STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to identify a medical symptom to justify the use of a physical restraint (trunk restraint) and failed to implement systemic approaches to reduce the restraint to the least restrictive method for 2 of 3 sampled residents (Resident #66 and Resident # 81) reviewed for physical restraints. Findings included: 1. Resident #66 was admitted 10/30/12 with cumulative diagnoses of Alzheimer ' s disease, anxiety and macular degeneration. A review of a physical therapy discharge summary dated 10/6/15 indicated Resident #66 was seen for abnormal posture and wheelchair positioning. Resident #66 was discharged using a high back wheelchair to achieve improved posture. A nursing note dated 12/7/15 indicated a fall at 5:50 PM in which Resident #66 leaned forward and fell from the wheelchair and a physician order was written on 12/8/16 for a lap buddy (a cushion that fits snuggly in a wheelchair) to the wheelchair for positioning purposes. A review of the Restraint Log completed by the	F 221	1. The administrator and Director of nursing will conduct an in-service to the restorative nurse by September 14, 2016 that the resident has the right to be free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the residents medical symptoms. That there must be a medical symptom identified to justify a physical restraint and implement a systematic approach to reduce the restraints to the least restrictive method. In addition, the administrator and Director of nursing will conduct an in-service/train the restorative nurse by September 14, 2016 on the facility's restraint policy, new restraint assessment sheet, new sheet titled "documentation of least restrictive restraint/safety device restraint", and new sheet titled "resident evaluation for least restrictive method of restraint/safety device". Restorative nurse will read and sign article titled "MDS News you can use" on physical restraints and will read and sign CMS's RAI Version 3.0 Manual, Section P: Restraints pages P-1 thru P-7. 2. The Administrator and Director of	9/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 restorative nurse indicated on 12/8/15 at 8:00 AM, wedge cushion was placed in Resident #66 ' s wheelchair for positioning purposes. At 1:30 PM, Resident #66 was noted to leaning over and throwing legs over the foot pedals while the wedge cushion was in place. A lap buddy was then placed in the wheelchair for correct positioning. The next Restraint Log note was dated 3/1/16 and indicated the lap buddy was used while Resident #66 was up in the wheelchair due to poor positioning and leaning forward. The last Restraint Log note dated 6/10/16 indicated the lap buddy was utilized to provide correct positioning in the wheelchair. Resident #66 ' s " repeatedly slides hips forward to the edge of the wheelchair and the lap buddy correct the spine and hip alignment. " A Fall Risk assessment dated 5/23/16 indicated Resident #66 was coded at a high risk for falls with no falls in the last 3 months. The annual Minimum Data Set (MDS) dated 6/20/16 indicated severe cognitive impairment with no behaviors. Resident #66 was coded as having one fall without injury, no impairment to the upper or lower extremities and as using a walker or wheelchair. There was no restraints coded on the MDS. Resident #66 was care planned for falls on 6/27/16 with the intervention for a lap buddy to assist with positioning. In an observation on 8/22/16 at 3:30 PM, Resident #66 was observed sitting with a lap buddy applied to her wheelchair in the common area of the secured unit.	F 221	nursing will conduct an in-service to all nursing staff and IDT by September 14, 2016 the facility's restraint policy, new restraint assessment sheet, new sheet titled "documentation of least restrictive method of restraint/safety device". Staff and IDT will read, learn, and sign article titled "MDS News you can use" on physical restraints and will read and sign CMS's RAI Version 3.0 Manual, Section P: Restraints pages P-1 thru P-7. 3. In this circumstance there is a need for a systematic change. This will be done by in-servicing and training restorative nurse, all nursing staff, and IDT on the following: the facility restraint policy, by introduction new facility forms to add to the facility restraint policy to include: new restraint assessment form, new documentation of least restrictive restraint/safety device restraint form, new restraint evaluation for least restrictive method of restraint/safety device form, and new restraint committee review form. Also, educate by using facility policy, article titled "MDS News you can use" and RAI manual Section P, and by direct observation to achieve compliance. 4. The facility Director of nursing and Quality Assurance and Performance improvement (QAPI) coordinator will conduct direct observations using new form titled "proper restraint use" to ensure that any and all restraints that are being used follow the facility policy and guidelines from the RAI manual. This will be done for resident # 66 and # 81 and for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 In another observation on 8/23/16 9:45 AM, Resident #66 was observed eating breakfast at the dining with a lap buddy to her wheelchair. At 10:36 AM, nursing assistant (NA) #1 removed the breakfast plate while Resident #66 was attempting to remove the lap buddy from the wheelchair. NA #1 stated "you know you can't take that off." In an interview on 8/23/16 at 9:50 AM, NA #1 stated she had known Resident #66 since her admission and was very familiar with her. NA #1 stated the lap buddy was placed on Resident #66 ' s wheelchair because she was able to walk but had a history of falling. NA #1 stated Resident #66 was able to take off the seat belt she had on her wheelchair once before but she could not take the lap buddy off. NA #1 stated she was told to take the lap buddy off every few hours to toilet Resident #66. In an observation on 8/23/16 at 12:00 PM, NA #1 and NA #2 were observed preparing to toilet Resident #66. NA #2 stated she knew Resident #66 since his admission to the facility. NA #2 asked Resident #66 to remove the lap buddy from the wheelchair. Resident #66 required redirection to attempt to remove the lap buddy four times before she made an attempt to remove it. Resident #66 was unable to remove the lap buddy from the wheelchair with prompting from NA #2. NA #1 stated Resident #66 was not able to take the lap buddy off by herself when asked. In an observation on 8/24/16 at 10:30 AM, Resident #66 was taken off the secured unit to a music activity with the lap buddy in place to her wheelchair. She was returned to the secured unit at 10:41 AM.	F 221	every current resident using a restraint to be completed by September 16, 2016 and on an ongoing basis any time a new restraint is to be used. The QAPI team will review all restraints being used; using new form titled "restraint committee review" in the daily QAPI meeting to be done by September 16, 2016 and on an ongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3	F 221		

