DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP						
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	-		OMB N	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		345212	B. WING			C 9/24/2015
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	
BETHES	DA HEALTH CARE FA	ACILITY			532 DUNN ROAD ASTOVER, NC 28301	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 164 SS=E	PRIVACY/CONFID)(4) PERSONAL ENTIALITY OF RECORDS e right to personal privacy and s or her personal and clinical	F 10	64		10/15/15
	medical treatment, communications, p meetings of family	cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private lent.				
	section, the resider	in paragraph (e)(3) of this at may approve or refuse the and clinical records to any he facility.				
	and clinical records resident is transferr	to refuse release of personal does not apply when the ed to another health care d release is required by law.				
	contained in the res the form or storage release is required	ep confidential all information sident's records, regardless of methods, except when by transfer to another n; law; third party payment dent.				
ABORATOR	by: Based on observat facility failed to mai posting signs that in restrictions and thic on 1 of 1 suppleme the facility failed to	NT is not met as evidenced tion and staff interviews, the ntain the resident 's privacy by ndicated the type of diet, fluid tkened liquids for 35 residents, nt carts located in the hallway, provide privacy for 1 of 1	NATURF		1. Resident #58,#28, and 35 resident names, diet, fluid restrictions, and thickened liquids that were displayed on the snack cart could have been effected by this deficient practice. The facility faile to protect the residents right to personal	d (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/13/2015

PRINTED: 10/20/2015

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.

Electronically Signed

	-	AND HUMAN SERVICES					APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345212	B. WING			C 	
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA HEALTH CARE FA	ACILITY			532 DUNN ROAD ASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164	Continued From pa	ige 1	F 1	64			
	sampled residents privacy curtain betw gastrostomy medic observation, and by administration reco the medication cart Findings included: 1) During the initial supplement cart wa hallway by room 14 which displayed 35 numbers, and the ty thickened liquids for During an observat AM the dietary mar supplement cart ou which is located ne down the 100 hall, a hall, which is located building. The cart fit the cart with reside and types of diet, fit liquids. 09/24/2015 10:33:: nursing assistant (N facility used the sig what type of diet re that " it probably sh s a HIPAA thing ". were always there '	(resident #58), by not pulling a veen two residents during a ation administration y leaving a medication rd unattended and open on tour on 9/21/15 at 4:15pm 1 as observed sitting in the .6. The cart had signs posted resident names and room ype of diet, fluid restriction and r each listed resident. ion on 09/24/2015 10:30:28 hager was observed pushing 1 it of the dietary department, ar the entrance of the building, and onto the locked unit 200 ed near the back of the had signs posted on the top of nt ' s names, room numbers, uid restrictions and thickened 28 AM During an interview with NA) #2, she stated that the ns so the staff would know sidents are on. She stated houldn ' t be there because it ' She stated that the signs "		54	 privacy and confidentiality of his or his personal and clinical records. The fawill ensure that. A. resident #58 will have personal proby the staff pulling the privacy curtain closed when administering medication is gastrostomy tube and all other personal care. B. Resident #28 will have their privation protected by the nurse. Inurse will close the Medication Administration record (MAR) after us and before leaving the medication call times. C. The facility will protect the 35 resinames, room numbers, diets, fluid restrictions, and thickened liquids sig that was posted on the snack cart by removing the signs off the snack car where they can be seen. 2. All residents could have been effect by this deficient practice. The facility ensure that all residents personal princluding accommodations, medical treatment, written telephone communications, personal care, visif and meetings of family and resident groups, including but not limited to. A. Not displaying resident names, roon numbers, type of diets, fluid restriction and thickened liquids on signs posted the snack cart. B. By closing the curtain completely a resident is receiving medication administration via gastrostomy tube 	acility rivacy n ons te The sing it art at ident gn y rt ected / will rivacy its, oom ons, ed on / when	
	with Nurse #2, she that the resident inf	stated she did not even realize formation was displayed on the Stated " I really don't			nurse to provide privacy. C. By the nurse closing the MAR wh leaving the medication cart, to protect	ien	

