PRINTED: 12/27/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		ATE SURVEY MPLETED
		345146	B. WING _			11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F O	00		
	through 11-16-18. Im	ey was conducted 11-13-18 Imediate Jeopardy was .12 at tag F689 at a scope				
	The tag F689 constitu Care.	uted Substandard Quality of				
		began on 7-22-18 and was . An extended survey was				
F 558 SS=D	Reasonable Accomm CFR(s): 483.10(e)(3)	odations Needs/Preferences	F 5	58		12/16/18
	services in the facility accommodation of re preferences except wendanger the health of other residents.	sident needs and				
	Based on observation interview, and record place a breath activation resident with quadriplication request assistance for	n, resident interview, staff review, the facility failed to sed call light within reach of a legia to allow for him to r one of one residents wed for accommodation of		Bethany Woods Nursing and Rehabilitation Center acknowle receipt of the Statement of Def and proposes this Plan of Corr the extent that the summary of factually correct and in order to compliance with applicable rule provisions of quality of care of	ficiencies rection to findings is o maintain es and	
	The findings included Resident #71 was init	: ially admitted to the facility		The Plan of Correction is subm written allegation of compliance Woods Nursing and Rehabilita	e. Bethany	
		ost recently readmitted on		Center s response to this State Deficiencies does not denote a with the Statement of Deficiencies does it constitute an admission	tement of agreement cies nor	
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITLE		(X6) DATE

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

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

12/07/2018

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345146	B. WING		44/46/2040
NAME OF P	ROVIDER OR SUPPLIER	040140		STREET ADDRESS, CITY, STATE, ZIP (11/16/2018
NAME OF T	NOVIDEN ON 3011 EIEN			33426 OLD SALISBURY ROAD BOX	
BETHANY	WOODS NURSING	AND REHABILITATION CENTER			1250
				ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE
F 558	Continued From p	page 1	F 5	558	
F 558	The quarterly Min assessment dated #71's cognition was dependent for (ADLs). Resident 71's platic 10/9/18, indicated staff for assistance. The Resident Carrindicated a mouth place since 5/19/2. An observation ar with Resident #71 was breath activated on the indicated that ask his roommated needed assistance. An observation ar with Resident #71 Resident #71 Resident #71 Resident #71 Resident #71 was breath activated of the indicated that ask his roommated needed assistance.	imum Data Set (MDS) d 10/1/18 indicated Resident was fully intact. Resident #71 or all Activities of Daily Living an of care, last reviewed I he was totally dependent on e with all ADLs. The Guide for Resident #71 The blowing call system was in IT. The dinterview were conducted I on 11/13/18 at 3:20 PM. The Salying on his back in bed. His call light was about a foot above ont #71 stated that he had the was not able to reach the call light to request assistance. When this occurred he had to the to press his call light if he e. The dinterview were conducted I on 11/14/18 at 9:00 AM. The sylving on his back in bed and his call light was over a foot above orted that he was unable to	F 5	deficiency is accurate. Fur Woods Nursing and Rehat reserves the right to refute deficiencies on this Statem Deficiencies through Inform Resolution, formal appeal and/or any other administration proceedings. F 558 How corrective action will be accomplished for those resent have been affected by the practice On 11/16/18 resident sea caplaced within reach by the Visual observations are periodially compliance rounds must having the potential to be a same deficient practice On 11/16/18 an observation completed by a nursing state ensure that all call lights we placed within residents for the audit revealed that 89 lights were within reach of All call lights not in reach of were placed appropriately	collitation Center any of the ment of mal Dispute procedure ative or legal De sidents found to deficient all light was hall nurse. erformed during monitoring. If other residents affected by the an audit was aff member to here properly heach. If of the call heresident. Ituring the audit
	on 11/16/18 at 6:5 on his back in bed activated call light and was inaccess	as conducted of Resident #71 50 AM. Resident #71 was lying d sleeping and his breath t was over a foot above his head sible to the resident. conducted with Nursing		What measures will be put systemic changes made to the deficient practice will n Beginning 11/17/18 re-edu initiated by the RN Staff Deficient will be put system to be put system to be put and the put system to be put system.	o ensure that ot recur

Facility ID: 923032

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SU COMPLET	
		345146	B. WING _			11/	16/2018
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				33	3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		Α	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	stated she was assig stated that Resident activated call light freassistance. She stat call light was to be pl Resident #71's mouthim. NA #9 was ask breath activated call. She indicated she hards is room yet so she hiplaced. An observation was considered call light was not within Resident was not within Resident was asked where Resident #71's breath activated call light was not within reach of his more position it himself. A phone interview was constituted in the sident within reach of his more position it himself. A phone interview was considered with Resident was asked where Resident #71's breath activated with Resident #71's breath activated with Resident was asked where Resident #71's breath activated was asked where Recall light was placed morning (11/16/18). recalled where it was	11/16/18 at 7:45 AM. NA #9 ned to Resident #71. She #71 utilized his breath equently to request ed that the breath activated	F	5558	Coordinator (SDC) for all staff regarding call lights to be placed within reach of the resident. Re-education will be completed by 12/16/18. Any staff members not receiving re-education by 12/16/18 will be allowed to work until education is completed. New hires and agency staff will receive this education during orientation to the facility. The assigned department heads (will include but not limited to nurse supervisors, Social workers, Quality Improvement (QI) nurse, Assistant Director of Nursing (ADON)) will be responsible for compliance round monitoring that includes the placement call lights on a daily basis at various tin including weekends. The assigned department heads will report to the Interdisciplinary Team any negative findings and corrective actions taken. How the facility plans to monitor its performance to make sure that solution are sustained The results of these daily compliance rounds will be given to the QI Nurse to track and trend. Findings will be reported at the monthly Quality Improvement (Q meeting for 3 months and quarterly thereafter. The Administrator or Director of Nursing (DON) will monitor the completed compliance rounds to identify any concerns expressed by residents related to call bell placement. The Administrator DON will immediately validate any	he ed not ff of nes	
	as he was not able to was asked where Re call light was placed morning (11/16/18). recalled where it was Resident #71 require	o reposition it himself. She sident 71 's breath activated at the end of her shift that She stated that she had not it. NA #16 indicated that if			The Administrator or Director of Nursing (DON) will monitor the completed compliance rounds to identify any concerns expressed by residents related to call bell placement. The Administrator	ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345146	B. WING		11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
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F 558	have asked his roomine would have yelled member pass the doc. An interview was con Administrator and Dir at 8:00 AM regarding activated call light not reach. They both ind were for staff to place activated call light wit times. Safe/Clean/Comforta	mate to call for assistance or out when he saw a staff orway to his room. ducted with the ector of Nursing on 11/6/18 Resident #71 's breath being placed within his icated their expectations. Resident #71 's breath hin reach of his mouth at all	F 58	timely manner. The QI Nurse will present Interdiscip Team (IDT) corrective actions and resident concern corrective actions to monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, recommendations. The administrate and/or DON will present trends and committee recommendations to the Executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Reasonab Accommodations Needs/Preference related to call lights. The administrator consulted with the medical director and the nurse pract regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	o the f and or QI	
SS=E	§483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environment use his or her person possible. (i) This includes ensure	onment. In to a safe, clean, elike environment, including iving treatment and g safely.				

	ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _		11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	,
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 584	independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary and comfortable int §483.10(i)(3) Clean in good condition; §483.10(i)(4) Privat resident room, as s §483.10(i)(5) Adequevels in all areas; §483.10(i)(6) Comflevels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT Sound levels. This REQUIREMENT Sound levels are interviews, the facil packaged terminal clean, walls clean a bathroom floors clean	ne facility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,	F 5	F 584 Safe/Clean/Comfortable/Homelil Environment How corrective action will be accomplished for those residents four have been affected by the deficient practice On 11/19/18, the maintenance direct	and to
	On 11/16/18 startin	g at 10:00 am to 12:15 pm, 32 were available for		and housekeeping supervisor cleane Packaged Terminal Air Conditioner (PTAC) Units in rooms 103, 105, 206	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING_			11	/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	-		ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
DETHAND	(WOODO NUIDOINO	AND DELIABILITATION OF NEED		33	3426 OLD SALISBURY ROAD BOX 1250			
BETHANY	WOODS NURSING	AND REHABILITATION CENTER		Al	LBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 584	Continued From p	age 5	F 5	584				
	1	cility halls 100 through 800 were			210, 305, 310, and 313.			
		ollowing concerns:			By 12/16/18, the maintenance director	· will		
		3 11 11 1			repair and paint the metal wall trim in			
	1. The PTAC units	s in rooms 103, 105, 206, 210,			rooms 200, 202, and 203.			
	305, 310, 313 wer	re observed to appear dirty with			By 12/16/18, the maintenance director	will		
		wer air intake vent, and grey			repair damage to the walls in rooms 2	11,		
	dust and white ma	atter in the air output.			301, 304, 606, 607, and 801A.			
	On 11/16/19 of 11	20 am an intension with			By 12/16/18, the maintenance director			
		:30 am an interview with PTAC units was conducted			and housekeeping supervisor will work collaboratively to clean, repair and/or			
		nce Director who stated that the			replace linoleum flooring in rooms 103	Ĺ		
		cleaned once a year by			200, 205, 206, 210, 211, 309, 313, 408			
	maintenance staff	which started in March 2018.			and 607.			
		were all completed and a few			How the facility will identify other resid	ents		
). The Maintenance Director			having the potential to be affected by t	he		
		interview he observed a dirty			same deficient practice			
		200 with dust, food and paper			On 11/20/18 the Maintenance director	-		
	·	output vent and commented TAC) are "really dirty" the unit			housekeeping supervisor performed a observation audit of all rooms in the	n		
		d and taken apart to be cleaned			facility to determine any other rooms			
	in the shop.	and taken apart to be dicarred			needing some type of wall repair, PTA	C		
	ar are errop.				cleaning, and/or cleaning/repair of	J		
	On 11/16/18 at 11	:55 am interview was conducted			bathroom floors. There were 74 room	S		
	with a maintenance	ce staff person who stated that			noted to need some type of wall repair	.,		
		ere cleaned once a year and			PTAC cleaning and/or repair and or			
		the facility depicting the			cleaning of bathroom floors.			
		which were documented as			By 12/16/18 the maintenance director			
	cleaned by highlig	inting.			formulate a prioritized repair calendar.			
	2. The metal wall	trim in rooms 200, 202, 203			11/17/18, the maintenance director an maintenance assistant began complet			
		and was rusted and rotted			the repairs and maintenance tasks in	"'IY		
		ated a hole approximately			order of priority. The cited room repair	rs		
	2-inches.	F.F			will be completed by 12/16/18.			
	In room 211, there	e was approximately a 4-inch			What measures will be put into place of	or		
	hole in the wall an	d bathroom door.			systemic changes made to ensure tha	t		
					the deficient practice will not recur			
		ultiple brown soil splatter spots						
	on the wall surrou	nding the bathroom door.			Beginning on 11/17/18 with completion	ı by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER	•	33	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002			