In an interview on 8/24/16 at 11:20 AM, the Administrator stated the lap buddy was an intervention initiated for positioning either by therapy or by the restorative nurse.

In an interview on 8/24/16 at 11:45AM, the rehabilitation director stated Resident #66 had not been seen for positioning since she was last seen in October 2015. He stated therapy did not recommend the lap buddy but it likely was initiated as a result of a fall team meeting after a fall. He also stated he was not aware of an attempt discontinue the lap buddy because the restorative nurse was over the restraints.

In an interview on 8/24/16 at 12:00 PM, restorative nurse recalled discussing the lap buddy as a fall intervention. She stated she was told during a fall team meeting that the lap buddy was for positioning to keep her from falling from the wheelchair. The restorative nurse stated there had been no attempt to remove the lap buddy or try a less restrictive intervention since it was apply last December. The restorative nurse stated she was not trained restraint usage or the need for reduction attempts.

In an interview on 8/25/16 at 2:00 PM, the Administrator stated it was her understanding that if the physician ordered the lap buddy for positioning, it was not considered a restraint. She stated that since Resident #66 was unable to remove the lap buddy, she understood it would be considered a restraint and attempts to use a less restrictive device should have been attempted.

2. Resident #81 was admitted 10/8/14 with dementia and benign prostate hypertrophy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 4	F 221		

A review of the last fall incident was 3/28/16 at 1:50 PM when Resident #81 was ambulating in the hall and lost his balance. Rest periods were encouraged.

A review of the physician orders indicated a wedge cushion was ordered 4/4/16 to be added to his wheelchair due to leaning.

Resident #81 was sent to the hospital due in issues unrelated to the fall in March on 4/7/16 and returned on 4/20/16 with orders for therapy.

A review of the physical therapy plan of care dated 4/21/16 indicated wheelchair mobility/management was not indicated as a functional deficit or did the occupational therapy plan of care dated 4/29/16.

A review of the Restraint Log completed by the restorative nurse indicated on 6/9/16 the wedge cushion was used to correct Resident #81 ' s positioning in the wheelchair. Without the wedge cushion, Resident #81 ' s hips slid forward and made self propelling in the wheelchair difficult. He was correctly and efficiently propelling self in the wheelchair with the wedge cushion. Another Restraint Logs note dated 6/23/16 indicated Resident #81 was leaning forward in the wheelchair. A Velcro alarming seat belt was applied but Resident #81 continued to lean forward. A lap buddy was applied and noted to provide correct positioning of hip and he was not leaning forward.

