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 ______	11/02/2017

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 IDR request for F 281. Survey team deleted the deficiency.	F 000		
F 272 SS=D	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 272		12/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 11/10/2017

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 272	Continued From page 1 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to completely assess one of fourteen residents on the Minimum Data Set (MDS) assessment in the area of mood (Resident #70). The findings included: Resident #70 was admitted to the facility 7/1/11. Cumulative diagnoses included other specified mental disorders due to known psychological condition, insomnia, restlessness and agitation, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, anxiety, Alzheimer's disease. A Quarterly Minimum Data Set dated 7/19/17 indicated Resident #70 was severely impaired in cognition. Section D for mood was not comprehensively assessed for Resident #70. D0100 for the resident mood interview indicated "yes". Section D0200 1 A through I was documented as "not assessed". On 11/1/17 at 4:43 PM, an interview was conducted with the Social Worker. She stated	F 272	F272 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	

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F 272	Continued From page 2 Resident #70 was able to answer questions but was asleep when the Social Worker went to interview her. When asked if she had tried to interview Resident #70 more than one time, she stated Resident 70 was asleep the first time and, when she tried to interview her the second time, the social Worker woke the resident up and she was throwing her hands up saying she was the princess. The Social stated she knew she could interview Resident #70 three days prior to the Assessment Reference Date of 7/19/17. On 11/2/17 at 8:38 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be complete and the mood interview should have been done.	F 272	administrative or legal proceeding. The position of Bethany Woods Nursing and Rehabilitation Center regarding the process that led to this deficiency for F272 was that staff failed to follow established facility policy and protocol related to fully assessing resident moods to ensure that a full assessment of each resident is completed. Mood was assessed by the social worker for resident #70 identified in the survey and a detailed social work general care plan note to reflect this assessment was completed by the social worker in the resident chart on 11/10/17. A 100% audit of Section D for all Minimum Data Sets was conducted by the Minimum Data Set RN Coordinator to ensure that mood was assessed for all residents and completed by 11/15/17. One missing assessment was noted by the Minimum Data Set RN Coordinator and this finding resulted in a full assessment completed by the social worker in a detailed social work general care plan progress note on 11/14/17. The Social Work staff was counseled and reeducated by the Administrator and Minimum Data Set RN Coordinator regarding the completion of Section D on the Minimum Data set on 11/13/17. An audit of Section D on the Minimum Data Set will be conducted by the Quality Assurance Nurse, Director of Nursing, Assistant Director of Nursing, and/or	

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F 272	Continued From page 3	F 272	corporate consultant beginning 11/17/17 with 10 residents audited weekly for four weeks, then 10 residents audited monthly for three months. The results of the audits will be taken to the Quality Improvement Committee by the Quality Assurance Nurse. The Quality Improvement Committee will review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual	F 278		12/1/17

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F 278	Continued From page 4 who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately code the Minimum Data Set in the areas of urinary catheter and diagnosis for three of fourteen sampled residents (Resident #139, #79 and #130. The findings included: 1. Resident #139 was admitted to the facility 2/25/16 and readmitted on 6/8/17. Cumulative diagnoses included: osteomyelitis and stage 4 pressure ulcer of the sacral region. An Annual Minimum Data Assessment (MDS) dated 10/10/17 indicated Resident #139 was cognitively intact. Section H for bladder and bowel was reviewed. H0100 for Appliances was documented as "no" for indwelling catheter A review of physician orders for October 2017 revealed an order for an indwelling urinary catheter due to nonhealing buttocks wounds. A review of the October 2017 Medication	F 278	F278 The 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	

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F 278 Continued From page 5

Administration Record revealed documentation for the indwelling catheter care was completed every shift for the entire month of October.

A review of the October Treatment Record revealed documentation that urinary leg strap monitoring was done daily for the month of October 2017.

On 11/1/17 at 4:39 PM, an interview was conducted with MDS Nurse #2 who stated she reviewed the physician orders and treatment nurse documentation when completing section H for urinary catheter. She stated the use of the indwelling catheter should have been noted as "yes" on the MDS.

On 11/02/2017 at 8:39 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS assessments to be accurate.

