VTENENT OF DEFICIENCIES (01) PROVIDERSUPPLIERCIAN (02) MULTIFIC CONSTRUCTION (02) MULTIFIC CONSTRUCTION			MEDICAID SERVICES			OMB NO. 09		
345146 B. WNG 01/21/2016 AME OF PROVIDER OR BUPFUER STREET ADDRESS.CUT; STATE, ZP DODE 33/26 OLD SALISBURY MOOD BCX 1250 THANY WOODS NURSING AND REHABILITATION CENTER STREET ADDRESS.CUT; STATE, ZP DODE 33/26 OLD SALISBURY MOOD BCX 1250 Auging CACH DEFICIENCY MUST BE PROCEEDED YEAL D PREFIX COOSE REFERENCE TO THE APPROPRIATE COORES TAG COORDINGT OR LOCIDENCIES D PREFIX COORS REFERENCE TO THE APPROPRIATE COORES TAG COMPACTION OR LSC IDENTIFYING INFORMATION) D PREFIX COORES COORES COORS REFERENCE TO THE APPROPRIATE D D F 000 INITIAL COMMENTS F 000 F 000 F 000 F 278 ACCUARCY/COORDINATION/CERTIFIED F 278 Z/18/16 F 278 ACCUARCY/COORDINATION/CERTIFIED F 278 F 278 Z/18/16 Z/18/16 A registered nurse must conduct or coordinate each assessment must accurately reflect the resident's status. F 278 Z/18/16 Z/18/16 A registered nurse must sign and certify tha the assessment is completed. Each individual who willfully and knowingly certifies a material and false statement in a resident assessment, or an			. ,			COMPLETE	IPLETED	
AME: OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRET, 2000E 101 SUMMARY STREMENT OF DEFICIENCIES 3328 OLD SALUSBURY ROAD BOX 1220 102 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, C 2002 103 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, C 2002 104 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, C 2002 105 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, C 2002 106 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, C 2002 107 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, C 2002 106 SUMMARY STREMENT OF DEFICIENCIES PROVIDERS PLANK, CATON SUMLID ALL COMMENTS 107 Complaints were investigated during the unannounced recertification and complaint investigations. Event ID#MFB011. F 200 107 The assessment must accurately reflect the resident's status. F 278 108 A registered nurse must conduct or coordinate each assessment. South Address and Certify the accuracy of that portion of the assessment. 108 Subject to a civil money penalty of not more than status and false statement in a resident assessment is subject to a civil money penalty of not more than status and false statement in a resident assessment is subject to a civil money penalty of not more than status and talse statement. 10<			345146	B. WING		_	016	
Literiany Woods Nursing AND REHABILITATION CENTER ALBEMARLE, NC 28002 (M2) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (ACAD BERICIENC MAST RE PRECEDED BY FULL REGULATION OR LaC DESTIFYING INFORMATION) ID PREFIX TAG IP MOVIDER'S PLAY OF CONFECTION (Each operation of the action of the assessment with the appropriate participation of the assessment is subject to a civil more participation of the assessment with and action of the assessment with and action of the assessment with a disk statement in a resident assessment is subject to a civil more participation of the assessment with a false statement. F 278	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
Provide ALBEMARE, NC 2002 PRECIN CONSERVENT OF LISC DESTRIPTION INFORMATION) ID PRECINATORY CONSECUENCES CONSERVENT OF LISC DESTRIPTION INFORMATION) ID PRECINATORY CONSECUENCES CONSERVENT OF LISC DESTRIPTION INFORMATION) ID PRECINATORY CONSECUENCES CONSERVENT OF LISC DESTRIPTION INFORMATION) ID PRECINATORY CONSERVENT OF LISC DESTRIPTION INFORMATION) ID ID <td< td=""><td>RETHANY</td><td></td><td>REHABILITATION CENTER</td><td>:</td><td>33426 OLD SALISBURY ROAD BOX 12</td><td>50</td><td></td></td<>	RETHANY		REHABILITATION CENTER	:	33426 OLD SALISBURY ROAD BOX 12	50		
Infertion Tag (EACH OBFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR US (DENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION AND/OULD BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 Complaints were investigated during the unannounced recertification and complaint investigation survey of 1/19/16-1/21/16. There were no deficiencies cited as a result of the complaint investigations. Event ID#MFB011. F 278 F 278 483.20(g) - (i) ASSESSMENT F 278 SS=D ACCURACY/COORDINATION/CERTIFIED F 278 The assessment must accurately reflect the resident's status. F 278 A registered nurse must conduct or coordinate each assessment with the appropriate participation of theat professionals. F 278 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment is completed. Each individual who completes a portion of the assessment is aubject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty and howingly causes another individual to certify a material and false statement in a resident assessment. Clinical disagreement does not constitute a material and false statement.			REHADIENTIANON GENTER		ALBEMARLE, NC 28002			
Complaints were investigated during the unannounced recertification and complaint investigation survey of 1/19/16–1/21/16. There were no deficiencies cited as a result of the complaint investigations. Event ID#MFB011. F 278 2/18/16 F 278 483.20(g) - (j) ASSESSMENT F 278 2/18/16 SS=D ACCURACY/COORDINATION/CERTIFIED F 278 2/18/16 The assessment must accurately reflect the resident's status. F 278 2/18/16 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. F 278 2/18/16 Lack individual who completes a portion of the assessment ust sign and certify the accuracy of that portion of the assessment. Luder 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. Clinical disagreement does not constitute a material and false statement.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COM E APPROPRIATE		
unannounced recertification and complaint investigation survey of 1/19/16–1/12/1/6. There were no deficiencies cited as a result of the complaint investigations. Event ID#MFB011. SS=0 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 sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who wilffully and knowingly certifies 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.	F 000	INITIAL COMMENTS	3	F 000				
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 is subject to a civil money penalty of not more than a resident assessment. Clinical disagreement does not constitute a material and false statement and false statement in a resident assessment.		unannounced recertif investigation survey of were no deficiencies complaint investigation 483.20(g) - (j) ASSES	fication and complaint of 1/19/161/21/16. There cited as a result of the ons. Event ID#MFB011. SSMENT	F 278		2/18	3/16	
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 wilfully 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 wilfully 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.	00-0	The assessment must accurately reflect 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.		each assessment wit	h the appropriate					
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.								
 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. 		assessment must sig	n and certify the accuracy of					
material and false statement.		willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a resident assessment penalty of not more th	y certifies a material and esident assessment is ey penalty of not more than essment; or an individual who y causes another individual nd false statement in a is subject to a civil money					
DRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
			SUPPLIER REPRESENTATIVE'S SIGNATUR	2E		(X6)	ATE	

