	-	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
		345212	B. WING		08/25/2016
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•
BETHESD	A HEALTH CARE FACIL	ΙТΥ		3532 DUNN ROAD EASTOVER, NC 28301	
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 221 SS=E	483.13(a) RIGHT TO PHYSICAL RESTRA		F 221		9/16/16
	physical restraints im	right to be free from any posed for purposes of ence, and not required to edical symptoms.			
	by: Based on observatio record review, the fac medical symptom to j restraint (trunk restra systemic approaches the least restrictive m residents (Resident # reviewed for physical included: 1. Resident #66 was	 is not met as evidenced ns, staff interviews and cility failed to identify a ustify the use of a physical int) and failed to implement to reduce the restraint to ethod for 2 of 3 sampled and Resident # 81) restraints. Findings admitted 10/30/12 with s of Alzheimer 's disease, 		1. The administrator and Director of nursing will conduct an in-service to the restorative nurse by September 14, 20 that the resident has the right to be free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the residents medical symptoms. That there must be medical symptom identified to justify a physical restraint and implement a systematic approach to reduce the restraints to the least restrictive method	16 e e a
	 anxiety and macular A review of a physical summary dated 10/6/was seen for abnorm positioning. Residen a high back wheelchar posture. A nursing note dated 5:50 PM in which Residen a second sec	degeneration. I therapy discharge 15 indicated Resident #66 al posture and wheelchair t #66 was discharged using air to achieve improved 12/7/15 indicated a fall at sident #66 leaned forward		In addition, the administrator and Direc of nursing will conduct an in-service/tra the restorative nurse by September 14 2016 on the facility's restraint policy, no restraint assessment sheet, new sheet titled "documentation of least restrictive restraint/safety device restraint", and n sheet titled "resident evaluation for least restrictive method of restraint/safety device". Restorative nurse will read an	tor iin ew ew es st
	was written on 12/8/1 that fits snuggly in a v for positioning purpos	elchair and a physician order 6 for a lap buddy (a cushion wheelchair) to the wheelchair ses. aint Log completed by the		sign article titled "MDS News you can a on physical restraints and will read and sign CMS's RAI Version 3.0 Manual, Section P: Restraints pages P-1 thru P 2. The Administrator and Director of	I
ABORATORY	I DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
Electroni	cally Signed				09/13/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/15/2016

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>		· · /	ATE SURVEY OMPLETED
		345212	B. WING			08/25/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BETHESD	A HEALTH CARE FACIL	ΙΤΥ		3532 DUNN ROAD EASTOVER, NC 28301		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 221	Continued From page	e 1	F 22	1		
	restorative nurse indi AM, wedge cushion v s wheelchair for posit PM, Resident #66 wa throwing legs over the wedge cushion was in then placed in the wh positioning. The next dated 3/1/16 and indi used while Resident is due to poor positionir last Restraint Log not the lap buddy was uti positioning in the whe repeatedly slides hips wheelchair and the la and hip alignment. " A Fall Risk assessme Resident #66 was co with no falls in the lass The annual Minimum 6/20/16 indicated sev with no behaviors. Re having one fall without the upper or lower ex walker or wheelchair. coded on the MDS. Resident #66 was ca	cated on 12/8/15 at 8:00 was placed in Resident #66 ' ioning purposes. At 1:30 as noted to leaning over and e foot pedals while the n place. A lap buddy was neelchair for correct Restraint Log note was cated the lap buddy was #66 was up in the wheelchair ng and leaning forward. The te dated 6/10/16 indicated lized to provide correct eelchair. Resident #66 ' s " is forward to the edge of the p buddy correct the spine ent dated 5/23/16 indicated ded at a high risk for falls at 3 months. Data Set (MDS) dated vere cognitive impairment esident #66 was coded as at injury, no impairment to tremities and as using a There was no restraints re planned for falls on vention for a lap buddy to		 nursing will conduct an in-se nursing staff and IDT by Sep 2016 the facility's restraint por restraint assessment sheet, it titled "documentation of least method of restraint/safety de and IDT will read, learn, and titled "MDS News you can us physical restraints and will re CMS's RAI Version 3.0 Manu P: Restraints pages P-1 thru 3. In this circumstance there a systematic change. This w in-servicing and training restraint policy, by new facility forms to add to the facility restraint policy, by new facility form, new documents form, new documents form, new restraint form, new restraint form, new restraint form, new restraint form, and new restraint form	tember 14, blicy, new new sheet t restrictive vice". Staff sign article se" on ead and sign ual, Section P-7. is a need for ill be done by orative nurse, the following: r introduction ne facility w restraint mentation of ety device evaluation for straint/safety nt committee y using IDS News you ection P, and eve	
	In an observation on Resident #66 was ob	8/22/16 at 3:30 PM, served sitting with a lap wheelchair in the common		conduct direct observations of form titled "proper restraint u that any and all restraints that used follow the facility policy guidelines from the RAI man be done for resident # 66 and	using new se" to ensure at are being and ual. This will	

