STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		6/6/19

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

Electronically Signed | 05/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan for potential for and actual weight loss for 1 of 3 sampled residents reviewed for nutrition (Resident #4). Findings included: Resident #4 was re-admitted to the facility on 3/27/19 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/28/19 indicated that Resident #4 had moderate cognitive impairment and needed supervision with eating. The assessment further indicated that Resident #4's weight was 146 pounds (lbs.) Resident #4's weight on 3/31/19 was 144 lbs. and on 4/10/19 was 126 lbs., 18 lbs. weight loss in less than 2 weeks. The dietary note dated 4/1/19 revealed that Resident #4 was readmitted with diagnoses of aspiration pneumonia, congestive heart failure and dementia. His diet was puree with nectar thick liquids. Resident #4 disliked puree food and his appetite was extremely poor. Nurse Practitioner (NP) notes indicated that tube feeding needed to be discussed with the family. His weight was currently stable however would likely see weight loss due to poor intake. Recommend tube feeding due to resident was not able to maintain nutrition needs and nutritional supplement twice a day for lunch and dinner.	F 656	F656 The plan of correcting the specific deficiency On 5/9/2019 resident # 4's care plan was updated to include focus of nutrition related to weight loss with resident goal, preferences, and interventions. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/24/2019, the Assistant Director of Nursing (ADON) audited the charts of all residents with significant weight loss in the past 90 days as indicated by the weight variance report to ensure there were care plans in place if indicated by report. There were four negative findings, and they were corrected on 5-25-2019 in the care plan and in the tray system by the Director of Nursing (DON) and the Food Service Director (FSD). On 5/24/2019, the ADON audited the charts of all residents with significant weight gain in the past 90 days as indicated by the weight variance report to ensure there were care plans in place if indicated by report. There were no negative findings in this audit. Systemic Change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 656	Continued From page 2 The dietary note dated 4/22/19 revealed that Resident #4's weight was 126 lbs. indicating a significant weight loss of 18% in 30 days. He continued on puree diet with nectar thick liquids. His appetite was poor and he received nutritional supplement. Tube feeding was not desired by family. Review of Resident #4's care plan revealed that there was no care plan developed for potential for and actual weight loss. On 5/9/19 at 10:54 AM, the MDS Nurse was interviewed. The MDS Nurse stated that the Dietary Manager (DM) was responsible for developing the care plan for nutrition including weight loss/weight gain. She further stated that she expected a care plan developed for weight loss for Resident #4. On 5/9/19 at 12:49 PM, the DM was interviewed. The DM stated that she was responsible for developing care plan for nutrition. The DM acknowledged that Resident #4 had a significant weight loss and a care plan should have been developed but she missed it. She added that it was an oversight. On 5/9/19 at 1:10 PM, the Director of Nursing (DON) was inter viewed. The DON stated that she expected the DM to develop a care plan when a resident was at risk for weight loss and when the resident had actual weight loss.	F 656	On 5/24/2019 the Director of Nursing in-serviced the minimum data set nurses (MDS) and the FSD on the development and revision of care plans to meet resident current status, including potential for and actual weight loss or gain. This in-service will be provided to any new MDS nurses and FSD's. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, staff facilitator, or unit manager will audit 10 resident care plans weekly for four weeks and monthly for two months to ensure that if the resident has had a significant weight loss or gain based on the medical record and/or weight variance report there is a care plan in place to address nutritional status including weight loss/gain as appropriate. The audit will be documented on the care plan audit tool. The QAPI committee will review the results of the care plan audit tool monthly for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for continued compliance. The administrator and/or DON will present the findings and recommendations to the QAPI committee for further recommendations and oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately transcribe physician orders for a respiratory medication ordered by the physician for 1 of 3 residents reviewed (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 3/12/18 with diagnoses that included dementia and Chronic Obstructive Pulmonary Disease (COPD). The most recent Minimum Data Set (MDS) coded as quarterly assessment and dated 3/7/19 revealed the resident had cognitive impairment and required supervision from staff for toileting and personal hygiene, limited assistance with dressing and extensive assistance for bathing. Shortness of breath was not indicated. A review of the medical record revealed an order dated 3/20/19 for Albuterol Neb 0.083% inhale contents of 1 vial via nebulizer twice daily. A review of the resident's monthly Physician Orders for April 2019 included a typed entry for Albuterol Neb 0.083% Inhale contents of 1 vial via nebulizer twice daily at 9am and 9pm and a handwritten entry that read Albuterol neb inhale 1 vial (3 milliliters) via neb twice a day at 9am and	F 658	F658 The plan of correcting the specific deficiency On 5/6/19 resident #1 was discharged from facility to acute care hospital. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By June 1, 2019 all resident's medication administration records will be audited weekly for four weeks and monthly for two months by the floor nurses to ensure orders are correct based on physician orders, including no duplicate orders. As of 5/24/2019 no negative findings have been noted during audit. Any negative findings noted will be corrected immediately by auditor. Systemic change On 5/9/2019 the director of nursing and the staff facilitator began an in-service with licensed nurses on the monthly medication reconciliation (MAR) process	6/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 9pm. The April 2019 Medication Administration Record (MAR) revealed the typed entry for Albuterol nebulizer's administration time had been changed to 9am and 5pm and was initialed by the nursing staff during 4/1/19 to 4/20/19. The handwritten entry for the Albuterol nebulizer's administration time had been changed to 9:30am and 8pm and was initialed by the nursing staff during 4/1/19 to 4/20/19. Resident #1's active care plan dated 4/29/19 revealed a care plan in place for ineffective breathing pattern related to COPD. Interventions included to administer medications as ordered by physician. An interview occurred with the Assistant Director of Nursing (ADON) on 5/9/19 at 9:48am. She indicated she had provided Resident #1 with the Albuterol Nebulizer on 4/19/19 at 5:00pm as scheduled. She further stated that she didn't notice the order listed twice on the MAR with different administration times and felt it was an oversight on her part. On 5/9/19 at 10:09am an interview was held with the Director of Nursing (DON). She identified her signature dated 3/27/19 for the check on Resident #1's April physician orders and as the handwritten entry for the Albuterol Nebulizer. She reviewed the orders and April MAR stating it was an oversight that she didn't see the typed entry for the medication thus writing in the order on the monthly physician orders and the April MAR. The DON further stated she would complete a medication error report related to the situation, contact the physician and begin a Performance	F 658	that includes verifying the new month's MARs with the current months MARs and all telephone orders received in the current month. Any discrepancies must be clarified. The new month's MAR must be verified by two licensed nurses and again when initiated. This in-service will be completed by June 6, 2019. The staff facilitator added this in-service to the orientation for new licensed nurses on 5/23/19. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit 10 MARs weekly for four weeks and monthly for two months to ensure orders are correct based on physician orders and there are no duplicate orders. This audit will be documented on the MAR audit tool. The QAPI committee will review the results of the MAR audit tools for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations to the QAPI committee for further recommendations and oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 5 Improvement Plan. A telephone interview was conducted with Nurse #2 on 5/9/19 at 10:18am. She indicated that she only gave one morning dose of the Albuterol nebulizer to Resident #1 during 4/1/19 to 4/20/19 and signed in the space for the 9am and 9:30am dose. She further added that she couldn't recall seeing the two entries on the MAR and felt it was an oversight on her part. On 5/9/19 at 10:40am an interview occurred with Nurse #3. She visualized the April MAR and stated that she wrote over the original handwritten entry as it was not very clear. She added that she was certain she only administered one nebulizer treatment to Resident #1 in the mornings of 4/1/19 to 4/20/19. Nurse #3 further stated it was an oversight on her part for not identifying the duplicate medication entry. A telephone call was placed to Nurse #4 who worked the 3pm to 11pm shift. A message was left for a return call that was not received during the survey. During an interview with the Administrator and ADON on 5/9/19 at 12:31pm, both stated it was their expectation for the orders to be transcribed correctly on the MAR's.	F 658		
F 842 SS=C	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		6/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 6	F 842		

accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 7 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of oxygen saturations (Resident #5), medications (Resident #5), Activities of Daily Living (Resident #1) and nutritional supplements (Resident #4) for 3 of 6 residents reviewed. The findings included: 1a) Resident #5 was initially admitted to the facility on 7/10/14 with diagnoses that included chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues), asthma and acute and chronic respiratory failure. The most recent Minimum Data Set (MDS) coded as quarterly assessment and dated 1/25/19 revealed the resident was cognitively intact and	F 842	F842 The plan of correcting the specific deficiency On 5/24/2019 resident # 5 was assessed by the staff facilitator with a current oxygen saturation of 94. This finding was documented on the medication administration record (MAR). On 5/24/2019 the current medication administration record for resident # 5 was audited by the director of nursing to determine if documentation was present for administration of Perfomomist 20. It was found that there were two times that there were no documentation of this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 8 used oxygen. The active care plan dated 2/8/19 revealed a care plan for ineffective breathing patterns as well as refusal of her medications. Interventions included to administer nebulizer treatments as ordered by the physician, monitor vital signs as ordered or per facility protocol and to monitor and document episodes of behavior. A review of the April 2019 physician orders indicated an order for Oxygen at 3 liters (L) at rest as needed and 5L during exertion, as well as oxygen saturations to be checked twice daily, on the 7am to 3pm and the 3pm to 11pm shifts. Review of the April 2019 Medication Administration Record (MAR) revealed oxygen saturations were not documented as obtained by the nurse or refused by the resident for 15 out of 30 days (4/1/19, 4/5/19 to 4/8/19, 4/12/19 to 4/16/19, 4/19/19 to 4/21/19 and 4/27/19 to 4/28/19). An interview was completed with the Administrator and the Assistant Director of Nursing (ADON) on 5/9/19 at 12:31pm. Both parties observed the multiple blank entries on the April 2019 MAR for the oxygen saturations twice daily. The ADON stated she wasn't sure if the nurse left the entry blank as an oversight or because the resident refused to have it obtained. The administrator and the ADON stated it was their expectation for the oxygen saturations to be monitored as ordered by the physician and be accurately documented on the MAR. A phone call was placed to Nurse #1 on 5/9/19 at 12:45pm. A message was left for a return call	F 842	medication being administered. Staff was educated on proper documentation on the MAR. The resident was assessed and physician was notified. Resident # 1 was discharged on 6/5/19 to acute care hospital. On 5/24/2019 the assistant director of nursing (ADON) and the hall Certified Nurse Aid (CNA) observed that resident # 4 ate his nutritional supplement as ordered. This supplement intake was documented in the medical record on 5/24/2019 by the hall CNA. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/23/2019 the assistant director of nursing and the unit manager audited all residents with orders for oxygen saturations to ensure documentation was present for the past 7 days as ordered. No negative findings. On 5/23/2019 an audit was started by nurse managers of current residents' medication administration records to ensure medication administration was documented as ordered. This audit will be completed by 6/6/2019. Any negative findings will be addressed immediately by auditor including assessment of resident and notification of physician. On 5/24/2019 the assistant director of nursing audited bathing documentation for past 7 days, to ensure bathing documentation matched resident care plan and/or bathing schedule. Several negative findings were found and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 9 that was not received during the survey. 1b) Resident #5 was initially admitted to the facility on 7/10/14 with diagnoses that included chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues), asthma and acute and chronic respiratory failure. The most recent Minimum Data Set (MDS) coded as quarterly assessment and dated 1/25/19 revealed the resident was cognitively intact and used oxygen. The active care plan dated 2/8/19 revealed a care plan for ineffective breathing patterns as well as refusal of her medications. Interventions included to administer nebulizer treatments as ordered by the physician, monitor vital signs as ordered or per facility protocol and to monitor and document episodes of behavior. A review of the April 2019 physician orders indicated an order for Perforomist 20 micrograms (mcg) inhale one vial via nebulizer twice daily. Medication was scheduled to be given at 8am and 8pm. Review of the April 2019 Medication Administration Record (MAR) revealed the nebulizer Perforomist was not documented as given on the 8pm dose for 4/20/19 to 4/22/19, 4/27/19 and 4/28/19. An interview was completed with the Administrator and the Assistant Director of Nursing (ADON) on 5/9/19 at 12:31pm. Both parties observed the multiple blank entries on the April 2019 MAR for 8pm dose of Perforomist nebulizer. The ADON stated she wasn't sure if the	F 842	corrective interventions were implemented. On 5/24/2019 the assistant director of nursing audited the documentation for past 7 days for current residents with supplement orders. Several negative findings were found and corrective interventions were implemented. Systemic Change On 5/23/2019 the staff facilitator and the director of nursing started an in-service with licensed nurses on medication administration, including documentation of nebulizer treatments, and obtaining oxygen saturations. This in-service will be complete by June 6, 2019. This in-service was added to the orientation for newly hired licensed nurses on 5/23/19 by the staff facilitator. On 5/23/2019 the staff facilitator and the director of nursing started an in-service with nursing staff (RNs, LPNs, and CNAs) on documentation of bathing, including refusals, and documentation of supplements under the supplement section. This in-service will be complete by June 6, 2019. This in-service was added to the orientation for newly hired nursing staff on 5/23/19 by the staff facilitator. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 10 nurse left the entry blank as an oversight or because the resident refused it. Both the Administrator and ADON stated it was their expectation for medications to be accurately documented on the MAR. A phone call was placed to Nurse #1 on 5/9/19 at 12:45pm. A message was left for a return call that was not received during the survey. 2) Resident #1 was originally admitted to the facility on 3/12/18 with diagnoses that included dementia and benign prostatic hyperplasia (an enlargement of the prostate gland). The most recent Minimum Data Set (MDS) coded as quarterly assessment and dated 3/7/19 revealed the resident had cognitive impairment and required supervision from staff for toileting and personal hygiene, limited assistance with dressing and extensive assistance for bathing. He was noted as being occasionally incontinent of bladder. The Bathing Look Back Reports for 3/18/19 to 4/30/19 were reviewed. Bathing was not consistently documented as provided 5 times for the 7am to 3pm shift (3/25, 4/7, 4/12,4/20,4/29/19) and 21 times for the 3pm to 11pm shift (3/18, 3/21, 3/23, 3/25, 3/26, 3/29, 3/30, 3/31,4/2, 4/4, 4/7, 4/8, 4/10, 4/11, 4/12, 4/13, 4/15, 4/16, 4/20, 4/29 and 4/30/19). The active care plan dated 4/29/19 revealed a care plan in place for Activities of Daily Living/Personal Care. Interventions included physical assistance and verbal cues during bathing.	F 842	The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit 10 medication administration records per week for four weeks and monthly for two months to ensure medication administration is documented as ordered. This audit will be documented on the MAR audit tool. The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit 10 residents weekly for four weeks to ensure documentation in the medical record is accurate and present regarding bathing and supplements as ordered. This audit will be documented on the F842 audit tool. The QAPI committee will review the results of the MAR, and F842 audit tool for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations to the QAPI committee for further recommendations and oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 11	F 842		