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.

PRINTED: 02/12/2016

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/ FORM APP OMB NO. 093	ROVI
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞY
		345146	B. WING		C 01/21/20	16
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				33426 OLD SALISBURY ROAD BOX	1250	
BETHANY	WOODS NURSING AND	D REHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMI THE APPROPRIATE	(X5) PLETIO DATE
F 278	Continued From page	- 1	Г о-	20		
F 2/0	Continued From page		F 27	^{'8}		
		Γ is not met as evidenced				
	by: Based on observation	on, staff interview and record		F278 Assessment Accura	CV	
		ed to accurately code		Bethany Woods Nursing a	-	
		g on the admission Minimum		Rehabilitation Center ackn		
	-	Eating on the subsequent		receipt of the Statement of	-	
	quarterly MDS for 1 of	of 19 residents (Resident		and proposes this Plan of	Correction to	
	#27). The findings in	ncluded:		the extent that the summar		
				factually correct and in ord		
		mitted on 8/4/15 and had		compliance with applicable		
		including cerebral palsy.		provisions of quality of care The Plan of Correction is s		
	receive anything by r	id a feeding tube and did not		written allegation of compli		
	receive anything by r	noutr.		Woods Nursing and Rehat		
	Review of the Nursin	g Assistant documentation		Center s response to this		
		aily Living Flow Sheet		Deficiencies does not deno		
		during the look back period		with the Statement of Defic	ciencies nor	
	for the Admission ME			does it constitute an admis	-	
		27 was totally dependent in		deficiency is accurate. Fui	-	
		I Hygiene, Dressing, Bed		Woods Nursing and Rehat		
	Mobility, Eating and	lolleting.		reserves the right to refute deficiencies on this Statem	•	
	Review of the Admiss	sion Minimum Data Set		Deficiencies through Inforr		
		revealed the following in the		Resolution, formal appeal		
	area of activities of d			and/or any other administra		
				proceedings		
	Personal Hygiene: se					
		- resident involved in				
	activity, staff provide	weight-bearing support		1. On 2/4/16 resident # 1	-	
	Drooping off			admission assessment wit		
	Dressing: self-perform	nance - resident involved in		and quarterly assessment		
		weight-bearing support		11/5/15 were modified to it ADL coding including perso	-	
	activity, stall provide	weight-bearing support		dressing, bed mobility, eat		
	Bed Mobility: self-per	formance		use. On 2/5/16 the modifie		
	• •	- resident involved in		were transmitted to the Na		
		weight-bearing support		Repository. On 2/5/16 the		
				assessments were accepte		
	Eating: self-performa	nce		National Repository.		