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F 584	In rooms 606 and 60 2-inch hole/damage In room 801A, the washing paint and hadamage with a deprior of 11/16/18 at 11:3 observation of walls Halls 100 and 200 washintenance Direct about the rusting mathrooms. 3. Rooms 103, 200, 408, and 607 all had stain/soil ring around linoleum flooring. The toilet where it maigrate. The linoleum	was approximately a 6-inch 07, there was approximately a in the bathroom wall each. wall lateral to the bed was ad approximately 15-inch wall ression of 1-inch. 0 am an interview with i, and bathroom condition on was conducted with the or who made no comment retal trim in the resident 's 205, 206, 210, 211, 309, 313, d bathroom floor brown d the toilet base in the here was a gap at the base of ret the floor and water could um appeared dry and	F	584	12/16/18, the Director of Nursing (DON and/or Staff Development Coordinator (SDC) initiated an in-service with licens nurses, nursing assistants, geriatric car assistants, and agency staff. The in-service reviewed the process for completing and submitting work orders repairs to include PTAC Units, metal w trims, and damage to the walls. After 12/16/18, the Staff Development Coordinator will educate all newly hireclicensed nurse, nursing assistant, geria care assistant, and agency staff on the work order process, during orientation the facility. By 12/16/18 the maintenance director of formulate a prioritized repair calendar. 11/17/18, the maintenance director and maintenance assistant began completing the repairs and maintenance tasks in order of priority. The cited room repairs will be completed by 12/16/18.	sed for all tric to will On I		
	resembled urine and the toilet floor was the compared to the oth floors. On 11/16/18 at 10:1 conducted with hous stated the caulk was toilet and the floor hicken. The linoleum was damaged and his	n had strong odor that d the stain ring at the base of he darkest and largest area her 9 observed bathrooms 5 am an interview was se keeper #3 on hall 200 who is missing from the base of the had become soiled and hard to har around the base of the toilet had more odor. House keeper had not created a work order			How the facility plans to monitor its performance to make sure that solution are sustained On 12 /10 /18, the department heads (administrator, director of nursing, unit managers, social services director, activities director, bookkeepers, payroll maintenance, housekeeping, and dieta manager) began weekly compliance monitoring rounds to ensure a clean ar functional environment. The departme heads will document findings on the Compliance Monitoring rounds tool for weeks. Identified issues will be	ry nd nt		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345146	B. WING		1	1/16/2018
NAME OF PI	ROVIDER OR SUPPLIER		_ 	STREET ADDRESS, CITY, STATE, ZIP COD		1710/2010
				33426 OLD SALISBURY ROAD BOX 12	50	
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From page	e 7	F 58	34		
	floors in rooms 200, 2 She further comment hard to clean in room	epair the soiled, stained 202, 203, 206, 210, and 211. ted the floor was especially 1 211.		immediately addressed by the head and reported to the addressed maintenance director, and/or housekeeping supervisor. The maintenance director and housekeeping supervisor will	ninistrator,	
		e keeper #4 who stated she wn soil at the base of the		issues related to a safe, clear comfortable, and homelike er	n,	
	toilet and commented and was harder to cle not aware of any plar the toilet.	d that it does not come off ean. House keeper #4 was n to replace the floor around		the monthly quality improvem committee for review, identifications, additional corrective a recommendations. The main director, housekeeping super	nent (QI) cation of actions, and atenance visor, and/or	
	observation of walls, Halls 100 and 200 wa	am an interview with and bathroom condition on as conducted with the r who made no comment		administrator will present trer committee recommendations executive QI committee for readditional recommendations,	to the eview,	
	toilet in the resident '			determine the need for continuous monitoring to ensure continuous compliance in the area of the	ed facility	
	with a maintenance so the resident bathroom rusted from moisture. The maintenance state toilet base is not caul water builds up unde damage. The floor's the toilet was soil that the toilet when cleani underneath. The tile from soil and the tile. There was no current	am interview was conducted staff person who stated that in wall metal trim which had was from washing the floor. If person further stated the liked at the floor because in the toilet and can cause is brown ring at the base of it staff pushed underneathing and damaged the tile was sealed but broke down needed to be replaced. It plan to replace the tile. The rson provided no comment or damaged walls.		maintaining a safe, clean, col and homelike environment fo residents.		
	On 11/16/18 at 2:30 p conducted with the A commented she was	dministrator who				