2 a. Resident #79 was readmitted to the facility on 7/24/17 with multiple diagnoses including Depression. The admission Minimum Data Set (MDS) assessment dated 7/31/17 indicated that Resident #79 had severe cognitive impairment and he had received an antidepressant medication during the last 7 days. The assessment further indicated that Resident #79 did not have a diagnosis of depression.

Resident #79's physician's orders for October 2017 were reviewed. There was an order for Prozac (an antidepressant) 20 milligrams (mgs) by mouth daily.

The Psychiatric Progress notes for Resident #79 were reviewed. The notes dated 7/26/17

F 278

Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

The position of Bethany Woods Nursing and Rehabilitation Center regarding the process that led to this deficiency for F278 was that staff failed to follow established facility policy and protocol related to correctly coding diagnosis and conditions on the Minimum Data Set.

Minimum Data Sets were corrected by the MDS RN Coordinator for Residents 139, 79, and 130 to accurately reflect coding of diagnosis and conditions identified in the survey. The modified assessments were accepted by the National Repository on 11/2/17.

On 11/13/17 The Director of Nursing, Quality Assurance Nurse, Assistant Director of Nursing, and/or the corporate consultant began auditing all in progress and export ready Minimum Data Sets completed for accuracy of diagnosis coding, and urinary catheters. The audit will be completed by 11/20/17. At the present time no additional errors in coding have been identified.

In service education will be given to the Minimum Data Set RN Coordinator and Minimum Data Set Nurse on 11/15/17 by the corporate consultant regarding accurately completing the Minimum Data Set.

On 11/20/17 the Quality Assurance Nurse,

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F 278	Continued From page 6 indicated that Resident #79 was on Prozac 20 mgs daily for Depression. On 11/1/17 at 4:36 PM, MDS Nurse #1 was interviewed. She reviewed the Psychiatric progress notes dated 7/26/17 for Resident #79. MDS Nurse #1 stated that the MDS assessment dated 7/31/17 should have been coded for depression under the diagnoses but it was not. On 11/1/17 at 5:02 PM, MDS Nurse #2 was interviewed. She stated that she completed the MDS assessment dated 7/31/17 for Resident #79. MDS Nurse #2 acknowledged that she have missed to code depression under the diagnoses for Resident #79. On 11/2/17 at 8:42 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be accurate. b. Resident #79 was readmitted to the facility on 7/24/17 with multiple diagnoses including Pulmonary Embolism (PE). The admission Minimum Data Set (MDS) assessment dated 7/31/17 indicated that Resident #79 had severe cognitive impairment and he had received an anticoagulant medication during the last 7 days. The assessment further indicated that Resident #79 did not have a diagnosis of PE. Resident #79's physician's orders for October 2017 were reviewed. There was an order for Coumadin 5 mgs by mouth daily. The doctor's Progress notes for Resident #79 were reviewed. The notes dated 7/3/17 indicated that Resident #79 was on Coumadin for history of	F 278	Director of Nursing, Assistant Director of Nursing, and/or corporate consultant will being auditing the Minimum Data Sets for correct active diagnosis coding and coding of urinary catheters using the Accuracy Audit Tool. 25% of completed assessments will be audited weekly for four weeks followed by a 25% audit of completed assessments monthly for three months. The results of the audit will be taken to the Quality Improvement Committee by the Quality Assurance Nurse. The Quality Improvement Committee will review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	

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F 278	Continued From page 7 PE. On 11/1/17 at 4:36 PM, MDS Nurse #1 was interviewed. She reviewed the doctor's progress notes dated 7/3/17 for Resident #79. MDS Nurse #1 stated that the MDS assessment dated 7/31/17 should have been coded for PE under the diagnoses but it was not. On 11/1/17 at 5:02 PM, MDS Nurse #2 was interviewed. She stated that she completed the MDS assessment dated 7/31/17 for Resident #79. MDS Nurse #2 acknowledged that she have missed to code PE under the diagnoses for Resident #79. On 11/2/17 at 8:42 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be accurate. 3. Resident #130 was admitted to the facility on 4/26/17 with multiple diagnoses that included depression. A physician ' s order dated 4/26/17 indicated Remeron (antidepressant) 15 milligrams (mg) once daily for Resident #130. A Mental Health Nurse Practitioner (MHNP) note dated 9/6/17 indicated Resident #130 continued on Remeron 15 mg once daily for appetite, depression, and insomnia. The quarterly Minimum Data Set (MDS) assessment dated 9/8/17 indicated Resident #130 ' s cognition was severely impaired. She was administered antidepressant medication on 7 of 7 days during the MDS review period. Section I, the Active Diagnoses Section, had not included depression as an active diagnosis.	F 278		