Facility ID: 922968

If continuation sheet Page 2 of 13

	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	FCORRECTION	IDENTIFICATION NOWBER.	A. BUILDIN	NG	C
		345212	B. WING _		09/24/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	-
BETHES	DA HEALTH CARE FA	ACILITY		3532 DUNN ROAD EASTOVER, NC 28301	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE DATE
F 164	Continued From pa	ge 2	F 16	64	
	remember seeing it usually pass the su	t up there before, but I do not pplements out " . She stated te information should not be		residents name, diagno medications.	osis, and
	displayed for others			3. A.Donald Pickney, D be in-serviced by Carol Administrator that all re	ine Horne,
	the dietary manage information is not s	upposed to be displayed. we use it is "because we have		right to personal privace confidentiality of his or clinical records, That re	y and her personal and
	had a recent turnov	ver of nursing assistants and ure that the staff do not give		room numbers, types o restrictions and thicken	f diets, fluid
	". Stated "it's pro	ents out to the wrong resident bably been about a week we e sign, because the nursing		be displayed on the sna resident information mu and kept confidential.	
	assistants do not ki	now the resident's diets, so we re they don't give out the		B. Pristina Blue, LPN, v by Caroline Horne, Adn residents has the right	ninistrator that all
	09/24/2015 11:03:0	0 AM During a joint interview		must provide privacy by curtain completely close	y always pulling the ed when
		nursing (DON) and I), both stated they expect all prmation to be covered and not		administering medication Gastrostomy tube. C. Angela Leonard, LPI	
	prominently display DON stated " we w	ed for the public to view. The vanted to make sure everyone but all the signs should be		nurse, will be in-service Horne, Administrator th information including bu	ed by Caroline hat all resident ut not limited to
	not displayed ".	dents ' personal information is		resident names, diagno medications must be pr confidential by closing t	rotected and kept the MAR before
	of nurse #4 of med nurse raised the he	9 PM During an observation ication administration, the ad of the bed for resident #58,		leaving the medication D. All staff will be in-ser resident has the right to	rviced that every o personal privacy
	abdomen to begin to via her gastrostomy	esident ' s gown, exposing her to administer her medications y tube. She did not pull the ted between the residents		and confidentiality of his and clinical record givin displaying resident nam	ng examples of, not nes, room
	during the medicati completion of the m	ted between the residents on administration. Upon nedication administration, gown back down in place for		numbers, diet, fluid rest thickened liquids on sna MAR open when walkin pulling privacy curtains	ack carts, leaving a ng away, and not

Facility ID: 922968

	-	AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
					(C
		345212	B. WING		09/2	24/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA HEALTH CARE FA	CILITY		3532 DUNN ROAD EASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164	Continued From pa	ge 3	F 16	4		
	nurse #4 she stated medication observa pull the privacy curt resident #38 during administration. She than that, but had ju the observation. 09/24/2015 10:57:3 the DON, Assistant and ADM. They join is to provide the res medication adminis resident. The DON have been pulled w medications ". 3) 9/23/15 9:35:16 / nurse #3 of medica the medication administe resident ' s name, d while she went into door, and administe resident #28. 09/24/15 10:25:50A nurse #3 she did no while she was in the 09/24/2015 10:57:3 DON she stated tha including the MAR, times. 09/24/2015 10:57:3	 a stated that she "knew better ust gotten nervous " during 6 AM During an interview with director of nursing (ADON) htly stated that the expectation sident with privacy during any tration that may expose the stated " the curtain should hen she administered the AM During an observation of tion observation, she left the ninistration record (MAR) open ation cart, exposing the liagnosis and medications resident #28 room, shut the ered the medications to M During an interview with ot recall leaving MAR open 		 4. LaDean Hair, RN, QA, will ensure all residents rights to personal privac confidentiality of his or her personal clinical records are protected by usinew QA form titled "resident privacy done weekly X's 90 days then mont an ongoing basis. Making sure resis privacy curtains are closed complet when receiving all care, no signs prion snack cart or anywhere in public with any resident information on it, a that MAR's must be closed when no using or leaving the medication cart 1. to be completed by 09/21/2015 2. to be completed by 09/21/2015 3. to be completed by 10/05/2015 4. to be completed by 10/15/2015 	acy and I and ing y" to be thly on dent tely resent c view and ot	

