DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				PLETED
		345146	B. WING				C 18/2013
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		10,2010
RETHANY		REHABILITATION CENTER		334	426 OLD SALISBURY ROAD BOX 1250		
DEMAN	WOODS NONSING AND			AL	BEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIF (INJURY/DECLINE/R A facility must immed consult with the resid known, notify the resi or an interested famil accident involving the injury and has the poi intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treatr consequences, or to o treatment); or a decis the resident from the §483.12(a). The facility must also and, if known, the resi or interested family m change in room or roo specified in §483.15( resident rights under regulations as specifi this section.	Y OF CHANGES COOM, ETC) iately inform the resident; ent's physician; and if dent's legal representative y member when there is an e resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a h, mental, or psychosocial reatening conditions or ); a need to alter treatment eed to discontinue an nent due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative nember when there is a pommate assignment as		157			1/15/14
	the address and phor	ne number of the resident's or interested family member.					
	by:	is not met as evidenced			Bethany Woods Nursing and		
	interviews, the facility	failed to notify the physician (Resident #1) receiving			Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	3	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 

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.

01/15/2014

PRINTED: 03/19/2014

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0 (X3) DATE SUI		
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLET		
					С	С	
		345146	B. WING		12/18/	2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		33426 OLD SALISBURY ROAD B	OX 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 (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE COTHE APPROPRIATE	(X5) COMPLETIO DATE	
F 157	Continued From page	<b>-</b> 1	F 15	57			
		and/or on thickened liquids,		and proposes this Plan	of Correction to		
		e vomiting, after consuming		the extent that the sum			
		ture diet and thinned liquids.		factually correct and in c			
				compliance with applica			
	The findings included	1:		provisions of quality of c	are of residents.		
				The Plan of Correction is			
		nitted to the facility on		written allegation of com	pliance.		
		wing diagnoses: traumatic					
		ia, gastrostomy tube and a failure post tracheotomy.		Bethany Woods Nursing Rehabilitation Center's r			
		ium Data Set (MDS) dated		Statement of Deficiencie			
	10/15/13, determined			denote agreement with t			
	cognitive impairments			Deficiencies nor does it			
	assistance with eating			admission that any defic	iency is accurate.		
	mechanically altered	diet and had no swallowing		Further, Bethany Woods	Nursing and		
	problem.			Rehabilitation Center res	<u> </u>		
				refute any of the deficier			
		conducted of Resident #1's		Statement of Deficiencie			
	medical chart. It indic	scribed on 10/8/13, stated		Informal Dispute Resolu appeal procedure and/o			
	-	a pureed with nectar thick		administrative or legal p	-		
		ceive a bolus feeding at 8			locecurig.		
	-	, only if she didn't eat 50% of					
		ostomy tube would be		F157			
	flushed with 60 cc (cu	ubic centimeter) before and					
	after feedings.			Criteria 1:			
				On 11/25/13 the assigned			
		eloped on 10/18/13 to		resident # 1 for a change	e in condition.		
		strostomy) feeding, required aining nutritional status		On 11/25/13 the assigne	ad nurse		
		ght loss related to cognitive		contacted Resident # 1's			
		(difficulty with swallowing).		(MD) for an order and R			
		esident #1 would receive		Responsible Party (RP)			
		and fluid intake as evidenced		resident being sent out			
		no signs or symptoms of		Medical Services (EMS)	due to change in		
	-	dration through the next		condition.			
		included: tube feed formula					
		ordered by the physician;		Criteria 2:	started on		
	maintain g-tube for fe	eding purposes; monitor for		A 100 percent audit was	started on		

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If continuation sheet Page 2 of 14