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F 278	Continued From page 8 An interview was conducted with MDS Nurse #1 on 11/1/17 at 4:30 PM. Section I of the 9/8/17 MDS for Resident #130 that had not indicated depression as an active diagnosis was reviewed with MDS Nurse #1. MDS Nurse #1 confirmed she completed this section of Resident #130 ' s 9/8/17 MDS. The MHNP note dated 9/6/17 that indicated Resident #130 received Remeron once daily for appetite, depression, and insomnia was reviewed with MDS Nurse #1. She revealed this was an error. MDS Nurse #1 indicated depression should have been coded as an active diagnosis on Resident #130 ' s 9/8/17 MDS assessment. An interview was conducted with the Director of Nursing on 11/2/17 at 8:37 AM. She indicated her expectation was for the MDS to be coded accurately.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279		12/1/17

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F 279	Continued From page 9	F 279		

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.

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F 279	Continued From page 10 (C) Discharge plans in the comprehensive care 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 staff interviews and record review, the facility failed to develop a Preadmission Screen and Resident Review (PASRR) level II care plan for 1 of (Resident #60) 1 residents reviewed for PASRR level II. The Findings included: Resident #60 was admitted on 08/27/14 with cumulative diagnoses of epilepsy, Parkinson's Disease, depression, anxiety and psychosis. The annual Minimum Data Set (MDS) dated 04/1717 indicated Resident #60 was cognitively intact. She was assessed as PASSR level II for other related conditions. Resident #60 indicated she had trouble sleep and felt tired 7 to 11 days of the 14 day MDS review period. She was assessed with no behaviors and no rejection of care. Resident #60 received antidepressant medication on 7 of 7 days during the MDS review period. An MDS Care Area Assessment (CAA) related to psychotropic medication for the 04/17/17 indicated she received antidepressant medication daily. In an interview on 10/31/17 at 5:20 PM, Social Worker (SW) #2 stated verified Resident #60's PASRR level II with no expiration date and only needed reassessment for a significant change in her condition. SW #2 stated Resident #60 was at her baseline. A review of Resident #60's care plan, most	F 279	F279 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 proceeding The position of Bethany Woods Nursing and Rehabilitation Center regarding the process that led to this deficiency for F279 was that staff failed to follow established facility policy and protocol related to developing comprehensive care plans.	

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F 279	Continued From page 11 recently revised on 10/26/17, revealed no identification or incorporation of her PASRR level II determination. In an interview on 11/01/17 at 4:30 PM, the MDS Nurse #1 stated it was her responsibility to ensure Resident #60 had a care plan for her PASRR level II status. She stated she had been the MDS Nurse for the facility for three months and she was in the process of updating the PASRR level II resident care plan and Resident #60's had not yet been updated to reflect her PASRR level II status. In an interview on 11/02/17 at 8:30 AM, the Director of Nursing stated it was her expectation that the care plan be comprehensive, accurate and followed. She stated the MDS nurses were ultimately responsible for initiating and revising the care plans.	F 279	The care plan for resident #60 was updated by the Minimum Data Set RN Coordinator on 11/1/17 to reflect the Level 2 PASRR. Care Plans for all residents with Level 2 PASRR were reviewed by the Minimum Data Set RN Coordinator and found to be in need of the reflection of the Level 2 PASRR. The Minimum Data Set RN Coordinator updated the care plans to reflect the Level 2 PASRR status. This was completed by 11/3/17. Minimum Data Set nurses and Social Workers were made aware by the administrator on 11/2/17 of the need to include Level 2 PASRR□s on the resident care plans. Any newly hired Minimum Data Set nurses or social work staff will also be educated regarding this process during their departmental orientation by their respective department heads. The Care Plans for those newly admitted residents with a Level two PASRR will be reviewed within 21 days of admission by the Minimum Data Set RN Coordinator to ensure that the PASRR level 2 is on the care plan. Care Plans for residents with a level two PASRR will be audited monthly times four months by the Quality Assurance Nurse, Director of Nursing, Assistant Director of Nursing, and/or the corporate consultant beginning 11/20/17. Results of the audits will be taken to the Quality Improvement Committee by the Quality Assurance Nurse. The Quality Improvement Committee will	

