. The DON stated she felt NA #8 demonstrated poor customer service by arguing with Resident #7 and using profanity in the hallway.</p> <p>An interview with the Administrator on 4/2/26 at 11:33 AM revealed that NA #3 witnessed the verbal exchange between Resident #7 and NA #8. The Administrator stated that NA #3 confirmed NA #8 argued with Resident #7 and used profanity while discussing NA #6. The Administrator further stated that this interaction should not have occurred, as it was unprofessional and demonstrated poor customer service for a staff member to argue or use inappropriate language in front of residents. The Administrator confirmed that NA #8 was terminated based on her admission that she argued with the resident and used profanity in the hallway, along with NA #3's corroboration of the unprofessional communication.</p>	F0550	Continued from page 13 observation Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring.	04/30/2026
F0558 SS = D	<p>Reasonable Accommodations Needs/Preferences</p> <p>CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record reviews, resident and staff interviews, the facility failed to ensure a resident's call light system was placed within reach and accessible for 1 of 8 residents reviewed for accommodation of needs (Resident #7).</p>	F0558	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 4/2/26, the assigned nursing assistant immediately placed mouth blowing call system in reach of resident #7.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 04/23/2026, the treatment nurse initiated an audit of all residents to ensure that call bells were placed in reach and easily assessable to the residents to include tap bells, call buttons and mouth blowing call systems. The treatment nurse will address all areas of concern identified during the audit to</p>	04/30/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/02/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Bethany Woods Nursing and Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>33426 Old Salisbury Road BOX 1250, Albemarle, North Carolina, 28002</b>	
(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
F0558 SS = D	<p>Continued from page 14 The findings included:</p> <p>Resident #7 was admitted to the facility on 1/19/21 with diagnoses including quadriplegia, diabetes mellitus, stage 3 chronic kidney disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 2/20/26 showed Resident #7 was cognitively intact, had impaired function in both upper and lower extremities, and was dependent on staff for all activities of daily living (ADL).</p> <p>Review of the active care plan, last reviewed 3/2/26, identified the resident required staff assistance for all ADL due to quadriplegia and utilized a mouth-blowing call system device to summon assistance. The care plan also indicated the resident exhibited problematic manner behaviors, including calling 911 when not receiving timely attention. Interventions included responding promptly to requests.</p> <p>Review of Resident #7's care guide (Kardex), last reviewed 3/2/26, confirmed the resident used a mouth-blowing call device.</p> <p>On 3/30/26 at 12:44 PM, an observation and interview conducted with Resident #7 revealed he was lying in bed. His call device was observed out of reach, positioned too far away from his mouth for activation. The resident stated he did not know how long it had been out of reach and that although the device was normally placed correctly, there were times he had to yell out to staff in the hallway to reposition it. He stated he yelled for help if he needed something because he was unable to move independently to reach the device.</p> <p>During an interview on 3/30/26 at 12:52 PM NA #2 stated she was assigned to Resident #7 on 3/30/26 from 7:00 AM to 3:00 PM. She indicated she was unaware the resident's call device was out of reach. She explained the device must be close enough to the resident's mouth for him to blow into it to activate the call system and reported it may have been moved during ADL care. NA #2 stated she had been in his room within the last hour but could not recall if she checked the placement of his call device. She stated that the resident could yell out if needed something. NA #2 immediately repositioned the call device within Resident #7's reach.</p> <p>On 4/1/26 at 2:20 PM, Unit Manager #3 reported Resident #7 was quadriplegic, dependent on staff for all care, and required the mouth-blowing call device to request assistance. She stated she was unaware</p>	F0558	<p>Continued from page 14 include placing call bell in reach when indicated and education of staff. The audit will be completed by 04/29/2026.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 04/23/2026, the Staff Development Coordinator initiated an in-service with all staff regarding Call Lights with emphasis on ensuring that call lights are within reach and easily assessable to residents to include tap bells, call buttons and/or mouth blowing call system. This in-service also include ensure mouth blowing call system is in reach/easily assessable of resident mouth. The in-services will be completed by 04/29/2026. After 04/29/2026, any staff who have not worked and received the in-service will complete education prior to their next scheduled shift, this includes agency and contract staff. All newly hired staff will be educated during orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The Medical Records, Unit Managers or weekend supervisors will audit 15 residents to include resident #7 weekly x 4 weeks then monthly x 1 month. This audit is to ensure call system to include tap bells, call button or mouth blowing call system is within reach and easily assessable to the resident. All areas of concern will be addressed during the rounds to include placing call system in reach of the resident and re-training of staff. The DON will review the audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.</p> <p>The Director of Nursing will present the audits to the Quality Assurance Committee monthly x 2 months for review and determine trends and/or issues that may need further interventions and the need for additional monitoring.</p>	04/30/2026