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/19/20 FORM APPROVI OMB NO. 0938-03	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING	C 12/18/2013		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				33426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	D REHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 157	(shortness of breath) intolerance-nausea, winfection or irritation the Another care plan was address nourishment requirement character inadequate intake, de cognitive impairment included that the tota resident's nutritional is stable weight, increas documented improve review. Interventions thickened liquids as of observe for signs and choking during meals On 11/23/13, the 24 ft that Resident #1 didr (3-11 pm) and had 1 On 12/15/13 at 3:15 ft Nurse Aide #1 (NA#1 #1 on 11/23/13 during she stated that Resid herself breakfast that her meal and she ater	of tube feeding ample aspiration, dyspnea or fever, formula vomitting or diarreha; o stoma site. As developed on 10/18/13 to a related to less than body erized by weight loss, ecreased appetite related to a, and pressure area. Goals I intake would meet the needs as evidenced by sed food intake and ement in wounds thru next listed were: diet and ordered; monitor and d symptoms of gagging or a and report to unit nurse.	F 15		et toted RP ents ation on ints, tor of hurse, or on b tor of a d there f a	
	<ul> <li>day, who brought her in regular soda to drink, although she remained on a nectar thickened diet. During her shift, she did not see her experience vomitting.</li> <li>Nurse #1 was interviewed by phone on 12/16/13 at 5:25 pm. She shared that she worked with Resident #1, every other weekend and that she received a bolus feeding if she ate less than 50%</li> </ul>			<ul> <li>any changes in resident condition. S were educated to notify the assigne nurse of changes in resident conditi</li> <li>Criteria 3:</li> <li>On 12/17/13, the Staff Facilitator ini in-servicing for all nurses that include the event of a medication change, incident/accident, any new orders, a</li> </ul>	Staff d on. tiated led "In	

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PRINTED: 03/19/2014 FORM APPROVED

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			
		345146	B. WING		С	
	ROVIDER OR SUPPLIER	545146		STREET ADDRESS, CITY, STATE, ZIP CODE	12	2/18/2013
NAIVIE OF PI	ROVIDER OR SUPPLIER			33426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AN	ID REHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID	SUMMARY	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIC
F 157	Continued From page	ge 3	F 157	7		
	of her pureed diet. S	She normally ate well, at about		change in condition, transfer or d	ischarge	
	75-100%, so she on	ly had to give her a bolus		out of facility, death, or anything o	-	
		/23/13, a visitor brought		normal for resident to include von		
		from the outside. She		you need to notify the MD and RF		
	-	ge can of soda in her room		appropriate, anytime of the day to		
		tor that Resident #1 was on ne said the visitor commented		third shift. If not sure when to not RP call the on-call nurse, Directo	•	
	to her, that she drur			Nursing (DON), or Administrator 1		
		ik inte.		directions. Documentation of time		
	Later that shift, Nurs	se #1 stated Resident #1		person contacted must be comple		
		ch well and appeared to be		Documentation of MD and RP no		
	full. The following da	ay, 11/24/13, she was told in		must occur at all times". This in-s	service	
		Resident #1 had vomitted		will continue until all nurses, Cer		
		ut seemed okay during the		Nursing Assistants (C.N.A s) and		
		herapist reported to her		non-nursing staff to include dietar	-	
		at she appeared lethargic.		therapy, and housekeeping are tr		
	#1 had volume over	thought that maybe Resident		No employee will be allowed to w without completion of this in-servi		
		beverages from an outside			ce.	
	source.	beverages nom an outside		On 12/17/13, the Regional Vice F	President	
				(RVP) in-serviced the administrat		
	Nurse #1 stated that	t she did not consult the		Director of Nursing on how to use		
	physician, nor recor	ded any vital signs because		Quality Improvement Incident/Acc		
		have a temperature and her		Review Audit Tool to show that an	•	
		I to be fine. On Sunday, she		significant change in a resident		
		it #1, continued to eat poorly.		condition has documentation of th		
		nterviewed on 12/16/13 at		nurse s assessment of the resid		
	-	that he worked with Resident ng 2nd shift and she ate		the MD and RP notification. This will continue to be utilized when a		
		needed a bolus feeding.		occurs requiring staff to contact a		
		viewed by phone on 12/17/13		supervisor, the director of nursing		
		ked 2nd shift on 11/23/13 and		administrator regarding a significa		
		ssigned to Resident #1. She		change in a resident⊡s condition		
		/, Resident #1 did not eat well		_		
		ekend, she recalled that she		On 12/17/13, the Administrator in		
		esident #1 had eaten food		in-service for all Administrative N		
	-	n outside sources. She stated		who take nurse on call. The adm		
	that the nurse told h had consumed ham	er in the shift report, that she		in-serviced the administrative nur	ses on	