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F 279	Continued From page 12	F 279	review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to implement the plan of care interventions related to falls for 1 of 1 resident reviewed for accidents (Resident #165). The findings included: Resident #165 was admitted to the facility on 9/23/16 and most recently readmitted on 8/10/17 with diagnoses that included non-traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), dementia, anxiety disorder, insomnia, psychosis, and mood disorder. The significant change Minimum Data Set (MDS) assessment dated 8/17/17 indicated Resident	F 282	F282 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.	12/1/17

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Continued From page 13

#165 ' s cognition was severely impaired. She was assessed with no behaviors and no rejection of care.

The Care Area Assessment (CAA) related to falls for the 8/17/17 MDS assessment indicated Resident #165 had been readmitted to the facility after a fall that resulted in hospitalization. Resident #165 was noted to be at risk for falls and was to be care planned to minimize her risks.

The plan of care for Resident #165 included the focus area of risk for falls related to impaired cognition. Resident #165 was noted to have had several falls with one fall on 8/8/17 resulting in major injury and hospitalization. The interventions included a fall mat on the floor when in bed. This intervention was initiated on 10/5/17.

An observation was conducted of Resident #165 on 11/1/17 at 7:57 AM. She was in bed in her room. Resident #165 was alert, but was not interviewable. Resident #165 had no fall mat on the floor beside her bed. The fall mat was observed in Resident #165 ' s bathroom.

An interview was conducted with Nursing Assistant (NA) #1 on 11/1/17 at 8:00 AM. She stated she normally worked on the first shift (7:00 AM to 3:00 PM) and Resident #165 was regularly assigned to her. She indicated Resident #165 was a fall risk and she had a fall with major injury a couple months ago. She reported the fall risk interventions included a low bed and a fall mat. NA #1 was asked if a fall mat was supposed to be next to Resident #165 ' s bed at all times. She indicated the fall mat was to be next to the bed anytime Resident #165 was in her bed. NA #1 was asked if a fall mat was next to Resident #165

F 282

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 proceeding.

The position of Bethany Woods Nursing and Rehabilitation regarding the process that led to this deficiency for F282 was that staff failed to follow established facility policy and protocol related to the failure to implement interventions noted in the resident care plan.

The fall mat for resident 165 was placed by the bed by the certified nursing assistant and nurse on the hall to ensure that care plan interventions were being carried out following the observation by the surveyor on 11/1/17.

All residents with fall mats identified as an intervention in the resident care plan were reviewed by the licensed nurses on each resident's hall through visual observation on 11/2/17 to ensure that fall mats were in place as identified in their care plan.
100 % of the nursing staff will receive in-service education regarding the following of care plan interventions, particularly those related to falls. This education was conducted by the Staff Facilitator and/or DON beginning 11/14/17 and completed by 12/1/17.

Using the Following Care Plan

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F 282	Continued From page 14 ' s bed at that present time. She stated she was not sure. An observation was conducted with NA #1 of Resident #165 on 11/1/17 at 8:03 AM. Resident #165 was in bed in her room and no fall mat was located next to the bed. The fall mat was observed in Resident #165 ' s bathroom. NA #1 stated the intervention for the fall mat may have been changed for Resident #165. She then stated the fall mat may have been moved when the breakfast tray was brought in that morning. An interview was conducted with the Director of Nursing (DON) on 11/1/17 at 9:14 AM. She stated she expected the plan of care interventions to be implemented.	F 282	Interventions Audit tool, a random audit of 10% of the care plans will be conducted bi-monthly for three months by the DON, ADON, Quality Assurance nurse and/or the facility consultant to ensure that care plan interventions are being followed particularly in the area of falls with completion by December 1, 2017. This will include visual observation of fall mats in particular prior to completion of the audit tool. The results of the audits will be taken to the Quality Improvement Committee by the Quality Assurance Nurse. The Quality Improvement Committee will review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		12/1/17