Facility ID: 922968

If continuation sheet Page 2 of 17

		MEDICAID SERVICES				0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345212	B. WING		08/	25/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHESD	A HEALTH CARE FACIL	ITY		3532 DUNN ROAD EASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 221	Continued From page	e 2	F 22			
	In another observation Resident #66 was ob the dining with a lap 10:36 AM, nursing as breakfast plate while attempting to remove wheelchair. NA #1 st take that off." In an interview on 8/2 stated she had know admission and was v stated the lap buddy ' s wheelchair becaus had a history of fallin #66 was able to take her wheelchair once take the lap buddy of to take the	on on 8/23/16 9:45 AM, oserved eating breakfast at buddy to her wheelchair. At ssistant (NA) #1 removed the		every current resident using a respective of the completed by September 16, on an ongoing basis any time a restraint is to be used. The QAP review all restraints being used; form titled "restraint committee r the daily QAPI meeting to be do September 16, 2016 and on an basis.	2016 and new I team will using new eview" in ne by	
	Resident #66 was tal music activity with th	8/24/16 at 10:30 AM, ken off the secured unit to a e lap buddy in place to her returned to the secured unit				

If continuation sheet Page 3 of 17

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/15/2016 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE	
		345212	B. WING				08/	25/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE		
BETHESD	A HEALTH CARE FACILI	ТҮ			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 PREF TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page	23	F	22 [,]	1			
	therapy or by the rest In an interview on 8/2 rehabilitation director been seen for position in October 2015. He s recommend the lap be initiated as a result of fall. He also stated he attempt discontinue th restorative nurse was In an interview on 8/2 restorative nurse reca buddy as a fall interve told during a fall team was for positioning to the wheelchair. The re had been no attempt try a less restrictive in last December. The re was not trained restra reduction attempts. In an interview on 8/2 Administrator stated in if the physician ordere positioning, it was not	he lap buddy was an or positioning either by orative nurse. 4/16 at 11:45AM, the stated Resident #66 had not ning since she was last seen stated therapy did not uddy but it likely was a fall team meeting after a was not aware of an he lap buddy because the over the restraints. 4/16 at 12:00 PM, alled discussing the lap ention. She stated she was meeting that the lap buddy keep her from falling from estorative nurse stated there to remove the lap buddy or itervention since it was apply estorative nurse stated she int usage or the need for 5/16 at 2:00 PM, the t was her understanding that						
	considered a restrain							

Facility ID: 922968

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/15/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE	
		345212	B. WING				08/	25/2016
NAME OF PI	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
BETHESD	A HEALTH CARE FACILI	ТҮ			3532 DUNN ROAD EASTOVER, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)N SHOULD B E APPROPRIA		(X5) COMPLETION DATE
F 221	Continued From page	- 4	F	221				
	1:50 PM when Reside	ll incident was 3/28/16 at ent #81 was ambulating in alance. Rest periods were						
		ian orders indicated a rdered 4/4/16 to be added to leaning.						
	issues unrelated to th	nt to the hospital due in e fall in March on 4/7/16 16 with orders for therapy.						
	dated 4/21/16 indicate mobility/management	was not indicated as a d the occupational therapy						
	restorative nurse indi cushion was used to a positioning in the whe cushion, Resident #8 made self propelling i was correctly and effi- wheelchair with the w Restraint Logs note d Resident #81 was lea wheelchair. A Velcro a applied but Resident is forward. A lap buddy provide correct position leaning forward.	alarming seat belt was						
	indicated severe cogr	sessment dated 6/18/16 hitive impairment with verbal rs, limited assistance with						