If continuation sheet Page 4 of 14

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE C	CONSTRUCTION	(X3) DAT	O. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>			CON	IPLETED
		0.154.40				С	
		345146	B. WING			12	2/18/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER			BEMARLE, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 157		<u>م</u>	<b></b>	57			
F 157	on a pureed diet with Resident #1 had zero her a bolus, thinning ivery slowly. After dinner, she wen and noticed a small a side, with her head fa out of the room, to ge When she began to w large volume of food, out forcefully. It smell yellow-brown in color observed that Reside She commented that like that before and I or ate food that she w shared that she gave treatment that night a (The physician order nebulizer treatment, e shortness of breath.) took the temperature and it seemed norma her notes. She felt that normal, so she stated doctor for this reason seemed fine to her wi Sunday evening too. felt that whatever cau discomfort, she got ric Nurse Aide #4 was in 1:15 pm. She shared Resident #1 on 11/25 7:15 am, providing ca she noticed that she s right side, with stuff c	vised visitors that she was thickened liquids. At dinner, o intake of food, so she gave it with water, which went in at into Resident #1's room mount of vomit on her right acing the wall. She walked et linens to clean her up. vipe her face, she stated that not pureed texture, came led sour and was . After this emesis, she ent #1 seemed to feel better. "I never seen her get sick wondered if she had a virus vas unfamiliar with. " She her a nebulizer (breathing) and her breathing was good. for November, 2013, listed every 6 hours, as needed for The nurse also said that she under Resident #1's arm, I, but she didn't record it in at everything seemed d that she did not contact the . In addition, Resident #1 hen she worked with her on She commented that she	F1	57	Incident/Accident Review Audit Tool to show that any significant change in a resident s condition has documentation of the nurse s assessment of the resident and the MD and RP notification. The administrative nurse team will me five times per week permanently to re- the nursing progress notes to ensure any significant change in a resident s condition has documentation that inclu- assessment of the resident, MD notification, and RP notification. Any areas of concern identified during the reviews will be addressed by assessments and notifications as appropriate for situation. Criteria 4: The Administrator and/or DON will rev- all completed Quality Improvement Incident/Accident Review Audit Tool the times a week ongoing to assure they completed and functioning as appropri- The Quality Improvement Executive Committee will review all audit informa- monthly for recommendations, take actions as appropriate, and to monitor continued compliance in this area.	ion on view that s udes se view nree are riate. ation	

Facility ID: 923032

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	IPLETED
						С
		345146	B. WING		12	2/18/2013
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
RETHANY		OREHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX 1250		
DEMAN		REHABIEITATION GENTER		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	e 5	F 15	7		
	breathing was shallow					
		r body. She left the room, to				
	get the nurse, who re	turned to assess her.				
		ody temperature of 105				
	degrees and orders w					
	pnysician, to send ne	er to the emergency room.				
	The Director of Nursi	ng (DON) was interviewed				
		am. She mentioned that				
	when she spoke to N	urse #2, she told her that				
		nitted (on 11/23/13) like				
	-	who was too full and that it				
		raordinary concerns. On n, the DON commented that				
		se should have contacted				
	-	Resident #1 had projectile				
	vomitting.					
		terviewed by phone on				
		and shared that he was not				
		#1 had projectile vomiting on would assume that staff				
		t occurred. He mentioned				
	that had he known th					
		e vomiting, he would have				
		mplications from dysphasia				
		it she didn't aspirate. He				
		a chest x-ray to make sure and also to make sure she				
	didn't have esophagu					
	The hospital records.	from 11/25/13 to 11/26/13				
	-	ead as follows: Resident #1				
	-	I and was admitted for acute				
		, clinical sepsis and benign				
		as noted to have acute				
		right upper lobe pneumonia veness. She was septic,				
	secondary to the pne					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/19/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345146	B. WING		C 12/18/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		33426 OLD SALISBURY ROAD B ALBEMARLE, NC 28002	OX 1250
		ATEMENT OF DEFICIENCIES			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLETIO TO THE APPROPRIATE DATE
F 157	Continued From page	e 6	F 1	57	
		e, within the hospital later			
		at the hospital on 11/26/13.			
	The death certificate	was obtained on 12/18/13			
	and recorded the cau	se of death as pneumonia			
	•	days onset before death.			
F 309			F 3	609	1/15/14
SS=D	TIIGHEST WELL BEI				
		eceive and the facility must			
	•	y care and services to attain			
	mental, and psychoso	st practicable physical, ocial well-being, in			
		comprehensive assessment			
	and plan of care.				
	This REQUIREMENT	is not met as evidenced			
	by:				
		iew, physician and staff failed to thoroughly assess		F309	
		dent #1) receiving tube		Criteria 1:	
	feeding, after projecti	le vomiting was first		On 11/25/13 the assigned	
	detected, and seek m			resident # 1 for a chang	e in condition.
	be obtained.	aluation and treatment could		On 11/25/13 the assigned	ed nurse
				contacted Resident # 1'	
				(MD) for an order and R	
	The findings included			Responsible Party (RP) resident being sent out	-
	Resident #1 was adm	nitted to the facility on		Medical Services (EMS)	
	10/8/13 with the follow	wing diagnoses: traumatic		condition.	
		a, gastrostomy tube and a			
		failure post tracheotomy. um Data Set (MDS) dated		Criteria 2: A 100 percent audit was	s started on
	10/15/13, determined	. ,		12/17/13 by the Facility	
	cognitive impairments			of all nurse progress no	