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F 323	Continued From page 15 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to implement the fall risk interventions for a resident at high risk for falls for 1 of 1 resident reviewed for accidents (Resident #165). The findings included: Resident #165 was admitted to the facility on 9/23/16 and most recently readmitted on 8/10/17 with diagnoses that included non-traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), dementia, anxiety disorder, insomnia, psychosis, and mood disorder. A review of Resident #165 ' s medical record for from 5/1/17 through 10/30/17 revealed she had one fall on 6/17/17 with no injury and one fall on 8/7/17 that resulted in a head injury and hospitalization. A fall risk evaluation dated 8/11/17 indicated	F 323	F323 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	

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F 323 Continued From page 16

Resident #165 was at high risk for falls.

The significant change Minimum Data Set (MDS) assessment dated 8/17/17 indicated Resident #165 ' s cognition was severely impaired. She was assessed with no behaviors and no rejection of care. Resident #165 required the extensive assistance of one staff with transfers, dressing, toileting, and personal hygiene. She required the limited assistance of 1 staff with walking in room/corridor and locomotion on/off the unit. Resident #165 was not steady on her feet, but she was able to stabilize without staff assistance.

The Care Area Assessment (CAA) related to falls for the 8/17/17 MDS assessment indicated Resident #165 had been readmitted to the facility after a fall that resulted in hospitalization. Resident #165 was noted to be at risk for falls and was to be care planned to minimize her risks.

The Resident Care Guide, a care guide for Nursing Assistant (NA) interventions, included an intervention added on 8/23/17 for a mat on the floor beside of the bed.

The plan of care for Resident #165 included the focus area of risk for falls related to impaired cognition. Resident #165 was noted to have had several falls with one fall on 8/8/17 resulting in major injury and hospitalization. The interventions included a fall mat on the floor when in bed. This intervention was initiated on 10/5/17.

An observation was conducted of Resident #165 on 11/1/17 at 7:57 AM. She was in bed in her room. Resident #165 was alert, but was not interviewable. Resident #165 had no fall mat on the floor beside her bed. The fall mat was

F 323

administrative or legal proceeding.

The position of Bethany Woods Nursing and Rehabilitation regarding the process that led to this deficiency for F323 was that staff failed to follow established facility policy and protocol related to implementing interventions to keep residents free from accidents/hazards.

The fall mat for resident #165 was placed by the bed by the certified nursing assistant and nurse on the hall following the observation by the surveyor on 11/1/17.

All residents with fall mats as an intervention for falls were visually observed by the hall nurses for each resident on 11/2/17 to ensure that fall mats were in place as directed on the care plan and care guides.

A checklist tool was developed by the Director of Nursing 11/15/17 for licensed nursing staff to visually observe and initial that fall mats are being placed by the bed as directed. The sheets will be kept on the medication cart so that nurses can observe and initial as they are completing their medication passes. Random visual observations for fall mats will be conducted by DON, ADON, QA nurse and/or the corporate consultant daily as they make rounds. Any fall mats that are not in place will be put into place as noted. 100% of all nursing staff received in-service education from the Staff

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F 323	Continued From page 17 observed in Resident #165 ' s bathroom. An interview was conducted with Nursing Assistant (NA) #1 on 11/1/17 at 8:00 AM. She stated she normally worked on the first shift (7:00 AM to 3:00 PM) and Resident #165 was regularly assigned to her. She indicated Resident #165 was a fall risk and she had a fall with major injury a couple months ago. She reported the fall risk interventions included a low bed and a fall mat. NA #1 was asked if a fall mat was supposed to be next to Resident #165 ' s bed at all times. She indicated the fall mat was to be next to the bed anytime Resident #165 was in her bed. NA #1 was asked if a fall mat was next to Resident #165 ' s bed at that present time. She stated she was not sure. An observation was conducted with NA #1 of Resident #165 on 11/1/17 at 8:03 AM. Resident #165 was in bed in her room and no fall mat was located next to the bed. The fall mat was observed in Resident #165 ' s bathroom. NA #1 stated the intervention for the fall mat may have been changed for Resident #165. She then stated the fall mat may have been moved when the breakfast tray was brought in that morning. NA #1 indicated the interventions that were supposed to be in place were on the Resident Care Guide. An interview was conducted with the Director of Nursing (DON) on 11/1/17 at 9:14 AM. She stated she expected the fall risk interventions to be implemented.	F 323	Facilitator, Quality Assurance Nurse, and/or the Director of Nursing regarding the new monitoring tool and the importance of maintaining resident safety by using the identified care interventions particularly fall mats. This education will be completed by 12/1/17. Fall mat placement checklists will be audited daily by the Quality Assurance Nurse, Assistant Director of Nursing, Director of Nursing, and/or Corporate Consultant for two weeks for those residents identified as needing fall mats to minimize risks. Following this review, fall mats checklists will be audited every two weeks for four weeks, then monthly for three months. The results of the audits will be taken to the Quality Improvement Committee by the Quality Assurance Nurse. The Quality Improvement Committee will review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2)	F 329		12/1/17