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	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002			
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F 584	bathroom floor condit	e 8 of the PTAC, walls, and ion and that "they would be administrator provided no	F	584				
F 585 SS=D	she expected mainter	irector of Nursing who stated nance to keep the PTAC rair the walls and bathroom I and/or soiled.	F	585			12/16/18	
	grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as t furnished, the behavior	ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or nices include those with eatment which has been that which has not been or of staff and of other concerns regarding their LTC						
	facility must make pro	ident has the right to and the ompt efforts by the facility to e resident may have, in paragraph.						
		ility must make information ance or complaint available						
	of all grievances rega	ility must establish a nsure the prompt resolution rding the residents' rights graph. Upon request, the						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
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F 585	to the resident. The ginclude: (i) Notifying resident i postings in prominent facility of the right to f (meaning spoken) or grievances anonymore of the grievance officican be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the coindependent entities to be filed, that is, the polymer of the grievance; and the coindependent entities to be filed, that is, the polymer of the grievance of the gr	copy of the grievance policy rievance policy must andividually or through clocations throughout the ile grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone expected time frame for or of the grievance; the right cision regarding his or her with whom grievances may entinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is eeing the grievance process, grievances through to their any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ing immediate action to tial violations of any resident	F	585			

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED				
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	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER	•	33	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	anyone furnishing se provider, to the admi as required by State (v) Ensuring that all vinclude the date the summary statement the steps taken to invisuomary of the pertiregarding the resider as to whether the griconfirmed, any corretaken by the facility and the date the write (vi) Taking appropriataccordance with State of the residents' right or if an outside entity the State Survey Age Organization, or locaton frights within its area (vii) Maintaining evid result of all grievance 3 years from the issued ecision. This REQUIREMENT by: Based on record revistaff interviews, the first written grievance residence. Findings included: 1. Resident #48 was according to the admits a second to the second test and test and test and test and te	ion of resident property, by rvices on behalf of the nistrator of the provider; and law; vritten grievance decisions grievance was received, a of the resident's grievance, vestigate the grievance, a nent findings or conclusions nt's concerns(s), a statement evance was confirmed or not ctive action taken or to be us a result of the grievance, ten decision was issued; te corrective action in te law if the alleged violation is is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents'	F	585	F 585 Grievances How corrective action will be accomplished for those residents found have been affected by the deficient practice On 12/6/18, the administrator mailed a written grievance summary to Resident #48 seriolent representative and handelivered a written grievance summary resident #71.	ts d	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		345146	B. WING _			1 11	/16/2018
NAME OF P	ROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE		7.10.20.10
				33	426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING	AND REHABILITATION CENTER		Al	LBEMARLE, NC 28002		
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F 585	Continued From p	page 11	F t	585			
	·	iving (ADL) self-care deficit.			How the facility will identify other residuating the potential to be affected by		
		ysician note dated 9/7/18 lent complained of increased			same deficient practice		
	urination especial increased Lasix fo	ly during the night secondary to or edema.			On 11/17 /18, the administrator review the grievance concern log for complet of the resolution process. The		
	resident complain diuretic dose increpersonal hygiene supplies for groor independent, and reminders. Care resident ADL reminders. The quarterly Min revealed the resident. The resident cognition. The reset up for ADLs at	ed 9/18/18 revealed the ed of increased urination with ease, the resident required ADL little or no help to include: ning within easy reach, dressing toileting supervision and plan updated on 11/18 revealed ained highly, physically imum Data Set dated 10/30/18 lent had a moderately impaired sident required supervision with nd was independent with set up tive diagnoses were CKD stage			administrator audited grievances filed from 11/1/18 through 11/16/18. The a revealed five grievances closed witho providing a written grievance summar follow-up to the resident/resident representative. Grievance follow ups those residents were mailed or hand delivered by 12/16/18. To protect othe residents having the potential to be affected, the facility will provide a writt grievance summary for all resident grievances filed after 11/16/18. What measures will be put into place systemic changes made to ensure that the deficient practice will not recur	audit ut y for er en	
	3 and activities of deficit. The reside pill). On 11/16/18 at 11 conducted with the September he was a church minister was changed and up by the minister again. The reside increase in his Laurinating frequent The resident state needed incontined leave for church,	daily living (ADL) self-care ent received a diuretic (water :45 am an interview was e resident who stated that in s planned for and picked up by to go to church. The resident dressed prior to being picked but had urine incontinence ent stated that he had a new six due to edema and was ly and felt it was out of control. ed he filed a grievance that he nce care again immediately to but it was not provided when the o leave. The resident decided			On 12/7/18, the corporate consultant in-serviced the social workers, directo nursing and administrator on the Resi Concerns and Grievance Guidelines process. The in-service included the facility will provide written response to resident/resident representative speal on behalf of the resident who file a grievance; a request for a written response is not required. The written response will include the date the grievance was received, a brief description of the grievance, a brief description of findings of investigation any corrective action. On 11/16/18, the social workers and/or	the king and	

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		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER Y WOODS NURSING AND	REHABILITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002			
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F 585	to leave with the mini odor in church. The in was filed, and he recommon staff to address stated he did not recommon resolution from the farman and interview was con administrator on 11/1 indicated that prior to grievance summaries reporting party for all that beginning in Augwas changed and the provide grievance sum reporting party. She written grievance sum Resident #48 or to the grievance dated 9/3/2 indicated that she exprelated to grievances. 2. Resident #71 was facility on 5/9/17 and readmitted on 8/22/18 included quadriplegia. The quarterly Minimulassessment indicated was fully intact. A Facility Concern/Grievance Finvestigation findings member voicing the concern/Grievance Finvestigat	ster and felt he had urine resident stated a grievance eived an in-person response his grievance. The resident eive a written grievance cility. ducted with the 4/18 at 3:00 PM. She August of 2018 written is were provided to the grievances. She revealed ust 2018 a corporate policy ey were instructed to only immaries if requested by the acknowledged that no inmary was provided to reporting party for the last The Administrator pected the regulations to be followed. initially admitted to the was most recently in the was m	F	585	the administrator began reviewing grievances during the morning interdisciplinary team (IDT) meeting to ensure resolutions and actions taken who be communicated to the resident and/oresident representative, including a writing grievance response. On 11/16/18, the administrator began reviewing the grievance concern log weekly and will ensure all grievances completed include written responses to the resident/resident representative. How the facility plans to monitor its performance to make sure that solution are sustained On 11/16/18, the social workers and/or administrator will begin presenting any issues related resident grievances to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The social workers and/or administrator will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of the grievance.	er etten	