Event ID: XWPN11

Facility ID: 923032

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	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:				· /	IPLETED
							С
		345146	B. WING		12	2/18/2013	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
		D REHABILITATION CENTER		33	426 OLD SALISBURY ROAD BOX 1250		
DETTIANT	WOODS NORSING AND	B REHABIEITATION CENTER		Al	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 309	Continued From page	0.7		00			
1 303	assistance with eatin		F 30	09	10/25/2012 to oncure that significant		
		diet and had no swallowing			10/25/2013 to ensure that significant changes in a resident s condition note	d	
	problem.	diet and had no swallowing			includes documentation of MD and RP	u	
					notification as appropriate. 37 resident	s	
	A record review was	conducted of Resident #1's			were identified as needing MD/RP		
	medical chart. It indic	cated that a physician			notification. All areas found were		
		scribed on 10/8/13, stated			immediately followed up with notificatio	n	
		a pureed with nectar thick			of MD and/or RP.		
		ceive a bolus feeding at 8					
		, only if she didn't eat 50% of					
		ostomy tube would be ubic centimeter) before and			A 100 percent audit was completed on 12/18/13 by Facility Nurse Consultants		
	after feedings.	ubic centimeter) before and			Director of Nursing, Assistant Director of		
	anter recaringe:				Nursing, Quality Improvement (QI) nurs		
	A Care Plan was dev	eloped on 10/18/13 to			Minimum Data Set (MDS) nurse,		
	address the tube (ga			treatment nurse, and Staff Facilitator or	n		
		aining nutritional status			all nurse's notes back to 1025/13 to		
		ght loss related to cognitive			assure that any changes in resident		
		a (difficulty with swallowing).			condition noted had documentation of a		
		esident #1 would receive			physical assessment. Audit revealed th	iere	
		and fluid intake as evidenced I no signs or symptoms of			were no residents with changes in condition needing documentation of a		
		/dration through the next			physical assessment.		
		included: tube feed formula			physical accessment.		
		ordered by the physician;			A 100 percent education to include		
		eeding purposes; monitor for			in-servicing and testing of all nursing st	aff	
	signs and symptoms	of tube feeding			and non-nursing staff was initiated by		
		ample aspiration, dyspnea			Staff Facilitator on 12/17/13 in regards	to	
	(shortness of breath)				any changes in resident condition. Staf	f	
		vomitting or diarreha;			were educated to notify the assigned		
	infection or irritation t	io sioma sile.			nurse of changes in resident condition.		
	Another care plan wa	as developed on 10/18/13 to			Criteria 3:		
	-	t related to less than body			On 12/17/13, the Staff Facilitator initiate	ed	
	requirement characte	-			in-servicing for all nurses that included		
		ecreased appetite related to			the event of a medication change,		
		, and pressure area. Goals			incident/accident, any new orders, any		
		I intake would meet the			change in condition, transfer or dischar	ge	
	resident's nutritional	needs as evidenced by		- 1	out of facility, death, or anything out of		