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F0558 SS = D	<p>Continued from page 15 of any issues with the device being out of reach and confirmed that it needed to be close enough to the resident's mouth for use.</p> <p>On 4/2/26 at 10:08 AM, another observation found the resident lying in bed watching television with the call device positioned above his head and out of reach. Resident #7 confirmed he could not access the device. He stated he would yell out or use his voice-activated phone to call the facility if he required assistance. He believed the device may have been pushed away earlier that morning during care.</p> <p>Attempts to reach NA #6, who provided early morning care on 4/2/26, were unsuccessful.</p> <p>During an interview on 4/2/26 at 10:15 AM NA #5 stated she was assigned to Resident #7 on 4/2/26 from 7:00AM to 3:00 PM. NA #5 indicated she was last in the residents' room sometime between 7:30 AM and 8:30 AM and had not observed the call device out of reach. She also stated she had not moved the call device that morning.</p> <p>At 10:19 AM on 4/2/26, Nurse #2 reported the resident had requested she move the call device closer during her earlier medication pass. She stated she repositioned it appropriately and that this was the first time she had observed it out of reach but noted he could yell out to staff if needed.</p> <p>During an interview with the Director of Nursing on 4/2/26 at 2:14 PM, she stated Resident #7 was able to make his needs known by yelling out or using his voice-activated cell phone. She reported she was unaware of any issues with the call device but confirmed her expectation was for the device to always be within the resident's reach.</p>	F0558		04/30/2026
F0583 SS = D	<p>Personal Privacy/Confidentiality of Records</p> <p>CFR(s): 483.10(h)(1)-(3)(i)(ii)</p> <p>§483.10(h) Privacy and Confidentiality.</p> <p>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private</p>	F0583	<p>F-583 Personal Privacy/Confidentiality of Records</p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 1/16/26, the Administrator removed nursing assistant #1 from the schedule pending investigation regarding not following personal privacy/confidentiality of records.</p> <p>On 1/17/26, the Administrator verbally educated nursing assistant #1 regarding HIPPA and the facility electronic device use policy with emphasis on not utilizing cell phones in resident care areas, face timing or taking photos or video recording of</p>	04/30/2026

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F0583 SS = D	<p>Continued from page 16 room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and resident and staff interviews, the facility failed to provide personal privacy during incontinence care when Nurse Aide (NA) #1 captured a picture of Resident #42 with her cellphone while in the room during care. Resident #42 was partially clothed and uncovered in the photo. This deficient practice affected 1 of 1 resident reviewed for privacy (Resident # 42).</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on 11/21/25 with diagnoses including diabetes type II, congestive heart failure, and peripheral vascular disease with a right below the knee amputation (BKA).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 2/25/26 revealed that Resident #42 was cognitively intact, frequently incontinent, and dependent on assistance for activities of daily living (ADL).</p> <p>The Director of Nursing (DON) interview was conducted on 04/02/26 at 9:11 AM. The DON stated they received a call from an anonymous caller on 1/16/26 stating he had a screenshot of a resident</p>	F0583	<p>Continued from page 16 residents. The employee is no longer employed at the facility.</p> <p>On 01/17/26, the Director of Nursing interviewed Resident #42. The resident was unaware of anyone using a phone or electronic device without his consent while providing care to him. He did not report any concerns about privacy violations.</p> <p>On 01/17/26, a physical assessment of resident #42 showed no evidence of any skin impairment or skin integrity issues. Resident #42 remains at his baseline.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 01/16/2026, the Staff Development Coordinator initiated staff questionnaires with all staff regarding Health Insurance Portability and Accountability Act (HIPAA) violations, including the recording of residents. This questionnaire is to identify any concerns related to the violation of residents' privacy and violation of the facility's Privacy Acknowledgment and Non-disclosure Agreement. Questionnaires were completed on 1/16/26. After 01/16/2026, all staff that have not worked and completed the questionnaire completed it upon their next scheduled shift. There were no additional concerns identified. To ensure on-going compliance, on 4/24/26, the Staff Development Coordinator re-initiated staff questionnaires with all staff regarding HIPPA to identify any concerns related to violation of residents' privacy to include non-alert and oriented residents and violations of the facility's Privacy Acknowledgment and Non-disclosure Agreement. Questionnaires will be completed on 4/29/26. After 4/29/26, all staff that have not worked and completed the questionnaire completed it upon the next scheduled shift.</p> <p>On 01/16/2026 the Social Workers completed resident interviews with all alert and oriented residents regarding concerns related to privacy to include but not limited to being photographed/recorded without consent. During the interviews the residents were educated on their right to privacy to include the right not to be photographed or recorded without consent. There were no additional concerns identified. On 4/24/26, the Social Worker re-initiated and completed resident interviews with all alert and oriented residents regarding concerns related to privacy to include but not limited to being</p>	04/30/2026

