SEP 04 2012

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X3) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345212 | A. BUILDING _____ B. WING _____ | 03/15/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BETHESDA HEALTH CARE FACILITY | 3632 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 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) | F 157 | | |

A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications), a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews the facility failed to notify the

1. Resident #92 could of been effected by this deficient practice. The facility will promptly notify the designated legal representative or interested family member and physician of any open area. 8/15/12

2. All residents could of been effected by this deficient practice. The facility will promptly notify the designated legal representative or interested family member and physician of any open skin area. 8/16/12

3.(a) Robin Staling, LPN, wound care nurse in-serviced by Caroline Horne, Administrator and Deborah Spell, RN, DON. to promptly notify the legal representative or interested family member and physician of any open skin areas. 8/27/12

(b) Caroline Horne, Administrator and Deborah Spell, RN, DON in-serviced all CNA's to promptly notify their nurse supervisor and Robin Starling, LPN, wound care nurse of any open skin areas. 8/27/12

(c) Robin Starling, LPN, wound care nurse inserviced by Caroline Horne, Administrator to review new weekly skin assessment book daily to ensure that all new open skin areas are appropriate assessed, documented, treated and that the legal representative interested family member and physician 8/21/12

(continue on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Caroline Horne TITLE: Administrator (X6) DATE: 8/30/12

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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| 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 _____ | 08/15/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BETHESDA HEALTH CARE FACILITY | 3632 DUNN ROAD FAYETTEVILLE, NC 28303 |

| (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 157 Continued From page 1

designated legal representative and physician of an opened skin area that resulted in an unstageable pressure ulcer for 1 of 1 sampled resident (Resident #92).

Findings included:

A review of the facility's protocol for pressure ulcers (undated) read in part "Any area above stage three, notify the MD."

Resident #92 was admitted into the facility on 8/8/12. Cumulative diagnoses included Pressure Ulcer, Cerebrovascular Accident (Hemiplegia), Diabetes and Failure to Thrive. The admission minimum data set was in process of being completed. The admission level of care screening tool (FL2) signed on 8/8/12 indicated Resident #92 mental status was intermittent to person, time, place and was totally dependent with all activities of daily living. The admission skin assessment completed on 8/8/12 identified a decubitus on the sacral and redness. The admission care plan section "pressure sores/skin care" was not completed.

A review of the nurses' note completed on 8/10/12 by Nurse #1 indicated "Small red opening at 3 o'clock in wound edges measuring .5 centimeters (cm) x .5 cm."

A review of the telephone orders for 8/10/12 revealed no specific ordered treatment for the small reddened opened skin area observed at 3 o'clock position by Nurse #1 on 8/10/12.

A review of the nurse's notes dated 8/10/12, 8/11/12, 8/12/12, 8/13/12, 8/14/12 revealed

F 157 (continued)

has been notified propmtly.

(d) Robin Starling, LPN, wound care nurse was in-serviced by Amy Watson, AMT clinical specialist on the importance of wound assessment and documentaton 8/27/12

(e) All nurses have been in-serviced by Amy Watson, AMT clinical specialist on reporting all open areas promptly to wound care nurse Robin Starling, LPN wound care nurse and in-serviced on the importance of notifying the legal representative, or interested family and the physician. 8/27/12

4. (a) All nurses are to assess and document weekly and as needed skin assessments in new weekly skin assessment book that is to be kept at nurses station using new weekly skin assessment sheets as a means of documentation and communication of all new open skin/pressure ulcer areas. 8/31/12

(b) QA nurse LaDean Hair, RN, ADON will ensure that legal representative, or interested family member and physician has been notified promptly by using new Q.A. Pressure ulcer Audit sheet weekly x's 30 days then monthly on an ongoing basis. 8/21/12

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| | 345212 | A. BUILDING _____ B. WING _____ | 08/15/2012 |