Facility ID: 923032

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OLITICI		MEDICAID SERVICES				O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY IPLETED	
						С	
		345146	B. WING		12	2/18/2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
BETHANY	WOODS NURSING AN	D REHABILITATION CENTER		33426 OLD SALISBURY ROAD BO ALBEMARLE, NC 28002	OX 1250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	Continued From pag	e 8	F 30	99			
	stable weight, increa			normal for resident to inc	clude vomitina.		
	<b>U</b> .	ement in wounds thru next		you need to notify the M	0.		
	review. Interventions			appropriate, anytime of t			
	thickened liquids as			third shift. If not sure wh			
		d symptoms of gagging or		RP call the on-call nurse	2		
		s and report to unit nurse.		Nursing (DON), or Admin	nistrator for		
				directions. Documentati	on of time and		
	On 11/23/13, the 24	hours shift reported noted		person contacted must t	be completed.		
	that Resident #1 didr	n't eat dinner on 2nd shift		Documentation of MD ar	nd RP notification		
	(3-11 pm) and had 1	episode of vomitting.		must occur at all times".	This in-service		
				will continue until all nur			
		nterviewed on 12/15/13 at		Nursing Assistants (C.N.			
		d with Resident#1, from 7 am		non-nursing staff to inclu			
		She stated that Resident #1		therapy, and housekeep			
		self breakfast that morning,		No employee will be allo			
		neal and she ate 50% of her		without completion of thi	s in-service.		
		recalled that Resident #1		On 12/17/12 the Design	al Vice Dresident		
		y, who brought her in regular gh she remained on a nectar		On 12/17/13, the Region			
		she came in the room to		(RVP) in-serviced the ac Director of Nursing on he			
		nence, she saw a red plastic		Quality Improvement Inc			
		t was left within reach of		Review Audit Tool to sho			
		visitor. She reported that she		significant change in a re			
		#1 show any signs of		condition has documenta			
	distress during her s			nurse s assessment of			
				the MD and RP notificati			
	Nurse #1 was intervi	ewed by phone on 12/16/13		will continue to be utilize			
		red that she worked with		occurs requiring staff to			
		ther weekend and that she		supervisor, the director of			
	received a bolus feed	ding if she ate less than 50%		administrator regarding	a significant		
		he normally ate well, at about y had to give her a bolus		change in a resident⊡s o	condition.		
		/23/13, a visitor brought		On 12/17/13, the Admini	strator initiated an		
	-	from the outside. She		in-service for all Adminis			
	recalled seeing a larg	ge bottle (maybe 20oz) of		who take nurse on call.	The administrator		
		d advised the visitor that		in-serviced the administr	rative nurses on		
	Resident #1 was on	thickened liquids. She said		how to use the Quality Ir	nprovement		
		d to her, that she drunk fine		Incident/Accident Review	-		
	when he gave her th	e beverage.		show that any significant	t change in a		