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F0583 SS = D	<p>Continued from page 17 from their facility that was taken by NA #1. The DON reported the photo was sent to her and at first, they could not identify the resident because you could not see the resident's face. The DON reported that you could see a person's backside, a leg amputation was noted, and part of a sweatshirt. The DON reported they narrowed it down by looking at only residents that had leg amputations, as well as the surroundings in the room. The DON reported they also spoke with NA #1 about their concerns. The DON reported NA #1 stated that she did recall a time when she was on her phone at the nurse's station and it was a Facetime call. The DON stated that NA#1 reported that she was putting the phone back in her pocket as she went into Resident #42's room and she assumes that the phone must have captured a view of Resident #42 before she got it put away. The DON reported that NA #1 reported not taking a picture of the resident but that her ex-boyfriend must have done a screenshot as she was putting the phone away. The DON reported that after she spoke with the anonymous caller about the concerns and received the picture from him, she requested that he delete the photo from his phone, and he agreed to do so. The DON reported that she asked NA #1 if she had the photo on her phone and she did not. The DON reported that it was the molding around the window that helped them to determine the time frame of the photo because the resident was in a different room during November and December 2025. The DON reported that NA #1 was terminated because she violated the cellphone policy. The DON reported that Resident #42 reported not recalling the incident happening. The DON felt NA #1 had taken the call on her cellphone but did not intend to invade Resident #42's privacy.</p> <p>The DON shared a photo of Resident #42 on 4/02/26 at 12:45 PM that was on her work cell phone. Resident #42 was lying on his right side facing the wall and window area receiving bowel incontinence care and had a right BKA. Resident #42's entire buttocks was uncovered and showing. Resident #42's genitals could not be seen in the photo. Resident #42 had feces behind his buttocks area on the bed. Resident #42 was wearing a striped, blue, yellow, and white long-sleeved shirt. Resident #42's face could not be seen in the photo, only the back of his head.</p> <p>An interview with NA #1 on 04/02/26 at 10:58 AM revealed that one evening she was working and continued to receive back-to-back calls on her cellphone from her ex-boyfriend. NA #1 reported that initially, she did not answer but while she was in Resident #42's room, the calls continued so she</p>	F0583	<p>Continued from page 17 photographed/recorded without consent. There were no new concerns identified.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 01/16/2026, the Staff Development Coordinator initiated an in-service with all staff including agency regarding the Privacy Acknowledgement and Non-disclosure Agreement, residents right to privacy and confidentiality for all aspects of care and services, and the electronic device policy to include not using electronic devices to photograph or record residents during care or without consent. The in-service was completed on 01/16/2026. After 01/16/2026, all staff that have not worked and received the in-service completed it upon their next scheduled shift. All newly hired and agency staff will be in-service by the Staff Development Coordinator during orientation. On 4/24/26, the Staff Development Coordinator re-initiated an in-service with all staff regarding the Privacy Acknowledgement and Non-disclosure Agreement, residents right to privacy and confidentiality for all aspects of care and services, and the electronic device policy to include not using electronic devices to photograph or record residents during care or without consent. The in-service will be completed on 04/29/2026. After 04/29/2026, all staff that have not worked and received the in-service completed it upon their next scheduled shift. The SDC will continue to educate all newly hired staff during orientation.</p> <p>On 01/17/2026, quizzes were initiated with all employees to ensure a successful understanding of the education on HIPPA and resident rights. Any staff that does not pass the quiz after 3 attempts will not be allowed to work until they are re-educated and successfully pass. The quizzes were completed on 01/17/2026. After 01/17/2026, all staff that had not taken and passed the quiz complete it upon the next scheduled works shift.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning 4/30/26, 10 staff-to-resident interactions will be observed to include staff in all departments. This audit is to ensure that staff interacting with residents appropriately during care and staff are not</p>	04/30/2026

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F0583 SS = D	<p>Continued from page 18 answered thinking it was an emergency call. NA #1 reported that she answered on Facetime with her earbuds in Resident #42's room. NA #1 reported that it was her boyfriend at the time, but it was not an emergency so she told him that she could not talk. NA #1 reported that later she found out that her phone had captured a picture of Resident #42's back side including his "booty." NA #1 reported that she was not exactly sure how this happened, only that maybe it happened as she was locking her phone and putting it away in her pocket. NA #1 could not remember the name of the resident that was in the photo. NA #1 reported that the administrative staff spoke to her about it and initially suspended her during the investigation and then later terminated her employment because she had violated the cellphone policy.</p> <p>An interview with Resident #42 was conducted on 03/30/226 at 1:49 PM. Resident # 42 stated he does not remember an incident where his picture was taken during incontinence care or working with NA #1. An additional interview with Resident #42 was conducted on 04/02/26 at 12:31 PM. Resident # 42 verbalized that if a picture was taken of him during incontinence care and his buttocks was showing it would not bother him. He stated, "People are going to do what they are going to do anyways. I don't care."</p> <p>An Administrator interview was conducted on 04/01/26 at 3:37 PM. The Administrator reported that the facility received a call on 1/16/26 from an anonymous caller stating that NA #1 had taken a photo of a resident while providing incontinence care. The Administrator reported that in the photo the resident was partially clothed and they were unable to identify him because you could not see his face. The Administrator reported that you could only see part of the back of his head, part of his backside, part of his sweatshirt, and part of his bed including some surroundings in the room including a windowpane. The Administrator reported that they were able to eventually identify who it was based on the windowpane area and his sweatshirt. The Administrator reported that they determined that the photo must have been taken between November and December 2025 when Resident #42 was in a previous room that matched the windowpane. The Administrator reported when they spoke to NA #1, she reported that her phone must have accidentally captured a picture of the resident when she was in his room providing care. The Administrator indicated that at the time, NA #1 stated that she was dating a guy that kept calling her that evening and she only answered her phone to say that she could not talk</p>	F0583	<p>Continued from page 18 utilizing technology, such as smartphones and other personal electronic devices to record or photograph residents during care or without resident consent. The audit will be completed by the Staff Development Coordinator weekly for 4 weeks then monthly for 1 month. Any areas of concern will be immediately addressed by the DON and Administrator. The Administrator or DON will review and initial the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.