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

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|---|---|---|---|---|
| F 157 | Continued From page 2<br>neither the designated legal representative nor the physician had been notified of a small reddened skin opening as documented by Nurse #1 on 8/10/12.<br><br>On 8/15/12 at 9:20 am, Resident #92 was observed when treatment was provided by Nurse #1. A second unstageable pressure ulcer (Pressure ulcer #2) was observed near the sacral area; opened with yellow slough that was not documented as present on admission into the facility. Pressure ulcer #2 was located 1.5 cm when measured by Nurse #1 from the unstageable sacral pressure ulcer (Pressure ulcer #1). Pressure ulcer #2 was not located within pressure ulcer #1, but was a separate unstageable pressure ulcer.<br><br>In an interview on 8/15/12 at 9:30 am, Nurse #1 indicated pressure ulcer #2 was the same reddened opened skin area positioned at 3 o'clock she observed on 8/10/12; that was now an unstageable pressure ulcer.<br><br>In an interview on 8/15/12 at 3:23 pm, the designated legal representative indicated she was notified today by Nurse #1 of a newly developed pressure ulcer on the sacral area.<br><br>In an interview on 8/15/12 at 5:45 pm, the Administrator and Director of Nursing revealed expectation was that the designated legal representative and the physician should have been notified on 8/10/12; after the reddened opened skin area was observed by Nurse #1. | F 157 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES | F 314 | | |

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| | 345212 | A. BUILDING _____ B. WING _____ | 08/15/2012 |

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

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| F 314 | Continued From page 3<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility failed to conduct a thorough assessment for care of an opened skin area that resulted in an unstageable pressure ulcer for 1 of 1 sampled resident (Resident #92).<br><br>Findings included:<br><br>A review of the facility's protocol for pressure ulcers (undated) read in part "It is our goal to keep our residents pressure ulcer free. In the event that a pressure occurs the following things must be done: measure the area, note whether or not the area is open and measure the depth. Note appearance of the area and whether drainage is present. If drainage is present note color, odor, and the amount of drainage. Assess resident for need of pressure relieving devices."<br><br>Resident #92 was admitted into the facility on 8/8/12. Cumulative diagnoses included Pressure Ulcer, Cerebrovascular Accident (Hemiplegia), Diebetes and Failure to Thrive. The admission minimum data set was in process of being completed. The admission level of care screening | F 314 | 1. Resident #92 could of been effected by this deficient practice. The facility will conduct a thorough assessment for care of the pressure ulcer. Deborah Spell, RN, DON and LaDean Hair, RN ADON will follow the protocol for pressure ulcers. Deborah Spell, RN, DON and LaDean Hair, RN,ADON will measure and note whether or not area is open and measure depth. Note appearance of the area and whether drainage is present. If drainage is present note color, odor, and amount of drainage, and assess resident for need of pressure relieving devices.<br><br>2. All residents could have been effected by this deficient practice. Deborah Spell, RN,DON and LaDean Hair, RN,ADON will conduct thorough assessments on all pressure ulcer areas on all the residents following the protocol for pressure ulcers. Deborah Spell,RN,DON and LaDean Hair,RN,ADON will measure and note whether or not area is open and measure the depth. Note appearance of the area and whether drainage is present. If drainage is present note color, odor, and amount of drainage, and assess resident for need of pressure relieving devices. | 8/15/12<br><br>8/16/12 |

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| BETHESDA HEALTH CARE FACILITY | 3532 DUNN ROAD EASTOVER, NC 28301 |

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| F 314 | Continued From page 4 | F 314 | (continued) | |

tool (FL2) signed on 8/8/12 indicated Resident #92 mental status was intermittent to person, time, place and was totally dependent with all activities of daily living. The admission skin assessment completed on 8/8/12 identified a decubitus on the sacral and redness. The admission care plan section "pressure sores/skin care" was not completed.