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F 585 F 600 SS=G	findings/summary of provided to Resident Further review reveal signed the Concern/obeen complete on 11. An interview was contil/13/18 at 3:20 PM. member filed a griev related to an appoint lack of transportation nor his family member grievance summary investigation. An interview was contal family member grievance summary investigation. An interview was contal family member grievance summaries reporting party for all that beginning in Augwas changed and the provide grievance surreporting party. She written grievance surreporting party. She written grievance surreporting party indicated that she expelled to grievances. Free from Abuse and CFR(s): 483.12(a)(1)	the grievance had not been #71 or to his family member. led the Administrator had Grievance Form as having /9/18. Inducted with Resident #71 on He stated that his family ance a couple of weeks ago ment he missed due to a late. He indicated neither he er had received a written reporting the findings of the late of August of 2018 written is were provided to the grievances. She revealed just 2018 a corporate policy lev were instructed to only mmaries if requested by the acknowledged that no many was provided to the reporting party for the late of the regulations is to be followed. In Neglect		685		12/16/18	
	Exploitation The resident has the neglect, misappropriand exploitation as d	om Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345146	B. WING		11/16/2018		
	ROVIDER OR SUPPLIER Y WOODS NURSING A	ND REHABILITATION CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002			
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F 600	any physical or che treat the resident's §483.12(a) The face §483.12(a)(1) Not uphysical abuse, cor involuntary seclusic This REQUIREMED by: Based on observation Practitioner (NP) are interviews and reconeglected to assess a resident with compain following a fall x-ray dated 10/30/1 through 7th ribs on (Resident #30) or 1 neglect. The finding Resident #30 was a cumulative diagnose Congestive Heart FLeg Syndrome and Resident #30's qual (MDS) dated 8/15/2 cognitive impairment (BIMS) score of 12 behaviors and limit Resident #30 was a cumulative films) score of 12 behaviors and limit Resident #30 was a cumulative impairment (BIMS) score of 12 behaviors and limit Resident #30 was a cumulative films) was a cumulative impairment (BIMS) score of 12 behaviors and limit Resident #30 was a cumulative films) was a cumulative impairment (BIMS) score of 12 behaviors and limit Resident #30 was a cumulative films)	ont, involuntary seclusion and smical restraint not required to medical symptoms. Illity must- use verbal, mental, sexual, or poral punishment, or on; NT is not met as evidenced Itions, resident, staff, Nurse and Medical Director (MD) ord review, the facility and treat tinued complaints of left rib on 10/17/18. A diagnostic are revealed fractures to the 3rd the left side. This was for 1 residents reviewed for an included: Indicated on 5/15/18 with the se of Atrial Fibrillation, failure, Osteoarthritis, Restless Delusional Disorder. Interly Minimum Data Set and indicated moderate and with a Brief Mental Status. She was coded with no end assistance with ambulation. Coded with no impairments to	F 600	F 600 Free From Abuse and Negle How corrective action will be accomplished for those residents four have been affected by the deficient practice Resident #30 has had decreased complaints of left side rib pain and is receiving scheduled pain medication along with an additional order for PR pain management. How the facility will identify other residenting the potential to be affected by same deficient practice. The DON and QI nurse reviewed incidents for the two weeks prior to November 16 to determine if any oth incidents resulted in complaints of pathat were untreated. The audit reveal no other residents with untreated pain The Interdisciplinary Team(IDT) will reall residents with incidents, including	nd to N dents the er ain aled n. eview falls		
	Resident #30's qua (MDS) dated 8/15/ cognitive impairme (BIMS) score of 12 behaviors and limit Resident #30 was of her upper or lower scheduled and as r medications. Resid	rterly Minimum Data Set 18 indicated moderate nt with a Brief Mental Status . She was coded with no ed assistance with ambulation. coded with no impairments to extremities. She was coded for needed (PRN) pain ent #30 was coded as nd as having no falls since		incidents for the two weeks prior to November 16 to determine if any oth incidents resulted in complaints of pa that were untreated. The audit revea no other residents with untreated pai The Interdisciplinary Team(IDT) will re	nin nled n. eview falls JIDT iew tt,		

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		345146	B. WING _			1/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•		
				33426 OLD SALISBURY ROAD BOX 12	50		
BETHANY	WOODS NURSING AN	D REHABILITATION CENTER		ALBEMARLE, NC 28002			
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F 600	Continued From pag	e 15	F 6	00			
	10/16/18 read Resident first shift with the Physerty (RP) notified. The state of th	g 24 Hour Report dated ent #30 slid to the floor on ysician and Responsible The 24-Hour Report indicated ed Tylenol 2 tablets on		director/attending physician a practitioner regarding the placorrection on 12/11/18 with recommendations noted. What measures will be put in systemic changes made to e	an of no changes or nto place or		
	dated 10/17/18 at 10	t report and nursing note :43 AM read Resident #30		the deficient practice will not	recur		
	ambulating on her overloset when she fell. read no injury, but Releft rib pain. The nurse correspondence was	fall in her room. She was wn from her wheelchair to her The report and nursing note esident #30 complained of sing note read a selft for the NP and Medical ention was a therapy screen.		Beginning 11/19/18, the Nurse be re-educated by the directed (DON) and/or RN staff development (SDC) on assess evaluation, monitoring, and protification of residents with complaints of pain. The re-education be completed by 12/16/18.	or of nursing opment sment, ohysician continued ducation will		
	dated 10/17/18 read sat on the floor and o walker and recliner. I left rib pain. The Nur	In Fax Communication sheet Resident #30 did not fall but caught herself using her Resident #30 complained of se Practitioner (NP) wrote ith her initials. The NP undated.		members not receiving re-ed 12/16/18 will not be allowed education is completed. Nev agency staff will receive this during orientation to the facil Facility staff will receive annuabuse, Neglect, and Misapper Property that includes asses	lucation by to work until w hires and education ity. ual training on ropriation of		
		g 24 Hour Report dated ent #30 received Tylenol 2		evaluation, monitoring, and r physician of residents with co complaints of pain. Training provided by the Staff Develo	notification of ontinued will be		
	and Medication Adm read Resident #30 w (treats nerve pain) th and Ultram (synthetic twice daily scheduled Norco (opioid used to needed for pain.	er 2018 Physician Orders inistration Record (MAR) ras receiving Neurontin ree times daily scheduled c opioid used to treat pain) d. There were also orders for treat pain) 1 tablet as		Coordinator or the Director of Residents exhibiting complain will be discussed in the daily after the occurrence. Discussinclude notification of attending Resident Representative, and interventions implemented at How the facility plans to more performance to make sure the are sustained.	f Nursing. nts of pain IDT meeting sion will ng physician, d whether re effective. itor its		