</p> <p>Beginning 4/30/26, The Staff Development Coordinator will complete 10 staff quizzes weekly for 4 weeks then monthly for 1 month utilizing a HIPAA Quiz. The purpose of the audit is to validate staff knowledge and understanding of residents' rights to privacy and confidentiality and the electronic device policy. The Staff Development Coordinator will provide reeducation for any identified areas of concern during the quiz.</p> <p>The Administrator or DON will present the findings of the audit tools and quizzes to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further intervention and the need for additional monitoring.</p>	04/30/2026

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F0583 SS = D	Continued from page 19 because she was at work. NA #1 explained she had earbuds in at the nurse's station and when she answered the call it was on FaceTime, which is when the picture must have been captured. The Administrator reported that even though they did believe the incident to be accidental, the employee was still terminated due to violation of the electronic device policy. The Administrator stated staff should maintain privacy during incontinence care and not use their cellphones when providing any type of care to the residents.	F0583		04/30/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning  CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.  The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.  This REQUIREMENT is NOT MET as evidenced by:  Based on observations, record reviews, and resident, staff, and Medical Director interviews, the facility failed to ensure oxygen was delivered at the prescribed rate. This deficient practice occurred for 1 of 4 residents reviewed for respiratory care (Resident #11).  Findings included:  Resident #11 was admitted to the facility on 12/24/25 with diagnoses which included chronic respiratory failure and COPD (chronic obstructive pulmonary disease).  The care plan dated 12/31/25 revealed Resident #11 had an intervention for oxygen therapy as ordered related to COPD.  A review of the electronic medical record for Resident #11 revealed a physician order dated 1/22/26 for oxygen therapy at 3 liters per minute (LPM) via nasal cannula continuously to keep oxygen saturation levels above 90%.  The admission Minimum Data Set (MDS) assessment dated 1/28/26 indicated Resident #11 was cognitively intact and was receiving oxygen therapy.	F0695	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  On 04/23/2026, the unit manager clarified the physician's order for the use of supplemental oxygen for resident #11 and updated the electronic record. The unit manager validated the resident was receiving oxygen at the prescribed flow rate per physician order.  2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  On 04/23/2026, the treatment nurse initiated an audit of all residents utilizing supplemental oxygen. This audit is to ensure all residents utilizing oxygen receive oxygen per physician order. The treatment nurse will address all concerns identified during the audit to include but not limited to clarification with the physician, resident need for supplemental oxygen to include flow rate and adjusting flow rate per physician order and/or education of staff. The audit will be completed by 04/29/2026.  3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.  On 04/23/2026, the staff development coordinator initiated an in-service with all nurses to include agency regarding Administration of Oxygen with emphasis on ensuring resident utilizing supplemental oxygen have a current physician order to include flow rate and that the oxygen is administered per physician orders. The in-service will be completed by 04/29.2026. After 04/29/2026, any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-service	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/02/2026</b>	
NAME OF PROVIDER OR SUPPLIER  <b>Bethany Woods Nursing and Rehabilitation Center</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>33426 Old Salisbury Road BOX 1250, Albemarle, North Carolina, 28002</b>		
(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
F0695 SS = D	<p>Continued from page 20</p> <p>An observation of Resident #11 was conducted on 3/30/26 at 2:20 PM. It was noted the oxygen concentrator was set at a flow rate of 2.5 LPM when viewed at eye level. Resident #11 was resting in bed and denied any shortness of breath, and she did not appear to be in respiratory distress.</p> <p>On 3/31/26 at 1:41 PM an observation was conducted of Resident #11's oxygen concentrator, and it was noted the oxygen concentrator was set at a flow rate of 2.5 LPM when viewed at eye level. Resident #11 was resting in bed and stated she was supposed to receive 3 LPM of oxygen therapy. She denied feeling short of breath, and she did not appear to be in respiratory distress.</p> <p>A review of the March 2026 medication administration record (MAR) revealed Medication Aide #1 had signed that Resident #11's oxygen concentrator was set at a flow rate of 3 LPM on 3/30/26 and 3/31/26.</p> <p>An observation and interview was conducted with Medication Aide (MA) #1 on 3/31/26 at 3:15 PM. MA #1 was accompanied to Resident #11's room to view the oxygen concentrator setting and immediately turned the oxygen concentrator flow rate to 0 LPM then adjusted the dial back and forth up the flow indicator field before stopping the dial stating that is how she would adjust the oxygen therapy flow level. MA #1 stood over the concentrator and stated, "See, 3 liters". MA #1 was asked to view the oxygen therapy setting at eye level and agreed when viewed at eye level the flow level setting read 2.5 LPM. She then adjusted the oxygen therapy dial to 3 LPM when viewed at eye level. According to MA #1, she had assessed Resident #11's oxygen concentrator on both 3/30/26 and again on 3/31/26 while standing over the concentrator and documented the oxygen therapy flow rate was 3 LPM. MA #1 stated she evaluated Resident #11's oxygen concentrator flow rate as part of the medication pass, and if she had any problems with the oxygen therapy then she would notify the Unit Manager who was overseeing her work.