If continuation sheet Page 4 of 13

PRINTED: 10/20/2015

		AND HUMAN SERVICES			FORM	: 10/20/2015 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY IPLETED	
		345212	B. WING			C 24/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BETHES	DA HEALTH CARE F	ACILITY	3532 DUNN ROAD EASTOVER, NC 28301				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 164	Continued From pa	age 4	F 164	L L			
	is to remain confide	ential at all times.					
F 278 SS=D	483.20(g) - (j) ASS ACCURACY/COOF	ESSMENT RDINATION/CERTIFIED	F 278	3		10/23/15	
	The assessment m resident's status.	ust accurately reflect the					
		must conduct or coordinate vith the appropriate Ith professionals.					
	A registered nurse assessment is com	must sign and certify that the pleted.					
		o completes a portion of the sign and certify the accuracy of assessment.					
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each as willfully and knowin to certify a material resident assessme	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money e than \$5,000 for each					
	Clinical disagreeme material and false s	ent does not constitute a statement.					
	by: Based on record re facility failed to acc	NT is not met as evidenced eview and staff interviews, the urately code section A of the (MDS) to reflect the Level II		1. Resident #5 could have been e by this deficient practice. The facil ensure that the MDS is coded acc	ity will		

Facility ID: 922968

				-	APPROVEI 0938-039
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE COM	E SURVEY PLETED
	345212	B. WING _		C 09/24/2015	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
DA HEALTH CARE FA	ACILITY		3532 DUNN ROAD EASTOVER, NC 28301		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
Preadmission Scre (PASRR) determina reviewed as Level I #5). Findings included: Resident #5 was in 03/31/2014 with dia and psychotic disor A review of section Screening and Res Resident #5's annu dated 04/01/2015 w indicated the reside PASRR and determ mental illness and/or results of this screet determine needs, a set of recommenda develop an individu A review of the facil residents revealed among the resident During an interview the facility Office M did indeed have a L The review of Resid revealed that Resid status. The MDS Coordina 09/24/2015 at 10:05	ening and Resident Review ation for one of one resident I PASRR resident. (Resident itially admitted to the facility on agnoses including depression der. A1500 (Preadmission ident Review (PASRR)) of al Minimum Data Set (MDS) vas conducted. Section A1500 ent was evaluated by Level II nined not to have a serious or intellectual disability. The ening and review are used to ppropriate care setting and a tions for services to help al's plan of care. Ity's list of Level II PASRR that Resident #5 was included is named on the list. Ton 09/24/2015 at 8:51 AM, anager confirmed Resident #5 level II PASRR status. dent 's PASRR II form lent #5 had Level II PASRR tor was interviewed on 5 AM, regarding the accuracy	F 27	 under section A1500 to reflect preadmission screening and review (PASRR) determination the results of this screening at are used to determine needs care setting and a set of recommendations for service develop an individual plan of used. 2. All residents could have be b this deficient practice. The ensure all the MDS's are cod under section A1500 to reflect preadmission screening and review (PASRR) determination the results of this screening at are used to determine needs care setting and a set of recommendations for service develop an individualized plan. 3. LaDean Hair, RN, MDS will in-serviced by Caroline Horner Administrator that all MDS's at A1500 must be coded correct the level II preadmission screening and review are used to determine appropriate care setting, and recommendations for service develop an individualized plan. 4. LaDean Hair RN, QA will er 	resident on to ensure and review , appropriate s to help care are een effected facility will ed accurately the level II resident on to ensure and review , appropriate s to help n of care. I be e, section tly to reflect eening and ermination to eening and needs, a set of is to help n of care are	
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER DA HEALTH CARE FA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Preadmission Scree (PASRR) determina reviewed as Level I #5). Findings included: Resident #5 was in 03/31/2014 with dia and psychotic disor A review of section Screening and Res Resident #5's annu dated 04/01/2015 w indicated the reside PASRR and determ mental illness and/or results of this scree determine needs, a set of recommenda develop an individu A review of the facil residents revealed among the resident During an interview the facility Office M did indeed have a L The review of Resid revealed that Resid status. The MDS Coordina 09/24/2015 at 10:00 of Resident #5's an	DEF CORRECTION IDENTIFICATION NUMBER: 345212 PROVIDER OR SUPPLIER DA HEALTH CARE FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Preadmission Screening and Resident Review (PASRR) determination for one of one resident reviewed as Level II PASRR resident. (Resident #5). Findings included: Resident #5 was initially admitted to the facility on 03/31/2014 with diagnoses including depression and psychotic disorder. A review of section A1500 (Preadmission Screening and Resident Review (PASRR)) of Resident #5's annual Minimum Data Set (MDS) dated 04/01/2015 was conducted. Section A1500 indicated the resident was evaluated by Level II PASRR and determined not to have a serious mental illness and/or intellectual disability. The results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #5 was included among the residents named on the list. During an interview on 09/24/2015 at 8:51 AM, the facility Office Manager confirmed Resident #5 did indeed have a Level II PASRR status. The review of Resident 's PASRR II form revealed that Resident #5 had Level II PASRR	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN SUMMARY STATEMENT OF DEFICIENCIES B. WING _ PROVIDER OR SUPPLIER JUNMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 5 F 27 Preadmission Screening and Resident Review (PASRR) determination for one of one resident reviewed as Level II PASRR resident. (Resident #5). F 27 Findings included: Resident #5 was initially admitted to the facility on 03/31/2014 with diagnoses including depression and psychotic disorder. F 21 A review of section A1500 (Preadmission Screening and Resident Review (PASRR)) of Resident #5's annual Minimum Data Set (MDS) dated 04/01/2015 was conducted. Section A1500 indicated the resident was evaluated by Level II PASRR and determined not to have a serious mental illness and/or intellectual disability. The results of this screening and review are used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #5 was included among the residents named on the list. During an interview on 09/24/2015 at 8:51 AM, the facility Office Manager confirmed Resident #5 did indeed have a Level II PASRR status. The review of Resident 's PASRR II form revealed that Resident #5 had Level II PASRR status. <	Resident #5 van individual's plan of correction and psycholic disorder. F 278 A review of section A1500 (Preadmission Screening and Resident #5 van individual's plan of corre resident #5 van individual's plan of correction and psycholic disorder. F 278 A review of section A1500 (Preadmission Screening and Resident #5 van individual's plan of correction and psycholic disorder. F 278 A review of section A1500 (Preadmission Screening and Resident #5 van individual's plan of correction and psycholic disorder. F 278 A review of section A1500 (Preadmission Screening and Resident #5 van individual's plan of care. F 278 A review of section A1500 (Preadmission Screening and Resident #5 van und Minimum Data Set (MDS) indicated the resident was evaluated by Level II PASRR are used to determine needs appropriate care setting and a set of recommendations for service develop an individual's plan of care. 2. All residents could have be this screening and review (PASRR) determination for service develop an individual's plan of care. A review of the facility's list of Level II PASRR and etermined on to have a serious mental illness and/or intellectual disability. The resident srevealed that Resident #5 was included among the residents named on the list. 3. LaDean Hair, RN, MDS will inserviced plan of care setting and a set of recommendations for service develop an individual's plan of care. A review of Resident *5 van lifty's list of Level II PASRR status. 3. LaDean Hair, RN, MDS will inservice determine appropriate care setting and a set of recommendations for service develop an individualized plan of care setting and a set	RS FOR MEDICARE & MEDICAID SERVICES OMB NO. OP DEFICIENCIES (X) PROVIDERSUPPLIERCLA. (X2) MULTIPLE CONSTRUCTION (X3) DATT 345212 B. WING COM PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 3532 DUNN ROAD DA HEALTH CARE FACILITY STREET ADDRESS, CITY, STATE, ZP CODE 3532 DUNN ROAD EACH DEFICIENCY STREET ADDRESS, CITY, STATE, ZP CODE 3532 DUNN ROAD Continued From page 5 PROVIDERS PLAN OF CORRECTION (CAOF CORRECTIVE & CITON SHOULD BE Preadmission Screening and Resident Review F 278 PROVIDERS PLAN OF CORRECTION (FASRR) determination for one of one resident review (PASRR) determination to ensure The review of Section A1500 (Preadmission Screening and Resident Review F 278 Under section A1500 to reflect the level II PASRR and determined to to have a serious review (PASRR) determination to ensure the review (PASRR) determination to ensure Resident #5's annual Minimum Data Set (MDS) Streemine needs, appropriate care setting and a set of recommendations for services to help develop an individual plan of care. 3. LaDean Hair, RN, MDS will be resident #S section A1500 reflect the level II PASRR and determine needs, appropriate care setting and a set of <td< td=""></td<>