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		345146	B. WING			1/16/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
RETHAN	/ WOODS NURSING AND	REHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX 12	250		
DETTIAN	WOODS NORSING AND	REHABILITATION CENTER		ALBEMARLE, NC 28002			
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F 600	Continued From page	e 16	F 60	00			
F 6000	#30 received no as n Review of the Octobe order for Tylenol 325 mouth every 4 hours hours. The MAR indic Tylenol 650 mg on 10 and 10/26/18. Review of the Rehab 10/18/18 read Reside participating in therap Review of the nursing 10/22/18 read Reside pain and received Ty Review of a nursing 2 10/23/18 read Reside facility with her RP or Review of a Physicia 10/23/18 read Reside complain of left uppe going to have her RP for evaluation if some documented per Nurs the date 10/24/18 and Review of the electro no nursing notes rega- continued complaints 10/17/18 until 10/29/2 Review of a nursing in PM read Resident #3 soreness to her left s	eeded doses of her Norco. er 2018 MAR read a standing milligrams (mg) 2 tablets by as needed for pain for 48 cated Resident #30 received 0/17/18, 10/23/18, 10/24/18 illitation screen dated ent #30 was not interested in by. g 24 Hour Report dated ent #30 complained of riblenol on third shift. 24 Hour Report dated ent #30 went out of the first shift. In Fax Communication dated ent #30 continues to rrib pain and stated she was a drop her off at the hospital ething was not done. The NP se #4, "no complaints" with done initials. In Fax Communication dated ent #30 continues to rrib pain and stated she was a drop her off at the hospital ething was not done. The NP se #4, "no complaints" with done initials.	F 60	The QI Nurse will review the pain for trending and tracking with repeat complaints of patasis for 12 weeks. The QI Nurse will present ID actions and reported abuse/lactions to the monthly quality improvement (QI) committee identification of trends, addit corrective actions, and record The administrator and/or DC trends and QI committee recommendations to the execommittee for review, addition recommendations, and to define a definition of trends and to define the Abuse/Neglect. The administrator consulted medical director and the nurregarding the plan of correct 12/11/18 with no changes or recommendations noted.	g of residents in on a weekly OT corrective neglect y e for review, cional mmendations. ON will present ecutive QI conal etermine the ag to ensure area of with the se practitioner tion on		

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	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX O ALBEMARLE, NC 28002	ODE	
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F 600	follows: Minimal di through seventh pusuggested. The xithe NP. Review of Resider dated 10/30/18 for reliever) four times. Review of a NP not read in part as follower as follower in coughing, deep brobed. Resident #30 help alleviate the purey concerned sir stated otherwise, somplaints. Review of the Nove Resident #30 recent work or Tylenol. In an interview on #30 reported she fexperienced left single her ribs and she render in the pain was stated the pain was stated she continuin bed and on transher left side with fare resident #30's car indicated she was complaints of sore	report dated 10/30/18 read as splaced fractures of the third obsterior lateral ribs left side ray was undated but initialed by at #30's MAR read an order Biofreeze (topical pain a daily to her neck. It dated 10/30/18 at 2:11 PM, ows: Resident #30 had a fall eeks ago and continues to cage pain that worsens with eaths or with repositioning in stated her pain medications do oain somewhat, but she is still noce it is ongoing. Resident #30 she is doing okay and has no ember 2018 MAR read ived no as needed doses of her 11/13/18 at 4:49 PM, Resident fell in October and immediately de pain. She stated she broke exceived no x-ray and saw no o weeks after the fall. She is bad but has improved. She es to have pain with movement in sfers. She reached to guard	Fé			

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		345146	B. WING _		1	11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	ND REHABILITATION CENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	10/30/18 indicated through 7th ribs. In to her complaints of ordered, documenti indicators of pain arif pain management. In an interview on 1 stated she was assi and assigned to het the NP was in the buste the NP about Resid side pain. Nurse #4 NP did not assess FS She stated the NP the #30 and administer it for pain. Nurse #4 Resident #30 was suleft side so Nurse Sx-ray order from the knowledge, the NP because she had le on 10/23/18. Nurse to report Resident # pain until another Pform dated 10/23/18. In an interview on 1 Assistant (NA) #10 complained of left s reported it to Nurse #30 continues to cotransfers.	fractures of her left 3rd fractures of the physician fractu	F6				
	Supervisor #3 state Resident #30 had a	1/14/18 at 3:05 PM, Nurse d she was aware that fall and was experiencing left d the NP wanted nursing staff					

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F 600	pain but confirmed th	tinued or worsening of the ere was little documentation	F€	600				
		ed an x-ray because						
	stated Resident #30 I her left side with care	15/18 at 8:50 AM, NA #11 nas complained of pain to . NA #11 stated when ined of pain, she would ed nurse.						
	stated it was her expedirected the nursing state #30, they would have worse, but she was lithe fall. The NP state	15/18 at 9:00 AM, the NP ectation that when she staff to monitor Resident contacted her if she got kely going to be sore from d staff reported to her that ing out with her RP and she						
	was able to function a neglected to report of The NP stated when 10/23/18, she stoppe she was out of the fac	at her baseline, but the nurse ontinued complaints of pain. the Nurse #4 faxed her on d in to see Resident #30, but cility with her RP and she						
	Supervisor #3. The N ordered the x-ray. Th results of 5 fractured confirmed she did no 10/30/18. She stated	P stated that was when she e NP confirmed the x-ray left side ribs. The NP t assess Resident #30 until there was no need for						
	already taking Ultram Tylenol as needed. T routinely review the n relied on the staff call Physician Communic	and that Resident #30 was twice daily for pain and he NP stated she did not ursing notes but rather ing her for sending her a ation Fax form. The NP the facility daily Monday						