The quarterly MDS assessment dated 6/18/16 indicated severe cognitive impairment with verbal and physical behaviors, limited assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5	F 221		

walking on the unit, unsteady gait with impairment to his lower extremities and the use of a wheelchair. Resident #81 was not coded for any falls or a trunk restraint.

A review of the care plan indicated the last review was 6/25/16 and Resident #81 was originally care planned for falls on 9/15/15. The application of the lap buddy was initiated as an intervention on 6/23/16.

A nursing note dated 6/13/16 at 4:00 PM indicated Resident #81 was restless and made multiple attempts to transfer himself without assistance. Constant wandering was observed while in his wheelchair on the secured unit.

A nursing note dated 6/16/16 at 4:40 PM read physical therapy and occupational therapy continue to work with the Resident #81 on gait and transfers. There was no observed loss of balance.

A nursing note dated 6/17/16 at 5:00 PM read Resident #81 propels in the wheelchair without difficulty.

A nursing note dated 6/22/16 at 2:30 PM read physical and occupational therapy continue to work on gait and transfers. Resident #81 can ambulate 150 feet with hand held assistance.

A nursing note dated 6/22/16 at 4:00 PM read Resident #81 was observed multiple times leaning forward. The note did not specify if the leaning was noted while ambulating or while sitting in his wheelchair.

A nursing note dated 6/23/16 read at 7:30 AM and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 6	F 221		

8:30 AM read Resident #81 was observed leaning forward in his wheelchair.

A nursing note dated 6/23/16 at 9:00 AM read a lap buddy was in place and Resident #81 was noted in upright proper sitting position. The lap buddy was discussed with the interdisciplinary team and orders were obtained for the lap buddy.

A review of the physician orders indicated the wheelchair wedge cushion was discontinued on 6/23/16 and a lap buddy was applied to Resident #81 ' s wheelchair for positioning.

A review of the occupational therapy discharge summary dated 6/23/16 indicated at the time of discharge, Resident #81 was able to maintain proper postural alignment while standing for ten minutes without a recovery period and able to bend to pick up items on the floor while maintaining balance.

A review of the physical therapy discharge note dated 6/30/16 Resident #81 was ambulating 300 feet with contact guard assistance to stand by assistance and able to maintain head and trunk balance. He was discharged to restorative nursing for ambulation.

In an observation on 8/25/16 at 8:47 AM, Resident #81 was observed sitting at the dining room table eating breakfast with a lap buddy applied to his wheelchair.

In an interview on 8/25/16 at 8:47 AM, Nursing Assistant (NA) #2 knew Resident #81 since his admission to the facility. NA #2 stated she had not received any training on the use of restrains but she was told the lap buddy needed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 7	F 221		

removed every few hours for toileting.

In an interview and observation on 8/25/16 at 9:22 AM, NA #1 stated she knew Resident #81 since his admission to the facility. She asked Resident #81 to remove the lap buddy from his wheelchair. Resident #81 required redirection to attempt to remove the lap buddy two times and made no effort to attempt to remove the lap buddy. NA #2 stated she had never observed Resident #81 leaning while in his wheelchair but rather was known to constantly stand up from his wheelchair up and fell a few times.

In an interview on 8/24/16 at 11:45 AM, the rehabilitation director stated Resident #81 was discharged from therapy on 6/30/16. He stated there was no therapy documentation regarding Resident #81 leaning while up on his wheelchair but it must have been discussed in a fall or Medicare meeting for restorative to have applied a lap buddy to his wheelchair.

In an interview on 8/24/16 at 12:00 PM, the restorative nurse stated she was unsure why she initiated the lap buddy but he must have been leaning that day and the group in the morning meeting decided to use a lap buddy. The restorative nurse stated she was told that if the lap buddy was for positioning, it was not considered a restraint. The restorative nurse stated there had been no attempt to remove the lap buddy or try a less restrictive intervention since it was apply last in June. The restorative nurse stated she was not trained restraint usage or the need for reduction attempts.