Event ID: MFBO11

Facility ID: 923032

If continuation sheet Page 2 of 6

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED
						С
		345146	B. WING			01/21/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
				33426 OLD SALISBURY ROA	D BOX 1250	
BEIHANT	WOODS NURSING ANL	OREHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 278	Continued From page	- 2	F 27	0		
1 2/0		- resident involved in	F 27		udit will be completed	
		weight-bearing support		by the DON of the las	udit will be completed	
	activity, stall provide	weight-bearing support				
	Tailat usa: calf parfor	manaa		of each resident accu Assessments modifie		
	Toilet use: self-perfor	- resident involved in		3. On 2/8/16 the M		
		weight-bearing support		begin in-servicing 10		
		weight-bearing support		shifts including PRN		
	During interview with	MDS Coordinator #1 and		and all new staff ong		
		on 1/21/16 at 2:00 PM they		correctly documentin		
		or the personal hygiene,		provided to each resi		
	-	y, eating and toilet use		importance of docum		
	activities of daily livin			The in-service will be	-	
	self-performance was	-		2/18/16. On 2/10/16 1	-	
	-	mission MDS, which they		consultant will in-serv		
	said was inaccurately	-		Coordinator and MDS		
	-	the Nursing Assistants		accuracy for ADLs fo	•	
		it was totally dependent.		assessment.		
		rs both indicated they did		4. On 2-10-16 the I		
		mission MDS had been		auditing MDS assess		
		or Resident #27 in these		coding accuracy usin		
		ey revealed that their own		Audit Tool. 25% of co		
		observations of the resident		assessments will be	-	
		d been totally dependent for		weeks, then 25% of c		
		on and throughout his stay in		assessment biweekly	•	
	the facility.	in and throughout his stay in			sessments monthly x	
				3months.		
	Review of the Quarte	rly Minimum Data Set			committee will review	
		revealed Resident #27 was		the results of the ADL		
		y dependent for personal		monthly for 6 months		
		ed mobility, and toilet use but		trends, actions taken		
	as extensive assistar			the need for and/or fr		
		5		continued monitoring		
	Interview with MDS C	Coordinator #1 and MDS		recommendations for		
		21/16 at 2:00 PM revealed		continued compliance		
		27 was on a continuous tube		and/or DON will pres		
		nothing by mouth he should		recommendations of		
		totally dependent for eating.		committee to the qua		
		hey did not know why the		committee for further		
		een inaccurately coded for		and oversight.		

Facility ID: 923032

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	A. BUILDING		
					С
		345146	B. WING		01/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BETHAN	WOODS NURSING AND	REHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI
F 278	Continued From page	e 3	F 278		
	Resident #27 in rega				
F 329 SS=D	-	GIMEN IS FREE FROM	F 329		2/18/16
	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.				
	resident, the facility n who have not used at given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio	ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and ons, unless clinically n effort to discontinue these			
	by: Based on record rev facility failed to discor medication as ordere residents (Resident #	is not met as evidenced iew and staff interviews, the ntinue an anti-psychotic d by the physician for 1 of 5 15) reviewed for tions. The findings included:		Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencie and proposes this Plan of Correction t the extent that the summary of finding factually correct and in order to mainta	o s is