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	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		3342	EET ADDRESS, CITY, STATE, ZIP CODE 26 OLD SALISBURY ROAD BOX 1250 BEMARLE, NC 28002		
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F 600	In a second interview Resident #30 was si NA #11 present in th complained of left sic ribs. She was guarde grimacing. NA #11 h complaint of pain annurse. In an interview on 11 confirmed she was a had cared for her sin AM on 11/15/18. She inform her that Resider today after br #30 had not complai was due her schedul Resident #30. A telephone call was at both phone number	vailable by phone when she v on 11/15/18 at 10:40 AM, tting up in her wheelchair with e room. Resident #30 de pain where she broke her ed of her left side with facial	Fé	600	DEPICIENCY)		
	#30 stated she was a stated her RP told he In a second interview the NP stated it was NA #11 heard Reside pain on 11/15/18, sh Resident #30's nurse A telephone call was	/16/18 at 8:20 AM, Resident feeling better today. She er to take it easy and rest. v on 11/16/18 at 10:20 AM, her expectation that when ent #30 complain of left side e would have reported it to e. s made to NA #11 on 11/16/18 hessage left to call the					

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	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	•	33426	ET ADDRESS, CITY, STATE, ZIP CODE OLD SALISBURY ROAD BOX 1250 EMARLE, NC 28002	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY 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)		(X5) COMPLETION DATE
F 600	surveyor regarding is complaints of pain of exit, there had been on 10/19/18 and 10/19/18/19 tated Resident #30's nurs. In a telephone call of #13 confirmed she will be the continuous of the nurs. In a second interview NA #10 confirmed she will be the continuous of the nurs. In a second interview NA #10 confirmed she will be the complain of left side always reported the lin an interview on 10/10/19/18, 10/26/18, stated he worked the 7:00 PM. Nurse #7 sontification that Res and that she never of went in to give her in the side always reported the line and that she never of went in to give her in the side and that she never of went in to give her in the side and that she never of went in to give her in the side and that she never of went in to give her in the side and that she never of the side and the side	not reporting Resident #30's in 11/15/18. At the time of no return phone call. In 11/16/18 at 11:35 AM, NA was assigned Resident #30 (22/18 for second shift. She Resident #30 complaining of ly when toileting and that she fit arm to reach due to the she reported the pain the e on both days. In 11/16/18 a 11:42 AM, NA was assigned Resident #30 I shift. She stated she recalled she was sore from the fall, of recall if she reported e. In 11/16/18 at 11:55 AM, he was assigned Resident #30 I shift. She stated she recalled she was sore from the fall, of recall if she reported e. In 11/16/18 at 11:55 AM, he was assigned Resident #30 I shift. She stated she recalled the was assigned Resident #30 I stated Resident #30 I stated Resident #30 I stated Resident #30 I shift. She stated he nocasion, but she complaints to the nurse. In 11/16/18 at 12:30 PM, Nurse is assigned Resident #30 on 10/27/18 and 10/28. He ose days from 7:00 AM to stated he received no ident #30 complained of pain complained of pain when he nedications.	F	600			
		view on 11/16/18 at 5:00 PM, s his expectation that there					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 ILBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	NP at the time when complained of pain of have been ordered at He further stated if R continued pain and the rule out injury, it was staff would have continued pain and the rule out injury, it was staff would have continued pain assessment continued awake for 2 we print Norco for pain as Right to be Free from CFR(s): 483.10(e)(1) §483.10(e) Respect at The resident has a right and dignity, including physical or chemical purposes of disciplinarequired to treat their consistent with §483.12 The resident has the neglect, misappropriation and exploitation as deincludes but is not lim corporal punishment,	essment completed by the Resident #30 first in 10/17/18 and x-ray would it that time to rule out injury. esident #30 reported in NP did not assess her to expectation that the nursing acted him for orders. All record indicated new is for Resident #30 to have a inpleted three times daily eas and to administer the ordered. Physical Restraints in Physical Restraints in Physical Restraints in to be treated with respect in the indicated in the indicated in this subpart. This intend to freedom from involuntary seclusion and ical restraint not required to edical symptoms.		600			12/16/18
	§483.12(a) The facilit	y must-					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345146	B. WING		11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 604	from physical or che purposes of disciplin are not required to to symptoms. When the indicated, the facility alternative for the led document ongoing restraints. This REQUIREMENT by: Based on record resinterviews, the facility utilizing bilateral sidd restraint which requipustify their use (Residuality 12 residents reviewed in the review of a partial evaluation for Residuality Improvement resident was oriented short-term and long and severely impair risks included the in The evaluation determined to the support of the resident was oriented to the interview of the resident was oriented and severely impair risks included the interview of the resident was oriented and severely impair risks included the interview of the resident was oriented and severely impair risks included the interview of the resident was oriented and severely impair risks included the interview of the resident was oriented and severely impair risks included the interview of the resident was oriented and the resi	re that the resident is free emical restraints imposed for the or convenience and that treat the resident's medical the use of restraints is an use the least restrictive that amount of time and the re-evaluation of the need for the interest amount of the need for interest amount of the need for interest amount of the need for interest amount of the need amount of the need amount of the need to person only with the interest amount of the n	F 60	F604 Right to be Free from Physi Restraints How corrective action will be accomplished for those residents fou have been affected by the deficient practice Residents #53 and #118 were reasse 11/15/18 for the need for side rails wi padding using the Physical Device Evaluation form. As a result of the re-assessment the padding was remellow the facility will identify other resident practice An audit was initiated on 11/19/18 by QI nurse to determine other residents side rails with padding. The audit revealed one other resident with side and padding. As a result of the	essed th oved. dents the the s with