In an interview on 8/25/16 at 2:00 PM, the Administrator stated it was her understanding that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 8 if the physician ordered the lap buddy for positioning, it was not considered a restraint. She stated that since Resident #81 was unable to remove the lap buddy, she understood it would be considered a restraint and attempts to use a less restrictive device should have been attempted.	F 221		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment on 1 (Resident #81) of 24 residents reviewed for a MDS accuracy. Findings included: Resident #81 was admitted to the facility on 10/8/14 with cumulative diagnoses of dementia and benign prostate hypertrophy (BPH). He was sent to the hospital on 4/7/16 and returned to the facility on 4/20/16 with a new diagnosis of aspiration pneumonia, a diet down-grade, weight	F 274	1. The administrator and Director of nursing will conduct an in-service with MDS/Care Plan coordinators by September 14, 2016 regarding: the facility must conduct a comprehensive assessment on a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a significant	9/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 9 loss and a urinary catheter due to urinary retention. A review of the MDS assessments submitted indicated an discharge with expected return MDS dated 4/7/16, an entry MDS dated 4/20/16, a quarterly MDS dated 4/27/16, 14 day MDS dated 5/04/16 and a 30 day MDS dated 5/18/16. The most recent MDS was a quarterly MDS dated 6/18/16. There was no evidence of a significant change assessment with Care Area Assessments (CAAs). In an interview on 8/25/16 at 11:15 AM, the MDS nurse stated there should have been a significant change MDS with CAAs completed when Resident #81 was readmitted due to the change in condition. In an interview on 8/25/16 at 2:00 PM, the Administrator stated she would have expected a complete MDS assessment that would have captured the changes in Resident #81 ' s condition upon readmission on 4/20/16.	F 274	change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both) In addition, the facility administrator and Director of nursing will conduct an in-service and training by September 14, 2016 to the MDS/Care Plan coordinators using CMS's RAI MDS 3.0 Manual from May 2011 pages 2-20 thru 2-27 Starting with significant change in status assess (CSA) and using article titled "MDS 3.0 questions " developed by OHCA's expert panel based on research of the existing MDS 3.0 manual and guidelines. 2. The administrator and Director of Nursing will conduct an in-service to the IDT by September 14, 2016 regarding: the facility must conduct a comprehensive assessment on a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 10	F 274	on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both) In addition, the facility administrator and Director of nursing will conduct an in-service and training by September 14, 2016 to the MDS/Care Plan coordinators and IDT using CMS's RAI MDS 3.0 Manual from May 2011 pages 2-20 thru 2-27 Starting with significant change in status assess (CSA) and using article titled "MDS 3.0 questions " developed by OHCA's expert panel based on research of the existing MDS 3.0 manual and guidelines. 3. In this circumstance there is not a need for systematic change but rather staff education and direct observation to achieve compliance. 4. The facility Director of Nursing and QAPI coordinator will conduct direct observations using new form titled "significant change and assessment" This form will be completed on all residents that the facility (IDT) determines there has been a significant change in the residents physical or mental condition to ensure that the MDS/Care Plan Coordinator has done a comprehensive assessment within 14 days. Resident # 81 will have a significant correction to prior comprehensive assessment done by September 16, 2016.	
F 278	483.20(g) - (j) ASSESSMENT	F 278		9/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	Continued From page 11 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to correctly code the most recent comprehensive Minimum Data Set (MDS) assessment for physical restraints for 2 of 3 Resident #66 and Resident #80) residents reviewed for restraints. Findings included:	F 278	1. The administrator and Director of nursing will conduct an in-service to MDS/Care Plan coordinators and restorative nurse by September 14, 2016 that the assessment must accurately reflect the resident's status. A registered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12 1. Resident #66 was admitted 10/30/12 with cumulative diagnoses of Alzheimer ' s disease, anxiety and macular degeneration. The most recent MDS was an annual assessment dated 6/20/16. She was coded with severe cognitive impairment with no behaviors. Resident #66 was coded as having one fall without injury, no impairment to upper or lower extremities and as using a walker or wheelchair. There was no Care Area Assessment (CAA) completed for a physical restraint either. In an observation on 8/22/16 at 3:30 PM, Resident #66 was observed sitting in a wheelchair with a lap buddy (a cushion that fits snuggly in a wheelchair) applied to the chair. In another observation on 8/23/16 at 9:45 AM, Resident #66 was sitting at the table eating breakfast with a lap buddy applied to her wheelchair. In an observation on 8/23/16 at 12:00 PM, Resident #66 was asked by nursing assistant (NA) #2 to remove the lap buddy from her wheelchair. Resident #66 required multiple request and redirection to attempt to remove the lap buddy. She was unable to remove it. NA #1 stated Resident #66 was not able to take the lap buddy off her wheelchair and it was applied to her wheelchair to keep her from falling. In an interview on 8/24/16 at 12:00 PM, the MDS nurse stated Resident #66 ' s 6/20/16 annual MDS should have been coded for a trunk restraint since she was unable to remove the lap buddy when asked. The MDS nurse also stated that had the MDS been correctly coded, a CAA would	F 278	nurse must conduct or coordinate each assessment with appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment. That the MDS must be coded correctly for physical restraints. In addition, the administrator and Director of nursing will conduct an in-service and training to the MDS/Care Plan coordinators and restorative nurse by September 14, 2016 on facility's restraint policy, new restraint assessment sheet, new sheet titled "documentation of least restrictive restraint/safety device restraint", and new sheet titled "restraint evaluation for least restrictive method of restraint/safety device". Restorative nurse will read and sign article titled "MDS News you can use" on physical restraints and will read and sign CMS's RAI Version 3.0 Manual, Section P: restraints pages P-1 thru P-7. 2. The administrator and Director of nursing will conduct an in-service to MDS/Care Plan coordinators, restorative nurse and IDT by September 14, 2016 that the assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with appropriate participation of health professionals. A registered nurse must sign and certify that the assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 13 have been completed. In an interview on 8/25/16 at 2:00 PM, the Administrator stated she would have expected the annual MDS assessment dated 6/20/16 would have been properly coded for the trunk restraint on Resident #66. 2. Resident #80 was admitted 9/03/2014 with cumulative diagnoses of Diabetes, Dementia, Hyperlipidemia, Anxiety Disorder, Depression and Psychotic Disorder. The most recent Minimal Data Set (MDS) was an annual assessment dated 8/10/2016. She was coded with moderately impaired cognition and inattention and disorganized thinking behaviors present. Resident #80 was coded as having no falls, no restraint, and no impairments to upper or lower extremities. There was no Care Area Assessment (CAA) completed for a physical restraint. During an observation on 8/22/2016 at 4:02 PM, Resident #80 was observed sitting in her Merrichair (enclosed framed wheeled walker) watching television in the Dayroom. In another observation on 8/23/2016 at 10:24 AM, Resident #80 was observed sitting in her Merrichair playing catch with a beach ball with other residents during activities. At lunchtime on 8/23/2016, Resident #80 was observed sitting in her Merrichair eating her lunch in the dining room. During an observation on 8/24/2016 at 3:45 PM, Resident #80 was asked by nursing assistant (NA) #2 to open the latch for the Merrichair. Resident #80 was asked several times and was redirected several times to open the latch on the Merrichair. She was unable to open the latch. NA #2 stated Resident #80 was not able to open	F 278	is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment. That the MDS must be coded correctly for physical restraints. In addition, the administrator and Director of nursing will conduct an in-service and training to the MDS/Care Plan coordinators, restorative nurse, IDT, and nursing staff by September 14, 2016 on facility's restraint policy, new restraint assessment sheet, new sheet titled "documentation of least restrictive restraint/safety device restraint", and new sheet titled "restraint evaluation for least restrictive method of restraint/safety device". Restorative nurse will read and sign article titled "MDS News you can use" on physical restraints and will read and sign CMS's RAI Version 3.0 Manual, Section P: restraints pages P-1 thru P-7. 