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483.45(d) Unnecessary Drugs-General.
Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

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F 329	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review, Mental Health Nurse Practitioner interview, and staff interview, the facility failed to obtain a Depakote (mood stabilizer) level as ordered by the physician for 1 (Resident #165) of 5 residents reviewed. The findings included: Resident #165 was admitted to the facility on 9/23/16 and most recently readmitted on 8/10/17 with diagnoses that included psychosis and mood disorder. The significant change Minimum Data Set (MDS) assessment dated 8/17/17 indicated Resident #165 ' s cognition was severely impaired. A physician ' s order from the Mental Health Nurse Practitioner (MHNP) dated 9/12/17 indicated an increase to Resident #165 ' s Depakote to 375 milligrams (mg) twice daily. The order also indicated a laboratory test was to be completed in 10 days for a Depakote level for Resident #165. Resident #165's hard copy and electronic medical records were reviewed and there was no Depakote level result related to the physician ' s order dated 9/12/17. An interview was conducted with the Director of Nursing (DON) on 10/31/17 at 5:20 PM. She stated she had reviewed the medical record of Resident #165 and she had contacted the laboratory provider. She revealed the 9/12/17 order for a Depakote level in 10 days for Resident #165 had not been completed. She reported she	F 329	F329 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 proceeding. The position of Bethany Woods Nursing and Rehabilitation regarding the process that led to this deficiency for F329 was that staff failed to follow established facility policy and protocol related to keeping residents free from unnecessary drugs. The laboratory test for Depakote levels as ordered by the nurse practitioner was conducted for resident #165 on 11/1/17	

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F 329	Continued From page 20 had contacted the MHNP and informed her the 9/12/17 order for a Depakote level in 10 days for Residnet #165 had not been completed. The DON indicated the MHNP asked to have the Depakote level completed the following morning (11/1/17). This interview with the DON continued. She explained the 9/12/17 physician ' s order for Resident #165 had been recorded by Nurse #2. She stated Nurse #2 had followed through with the Depakote dosage change related to the 9/12/17 physician ' s order for Resident #165, but the laboratory test for the Depakote level had been missed. She reported her expectation was physician ' s orders for laboratory tests to be completed as ordered. A phone interview was conducted with the MHNP on 11/1/17 at 3:15 PM. She stated she had been informed by the DON on 10/31/17 that her order dated 9/12/17 for a Depakote level in 10 days for Resident #165 had not been completed. She reported she instructed the DON to have a Depakote level completed on the following morning (11/1/17). The MHNP indicated she ordered a Depakote level anytime she made a change to that medication. She stated her expectation was for laboratory tests to be completed as ordered.	F 329	with results received 11/2/17 indicating levels were within normal limits. A 100% audit was conducted by the Quality Assurance Nurse and completed by 11/15/17 of all residents receiving Depakote to ensure that any laboratory orders related to Depakote levels were completed as ordered and no adverse findings were discovered. There were no incomplete lab orders for those residents receiving Depakote. While nurses are aware that all lab orders are to be followed, the focus of this audit was those residents receiving Depakote. 100% of all licensed nursing staff received in-service education from the Director of Nursing regarding following orders related to laboratory tests beginning 11/20/17 with completion by 12/1/17. The Quality Assurance Nurse, Director of Nursing, Assistant Director of Nursing, and/or the Corporate Consultant will do a focused laboratory test audit monthly for three months for all residents on Depakote to ensure that any orders for laboratory tests for those residents are carried out appropriately. While nurses have been educated on the importance of following all laboratory testing orders, this audit will be focused on orders for those residents receiving Depakote. Other laboratory tests will not be a part of this audit. The results of the audits will be taken to the Quality Improvement Committee by the Quality Assurance Nurse.	