Facility ID: 922968

If continuation sheet Page 5 of 17

						FORM): 09/15/2016 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345212	B. WING		_	08/	25/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
BETHESD	A HEALTH CARE FACIL	ITY		3532 DUNN ROAD EASTOVER, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	to his lower extremitie wheelchair. Resident falls or a trunk restrain A review of the care p was 6/25/16 and Res planned for falls on 9/ the lap buddy was init 6/23/16. A nursing note dated indicated Resident #8 multiple attempts to tr assistance. Constant while in his wheelcha A nursing note dated physical therapy and continue to work with and transfers. There balance. A nursing note dated Resident #81 propels difficulty. A nursing note dated physical and occupati work on gait and trans ambulate 150 feet with A nursing note dated Resident #81 was obs leaning forward. The leaning was noted wh sitting in his wheelcha	nsteady gait with impairment es and the use of a t #81 was not coded for any nt. olan indicated the last review ident #81 was originally care (15/15. The application of tiated as an intervention on 6/13/16 at 4:00 PM 81 was restless and made ransfer himself without t wandering was observed ir on the secured unit. 6/16/16 at 4:40 PM read occupational therapy the Resident #81 on gait was no observed loss of 6/17/16 at 5:00 PM read in the wheelchair without 6/22/16 at 2:30 PM read ional therapy continue to sfers. Resident #81 can th hand held assistance. 6/22/16 at 4:00 PM read served multiple times note did not specify if the nile ambulating or while	F 221				

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/15/2016 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		345212	B. WING				08/	25/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
BETHESD	A HEALTH CARE FACILI	ITY			3532 DUNN ROAD EASTOVER, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 221	 8:30 AM read Resider forward in his wheeld A nursing note dated lap buddy was in place noted in upright prope buddy was discussed team and orders were A review of the physic wheelchair wedge cus 6/23/16 and a lap bud #81 's wheelchair for A review of the occup summary dated 6/23/ discharge, Resident # proper postural alignm minutes without a rece bend to pick up items maintaining balance. A review of the physic dated 6/30/16 Reside feet with contact guar assistance and able to balance. He was disc nursing for ambulation In an observation on 8 Resident #81 was obs room table eating bre- applied to his wheelch In an interview on 8/2 Assistant (NA) #2 kne admission to the facilit 	nt #81 was observed leaning hair. 6/23/16 at 9:00 AM read a ce and Resident #81 was er sitting position. The lap with the interdisciplinary e obtained for the lap buddy. cian orders indicated the shion was discontinued on ddy was applied to Resident positioning. ational therapy discharge 16 indicated at the time of 481 was able to maintain ment while standing for ten overy period and able to on the floor while cal therapy discharge note ent #81 was ambulating 300 d assistance to stand by o maintain head and trunk harged to restorative n. 8/25/16 at 8:47 AM, served sitting at the dining akfast with a lap buddy hair. 25/16 at 8:47 AM, Nursing ew Resident #81 since his ity. NA #2 stated she had	F	221		-FICIENCY)		
	room table eating bre applied to his wheelch In an interview on 8/2 Assistant (NA) #2 kne admission to the facili not received any train	akfast with a lap buddy hair. 5/16 at 8:47 AM, Nursing w Resident #81 since his						

Facility ID: 922968

If continuation sheet Page 7 of 17

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/15/2016 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		345212	B. WING			-	08/	25/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
BETHESD	A HEALTH CARE FACILI	ТҮ			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 PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 221	9:22 AM, NA #1 state since his admission to Resident #81 to remove wheelchair. Resident attempt to remove the made no effort to atter buddy. NA #2 stated Resident #81 leaning rather was known to o wheelchair up and fel In an interview on 8/2 rehabilitation director discharged from thera there was no therapy Resident #81 leaning but it must have been Medicare meeting for a lap buddy to his who In an interview on 8/2 restorative nurse state initiated the lap buddy leaning that day and to meeting decided to us restorative nurse state lap buddy was for pos considered a restraint stated there had been	burs for toileting. beservation on 8/25/16 at d she knew Resident #81 o the facility. She asked ove the lap buddy from his #81 required redirection to a lap buddy two times and mpt to remove the lap she had never observed while in his wheelchair but constantly stand up from his I a few times. 4/16 at 11:45 AM, the stated Resident #81 was apy on 6/30/16. He stated documentation regarding while up on his wheelchair o discussed in a fall or restorative to have applied eelchair. 4/16 at 12:00 PM, the ed she was unsure why she y but he must have been the group in the morning se a lap buddy. The ed she was told that if the	F	22*		PEFICIENCY)		
	since it was apply las nurse stated she was or the need for reduct In an interview on 8/2	t in June. The restorative not trained restraint usage tion attempts.						