</p> <p>On 3/31/26 at 3:31 PM Unit Manager (UM) #1 was interviewed. According to UM #1, she periodically checked the oxygen therapy concentrator flow rate settings when she entered a resident's room. However, she indicated she had not assessed Resident #11's oxygen therapy concentrator flow rate setting on 3/30/26 or 3/31/26.</p> <p>The Medical Director was interviewed on 4/1/26 at</p>	F0695	<p>Continued from page 20 during orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The Unit Managers and/or Weekend Supervisor will review 5 residents receiving supplemental oxygen weekly x 4 weeks then monthly x 1 month utilizing Oxygen Audit Tool. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and that the oxygen was administered per physician order. The Unit Managers or Weekend Supervisor will address all concerns identified during the audit to include clarifying orders when indicated and administering oxygen per physician orders, changing water bottle or cleaning equipment when indicated and/or re-training of staff. The Director of Nursing (DON) will review the Oxygen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.</p> <p>The Director of Nursing will forward the Oxygen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review to determine issues and trends to include continued monitoring frequency.</p>	04/30/2026

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F0695 SS = D	<p>Continued from page 21 12:16 PM and stated Resident #11 tended to get short of breath with activity, and it was his expectation that staff would follow orders as written for Resident #11 to receive oxygen therapy at 3 LPM.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/2/26 at 2:01 PM who stated Resident #11's oxygen therapy should have been delivered correctly at 3 LPM as ordered.</p>	F0695		04/30/2026
F0759 SS = D	<p>Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41% for 2 of 3 residents observed for medication administration (Resident #129 and Resident #110). The findings included a. Resident #129 was admitted to the facility on 3/26/26 with diagnoses of atrial fibrillation and cardiomyopathy. A review of Resident #129's active physician's orders included a current order for March 2026 of metoprolol succinate 25 milligrams (mg) by mouth once daily. Hold for systolic blood pressure less than 110 or heart rate less than 60. On 4/1/26 at 9:00 AM Nurse #3 was observed as she obtained Resident #129's blood pressure and heart rate. Resident #129's blood pressure was noted as 110/64 and heart rate was 79. Nurse #3 stated she was going to hold Resident #129's metoprolol succinate since her systolic (top number) blood pressure was so close to the hold parameter ordered by the physician. Nurse #3 did not call the physician to obtain and order to hold the medication, and she did not give Resident #129 her ordered dose of metoprolol succinate.</p>	F0759	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  On 04/01/2026, the unit manager assessed Resident #129 with no adverse reactions from Metoprolol being held, the provider was notified of assessment with no new orders received.  On 04/01/2026, the unit manager assessed Resident #10 with no adverse reactions from the administration of Flonase. A Medication Self-Administration assessment was completed to include education of dose and how to administer. The resident was determined safe to self-administer medication. The provider was notified with new order for Resident #10 to self-administer medication under the supervision of the nurse.  On 04/23/2026, the Staff Development Coordinator educated Nurse #3 regarding rights of medication administration to include following physician's order for holding medications with parameters and providing instructions to residents who self-administer medications. The nurse verbalized understanding of the education. The nurse successfully completed a med pass observation following the education.  2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  On 04/23/2026, the unit managers initiated Medication Pass Audits with all nurses and medication aides to include agency to ensure (1) all medications were given per physician order and according to established guidelines/procedures to include to following parameters for holding medications with provider notification and (2) ensuring instructions for administering medications is provided to residents assessed to safely self-administer medications. The unit managers will immediately address all areas of concern during the</p>	04/30/2026

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F0759 SS = D	<p>Continued from page 22</p> <p>b. Resident #10 was admitted to the facility on 10/19/23 with diagnoses of chronic obstructive pulmonary disease.</p> <p>A review of Resident #10's active physician's orders included a current order for March 2026 of fluticasone propionate 0.05 mg/actuation metered dose nasal spray, 2 sprays in both nostrils one time a day.</p> <p>On 4/1/26 at 9:12 AM Nurse #3 was observed as she handed Resident #10 the bottle of fluticasone nasal spray without any instructions on use. Resident #10 then rapidly administered 3 sprays of the medication back-to-back in the right nostril then repeated the 3 rapid sprays in the left nostril. Nurse #3 stood in front of Resident #10 and did not attempt to correct Resident #10's administration technique. The resident then handed the nasal spray back to Nurse #10 who exited the room.</p> <p>Nurse #3 was interviewed on 4/1/26 at 9:14 AM who stated Resident #10 preferred to administer her own nasal spray and liked to do it her own way. Nurse #3 stated she should have educated Resident #10 when she administered the medication incorrectly, but Resident #10 was in a hurry to go outside and did not like to wait around for education.</p> <p>Unit Manager (UM) #2 was interviewed on 4/1/26 at 2:55 PM and stated she expected Nurse #3 to administer the metoprolol succinate to Resident #129 according to the physician's order. She further stated Nurse #3 should have administered the fluticasone nasal spray herself instead of allowing Resident #10 perform the task. UM #2 stated Nurse #3 should have administered one spray per nostril and then repeated the same step for the second spray for correct administration of the ordered dosage.