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY	
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED	
					С	
	345146	B. WING		12	/18/2013	
ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE			
		:	33426 OLD SALISBURY ROAD BOX 1250			
WOODS NORSING AND	REHABILITATION CENTER		ALBEMARLE, NC 28002			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE	
Continued From page	e 9	F 309				
wouldn't eat her lunch full. The following day her shift report that R Saturday evening but night, although the th Sunday morning, that She shared that she if #1 had volume overlo consumed food and the source. Nurse #1 stated that if physician, nor record she knew she didn't h respirations seemed shared that Resident Nurse Aide #2 was in 3:58 pm. He stated th #1 on 11/23/13 during poorly for him, and ne Nurse # 2 was intervi at 5:11 pm. She work on 11/23/13 and 11/2 Resident #1. She sha #1 did not eat well for recalled that she was had eaten food earlie sources. She stated th shift report, that she h chips and soda, althour visitor that she was o thickened liquids. At o	h well and appeared to be y, 11/24/13, she was told in esident #1 had vomitted t seemed okay during the erapist reported to her t she appeared lethargic. thought that maybe Resident oad, since she had beverages from an outside she did not consult the ed any vital signs because have a temperature and her to be fine. On Sunday, she #1, continued to eat poorly. terviewed on 12/16/13 at hat he worked with Resident g 2nd shift and she ate eeded a bolus feeding. ewed by phone on 12/17/13 ed 2nd shift (3 pm to 11 pm) 4/13 and was assigned to ared that normally, Resident r supper. That weekend, she informed that Resident #1 r that day, from outside that the nurse told her in the had consumed hamburger, ough staff had advised her n a pureed diet with dinner, Resident #1 had zero e gave her a bolus, thinning it		of the nurse □s assessment of the resident and the MD and RP not resident and the MD and RP not The administrative nurse team of the times per week permanent the nursing progress notes to e any significant change in a reside condition has documentation the assessment of the resident, MD notification, and RP notification areas of concern identified durin reviews will be addressed by assessments and notifications and appropriate for situation. Criteria 4: The Administrator and/or DON all completed Quality Improvem Incident/Accident Review Audit times a week ongoing to assure completed and functioning as a The Quality Improvement Exect Committee will review all audit i monthly for recommendations, actions as appropriate, and to recommendations.	he tification will meet y to review nsure that dent⊟s at includes o . Any ng these as will review hent Tool three they are ppropriate. utive information take nonitor		
	Continued From page Continued From page Continued From page Later that shift, Nurse wouldn't eat her lunch full. The following day her shift report that R Saturday evening but night, although the th Sunday morning, that She shared that she #1 had volume overlow consumed food and the source. Nurse #1 stated that physician, nor record she knew she didn't fr respirations seemed shared that Resident Nurse Aide #2 was in 3:58 pm. He stated th #1 on 11/23/13 during poorly for him, and ne Nurse # 2 was intervi at 5:11 pm. She work on 11/23/13 and 11/2 Resident #1. She sha #1 did not eat well for recalled that she was had eaten food earlie sources. She stated to shift report, that she for chips and soda, althout visitor that she was of thickened liquids. At for with water, which were	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345146         ROVIDER OR SUPPLIER         WOODS NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 9         Later that shift, Nurse #1 stated Resident #1 wouldn't eat her lunch well and appeared to be full. The following day, 11/24/13, she was told in her shift report that Resident #1 had vomitted Saturday evening but seemed okay during the night, although the therapist reported to her Sunday morning, that she appeared lethargic. She shared that she thought that maybe Resident #1 had volume overload, since she had consumed food and beverages from an outside	DF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPL         CORRECTION       345146       B. WING         345146       B. WING       B. WING         ROVIDER OR SUPPLIER       345146       B. WING         WOODS NURSING AND REHABILITATION CENTER       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 9       F 305         Later that shift, Nurse #1 stated Resident #1 wouldn't eat her lunch well and appeared to be full. The following day, 11/24/13, she was told in her shift report that Resident #1 had vomitted Saturday evening but seemed okay during the night, although the therapist reported to her Sunday moming, that she appeared lethargic. She shared that she thought that maybe Resident #1 had volume overload, since she had consumed food and beverages from an outside source.         Nurse #1 stated that she did not consult the physician, nor recorded any vital signs because she knew she didn't have a temperature and her respirations seemed to be fine. On Sunday, she shared that Resident #1, continued to eat poorly. Nurse Alde #2 was interviewed on 12/16/13 at 3:58 pm. He stated that he worked with Resident #1 on 11/23/13 during 2nd shift and she ate poorly for him, and needed a bolus feeding. Nurse # 2 was interviewed by phone on 12/17/13 at 5:11 pm. She worked 2nd shift (3 pm to 11 pm) on 11/23/13 and 11/24/13 and was assigned to Resident #1. She shared that normally, Resident #1 had eaten food earlier that day, from outside sources. She stated that the nurse told her in the shift report, that she had consumed hamburger, chips and soda, although st	predenotes construction       (x1) Revueensuperuercutation       (x2) MULTIPLE CONSTRUCTION         345146       B. WING         ROWDER OR SUPPLIER       STREET ADDRESS. CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCES       B. WING         (RACH DEFICIENT MUMBER:       STREET ADDRESS. CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCES       B. WING         (RACH DEFICIENT MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D         Continued From page 9       F 309         Continued From page 9       F 309         Later that shift, Nurse #1 stated Resident #1 wouldn't eat her lunch well and appeared to be full. The following day, 11/21/13, she was told in her shift report that Resident #1 had vomitted       The administrative nurse team five times per week permanent five times per	precencevcies       (*1) PROVIDERSUPPLIER       (*2) MUTHPLE CONSTRUCTION       (*2) MUTHPLE CONSTRUCT	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/19/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE S COMPL	SURVEY LETED
		345146	B. WING		_	C 12/1	; 18/2013
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BETHAN	( WOODS NURSING AND	REHABILITATION CENTER		3426 OLD SALISBURY RO 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 CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	out of the room, to ge re-entered the room, when she noted that I pureed texture, came smelled sour and was the 2nd emesis, she of seemed to feel better never seen her get si wondered if she had a was unfamiliar with." her a nebulizer (breat and her breathing wa for November, 2013, every 6 hours, as nee breath.) The nurse als temperature under Re seemed normal, but s notes. She felt that ev she stated that she di this reason. In addition to her when she work evening too. She corr whatever caused Res got rid of it, when she In a written statement #3 she wrote, that eac 11/24/13), she checked midnight during her ro On these occasions, and flushed her g-tub belly band was in place. She that her head of bed v reported vomiting and from too much feedin touched her skin, the to the touch, and her	et linens to clean her up. She and began to wipe her face large volume of food, not cout forcefully. She said it s yellow-brown in color. After observed that Resident #1 . She commented that "I ck like that before and I a virus or ate food that she She shared that she gave thing) treatment that night s good. (The physician order listed nebulizer treatment, eded for shortness of so said that she took the esident #1's arm, and it she didn't record it in her verything seemed normal, so id not contact the doctor for on, Resident #1 seemed fine ted with her on Sunday mented that she felt that sident #1's discomfort, she e vomitted. t, dated 11/28/13 from Nurse ch night (11/23/13 and	F 309				