3. In this circumstance there is a need for a systematic change. This will be done by in-servicing and training nursing staff, MDS/Care Plan coordinators, IDT, and restorative nurse on the following: the facility restraint policy, by introducing new facility forms to add to the facility restraint policy to include: new restraint assessment form, new documentation of least restrictive restraint/safety device restraint form, new restraint evaluation for least restrictive method of restraint/safety device form, and new restraint committee review form. Also, educate on restraints, using facility policy, article titled "MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 14 the Merrichair latch. She stated the Merrichair assisted Resident #80 with her ambulation and positioning, but she had not seen her ever open the latch. In an interview on 8/25/2016 at 9:30 AM, the MDS Nurse stated Resident #80 ' s annual MDS dated 8/10/2016 should have been coded for a restraint since she was unable to remove the Merrichair latch when asked. The MDS nurse also stated that had the MDS been correctly coded, a CAA would have been completed. In an interview on 8/25/16 at 11:00 AM, the Facility Administrator stated she would have expected the annual MDS assessment dated 8/10/2016 would have been properly coded for the restraint used for Resident #80.	F 278	news you can use", and CMS's RAI version 3.0 manual, and by direct observations to achieve compliance. 4. The facility Director of nursing and QAPI coordinator will conduct direct observation using new form titled "proper restraint use" to ensure that any and all restraints that are being used follow the facility policy and the guidelines from CMS's RAI manual. This will be done for resident #66 and #81, and all other residents that restraints are being used by September 16, 2016 and on an ongoing basis any time a new restraint is to be used. The QAPI team will review all restraints being used; using new form titled " restraint committee review" in the daily QAPI meeting to be done by September 16, 2016.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to administrator ordered three times daily (TID) and four times daily (QID) medications within the administration timeframe for 1 (Resident #18) of 3 residents observed during a medication administration. Findings included: During a medication pass on 8/24/16 Nurse #1	F 332	1. The administrator and Director of nursing will conduct an in-service and train the medication nurse that administered medications out of the time frame to resident #18 by September 14, 2016, the facility policy for medication administration and the "5 rights" of medication administration.	9/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 15 was restocking her medication cart with drinking cups. She began pulling medications for Resident #18 at 9:09 AM. Nurse #1 administered Resident #18 ' s prescribed 8:00 AM medications at 9:34 AM. The following medications were not given with the prescribed time frame: Neurontin 400 milligrams (mg) by mouth three times daily at 8:00 AM, 12:00 PM and 4:00 PM Sinemet 25-100 mg by mouth four times daily at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM Systane one drop in each eye four times daily at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM In an interview on 8/24/16 at 9:37 AM, Nurse #1 stated she was aware she could administer medications ordered at 8:00 AM between 7:00 AM and 9:00 AM but after 9:00 AM, Resident #18 ' s medications were considered late. Nurse #1 stated she started her medication pass after she got report a little after 7:00 AM and nothing unusual occurred the cause her to be behind on her medication pass. In an interview on 8/24/16 at 3:30 PM, the Charge Nurse stated she supervised the nurses on the hall and she observed Nurse #1 passing medications on the hall at approximately 7:20 AM when she arrived at work. The Charge Nurse stated she was not aware of any issues regarding timeliness of medication administration or anything that occurred unusual early in the shift to cause Nurse #1 to be late passing the 8:00 AM medications. In an interview on 8/25/16 at 9:56 AM, the Administrator stated she expected all resident medications be given within the ordered time	F 332	2. The administrator and Director of Nursing will conduct an in-service and train all nurses by September 14, 2016, the facility policy on medication administration and the "5 rights" of medication administration. 3. In this circumstance there is no need for systematic change but rather education and direct observation to achieve compliance. 4. The facility Director of nursing and QAPI coordinator will conduct daily observations for 1 month regarding nurses administering medications in the proper time frame. These observations will be documented and reviewed daily during morning meetings for compliance. Nurses failing to comply will be subject to facility progressive disciplinary code up to and including termination of employment. Following 1 month of daily observations the facility will conduct monthly observations and report through facility's monthly QAPI program ensuring results are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 16 frames. If the medications were not administrated at the times ordered, the physician should be contacted for orders to adjust medication administration times for medications given more than once daily.	F 332		