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F 329	Continued From page 21	F 329	The Quality Improvement Committee will review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 520		12/1/17

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

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F 520	Continued From page 22 (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 12/01/16. This was for six deficiencies which was recited during the recertification survey of 11/02/17 in Resident Assessment at F272, F278, F279, F281 and F282. The second recited area was in Quality of Care and Treatment at F323. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F272- Based on record review and staff interviews, the facility failed to completely assess one of fourteen residents on the Minimum Data Set (MDS) assessment in mood (Resident #70). F278-Based on medical record review and staff	F 520	F520 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 proceeding.	

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F 520	Continued From page 23 interviews, the facility failed to accurately code the Minimum Data Set in the areas of urinary catheter and diagnosis for three of fourteen sampled residents (Resident #139, #79 and #130. F279-Based on staff interviews and record review, the facility failed to develop a Preadmission Screen and Resident Review (PASRR) level II care plan for 1 of (Resident #60) 1 residents reviewed for PASRR level II. F281-Based on record review, observation and staff interview, the facility failed to date the dressing after the dressing change for 1 of 1 sampled resident observed for pressure ulcer (Resident #39). F282-Based on record review, observation, and staff interview, the facility failed to implement the plan of care interventions related to falls for 1 of 1 resident reviewed for accidents (Resident #165). F323-Based on record review, observation, and staff interview, the facility failed to implement the fall risk interventions for a resident at high risk for falls for 1 of 1 resident reviewed for accidents (Resident #165). In an interview on 11/02/17 at 9:00 AM, the Administrator and the Quality Assurance nurse acknowledged understanding of the reciting of F272, F278, F279, F281, F282 and F323 during the recertification survey of 11/02/17. The Administrator stated since the last recertification survey of 12/01/16, the facility had hired a full time Quality Assurance nurse and a new	F 520	The position of Bethany Woods Nursing and Rehabilitation regarding the process that led to this deficiency for F520 was that staff failed to follow established facility policy and protocol related to sustaining an effective quality assurance program. On November 15, 2017 the facility Quality Improvement Committee held a meeting. The Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Minimum Data Assessment Nurses, Maintenance Supervisor, Housekeeping Supervisor, and Social Worker will attend QI Committee Meetings on an ongoing basis and the administrator will assign additional team members to attend as appropriate. On November 6, 2017 the Facility Consultant in-serviced the Facility Administrator, Director of Nursing, Minimum Data Set Nurses, Treatment Nurse, Social Worker, Assistant Director of Nursing, Maintenance Supervisor, and Housekeeping Supervisor related to the appropriate functioning of the Quality Improvement Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F272, F278, F279, F281, F323, and F282 Assessments. As of November 7, 2017, after the Facility Consultant in-service, the	

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F 520	Continued From page 24 Minimum Data Set (MDS) nurse. She stated both the new MDS nurse and Quality Assurance nurse had been in their respective roles for about three months. The Administrator stated she felt the repeat citations were related to the recent changes in the MDS staff and the facility was still in the process of correcting the identified concerns	F 520	facility Quality Improvement Committee will begin identifying other areas of quality concern through the Quality Improvement review process. For example the committee may review falls and incidents trends, review readmission trends, review MDS and care plan accuracy, and review any facility consultant concerns. The Facility Quality Improvement Committee will meet monthly and/or at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F 278, F272, F279, F281, F282, and F323. These corrective actions will be reviewed in these Quality Improvement Committee meetings. The Committee will continue to meet monthly and/or at a minimum of quarterly. The Quality Improvement Committee, including the Medical Director, will review monthly compiled Quality Improvement report information, review trends, and review corrective actions taken with the completion dates. The Quality Improvement Committee will validate the facility□s continued progress in correction of deficient practices or identified concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. The Administrator will review any ongoing	

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F 520	Continued From page 25	F 520	concerns with the Facility Consultant and/or the Regional Vice President. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	
F 526 SS=D	Hospice CFR(s): 483.70(o)(1)-(4) (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 526		12/1/17

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F 526	Continued From page 26 the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the	F 526		

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determination to change the level of services provided.