Facility ID: 922968

If continuation sheet Page 6 of 13

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		345212	B. WING _			C 24/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
BETHES	DA HEALTH CARE F	ACILITY		3532 DUNN ROAD EASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	II PASRR was read coded correctly. On 09/24/2015 at 1 Nursing indicated in	10:50 AM, the Director of t was her expectation that the termination would be coded	F 27	78 sections A1500. Then to titled "MDS section A15 done on all new admiss done on all quarterly an assessments on an ong ensure that MDS sectio accurately to reflect the preadmission screening review (PASRR) determ the results of this scree are used to determine r care setting and a set o recommendations for so develop an individualize used.	00, form 2" to be ions, and to be d annual going basis.to n A1500 is coded level II g and resident ning and review needs, appropriate f ervices to help	
F 312 SS=D	DEPENDENT RES A resident who is u daily living receives maintain good nutr and oral hygiene.	CARE PROVIDED FOR BIDENTS nable to carry out activities of s the necessary services to ition, grooming, and personal NT is not met as evidenced	F 3 [^]	12		10/23/15
	Based on observa interviews, the facil for one of four resid Daily Living (ADLs) Findings included: Resident #64 was	admitted to the facility on ident's diagnoses included		 Resident #64 could by this deficient practice ensure that this residen necessary services to n nutrition, grooming, and hygiene by cleaning resident thoroughly making sure and trimmed neatly. All residents could had be a sure could had be sure could had be a sure could had be a sure could had be a s	e. The facility will t receives the naintain good I personal and oral ident #64 nails they are cleaned	

Facility ID: 922968

If continuation sheet Page 7 of 13

		E & MEDICAID SERVICES	L				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	SURVEY PLETED
		345212	B. WING			(09/2	C 24/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BETHES	DA HEALTH CARE F	ACILITY			532 DUNN ROAD ASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 312	noted Resident #64	4 was severely cognitively	F 3	12	ensure that all residents receive the		
	impaired and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one or two persons. On 9/22/2015 at 5:00 PM, Resident #64 was				necessary services to maintain goo nutrition, grooming, and personal a hygiene by checking all the residen in the facility to ensure all resident are clean and trimmed neatly.	nd oral ts nails	
	observed in her wh nails were long on matter underneath	eelchair. All of Resident #64's both hands and had black			3. All nursing staff including nurses certified nursing assistants will be in-serviced by Caroline Horne, Administrator on proper nail care in the policy and procedure to ensure	cluding	
	Aide (NA) #2 stated or bed baths accor care, including was was provided durin	d residents received showers ding to their schedule. ADL shing hair and trimming nails, ig that time to residents. NA #2 4 was scheduled for a shower			 4. A. LaDean Hair, RN, QA, will ensure that all residents receive the necessary 	/giene. sure	
		:48 AM, Resident #64 was immed fingernails with black			services to maintain good nutrition, grooming, and personal and oral hy related to nail care by using new Q titled "nail care(now)" checking all residents now.	/giene	
	observed again wit untrimmed fingerna underneath. Nurse scheduled for show for 3-11 PM shift, a provided during sho also reported NAs resident 's nail car	9/23/2015 at 2:51 PM, Resident #64 was erved again with Nurse #1. The resident had immed fingernails with black matter erneath. Nurse #1 reported the resident was eduled for shower on Mondays and Fridays 8-11 PM shift, and nail care should be rided during shower or as needed. Nurse #1 reported NAs were responsible for the dent 's nail care as needed as somedays the dent needed set up only help with eating.			B. LaDean Hair, RN, QA, will ens that all residents receive the neces services to maintain good nutrition, grooming, and personal and oral hy related to nail care on an ongoing b using new QA form titled "nail care" done monthly on an ongoing basis.	sary ⁄giene þasis ' to be	
	Director of Nursing was ADL care inclu	3/2015, in an interview, the (DON) stated her expectation iding nail care would be uled and as needed.					