</p> <p>The Director of Nursing (DON) was interviewed on 4/2/26 at 2:01 PM and explained that Nurse #3 was using "nursing discretion" when she held the metoprolol succinate for Resident #129, and that Nurse #3 had contacted the physician to inform him she held it later that afternoon on 4/1/26. The DON further stated Nurse #3 should have administered the fluticasone nasal spray for Resident #10 according to the physician's order.</p>	F0759	<p>Continued from page 22</p> <p>audit to include assessment of resident when indicated, notification of physician for any identified concerns, obtaining new orders when appropriate and education of staff. The audit will be completed by 04/29/2026. After 04/29/2026, any nurse or medication aide who has not worked or had a Medication Pass Audit completed, will have the Medication Pass Audit completed at the next scheduled work shift. All newly hired nurses or medication aides will have the Medication Pass Audit completed.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 04/23/2026, the SDC an in-service with all nurses and medication aides to include agency regarding (1) Medication Administration to include the rights of a medication pass, administering medications according to established guidelines/procedures to include parameters for holding medications and notification of the provider when medications not administered per order for further recommendations and (2) Self-Administration of Medication with emphasis on providing education to residents who have been assessed to safely self-administer medications and obtaining an order to self-administer medication. In-service will be completed by 04/29/2026. After 04/29/2026, any nurse or medication aide to include agency who has not worked or received the education will receive it prior to the next scheduled work shift. All newly hired nurses and medication aides to include agency will be in-serviced by the SDC during orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The unit managers will complete 10 medication pass observations with nurses/medication aides to include agency and nurse #3 utilizing the Medication Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure (1) all medications were given per physician order and according to established guidelines/procedures to include to following parameters for holding medications with provider notification and (2) ensuring the nurse/medication aide provided education to residents who have been assessed to safely self-administer medications and obtaining an order to self-administer medication. The unit managers will immediately address all areas of concern during the audit to include assessment of</p>	04/30/2026

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F0759 SS = D		F0759	Continued from page 23 resident when indicated, notification of physician for any identified concerns, obtaining new orders when appropriate and education of staff. The Director of Nursing (DON) will review the Medication Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed.  The Director of Nursing will forward the audits to the Quality Assurance Performance Improvement (QAPI) Committee for review and to determine trends and/or issues that may need further interventions and the need for additional monitoring.	04/30/2026
F0732 SS = C	Posted Nurse Staffing Information  CFR(s): §483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information.  §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:  (i) Facility name.  (ii) The current date.  (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:  (A) Registered nurses.  (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).  (C) Certified nurse aides.  (iv) Resident census.  §483.35(g)(2) Posting requirements.  (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F0732	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  On 04/24/2026, the scheduler under the oversight of the Director of Nursing reviewed and updated the Daily Staffing Schedules for 3/1/26, 3/2/26, 3/3/26, 3/4/26, 3/5/26, 3/6/26, 3/7/26, 3/8/26, 3/12/26, 3/13/26, 3/14/26, 3/17/26, 3/19/26, 3/20/26, 3/21/26, 3/24/26, 3/26/26, 3/27/26, and 3/28/26.  2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  On 04/24/2026, the Director of Nursing initiated an audit of Daily Nursing Staff Sheets for the past 30 days to ensure all sheets were completed accurately to include resident census, RN hours, license practical nurse (LPN) hours, nursing assistant (NA) hours and that the current day was posted per facility protocol and in a location easily assessable to residents and visitors. The scheduler, under the oversight of the Director of Nursing, will update staffing sheet for all concerns identified. The audit will be completed by 04/29/2026.  3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.  On 04/23/2026, the Staff Development Coordinator initiated an in-serviced with the Director of Nursing (DON), staff scheduler and all nurses regarding Posting of Daily Nurse Staffing Sheet with emphasis on completing Daily Nursing Staff Sheets with accurate information to include the census at the beginning of each shift, RN/LPN hours, NA hours and posting staffing sheet posted per facility	04/30/2026

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<p>F0732 SS = C</p>	<p>Continued from page 24</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to post accurate daily staffing information as compared to the daily staffing schedules for licensed and unlicensed nursing staff for 19 out of 30 days (3/1/26, 3/2/26, 3/3/26, 3/4/26, 3/5/26, 3/6/26, 3/7/26, 3/8/26, 3/12/26, 3/13/26, 3/14/26, 3/17/26, 3/19/26, 3/20/26, 3/21/26, 3/24/26, 3/26/26, 3/27/26, and 3/28/26).</p> <p>The findings included:</p> <p>A review of the facility's daily posting for nursing staff for the past 30 days (3/1/26 to 3/30/26) as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following:</p> <p>a. The nursing schedule for 3/1/26 indicated that 12 Nurse Aides (NAs) worked from 7:00 AM to 3:00 PM, 5 Licensed Practical Nurses (LPNs) worked 11:00 PM to 7:00 AM and one Medication Aide (MA) worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/1/26 documented that 14 NAs worked 7:00 AM to 3:00 PM, 6 LPNs worked 11:00 PM to 7:00 AM and no MA worked 11:00 PM to 7:00 AM.</p> <p>b. The nursing schedule for 3/2/26 indicated that 4 Registered Nurses (RNs) worked 7:00 AM to 3:00</p>	<p>F0732</p>	<p>Continued from page 24</p> <p>protocol and in a 04/29/2026 any nurse or staff scheduler who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses and staff schedulers will be in-serviced by the Staff Development Coordinator during orientation regarding Posting of Daily Nurse Staffing Sheet.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The Administrator will audit the Daily Nurse Staffing Sheets to include weekends 3 times a week x 4 weeks then monthly x 1 month to ensure staff sheets includes complete and accurate information prior to the beginning of each shift to include RN hours utilizing the Daily Staffing Audit Tool and that the Daily Nursing Staff Sheet is posted per facility protocol and in a location easily assessable to residents and visitors. Retraining will be immediately conducted by the Director of Nursing for any identified areas of concern. The Administrator will review and initial the Daily Staffing Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed.</p> <p>The Administrator and/or DON will forward the results of the Daily Nurse Staffing Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.</p>	<p>04/30/2026</p>