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DEPARTMENT OF HEALTH AND I CENTERS FOR MEDICARE & ME					FORM	D: 03/19/2014 MAPPROVED D. 0938-0391
	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345146	B. WING			C 12/18/2013	
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY WOODS NURSING AND RE	EHABILITATION CENTER			33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
during her shifts and she She wrote that she didn't about Resident #1 that s Nurse Aide #3 was interv 12/16/13 at 6:02 pm. She newly hired and going th she was asked to bathe of 11/25/13, around 7:15 that Resident #1 was stil entered her room, lying i the bed, slightly elevated a taller height, so that sh her. As Resident #1 awo seemed upset and was g trouble breathing. She st	41's breathing was normal e appeared to be asleep. t notice anything unusual shift. viewed by phone on e stated that she was mough orientation when Resident #1, the morning a m. She commented II asleep when she in bed, with the head of d. She raised the bed, to be could stand to bathe oke, she noticed that she gasping for air, having tated that " Resident #1 ole bed was wet from her have an odor. I saw red as a rash. I didn't notice her mouth. I called out to also in the room, and non for Resident #1 to responded, ' yes'. To od, she was too hot." de #4, came over to d saw the splotches on the nurse. Nurse Aide take Resident #1's blood cessful, as well as other tried. She mentioned et a temperature under degrees.	F	309			

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	MENT OF HEALTH AN		FRINTED: 03/19/2014 FORM APPROVED OMB NO. 0938-0391				
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345146	B. WING			C 12/18/2013	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	a clear substance with breathing was shallow splotches all over her get the nurse, who re Resident #1 had a bo degrees and orders w physician, to send he The Director of Nursir on 12/17/13 at 10:50 when she spoke to Nr Resident #1 had vom anyone else would, w didn't' create any ext 12/18/13 at 12:40 pm in retrospect, the nurs the physician when R vomitting. The Physician was in 12/17/13 at 11:00 am aware that Resident # 11/23/13 and that he would contact him if it that had he known that experienced projectile wanted to rule out cor and to make sure that would have ordered at the tube was patent, at didn't have esophagu The hospital records, were reviewed and re arrived to the hospital bronchial pneumonia, hypertension. She wat	oming out of her mouth, like h bits of food. Resident #1's v and she had blue body. She left the room, to turned to assess her. dy temperature of 105 vere sought from the r to the emergency room. ng (DON) was interviewed am. She mentioned that urse #2, she told her that itted (on 11/23/13) like tho was too full and that it raordinary concerns. On , the DON commented that se should have contacted esident #1 had projectile terviewed by phone on and shared that he was not #1 had projectile vomiting on would assume that staff t occurred. He mentioned at Resident #1 had e vomiting, he would have mplications from dysphasia t she didn't aspirate. He a chest x-ray to make sure and also to make sure she	F	309			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/19/2014 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345146	B. WING				C 12/18/2013	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C					
BETHANY	REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002			0			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 309	secondary to the pnet transferred to Hospica that day and expired The death certificate and recorded the cau pulmonary arrest with	veness. She was septic, umonia. She was e, within the hospital later at the hospital on 11/26/13. was obtained on 12/18/13 se of death as cardio	F 3	09				

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