If continuation sheet Page 8 of 17

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345212	B. WING		08/25/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BETHESD	A HEALTH CARE FACIL	ΙТΥ		3532 DUNN ROAD EASTOVER, NC 28301	
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 221 F 274	stated that since Resi remove the lap buddy considered a restrain restrictive device sho		F 221 F 274		9/16/16
SS=D	facility determines, or that there has been a resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside				
	by: Based on staff interv facility failed to compl Minimum Data Set (M (Resident #81) of 24 M MDS accuracy. Findin Resident #81 was add 10/8/14 with cumulati and benign prostate h sent to the hospital or facility on 4/20/16 with	mitted to the facility on ve diagnoses of dementia hypertrophy (BPH). He was n 4/7/16 and returned to the		1. The administrator and Director of nursing will conduct an in-service wi MDS/Care Plan coordinators by September 14, 2016 regarding: the must conduct a comprehensive assessment on a resident within 14 after the facility determines, or shou have determined, that there has bee significant change in the resident's physical or mental condition. (For purposes of this section, a significant	th facility days Id en a

Facility ID: 922968

If continuation sheet Page 9 of 17

CENTER STATEMENT (AND PLAN OF NAME OF P	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER A HEALTH CARE FACILI SUMMARY STA	TY	A. BUILDING B. WING S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 532 DUNN ROAD CASTOVER, NC 28301 PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL	FORI OMB NC (X3) DATE COMF 08/	D: 09/15/2016 M APPROVED D. 0938-0391 SURVEY PLETED /25/2016
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	'RIATE	DATE
F 274	indicated an discharg dated 4/7/16, an entry quarterly MDS dated 5/04/16 and a 30 day most recent MDS was 6/18/16. There was no change assessment v (CAAs). In an interview on 8/2 nurse stated there sho change MDS with CA Resident #81 was rea in condition. In an interview on 8/2 Administrator stated s	heter due to urinary assessments submitted e with expected return MDS / MDS dated 4/20/16, a 4/27/16, 14 day MDS dated MDS dated 5/18/16. The s a quarterly MDS dated o evidence of a significant with Care Area Assessments 5/16 at 11:15 AM, the MDS ould have been a significant As completed when admitted due to the change 5/16 at 2:00 PM, the she would have expected a sment that would have s in Resident #81 ' s	F 274	change means a major decline or improvement in the resident's status will not normally resolve itself withou further intervention by staff or by implementing standard disease-rela clinical interventions, that has an im on more than one area of the reside health status, and requires interdisciplinary review or revision of care plan, or both) In addition, the facility administrator Director of nursing will conduct an in-service and training by September 2016 to the MDS/Care Plan coordin using CMS's RAI MDS 3.0 Manual f May 2011 pages 2-20 thru 2-27 Star with significant change in status ass (CSA) and using article titled "MDS questions " developed by OHCA's e panel based on research of the exis MDS 3.0 manual and guidelines. 2. The administrator and Director of Nursing will conduct an in-service to IDT by September 14, 2016 regardin the facility must conduct a comprete assessment on a resident within 14 after the facility determines, or shou have determined, that there has bees significant change in the resident's physical or mental condition. (For purposes of this section, a significar change means a major decline or improvement in the resident's status will not normally resolve itself withou further intervention by staff or by implementing standard disease-rela clinical interventions, that has an im	ted pact int's f the and r 14, ators rom ting ess 3.0 xpert ting the ng: ensive days Id en a it that it that it	