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F0732 SS = C	<p>Continued from page 26</p> <p>k. The nursing schedule for 3/14/26 indicated that 5 LPNs worked from 7:00 AM to 3:00 PM and 8 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/14/26 documented that 6 LPNs worked 7:00 AM to 3:00 PM and 11 NAs worked 11:00 PM to 7:00 AM.</p> <p>l. The nursing schedule for 3/17/26 indicated that 6 LPNs worked 7:00 AM to 3:00 PM, 5 LPNs worked 11:00 PM to 7:00 AM and 7 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/17/26 documented that 5 LPNs worked 7:00 AM to 3:00 PM, 4 LPNs worked 11:00 PM to 7:00 AM and 9 NAs worked 11:00 PM to 7:00 AM.</p> <p>m. The nursing schedule for 3/19/26 indicated that 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/19/26 documented that 8 NAs worked from 11:00 PM to 7:00 AM.</p> <p>n. The nursing schedule for 3/20/26 indicated that 6 LPNs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/20/26 documented that 5 LPNs worked 7:00 AM to 3:00 PM.</p> <p>o. The nursing schedule for 3/21/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/21/26 documented that 11.4 NAs worked 7:00 AM to 3:00 PM.</p> <p>p. The nursing schedule for 3/24/26 indicated that 7 LPNs worked 7:00 AM to 3:00 PM and 10 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/24/26 documented that 6 LPNs worked from 7:00 AM to 3:00 PM and 8 NAs worked from 11:00 PM to 7:00 AM.</p> <p>q. The nursing schedule for 3/26/26 indicated that no RN worked and 6 LPNs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/26/26 documented that one RN and 4 LPNs worked 11:00 PM to 7:00 AM.</p> <p>r. The nursing schedule for 3/27/26 indicated that one MA 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 3/27/26 documented that no MA worked 11:00 PM to 7:00 AM.</p>	F0732		04/30/2026

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<p>F0732 SS = C</p>	<p>Continued from page 27 s. The nursing schedule for 3/28/26 indicated that 9 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/28/26 documented that 10 NAs worked from 11:00 PM to 7:00 AM.</p> <p>On 4/2/26 at 8:39 AM, an interview occurred with the Staffing Scheduler who stated that she managed the staffing schedule and daily postings. She reviewed the staffing schedules and daily postings and verified the number of staff working from 3/1/26 to 3/30/26 did not match. She stated that she failed to update the daily posted nurse staffing sheet when a staff member called out, was a no-show, or came in to cover a need.</p> <p>The Administrator was interviewed on 4/2/26 at 11:22 AM, and stated that the daily staff schedule posting, and the staffing schedule should match the number of staff worked on any given shift.</p>	<p>F0732</p>		<p>04/30/2026</p>
<p>F0584 SS = B</p>	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.</p> <p>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.</p> <p>The facility must provide-</p> <p>§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.</p> <p>(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.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in</p>	<p>F0584</p>	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 04/07/2026 the Maintenance Director under the oversight of the Administrator initiated repairs to walls and surrounding areas to include painting when indicated for residents 3, 8, 31, 37, 63, 65, and 72. Room repairs will be completed by 04/29/2026.</p> <p>On 04/08/2026 cleaned Resident #3's Packaged Terminal Air Conditioner (PTAC) unit.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 04/20/2026, the Maintenance Director, under the oversight of the Administrator, initiated an audit of resident rooms and resident care areas to include walls and PTAC units. This audit is to ensure all areas and rooms provide a safe, clean, comfortable and homelike environment. Work orders will be completed for all areas in need of repair and PTAC units will be cleaned as indicated. The audit will be completed by 04/29/2026.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p>	<p>04/30/2026</p>

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/02/2026</b>
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F0584 SS = B	Continued from page 28 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 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 ensure resident rooms were maintained in good repair for 7 of 19 resident rooms reviewed for clean, comfortable and homelike environment (Residents #3, # 8, #31, #37, #63, #65, and #72). The facility also failed to ensure the Packaged Terminal Air Conditioner (PTAC) unit (Resident #3) was kept clean for 1 of 19 resident rooms observed. This deficient practice affected 3 of 8 facility hallways.  The findings included:  1 a. On 3/30/26 at 10:31 AM, observation of Resident #63's room revealed scattered areas of damage to the wall behind the head of the bed, with sheetrock exposed.  b. On 3/30/26 at 10:44 AM, observation of Resident #31's room showed scattered areas of wall damage behind the head of the bed that extended to the left side of the room on the same wall, with exposed sheetrock.  c. On 3/30/26 at 10:56 AM, observation of Resident #37's room revealed multiple scattered areas of wall damage on the left side of the bed, with sheetrock exposed.  