### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345212	B. WING _		C 04/05/2018	
NAME OF PROVIDER OR SUPPLIER  BETHESDA HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3532 DUNN ROAD EASTOVER, NC 28301	,	
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must I medical record if the r and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by the (iii)Reviewed and revi team after each asses comprehensive and q assessments. This REQUIREMENT by: Based on record revi facility failed to invite conference for 1 of 1 (Residents # 17). Fin	ensive Care Plans brehensive care plan must  days after completion of seessment. erdisciplinary team, that ited to sician. e with responsibility for the  and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's breaticipation of the resident resentative is determined development of the  staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary esment, including both the uarterly review  is not met as evidenced ew and staff interviews, the the resident in the care plan sampled resident	F 6	1. The Administrator will conduct in-service with the MDS/Care Placoordinators on 04/24/18 to incluall Care Plans must be developed days after the completion of the comprehensive assessment and by the interdisciplinary team, that but is not limited to: the attending	nn de that d within 7 prepared t includes	

04/20/2018 **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.

Facility ID: 922968

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DOVIDED OD SUDDI IED	343212		CTDEET ADDRESS CITY STATE 71D CODE	02	/05/2018	
ROVIDER OR SUPPLIER						
BETHESDA HEALTH CARE FACILITY						
			EASTOVER, NC 28301			
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depression. The qual (MDS) assessment of Resident # 17's cogn had no short or long of Review of the interdist attendance record date Resident # 17 had a record did not indicat attended the conference of the con	arterly Minimum Data Set ated 1/3/2018 indicated that ition was intact. The resident term memory problems.  Sciplinary care conference ated 1/4/2018 revealed that care plan conference. The e that the resident had noce.  AM, Resident # 17 was ident stated that she had not e plan conference for the last indicated she wanted to be an o staff had discussed with and progress in her health. The she was admitted to the she further indicated she indicated she indicated she in the she was admitted to the she was admitted to the she was admitted to the she further indicated she int # 17 to the last care on 1/4/2018. She added that the conference is due she will ted.  FM, the Administrator was ted that she expected the be held every 3 months and ent's representative should	F 65	physician, a registered nurse wir responsibility for the resident, a with responsibility for the resident member of food and nutrition se staff, to the extent practicable, the participation of the resident and resident's representative(s). An explanation must be included in resident's medical record if the participation of the resident and resident representative is determined to the development resident's care plan, and other a staff or professionals in discipling determined by the resident's near requested by the resident, and react and revised by the interdisciplinal after each assessment, including comprehensive and quarterly reassessments. Finally, to ensure resident or responsible party involved to the care plan with signature and to circle if they cannot come in the appropriate box.  2. The Administrator will in-serving staff and all department heads/interdisciplinary team on 04/26/2018 to include that all Camust be developed within 7 days completion of the comprehensive assessment and prepared by the interdisciplinary team, that including the limited to: the attending physical staff and all department interdisciplinary team, that including the properties of the attending physical staff and the comprehensive assessment and prepared by the interdisciplinary team, that including the properties of the attending physical staff and all department interdisciplinary team, that including the properties of the attending physical staff and the resident and re	nurse aide nt, a rvices ne the a their nined not of the appropriate es as eds or as reviewed ary team g both the view that the ritation is ith their me or did . ice all are Plans s after the ee des but is sician, a		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page depression. The qual (MDS) assessment of Resident # 17's cogn had no short or long is Review of the interdis attendance record da Resident # 17 had a record did not indicat attended the conference On 4/3/2018 at 11:46 interviewed. The residen invited to a care 3 months. She also in discharged home but her about her goals a She indicated she was compared to the time facility.  On 4/4/18 at 10:59 A indicated she was residents and resider care plan conference did not invite Reside planning conference next time the residen make sure she is invi  On 4/4/2018 at 12:25 interviewed. She sta care plan meeting to the residents or residents	A HEALTH CARE FACILITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 depression. The quarterly Minimum Data Set (MDS) assessment dated 1/3/2018 indicated that Resident # 17's cognition was intact. The resident had no short or long term memory problems.  Review of the interdisciplinary care conference attendance record dated 1/4/2018 revealed that Resident # 17 had a care plan conference. The record did not indicate that the resident had attended the conference.  On 4/3/2018 at 11:46 AM, Resident # 17 was interviewed. The resident stated that she had not been invited to a care plan conference for the last 3 months. She also indicated she wanted to be discharged home but no staff had discussed with her about her goals and progress in her health. She indicated she was feeling much better compared to the time she was admitted to the facility.  On 4/4/18 at 10:59 AM, The MDS coordinator indicated she was responsible for inviting the residents and residents' representative to the care plan conference. She further indicated she did not invite Resident # 17 to the last care planning conference on 1/4/2018. She added that next time the resident's conference is due she will make sure she is invited.  On 4/4/2018 at 12:25 PM, the Administrator was interviewed. She stated that she expected the care plan meeting to be held every 3 months and the residents or resident's representative should be invited in the care plan conference every 3	A BUILDING  345212  B. WING  ROVIDER OR SUPPLIER  A HEALTH CARE FACILITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  depression. The quarterly Minimum Data Set (MDS) assessment dated 1/3/2018 indicated that Resident # 17's cognition was intact. The resident had no short or long term memory problems.  Review of the interdisciplinary care conference attendance record dated 1/4/2018 revealed that Resident # 17 had a care plan conference .The record did not indicate that the resident had attended the conference.  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She added that next time the residents representative to the care plan conference on 1/4/2018 and 1/2018 to include that all Care Plans must be developed within 7 days after the completion of the comprehensive assessment and prepared by the interdisciplinary team, that includes but is not limited to: the attending physician, a registered nurse with responsibility for the resident and res	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345212	B. WING			04//	05/2018	
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				3532 DUNN ROAD				
BETHESD	A HEALTH CARE FACIL	ITY		EASTOVER, NC 28301				
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F 657	Continued From page	e 2	F6	resident and the resident's representative(s). An explana included in a resident's medic the participation of the resider resident representative is det practicable for the developmer resident's care plan, and other staff or professionals in discip determined by the resident's requested by the resident, and revised by the interdiscip after each assessment, inclusion comprehensive and quarterly assessments. Finally, to ensure resident or responsible party documented on the care plan signature and to circle if they not come in the appropriate be ensure that all staff is knowle regulation 483.21 Care Plan revision and that they are expected be present for these meeting explained that this is a necessmandatory process to ensure receives the best possible care deucation and inspection. The Plan coordinators will ensure necessary persons will be predevelopment of the comprehences and the comprehence is documented.  4. The facility's QAPI coordin conduct an audit of all comprehence plans using new QAPI to a cordinators using new quality of a cordinators using new QAPI to a cordinators using new quality and the cordi	cal record ent and the termined nent of the er appropriphines as needs or and reviewed olinary tearding both to review ure that the invitation in with their came or doox. This wadgeable of timing and pected to pment and so it will be sary and er the resident enter staff the MDS/Cate that all the ensive Carriat present:	if ir oot iate as d m the e is did f l to e ent d are		