Event ID: HQ6M11

Facility ID: 922968

If continuation sheet Page 10 of 17

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345212	B. WING		08/25/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/20/2010
				3532 DUNN ROAD	
BETHESD	A HEALTH CARE FAC		1	EASTOVER, NC 28301	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIC
F 274	Continued From pa	ge 10	F 274	 on more than one area of the resident health status, and requires interdisciplinary review or revision of the care plan, or both) In addition, the facility administrator ar Director of nursing will conduct an in-service and training by September 2016 to the MDS/Care Plan coordinate and IDT using CMS's RAI MDS 3.0 Manual from May 2011 pages 2-20 thr 2-27 Starting with significant change in status assess (CSA) and using article titled "MDS 3.0 questions " developed OHCA's expert panel based on resear of the existing MDS 3.0 manual and guidelines. 3. In this circumstance there is not a n for systematic change but rather staff education and direct observation to achieve compliance. 4. The facility Director of Nursing and QAPI coordinator will conduct direct observations using new form titled "significant change and assessment" form will be completed on all residents that the facility (IDT) determines there been a significant change in the reside physical or mental condition to ensure the MDS/Care Plan Coordinator has d a comprehensive assessment within 1 days. Resident # 81 will have a significant change in factor with the facility and the set of the	ne nd 14, ors u
F 278	483.20(g) - (j) ASS	ESSMENT	F 278	2016.	9/16/16

	-	ID HUMAN SERVICES				FORM	/ APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		345212	B. WING			08/	25/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 00/</u>	25/2010
BETHESD	A HEALTH CARE FACIL	ITY			532 DUNN ROAD		
				E	ASTOVER, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	a 11		278			
SS=D)INATION/CERTIFIED		278			
	The assessment mus resident's status.	t accurately reflect the					
	A registered nurse mu	ust conduct or coordinate					
	each assessment with						
	participation of health	professionals.					
	A registered nurse mu assessment is complete	ust sign and certify that the eted.					
		completes a portion of the n and certify the accuracy of sessment.					
	willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material and	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each					
	Clinical disagreement material and false sta	t does not constitute a tement.					
	by: Based on observatio record review, the fac the most recent comp Set (MDS) assessme	is not met as evidenced ns, staff interviews and sility failed to correctly code orehensive Minimum Data ent for physical restraints for ind Resident #80) residents s. Findings included:			1. The administrator and Director of nursing will conduct an in-service to MDS/Care Plan coordinators and restorative nurse by September 14, 20 that the assessment must accurately reflect the resident's status. A registere		

Event ID: HQ6M11

Facility ID: 922968

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PRINTED: 09/15/2016

		MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-039	
	LAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	. ,	COMPLETED		
		345212	B. WING		0	8/25/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
BETHESD	A HEALTH CARE FACIL	ΙТΥ		3532 DUNN ROAD EASTOVER, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 278	Continued From page	e 12	F 27	8			
	Continued From page 12 1. Resident #66 was admitted 10/30/12 with cumulative diagnoses of Alzheimer 's disease, anxiety and macular degeneration. The most recent MDS was an annual assessment dated 6/20/16. She was coded with severe cognitive impairment with no behaviors. Resident #66 was coded as having one fall without injury, no impairment to upper or lower extremities and as using a walker or wheelchair. There was no Care Area Assessment (CAA) completed for a physical restraint either. In an observation on 8/22/16 at 3:30 PM, Resident #66 was observed sitting in a wheelchair with a lap buddy (a cushion that fits snuggly in a wheelchair) applied to the chair. In another observation on 8/23/16 at 9:45 AM, Resident #66 was sitting at the table eating breakfast with a lap buddy applied to her wheelchair. In an observation on 8/23/16 at 12:00 PM, Resident #66 was asked by nursing assistant (NA) #2 to remove the lap buddy from her wheelchair. Resident #66 required multiple request and redirection to attempt to remove the			nurse must conduct or assessment with appro of health professionals. must sign and certify the is completed. Each indi completes a portion of must sign and certify the portion of the assessme must be coded correctly restraints. In addition, the adminis of nursing will conduct a training to the MDS/Ca coordinators and restor September 14, 2016 or policy, new restraint as new sheet titled "docum restrictive restraint/safe restraint", and new she evaluation for least rest restraint/safety device". will read and sign articly you can use" on physic will read and sign CMS Manual, Section P: rest thru P-7.	opriate participation . A registered nurse that the assessment ividual who the assessment he accuracy of the ent. That the MDS y for physical strator and Director an in-service and re Plan rative nurse by in facility's restraint isessment sheet, mentation of least ety device tet titled "restraint trictive method of . Restorative nurse e titled "MDS News cal restraints and i's RAI Version 3.0 traints pages P-1		
	buddy off her wheelcl wheelchair to keep he	-		2. The administrator an nursing will conduct an MDS/Care Plan coordir nurse and IDT by Septe	in-service to nators, restorative ember 14, 2016		
	nurse stated Residen MDS should have be since she was unable	24/16 at 12:00 PM, the MDS t #66 ' s 6/20/16 annual en coded for a trunk restraint e to remove the lap buddy S nurse also stated that had		that the assessment me reflect the resident's sta nurse must conduct or assessment with appro of health professionals.	atus. A registered coordinate each priate participation		

