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 01/21/2016

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 000	INITIAL COMMENTS 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 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT 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.	F 278		2/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/05/2016

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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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to accurately code activities of daily living on the admission Minimum Data Set (MDS) and Eating on the subsequent quarterly MDS for 1 of 19 residents (Resident #27). The findings included: Resident #27 was admitted on 8/4/15 and had cumulative diagnosis including cerebral palsy. Resident #27 also had a feeding tube and did not receive anything by mouth. Review of the Nursing Assistant documentation on the Activities of Daily Living Flow Sheet (computerized data) during the look back period for the Admission MDS (8/6/15 - 8/12/15) indicated Resident #27 was totally dependent in the areas of Personal Hygiene, Dressing, Bed Mobility, Eating and Toileting. Review of the Admission Minimum Data Set (MDS) dated 8/12/15 revealed the following in the area of activities of daily living (ADL). Personal Hygiene: self-performance Extensive assistance - resident involved in activity, staff provide weight-bearing support Dressing: self-performance Extensive assistance - resident involved in activity, staff provide weight-bearing support Bed Mobility: self-performance Extensive assistance - resident involved in activity, staff provide weight-bearing support Eating: self-performance	F 278	F278 Assessment Accuracy Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings 1. On 2/4/16 resident # 27 MDS admission assessment with ARD 8/12/15 and quarterly assessment with ARD 11/5/15 were modified to identify accurate ADL coding including personal hygiene, dressing, bed mobility, eating, and toilet use. On 2/5/16 the modified assessments were transmitted to the National Repository. On 2/5/16 the modified assessments were accepted by the National Repository.	

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F 278	Continued From page 2 Extensive assistance - resident involved in activity, staff provide weight-bearing support Toilet use: self-performance Extensive assistance - resident involved in activity, staff provide weight-bearing support During interview with MDS Coordinator #1 and MDS Coordinator #2 on 1/21/16 at 2:00 PM they acknowledged that for the personal hygiene, dressing, bed mobility, eating and toilet use activities of daily living Resident #27 ' s self-performance was coded as extensive assistance, on the Admission MDS, which they said was inaccurately coded given the documentation from the Nursing Assistants indicating the resident was totally dependent. The MDS Coordinators both indicated they did not know why the Admission MDS had been inaccurately coded for Resident #27 in these areas. In addition, they revealed that their own interactions with and observations of the resident confirmed that he had been totally dependent for ADL care at admission and throughout his stay in the facility. Review of the Quarterly Minimum Data Set (MDS) dated 11/5/15 revealed Resident #27 was coded as being totally dependent for personal hygiene, dressing, bed mobility, and toilet use but as extensive assistance for eating. Interview with MDS Coordinator #1 and MDS Coordinator #2 on 1/21/16 at 2:00 PM revealed that since Resident #27 was on a continuous tube feeding and received nothing by mouth he should have been coded as totally dependent for eating. They both indicated they did not know why the Quarterly MDS had been inaccurately coded for	F 278	2. On 2/10/16 an audit will be completed by the DON of the last MDS assessment of each resident accuracy of ADL coding. Assessments modified as necessary. 3. On 2/8/16 the MDS coordinator will begin in-servicing 100% of CNAs on all shifts including PRN and weekend staff and all new staff ongoing related to correctly documenting the ADL assistance provided to each resident and the importance of documenting each shift. The in-service will be completed by 2/18/16. On 2/10/16 the MDS corporate consultant will in-service the MDS Coordinator and MDS nurse on coding accuracy for ADLs for each resident MDS assessment. 4. On 2-10-16 the DON will begin auditing MDS assessments for ADL coding accuracy using the ADL Accuracy Audit Tool. 25% of completed assessments will be audited weekly x 4 weeks, then 25% of completed assessment biweekly x 8 weeks, then 25% of completed assessments monthly x 3months. 5. The monthly QI committee will review the results of the ADL Accuracy Audit Tool monthly for 6 months 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 of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 278	Continued From page 3 Resident #27 in regards to eating.	F 278		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to discontinue an anti-psychotic medication as ordered by the physician for 1 of 5 residents (Resident #15) reviewed for unnecessary medications. The findings included:	F 329	Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain	2/18/16

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F 329	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. " A review of the Medication Administration Record (MAR) dated January 2016 revealed Risperdal 0.5 mg 1 tablet po every morning was initialed as administered on 1/8/16, 1/9/16, 1/10/16, 1/11/16 and 1/12/16. Risperdal 0.25 mg 1 tablet po daily at 2:00 PM was discontinued on 1/7/16. Risperdal 0.5 mg 1 tablet po every night at bedtime was discontinued on 1/7/16. An interview was conducted with Med Aide #1 on 1/21/16 at 10:14 AM. Med Aide #1 stated she administered Risperdal 0.5 mg at 9:00 AM to Resident #15 on 1/8/16 and 1/12/16 because the medication was not discontinued on the MAR. An interview was conducted with Nurse #1 on 1/21/16 at 10:24 AM. Nurse #1 stated that Nurse #2 signed the physician order dated 1/7/16 to discontinue Risperdal and she was expected to discontinue the medication on the MAR on 1/7/16.	F 329	compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings 1.On 1-12-16 resident # 15□s Risperdal was discontinued. On 1-21-16 the physician was notified of resident # 15□s Risperdal not being discontinued on 1/7/2015 as ordered. No new orders received. 2.On 2-4-16 a 100% audit was completed of each residents orders for the past 30 days to ensure orders to discontinue medications were discontinued from MAR accurately by the Assistant Director of Nursing, with no negative findings. 3.On 2-2-16 the DON began in-servicing 100% of licensed staff including all nurses all shifts, PRN, weekends, and new staff	

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F 329	Continued From page 5 An interview was conducted with the Director of Nursing on 1/21/16 at 10:50 AM. She stated the nurse that transcribed the physician ' s order was expected to discontinue all scheduled Risperdal on the MAR as the order instructed. An interview was conducted with Nurse #2 on 1/21/16 at 11:13 AM. Nurse #2 stated she was not aware that she had not discontinued Risperdal 0.5 mg at 9:00 AM on 1/7/16. Nurse #2 stated she was expected to discontinue Risperdal 0.5 mg at 9:00 AM, Risperdal 0.25 mg at 2:00 PM and Risperdal 0.5 mg at 9:00 PM on the MAR. Nurse #2 stated she did not know why she did not discontinue the 9:00 AM dose of Risperdal on the MAR. An interview was conducted with Nurse #3 on 1/21/16 at 11:35 AM. Nurse #3 stated she did not administer Risperdal 0.5 mg at 9:00 AM on 1/9/16, 1/10/16 and 1/11/16 to Resident #15. She was unable to explain why she had documented the administration of Risperdal 0.5 mg at 9:00 AM on 1/9/16, 1/10/16 and 1/11/16 on the MAR.	F 329	ongoing on correctly transcribing an order and to ensure the entire order is carried out including if a medication is discontinued that it needs to be discontinued from MAR correctly. This in-service will be completed 2-18-16. 4.On 2-4-16 the Assistant Director of Nursing began auditing 100% of resident orders for discontinuing medications for accuracy using the Discontinued Medications Audit Tool. The audit will be completed by 2-18-16. It will then be conducted by the ADON 5x/week x 4 weeks then weekly x 8 weeks then monthly x 3 months. Any negative findings will be corrected immediately and physician will be notified. 5.The monthly QI committee will review the results of the Discontinued Medications Audit Tool monthly for 6 months 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 of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	