A telephone interview was completed with Nurse Aide (NA) #1 on 5/8/19 at 3:35pm. She indicated Resident #1 was scheduled for showers on her shift (3p to 11p) on Wednesday and Saturdays. She stated that often he would refuse at least one scheduled shower a week however she would be able to provide it to him on a different day. NA#1 stated each shift was to document on the Bathing Flow Record if a bath was provided and the type. She further stated that she might not have documented whether a bath was provided or refused for some days.

On 5/9/19 at 9:48am an interview was conducted with the ADON. She stated the NA's were to document on the Bathing Flow Record whether they provided a bath, what type of bath was provided and if not provided the reason. She visualized the blank areas on the Bathing Look Back Report for 3/17/19 to 4/20/19 and added the second shift aides should have documented whether a bath was provided or not. She further stated her expectation was for the flow records to be complete and accurate.

3. Resident #4 was re-admitted to the facility on 3/27/19 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/28/19 indicated that Resident #4 had moderate cognitive impairment and needed supervision with eating. The assessment further indicated that Resident #4's weight was 146 pounds (lbs.)

Resident #4's weight on 3/31/19 was 144 lbs. and on 4/10/19 was 126 lbs., 18 lbs. weight loss in less than 2 weeks.

The dietary note dated 4/1/19 revealed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 12	F 842		

Resident #4 was readmitted with diagnoses of aspiration pneumonia, congestive heart failure and dementia. His diet was puree with nectar thick liquids. Resident #4 disliked puree food and his appetite was extremely poor. Nurse Practitioner (NP) notes indicated that tube feeding needed to be discussed with the family. His weight was currently stable however would likely see weight loss due to poor intake. Recommend tube feeding due to resident was not able to maintain nutrition needs and nutritional supplement twice a day for lunch and dinner.

On 4/2/19, Resident #4 had a doctor's order for nutritional supplement twice a day with lunch and dinner.

On 5/9/19 at 10:50 AM, the Assistant Director of Nursing (ADON) was interviewed. She stated that the Nursing Assistants (NAs) were responsible for documenting the intake of the nutritional supplement on the Therapeutic Supplement form.

The Therapeutic supplement form for April 2019 was reviewed. The nutritional supplement was not consistently documented as provided 15 times for lunch (April 4, 5, 7, 8, 9, 12, 13, 14, 15, 18, 19, 22, 23, 27 and 28) and 10 times for dinner (April 11, 12, 13, 14, 15, 19, 21, 24, 27, and 28).

The Therapeutic Supplement for May 1-9, 2019 was reviewed. The form did not have documentation that the nutritional supplement was provided 4 times for lunch (May 2, 3, 6 and 7).

On 5/9/19 at 11:45 AM, Nurse Aide (NA) #2 was interviewed. She stated that nutritional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 842	Continued From page 13 supplements were documented on the Therapeutic supplement form. NA #2 indicated that she didn't know why the supplement for Resident #4 was not documented consistently. On 5/9/9 at 11:40 AM, the ADON was interviewed. She indicated that she expected the NAs to document the nutritional supplement as ordered including the percentage of intake.	F 842		