Facility ID: 922968

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	OF DEFICIENCIES						<u>NO. 0938-03</u>		
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345212	B. WING			o	8/25/2016		
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
BETHESD	ETHESDA HEALTH CARE FACILITY			3532 DUNN ROAD EASTOVER, NC 28301					
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE		
F 278	Continued From page	e 13	F 27	78					
	have been completed				is completed. Each individual who				
	and a set completed				completes a portion of the assessment				
	In an interview on 8/2			must sign and certify the accuracy of th					
	Administrator stated s			portion of the assessment. That the MD					
	the annual MDS asse			must be coded correctly for physical					
	have been properly c on Resident #66.	oded for the trunk restraint			restraints.				
					In addition, the administrator and Direct				
		admitted 9/03/2014 with			of nursing will conduct an in-service and	d			
	•	s of Diabetes, Dementia, ety Disorder, Depression and			training to the MDS/Care Plan	. d			
	Psychotic Disorder.			coordinators, restorative nurse, IDT, an nursing staff by September 14, 2016 or					
	Data Set (MDS) was			facility's restraint policy, new restraint	1				
	dated 8/10/2016. Sh			assessment sheet, new sheet titled					
	moderately impaired			"documentation of least restrictive					
	disorganized thinking			restraint/safety device restraint", and ne	ew				
		ded as having no falls, no			sheet titled "restraint evaluation for leas				
	restraint, and no impa	airments to upper or lower			restrictive method of restraint/safety				
	extremities. There w	as no Care Area			device". Restorative nurse will read and				
	Assessment (CAA) c	ompleted for a physical			sign article titled "MDS News you can u				
	restraint.				on physical restraints and will read and				
					sign CMS's RAI Version 3.0 Manual,	-			
	•	n on 8/22/2016 at 4:02 PM,			Section P: restraints pages P-1 thru P-7	1.			
	Resident #80 was ob	framed wheeled walker)			3. In this circumstance there is a need to	for			
		the Dayroom. In another			a systematic change. This will be done				
	•	2016 at 10:24 AM, Resident			in-servicing and training nursing staff,	,			
		ting in her Merrichair playing			MDS/Care Plan coordinators, IDT, and				
		all with other residents during			restorative nurse on the following: the				
	activities. At lunchtim	ne on 8/23/2016, Resident			facility restraint policy, by introducing ne	ew			
		ting in her Merrichair eating			facility forms to add to the facility restra	int			
	her lunch in the dining	-			policy to include: new restraint				
	-	n on 8/24/2016 at 3:45 PM,			assessment form, new documentation	of			
		ked by nursing assistant			least restrictive restraint/safety device	for			
		atch for the Merrichair.			restraint form, new restraint evaluation				
		ked several times and was nes to open the latch on the			least restrictive method of restraint/safe device form, and new restraint committe	-			
		unable to open the latch.			review form. Also, educate on restraints				
	mernenali. Olie was	מהמטוכ נט טורבוו נווב ומנטוו.	1		TOTICAL TOTIC AND CONCALE OF TEST AND	υ,	1		