A review of the nurses' note completed 8/8/12 on admission indicated "Sacral decub noted with some drainage and redness."

A review of the telephone order initiated on 8/9/12 stated "Clean unstegeable wound to sacrum with normal saline. Apply santyl cover and dry dressing, change every day and prn."

A review of the nurses' note completed on 8/10/12 by Nurse #1 indicated "Small red opening at 3 o'clock in wound edges measuring .5 centimeters (cm) x .5 cm." The nurses note further stated that Santyl and calcium alginate remain in use to the sacral wound that measured 7 cm (length) x 6 cm (width).

A review of the telephone orders for 8/10/12 revealed there was no ordered treatment for the small reddened opened skin area observed at 3 o'clock position by Nurse #1 on 8/10/12.

On 8/15/12 at 9:20 am, Resident #92 was observed when treatment was provided by Nurse #1. A second unstageable pressure ulcer (Pressure ulcer #2) was observed near the sacral area; opened with yellow slough that was not documented as present on admission into the facility. Pressure ulcer #2 was located 1.5 cm

3. (a) Amy Watson, AMT clinical specialist 8/27/12 in-serviced all nurses on wound assessment and documentation.

(b) All CNA's have been in-serviced 8/27/12 by Caroline Horne, Administrator and Deborah Spell, RN,DON on proper notification of any new skin areas or concerns to Robin Starling, LPN,wound care nurse promptly. In-serviced on the importance of proper skin care and wound care.

(c) All nurses in-serviced how to do 8/27/12 proper skin assessments and documentation on the new weekly skin assessment forms. Instructed to leave weekly skin assessment book at nurses station at all times as a means of documentation and communication. Instructed to do weekly skin assessments on assigned rooms to be done weekly and as needed with any new skin concerns.

(d) Wound care nurse Robin Starling, 8/27/12 LPN is to check weekly skin assessment book daily. Any new open skin areas are to be assessed and documented on/ taken care of following facility protocol.

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

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F 314 Continued From page 5

when measured by Nurse #1 from the unstageable sacral pressure ulcer (Pressure ulcer #1). Pressure ulcer #2 was not located within pressure ulcer #1 but was a separate unstageable pressure ulcer.

In an interview on 8/15/12 at 9:30 am, Nurse #1 indicated pressure ulcer #2 was the same reddened opened skin area positioned at 3 o'clock she observed on 8/10/12, that was now an unstageable pressure ulcer.

In an interview on 8/15/12 at 1:15 pm, the Assistant Director of Nursing (ADON) stated there should have been a treatment plan initiated for the skin area assessed as opened by Nurse #1 on 8/10/12. The ADON concluded a specific treatment to the skin area would have been an approach to prevent the area from worsening.

In an interview on 8/15/12 at 5:15 pm, Nurse #2 stated she completed the admission head to toe skin assessment and observed one sacral decubitus (pressure ulcer #1) on admission on 8/8/12. She indicated she did not notice any other opened skin areas.

On 8/15/12 at 6:35 pm accompanied by the Director of Nursing, ADON and the Administrator (a registered nurse) pressure ulcer #2 was observed. The ADON measured pressure ulcer #2 at .9 cm (length) x .6 cm (width) x .2 cm (depth) located at 3 o'clock position that revealed an increase in size.

A review of the nurses note entry completed after reassessment by the ADON on 8/15/12 read in part "Small sacral wound at 3 o'clock .9 cm

F 314 (continued)

(e) Wound care nurse Robin Starling, LPN is to properly assess and document all new wounds/pressure ulcers using new weekly wound progress report sheet then weekly on an ongoing basis until healed. 8/27/12

4. LaDean Hair, RN,ADON,QA is to use new QA Pressure Ulcer Audit sheet to ensure new pressure ulcer areas that have been reported are assessed, documented on, and receiving proper treatment by Robin Starling, LPN, wound care nurse. LaDean Hair, RN, ADON, QA is to do this weekly x's 30 days the monthly on an ongoing basis. 8/21/12