In an interview with the Maintenance Director on 4/2/26 at 12:30 PM, he stated he was aware that walls in resident rooms throughout the facility needed repair. He reported he was behind on room repairs and believed the damage was caused by	F0584	Continued from page 28  On 04/23/2026, the Maintenance Director was in-serviced by the Administrator regarding the responsibility to ensure all resident rooms and resident care provide a safe, clean, comfortable and homelike environment to include timely repair of walls and notification of the Administrator when repairs cannot be completed timely for further recommendations.  On 04/23/2026, the Housekeeping Supervisor was in-serviced by the Administrator regarding responsibility to ensure PTAC units are cleaned routinely to provide a safe, clean, comfortable and homelike environment.  On 04/23/2026, the Staff Development Coordinator initiated an in-service for all staff to include agency regarding notifying Maintenance of any resident's rooms in need of repair by completing a work order in TELS system. In-services will be completed by 04/29/2026. After 04/29/2026, any staff to include agency who have not worked will receive prior to the next scheduled work shift. All newly hired staff to include staff will be in-serviced by the Staff Development Coordinator during orientation.  4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:  The Administrator and Department Managers will monitor all areas of the facility to include 10 resident rooms and PTAC units to ensure all areas and rooms provide a safe, clean, comfortable and homelike environment weekly x 4 weeks then monthly x 1 utilizing a Homelike Environment Audit tool and completing a work order in TELS for all identified areas of concern. The Maintenance Director and/or Housekeeping Supervisor will immediately address any identified areas of concern during the audit. The Administrator will review the Homelike Environment Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed.  The Administrator will present the findings of the Homelike Environment Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine the need for further frequency of monitoring.	04/30/2026

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F0584 SS = B	<p>Continued from page 29 movement of the bed. He stated his plan was to begin wall repairs the following week.</p> <p>During an interview with the Administrator on 4/2/26 at 11:22 AM, he stated it was important for resident rooms to be maintained in good repair and kept homelike.</p> <p>2a. On 3/30/26 at 12:38 PM, an observation of Resident #65's room showed scrape marks on the wall to the left side at the head of the bed. The scrapes exposed white material with a chalk-like appearance.</p> <p>A subsequent observation completed on 4/1/26 at 12:42 PM revealed the wall in Resident #65's room continued to exhibit the same scrape marks as observed on 3/30/26.</p> <p>b. On 3/30/26 at 12:55 PM, observation of Resident #72's room revealed scrape marks on the wall at the head of the bed and along the full length of the wall along the left side of the bed. The scrapes exposed white wall material with a chalk-like appearance.</p> <p>A subsequent observation completed on 4/1/26 at 12:45 PM revealed the walls in Resident #72's room continued to exhibit the same scrape marks as observed on 3/30/26.</p> <p>An observation and interview were conducted with the Maintenance Director on 4/1/26 at 4:01 PM. He reported he had been in the position for one month and was the only staff member in the department. After observing the resident room walls, the Maintenance Director stated he had repaired the damaged areas in Resident #65 and Resident #72's rooms approximately one week prior to survey. He noted the beds in both rooms continued to be pushed against the walls, and he believed the raising and lowering of the beds caused the recurring scrape marks. According to the Maintenance Director, he was seeking a more permanent solution to prevent continued wall damage.</p> <p>On 4/2/26 at 11:22 AM, the Administrator was interviewed and reported the Maintenance Director was behind on wall patching and repairs, noting scratches reappeared in rooms where repairs had been previously completed. The Administrator acknowledged resident rooms should be kept in good repair and home-like and stated he would explore more permanent wall protection to prevent damage from beds and wheelchairs.</p>	F0584		04/30/2026

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<p>F0584 SS = B</p>	<p>Continued from page 30</p> <p>3a. On 3/30/26 at 10:30 AM, an observation of Resident #3's room revealed a large, scuffed area approximately 13 inches in size at the bottom corner of the wall between the closet and sink. The area had a thick application of patch but had not been sanded or painted. In addition, Resident #3's Packaged Terminal Air Conditioner (PTAC) unit revealed a large amount of grey dust particles to the left interior of the top vents.</p> <p>An observation and interview were conducted with the Maintenance Director on 4/1/26 at 10:15 AM. He observed the damaged wall at the bottom corner between the closet and sink of Resident #3's room and the large amount of grey dust particles to the left interior of the top vents of the PTAC unit. He indicated the wall was frequently damaged from the wheelchair and he had not finished repairing the area. He also indicated that he was responsible for cleaning the inside of the PTAC vents with the vacuum cleaner. The Maintenance Director stated that he tried to make a round in the facility every six months to clean the inside of the PTAC units but had gotten behind. He acknowledged Resident #3's wall and PTAC required attention and would be addressed.</p> <p>b. On 3/30/26 at 12:00 PM, an observation of Resident #8's room revealed multiple scattered areas of damage to the wall behind the head of the bed, exposing the sheetrock. In addition, the vinyl baseboard was coming away from the wall under the sink area, exposing the bare wall.</p> <p>An observation and interview were conducted with the Maintenance Director on 4/1/26 at 10:18 AM. He observed the area of exposed sheetrock behind the head of Resident #8's bed as well as the vinyl baseboard that was not attached to the wall under the sink. He indicated that he had gotten behind with room repairs and that movement of the bed had most likely caused damage to the wall. The Maintenance Director stated that he would like to find a more permanent fix to prevent damage to the walls where the head of the beds are located. He stated the areas required attention and would be addressed.</p> <p>The Administrator was interviewed on 4/2/26 at 11:22 AM and stated it was important for the residents' rooms to be in good repair and homelike.</p>	<p>F0584</p>		<p>04/30/2026</p>