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ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED			
		345212			08/25/2016	
	ROVIDER OR SUPPLIER A HEALTH CARE FACIL	ITY	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3532 DUNN ROAD EASTOVER, NC 28301		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 278	Continued From page	e 14	F 278	3		
	assisted Resident #8 positioning, but she h the latch.	She stated the Merrichair 0 with her ambulation and ad not seen her ever open		news you can use", and CMS's RAI version 3.0 manual, and by direct observations to achieve compliance		
	Nurse stated Resider 8/10/2016 should hav since she was unable latch when asked. The that had the MDS been	5/2016 at 9:30 AM, the MDS at #80 ' s annual MDS dated we been coded for a restraint to remove the Merrichair to remove the Merrichair and MDS nurse also stated en correctly coded, a CAA		4. The facility Director of nursing an QAPI coordinator will conduct direct observation using new form titled "p restraint use" to ensure that any and restraints that are being used follow facility policy and the guidelines from	t roper d all the n	
	Facility Administrator expected the annual	5/16 at 11:00 AM, the stated she would have MDS assessment dated e been properly coded for		CMS's RAI manual. This will be don resident #66 and #81, and all other residents that restraints are being us September 16, 2016 and on an ong basis any time a new restraint is to I used. The QAPI team will review all restraints being used; using new for titled " restraint committee review" in daily QAPI meeting to be done by September 16, 2016.	sed by oing be m	
	483.25(m)(1) FREE (RATES OF 5% OR M	OF MEDICATION ERROR	F 332	· · ·	9/14/16	
	The facility must ensumedication error rates	ure that it is free of s of five percent or greater.				
	by:	is not met as evidenced		1. The administrator and Director o	f	
	record review, the fac ordered three times of daily (QID) medicatio	ility failed to administrator laily (TID) and four times ns within the administration dent #18) of 3 residents		nursing will conduct an in-service ar train the medication nurse that administered medications out of the frame to resident #18 by September 2016, the facility policy for medication	nd time r 14,	

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345212	B. WING		0	8/25/2016
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
BETHESDA HEALTH CARE FACILITY		3532 DUNN ROAD EASTOVER, NC 28301				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 332	was restocking her m cups. She began pull #18 at 9:09 AM. Nurs #18 's prescribed 8:0 AM. The following me with the prescribed til Neurontin 400 m three times daily at 8: PM Sinemet 25-100 at 8:00 AM, 12:00 PM Systane one dro at 8:00 AM, 12:00 PM In an interview on 8/2 stated she was aware medications ordered AM and 9:00 AM but 's medications were stated she started he got report a little after unusual occurred the her medication pass. In an interview on 8/2 Nurse stated she sup hall and she observed medications on the ha when she arrived at w stated she was not av timeliness of medicati	edication cart with drinking ing medications for Resident of AM medications at 9:34 edications were not given me frame: hilligrams (mg) by mouth too AM, 12:00 PM and 4:00 mg by mouth four times daily A, 4:00 PM and 8:00 PM p in each eye four times daily A, 4:00 PM and 8:00 PM p in each eye four times daily A, 4:00 PM and 8:00 PM 24/16 at 9:37 AM, Nurse #1 e she could administer at 8:00 AM between 7:00 after 9:00 AM, Resident #18 considered late. Nurse #1 r medication pass after she r 7:00 AM and nothing to cause her to be behind on 24/16 at 3:30 PM, the Charge bervised the nurses on the d Nurse #1 passing all at approximately 7:20 AM work. The Charge Nurse ware of any issues regarding ion administration or d unusual early in the shift to a late passing the 8:00 AM	F 33	 2. The administrator and I Nursing will conduct an in train all nurses by Septem the facility policy on medic administration and the "5 medication administration 3. In this circumstance the for systematic change but education and direct obse achieve compliance. 4. The facility Director of r QAPI coordinator will com- observations for 1 month nurses administering med proper time frame. These will be documented and re during morning meetings Nurses failing to comply w facility progressive discipl and including termination Following 1 month of daily the facility will conduct me observations and report th monthly QAPI program er are sustained. 	-service and her 14, 2016, cation rights" of - ere is no need a rather ervation to hursing and duct daily regarding lications in the observations eviewed daily for compliance. vill be subject to inary code up to of employment. y observations onthly nrough facility's	

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DEPARTMENT OF HEALTH AN					FORM	APPROVED
CENTERS FOR MEDICARE & I						0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345212	B. WING			08/25/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA			EET ADDRESS, CITY, STATE, ZIP CODE			
BETHESDA HEALTH CARE FACILI		2 DUNN ROAD STOVER, NC 28301				
PREFIX (EACH DEFICIENC)	D SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE
at the times ordered, the contacted for orders to	ions were not administrated the physician should be	F	332			

Event ID: HQ6M11

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