Facility ID: 922968

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		AND HUMAN SERVICES			FORM	10/20/2015 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT COM	E SURVEY IPLETED			
		345212	B. WING			C 24/2015			
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		0 . 0			
BETHES	DA HEALTH CARE FA	ACILITY	3532 DUNN ROAD EASTOVER, NC 28301						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 431	Continued From pa	ae 8	F 431						
F 431 SS=E	483.60(b), (d), (e) [-	F 431			10/23/15			
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is in reconciled. Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and permi have access to the The facility must princip permanently affixed comprehensive Dru Control Act of 1976 abuse, except when package drug distri	e expiration date when State and Federal laws, the III drugs and biologicals in ints under proper temperature t only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can							
	This REQUIREMEN	NT is not met as evidenced							

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES	-		0	FORM. MB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		345212	B. WING			C 09/24/2015	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA HEALTH CARE FA	ACILITY			532 DUNN ROAD ASTOVER, NC 28301		
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 431	Continued From pa	-	F 4	31		<i>.</i>	
	Based on observation, staff interview and the medication storage policy review, the facility failed to discard expired medications for 1 of 2 medication rooms (100 hall medication room), the facility failed to properly store medications to be administered to the residents for 2 of 3 nurses administering medications, and failed to date multidose tuberculin vial for 1 of 2 refrigerators. Findings included: The facility 's medication policy, (no date provided) was reviewed. Page #48 of medication policy under " discontinued drugs " states " contrary to the instruction on the drug returned to pharmacy or released to the patient form, the				 All residents could have been end by this deficient practice. The facilitiensure that 		
					A. no medications are left unattend the medication cart or in a resident B. That all medications are inspec	s room.	
					expiration dates and that all medica are dated when opened including b limited to Tuberculin (TB) vials.	ations	
					C. That all expired medications are promptly to the pharmacy per our f	acility	
					policy and procedure to be destroy This is to ensure all Drugs and biol		
					used in the facility are labeled in accordance with currently accepted	b	
	form along with oth pharmacy complete	nurse must list all controlled substances on the form along with other medications. The pharmacy complete the form supplied by the State Drug Authority ". #4 states " return			professional principles, and include appropriate accessory and caution instructions, and the expiration date applicable.	ary	
	medications and fo states " if medication	rms to the pharmacy ", and #5 ons are to be discharged with the responsible party sign the			 All residents could have been ef by this deficient practice. The facilit 		
	form then forward t				ensure that A. No medications are left unattend the medication cart or in a resident	ded on	
	storage and use da that Tuberculin vial	ated November 2013 indicated s in use more than 30 days d due to possible oxidation			B. That all medications are inspect expiration dates and that all medications are dated when opened including b	ed for ations	
		nich may affect potency.			limited to Tuberculin (TB) vials. C. That all expired medications are	e sent	
	medication room re	:40 AM observation of 100 hall evealed outdated medications			promptly to the pharmacy per our factorial policy and procedure to be destroy	ed.	
	7.5 mg filled on 9/4	filled on 11/18/2013 & Warfarin /2014 stored in a cabinet.			This is to ensure all Drugs and biol used in the facility are labeled in accordance with currently accepted	b	
) AM During an interview with the facility policy of			professional principles, and include appropriate accessory and caution		