Event ID: MFBO11

Facility ID: 923032

If continuation sheet Page 4 of 6

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/12/20 RM APPROVE IO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING		0,	C 1/21/2016	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
RETHANY	WOODS NURSING AND	D REHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX 1250)		
				ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 329	Continued From page	e 4	F 32	29			
	Continued From page 4 Resident #15 was admitted to the facility on 9/25/15 with multiple diagnoses including psychosis, Alzheimer 's disease, dementia and anxiety. A review of the Physician 's orders revealed an order dated 11/5/15 which stated Risperdal (an anti-psychotic medication) 0.5 milligrams (mg) 1 tablet by mouth (po) every morning for psychosis and dementia. Risperdal 0.25 mg 1 tablet po daily at 2:00 PM for psychosis and dementia. Risperdal 0.5 mg 1 tablet po every night at bedtime for psychosis and dementia. A review of the Physician 's orders revealed an order dated 1/7/16 which stated " discontinue Risperdal. "			compliance with applicable rule provisions of quality of care of The Plan of Correction is subm written allegation of compliance Woods Nursing and Rehabilita Center⊡s response to this Stat Deficiencies does not denote a with the Statement of Deficience does it constitute an admission deficiency is accurate. Further Woods Nursing and Rehabilita reserves the right to refute any deficiencies on this Statement Deficiencies through Informal I Resolution, formal appeal proc and/or any other administrative proceedings	residents. itted as a e. Bethany tion tement of agreement cies nor n that any r, Bethany tion Center of the of Dispute pedure		
	(MAR) dated January 0.5 mg 1 tablet po ev administered on 1/8/ and 1/12/16. Risperd at 2:00 PM was disco 0.5 mg 1 tablet po ev discontinued on 1/7/ An interview was con 1/21/16 at 10:14 AM. administered Risperd Resident #15 on 1/8/ medication was not of An interview was con 1/21/16 at 10:24 AM. #2 signed the physici	cation Administration Record y 2016 revealed Risperdal very morning was initialed as 16, 1/9/16, 1/10/16, 1/11/16 lal 0.25 mg 1 tablet po daily pontinued on 1/7/16. Risperdal very night at bedtime was 16. nducted with Med Aide #1 on . Med Aide #1 stated she dal 0.5 mg at 9:00 AM to '16 and 1/12/16 because the discontinued on the MAR. nducted with Nurse #1 on . Nurse #1 stated that Nurse ian order dated 1/7/16 to al and she was expected to cation on the MAR on		 1.On 1-12-16 resident # 15□s was discontinued. On 1-21-16 physician was notified of reside Risperdal not being discontinue 1/7/2015 as ordered. No new or received. 2.On 2-4-16 a 100% audit was of each residents orders for the days to ensure orders to discontinued accurately by the Assistant Dire Nursing, with no negative findin 3.On 2-2-16 the DON began in 100% of licensed staff including 	the ent # 15⊡s ed on orders completed e past 30 ntinue I from MAR ector of ngs.		
	1/7/16.			all shifts, PRN, weekends, and	•		

Facility ID: 923032

If continuation sheet Page 5 of 6

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) D	NO. 0938-039 NATE SURVEY OMPLETED
		345146	B. WING			C 01/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	WOODS NURSING AND	REHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	An interview was com Nursing on 1/21/16 at nurse that transcribed expected to discontin on the MAR as the or An interview was com 1/21/16 at 11:13 AM. not aware that she ha Risperdal 0.5 mg at 9 stated she was expect 0.5 mg at 9:00 AM, R and Risperdal 0.5 mg Nurse #2 stated she of discontinue the 9:00 A MAR. An interview was com 1/21/16 at 11:35 AM. administer Risperdal 1/9/16, 1/10/16 and 1 was unable to explain the administration of I	ducted with the Director of 10:50 AM. She stated the I the physician 's order was ue all scheduled Risperdal der instructed. ducted with Nurse #2 on Nurse #2 stated she was id not discontinued :00 AM on 1/7/16. Nurse #2 ted to discontinue Risperdal isperdal 0.25 mg at 2:00 PM at 9:00 PM on the MAR. did not know why she did not AM dose of Risperdal on the ducted with Nurse #3 on Nurse #3 stated she did not	F 3	 ongoing on correctly transcribiand to ensure the entire order out including if a medication is discontinued that it needs to b discontinued from MAR correctin-service will be completed 2-4. On 2-4-16 the Assistant Diree Nursing began auditing 100% orders for discontinuing medicaccuracy using the Discontinu Medications Audit Tool. The autompleted by 2-18-16. It will the conducted by the ADON 5x/we weeks then weekly x 8 weeks monthly x 3 months. Any negating will be corrected immer physician will be notified. 5. The monthly QI committee with results of the Discontinued Medications Audit Tool monthly months for identification of treataken, and to determine the net and/or frequency of continued and make recommendations for monitoring for continued comp administrator and/or DON will findings and recommendations monthly QI committee to the q executive QA committee for fur recommendations and oversig 	is carried e tly. This 18-16. ctor of of resident ations for ed udit will be eek x 4 then ative ediately and vill review y for 6 nds, actions eed for monitoring, or liance. The present the s of the uarterly rther	

Facility ID: 923032

If continuation sheet Page 6 of 6