(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice

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F 526	Continued From page 28 administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners	F 526		

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F 526	Continued From page 29 participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a	F 526		

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Continued From page 30

description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20.
This REQUIREMENT is not met as evidenced by:
Based on staff and hospice interviews and record review, the facility failed to maintain updated hospice documentation in the medical record for 1 (Resident #32) of 1 reviewed for hospice services. The findings included:

Resident #32 was admitted 08/18/16 with cumulative diagnoses of coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease and diabetes.

Resident #32 had a significant change Minimum Data Set (MDS) dated 08/16/17. The MDS indicated Resident #32 had severe cognitive impairment, no behaviors and was total care for her activities of daily living (ADLs). She was coded for a life expectancy of 6 months or less and hospice services.

The care plan last revised 09/15/17 read Resident #32 had a terminal prognosis and started hospice services in August 2017.

A review of the initial hospice comprehensive assessment and hospice plan of care dated 08/15/17 read the hospice nurse was to see Resident #32 once every week.

A review of the electronic medical record and hard copy medical record indicated the hospice nurse visited Resident #32 on 08/15/17, 09/06/17, 10/11/17 and 10/18/17.

F 526

F526

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 proceeding.

The position of Bethany Woods Nursing and Rehabilitation regarding the process that led to this deficiency for F526 was that staff failed to follow established facility policy and protocol related to failing to maintain updated hospice

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F 526	Continued From page 31 In an interview on 10/31/17at 3:00 PM, the Medical Records Clerk stated all the hospice nursing notes for Resident #32 had been scanned into the electronic medical record and there was no evidence of hospice nursing notes for the weeks ending 08/25/17, 09/01/17, 09/15/17, 09/22/17, 09/29/17,10/06/17,10/20/17 and 10/27/17. In an interview on 10/31/17 at 3:20 PM, the Administrator stated the Director of Nursing (DON) was the hospice point of contact for the facility. The DON stated the hospice nurse was in the facility several times weekly and communicated with her about Resident #32 but she was not aware that the weekly hospice nurse visit notes were not readily available in Resident #32's medical record. The DON stated it was her expectation that the hospice documentation be in Resident #32's medical record. In another interview on 10/31/17 at 4:10 PM, the Administrator provided copies of hospice nursing notes dated 08/23/17, 08/30/17, 09/12/17, 09/20/17, 09/27/17 and 10/04/17. All notes indicated they were faxed to the facility on 10/31/17 at 3:34 PM. The Administrator stated it was her expectation that hospice documentation be in Resident #32' medical record. In an interview on 11/01/17 at 10:00 AM, the hospice nurse stated her agency was having difficulty with their electronic medical records. She stated she sent her notes electronically to the facility but apparently, the notes were not actually being transmitted. She stated she was not aware that her documentation was missing on Resident #32.	F 526	documentation in the medical record. All progress notes for resident #32 were received by the Medical Records Director from hospice and placed in the resident□s medical record on 11/3/17. Medical records for all residents currently receiving hospice services were reviewed by the Medical Records Director and progress notes for all visits not in the record were received from the Hospice Medical Records Director 11/3/17. All hospice progress notes were present and in the chart 11/3/17. Beginning 11/13/17 the Medical Records Supervisor will receive a list of all hospice visits provided for the previous week from the hospice provider. The medical records director will then review the list to ensure that documentation is in the medical record for each visit. The medical records director was in-serviced by the Administrator on this procedure on 11/10/17. All hospice visits will be audited to ensure that they are available on the medical record the Quality Assurance Nurse, DON, ADON, and/or the facility consultant weekly beginning 11/20/17 for four weeks using the list of hospice visits provided to the Medical Records supervisor, followed by a monthly audit for three months. The results of the audits will be taken to the Quality Improvement Committee by the Quality Assurance Nurse. The Quality Improvement Committee will	

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F 526	Continued From page 32 At the time of survey exit on 11/2/17, the facility had not provided a hospice nursing note for the week ending 10/27/17.	F 526	review the results of the audits monthly times 3 months with recommendations and follow up as needed to ensure continued compliance in this area and to determine the need for any further QI monitoring.	