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| | 345212 | A. BUILDING _____ B. WING _____ | 08/15/2012 |

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| BETHESDA HEALTH CARE FACILITY | 3532 DUNN ROAD EASTOVER, NC 28301 |

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|---|---|---|---|---|
| F 314 | Continued From page 6<br>(length) x .8 cm (width) x .2 cm (depth) unstageable with yellow slough. Scant amount of bloody drainage in wound bed. No odor present." | F 314 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345212 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 09/27/2012 |

OCT 10 2012

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. These buildings (0102 and 0202) are Type III construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | 1. The facility could have been effected by the 20 minute door to the main soiled linen/trash room. The facility will order and install a one hour fire-rated construction (with 3/4 hour fire-rated door). Door will be self-closing to protect the facility. | ~~10/08/12~~ 11/11/12 |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>By observation on 9/27/12 at approximately 10:00 AM the following hazardous area was non-compliant, specific findings include one of the doors to the main soiled room at the nurses station was a 20 minute door without a closure. | K 029 | 2. All doors in the facility could be effected by this deficient practice. All doors will be checked for proper fire-rating and self-closers to ensure the facility is protected from all hazardous areas.<br><br>3. Caroline Horne, Administrator Inserviced Neil Walker, Maintenance supervisor to make sure all hazardous areas are protected with proper equipement to protect the facility, resident's, staff, and visitors by making sure areas are separated from other spaces by smoke resisting partitions and doors. Doors are self- closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted.<br><br>4. LaDean Hair, RN, QA has checked all hazardous areas/storage rooms to ensure they have the proper equipement (fire-rated and self-closures) to keep the facility safe. | 9/28/12<br><br>9/27/12<br><br>9/28/12 |
| K 072<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free of all obstructions or impediments to full instant | K 072 | | |

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

Caroline Horne, Administrator — 10/10/12

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 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.

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|---|---|---|---|
| | 346212 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 09/27/2012 |

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

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| K 072 | Continued From page 1<br>use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br><br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70(a)<br>By observation on 9/27/12 at approximately 10:00 AM the following obstruction was observed as non-compliant, specific findings include, corridor door to the small storage (across from the FACP room) swings into the corridor without a listed closure and the door does not swing 180 degrees but leaves a projection of approximately 18" into the corridor. NFPA 7.2.1.4.4 states during its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. | K 072 | 1. The facility could have been effected by this deficient practice. The small storage (across from the FACP room) could not swing open at 180 degrees due to a telephone hanging on the wall behind the door and a coke machine. Neil Walker, Maintenance supervisor moved the telephone and coke machine. The door is now able to swing 180 degrees, it does not project more than 7 inches into the required width of the aisle, corridor, passageway, or landing, when fully open.<br><br>2. All doors could have been effected by this deficient practice. All doors will be checked to ensure they have a listed closure or they do not project more than 7 inches into the required width of the aisle, corridor, passageway, or landing, when fully open.<br><br>3. Caroline Horne, Administrator Inserviced Neil Walker, Maintenance supervisor that all door have listed closures or they do not project more than 7 inches into the required width of the aisle, corridor, passageway, or landing, when fully opened. Ensure all doors that do not have closures can open 180 degrees.<br><br>4. LaDean Hair, RN, QA has checked all doors to ensure they swing open 180 degrees or are self-closing with listed closures. That no door projects more than 7 inches into the required width of the aisle, corridor, passageway, or landing, when fully opened. | 10/5/12<br><br>10/10/12<br><br>10/8/12<br><br>10/10/12 |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|
| | 345212 | A. BUILDING 02 - BUILDING 02<br>B. WING _____ | 09/27/2012 |

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

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| K 000 | INITIAL COMMENTS<br><br>There were no Life Safety Code Deficiencies noted at time of survey. | K 000 | | |

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

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