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	OF DEFICIENCIES	KANNER STATE STREAM STREA				(X3) DATE	0938-039 SURVEY PLETED
		345212	B. WING			(09/2) 24/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BETHES	DA HEALTH CARE F	ACILITY			532 DUNN ROAD ASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 431	Continued From pa	age 10 e, states " we usually give the	F 4	31	instructions, and the expiration date	when	
	meds back to the f	amily, we can't use them nixed pills in one bottle of			applicable.		
	meds " . She stated that another " evening sh nurse is responsible for checking the medication rooms for expired medications " .	e for checking the medication			 All nurses will be in-serviced by Caroline Horne, Administrator to en that they are trained and know that drugs and biological used in the fac 	all	
	DON regarding the medications and m	5 10:19:14 AM During an interview with rding the facility policy of expired ns and medications brought from the s home, she stated that is the facility			are labeled in accordance with curra accepted professional principles, ar include the appropriate accessory a cautionary instructions, and the exp	ently nd and	
	medications broug	d back any expired pharmacy, and unidentified ht from the residents home ht back home with the			date when applicable. in-service inc but not limited to: A. no medications should be left unattended on the medication cart or in a residents roo	6	
	residents family. T is too long of a time	The DON stated that two weeks e frame to return the redications should be sent			That all medications are to be inspector for expiration dates and that all medications are to be dated when opened. C. That all expired medication	ected tions	
	the Administrator (<i>i</i> policy of expired m	14 AM During an interview with ADM) regarding the facility edication and medications			are to be sent promptly to the phar per our facility policy and procedure destroyed.	e to be	
	that it was her expe medications should medications brough	esident ' s home, she stated ectation that expired d be discarded and ht from the resident ' s home to the resident ' s family.			 4. LaDean Hair, RN, QA, will ensure A. No medications are left unattend the medication cart or in a residents B. That all medications are inspected expiration dates and that all medications 	ed on s room. ed for	
		4:44:19 PM During an			are dated when opened including b limited to TB vials.		
	observation of nurs administration, she medication cart for	e #4 of medication pulled the medications from resident #58, prepared uting them in water for			C. That all expired medications are promptly to the pharmacy per our fa policy and procedure to be destroyed using new QA form titled " Medication	acility ed. by	
	gastrostomy tube a then went to another	administration, locked cart, and er residents room, turning her nd leaving the medications on			to be done weekly X's 90 days then monthly on an ongoing basis.		

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		AND HUMAN SERVICES				FORM	10/20/2015 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		345212	B. WING				C 24/2015		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
BETHES	DA HEALTH CARE FA	ACILITY	3532 DUNN ROAD EASTOVER, NC 28301						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 431	for resident #58 and semi-private room f #38, and shut the d begin to administer gastrostomy tube, b something ", so sh bedside table, exite Upon returning to th administer the med 9/24/15 12:05 PM E nurse #4 stated she medications unatter resident 's room. 2b) 9/23/15 9:35:16 nurse #3 of medica out a bag containing Voltaren gel from th gel that was opened opened, and placed resident #28, includ Voltaren gel, but lef Voltaren gel on top unattended while sh room, shut the door medications to resid were not in her view 09/24/15 10:25:50A nurse #3 regarding on her cart. She st remember the 2 tub new and the other v about leaving them States it is not okay unattended and you	d then entered the for resident #58 and resident loor. She was preparing to her medications via her but stated she " forgot e left the medications on the ed the room and shut the door. he room, she began to lications. During a phone interview with e would not normally leave nded on the cart or in the 6 AM During an observation of tion administration, she pulled g topical medications of he medication cart, 1 Voltaren d and 1 that had not been d the mon top of her cart for collected the medications for ling 1 opened vial of the it the second unopened vial of of her medication cart he went into resident #28 r, and administered the dent #28, the medications	F 4	131					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						PRINTED: 10/20/2015 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
3452		345212	B. WING		C 09/24/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BETHESDA HEALTH CARE FACILITY			3532 DUNN ROAD EASTOVER, NC 28301				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 431	 Continued From page 12 unattended. States " I open the MAR to check for medications that are due, go through my meds, pull them out and verify the orders, and then I lock up my cart when I go into the resident ' s room ". 09/24/2015 10:57:36AM During an interview with DON regarding unattended medications. The DON states that " the nurse is to have their eyes on the medication cart at all times ", the cart should be locked when the nurse is not within reach and medications should never be left unattended at any time. 09/24/2015 10:57:36 AM During an interview with ADM regarding unattended medications. She stated that it is her expectation that medications should never be left unattended and should be kept locked on the medication cart. 		F 431	1			
	medication storage	AM During an observation of on the locked unit (200 hall), vial of Tuberculin 5TU/0.1ml date of opening.					
		A Staff interview with Nurse #2 I that it was missed. Stated t.					
		M Interview with DON/ADON ted that staff would date when vials.					
	1]	

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