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		345212	B. WING _			04/05/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
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DETTILOD	A HEALIN OAKE I AOIL			EASTOVER, NC 28301			
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F 657	Continued From pag	e 3	F 6	"care plan development" to e Care Plans must be develop days after the completion of comprehensive assessment by the interdisciplinary team, but is not limited to: the atter physician, a registered nurse responsibility for the resident with responsibility for the res member of food and nutrition staff, to the extent practicable participation of the resident a resident's representative(s). explanation must be included resident's medical record if the participation of the resident a resident representative is de practicable for the developmant resident's care plan, and othe staff or professionals in discidetermined by the resident, and and revised by the interdiscing after each assessment, included comprehensive and quarterly assessments. Finally, to ensame resident or responsible party documented on the care plan signature and to circle if they not come in the appropriate lensure that all staff is knowled regulation 483.21 Care Plan revision and that they are exampled in the process of develope present for these meeting explained that this is a necessment of the process of developed the process to ensure receives the best possible called the process of developed the process	ed within 7 the and prepared that includes ding with t, a nurse aide ident, a services e, the and the An d in a he and their termined not ent of the er appropriate plines as needs or as nd reviewed colinary team ding both the y review ure that the invitation is n with their y came or did box. This will edgeable of timing and pected to opment and to ys. It will be essary and e the resident are. This form		

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NAME OF P	ROVIDER OR SUPPLIER	0.02.12		STREET ADDRESS, CITY, STATE, ZIP CODE		04/05/2018
				3532 DUNN ROAD	•	
BETHESDA HEALTH CARE FACILITY				EASTOVER, NC 28301		
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