	resident and the and been due to a compound was not signed as of A review of the residual Data Set dated 9/20 severely cognitively	atives were explained to the swer indicated they had not orehension deficit. This form complete. dent 's quarterly Minimum ol/18 revealed the resident was impaired and required e for all activities of daily		re-assessment the padding was removed. What measures will be put into place systemic changes made to ensure the the deficient practice will not recur. Beginning on 11/19/18 and complete 12/16/18, all licensed nurses were re-educated regarding the assessment.	or at d by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345146	B. WING _			1 1	1/16/2018			
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE					
				33	426 OLD SALISBURY ROAD BOX 1250					
BETHANY	WOODS NURSING A	AND REHABILITATION CENTER		ΑI	LBEMARLE, NC 28002					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE			
F 604	Continued From p	age 24	F	304						
		nt was unable to make her nysical restraints bed rail not			the need for side rails with padding, and/or restraints. Assessments for the need for side rails, padding, and/or restraints will be completed by a licens					
	10/4/18 revealed a	sident 's care plan updated a problem for skin tears which n of padded side rails to			nurse quarterly in conjunction with the MDS assessment. Re-education regarding physical devices and their units of the control					
	prevent skin tears	Padded side rails and winged on 1/11/17. Repetitive			and purpose was provided by the Staf Development nurse for all nursing staf	f	TI/16/2018 COMPLETION DATE			
	movement preven 1/13/17.	tion of skin tears initiated on			including nursing assistants, This education was completed by December 16, 2018 Any staff not receiving	er				
	of the resident 's rails were noted.	on an observation was done oom and bilateral padded side The resident was observed in a air with frequent movement of			education by 12/16/18 will not be allow to work until education is completed. In new hires including agency staff will education regarding restraints upon					
	her extremities that non-purposeful.	at appeared to be			orientation. How the facility plans to monitor its performance to make sure that solutio	ns				
		20 pm an observation was done room and bilateral padded side			are sustained The Director of Nursing (DON) will perform a 10% audit for assessment a risk versus benefits education in the a					
	conducted with Tre assigned to Resid	5 pm An interview was eatment Nurse (TN) who was ent #53 and stated that the side o prevent the resident from			of physical restraints for 12 weeks; the quarterly thereafter on the assessmen and risk versus benefits education. The DON and or RN QI nurse will shall the properties of th	t				
	falling out of bed. resident cannot ge time. The pads we	TN commented that the et out of bed on her own at this ere added to the side rails to			the results of the Audits with the interdisciplinary team (IDT) at least we for 12 weeks.	-				
	•	TN stated she was not aware for safety were considered a			The DON and/or QI RN will present ID corrective actions to the monthly qualit improvement (QI) committee for review identification of trends, additional	ty				
	11/14/18 at 3:20 p Resident #53 date complete was revi	conducted with the QI Nurse on m. The Bed Rail Evaluation for d 11/27/17 that was partially ewed with the QI Nurse. She partially completed this			corrective actions, and recommendation. The administrator and/or DON will prestrends and QI committee recommendations to the quarterly quality assurance and performance improvem	sent lity				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING	B. WING		11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 ILBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	completed. The QI N had not provided any rail evaluations she connone of the assessment complete. The QI Nu Evaluation form was February 2018. She no bed rail evaluation been conducted. She have a restraint assed one any restraint as facility had no restrain. The interview with the she was asked why side rails used in corpadding and if these assessed to determine a physical restraint. The interview with the she was asked why side rails used in corpadding and if these assessed to determine a physical restraint. The interview implements were implement sustained a skin tear believed the skin tear believed the skin tear believed movement.	firmed that it was never fully Nurse further revealed she reducation on any of the bed completed, and this was why ents were marked as urse indicated this Bed Rail no longer in use as of stated that since that time ins and/or re-evaluations had be reported that the facility did essment, but that she had not essessments because the ints in use. The QI Nurse continued and Resident #53 had bilateral interventions had been the if they met the definition of She stated that padded side the ded after Resident #53 to her arm (12/17). It was reame from the resident inst the side rail from the Evaluation dated 11/15/18	F	604	(QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of assessment of physical restraints. The administrator consulted with the medical director and the nurse practition regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	e e		
	who indicated the de padded side rails. The which led to consider unsafe movement of was noted to use the the benefit of the precises noted as none. The remove the padded so form indicated, "This	s completed by the QI Nurse vice currently in use was be specific medical symptom ration of device use was extremities. Resident #53 padded side rails daily with vention of injury and the The resident was not able to side rails independently. The device does not impede t in bed. This resident has						

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 33426 OLD SALISBURY ROAD I ALBEMARLE, NC 28002	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 604	does not meet the A follow-up intervie Nurse on 11/15/18 Device Use Evalua Resident #53 was She confirmed she She stated she spo Consultant last eve directed to complet indicated she went and reviewed it wit The QI Nurse indic #53 was unable to assistance it was d rails were not a res padded side rails w from falling out of the specifically prevent her body on the sid moving around in the An interview was of Administrator on 10 stated that education should have been a and/or RP at the tin and that reassess upon any change in interventions. Re usage in conjunction reviewed with the A revealed that no as determine if the bilic conjunction with th definition of a physical	but of bed therefore this device classifications of a restraint". It was conducted with the QI at 12:00 pm. The Physical Ition dated 11/15/18 for reviewed with the QI Nurse. It completed this evaluation. It was eximple the Facility Nurse ening (11/14/18) and she was the this assessment. She through the form this morning in the Facility Nurse Consultant. It is afely get out of bed without etermined the padded side etermined the padded side etermined the padding it is the thin the facility Resident #53 and that the padding it is related to the resident from injuring it is related to the resident in the facility Resident #53 and benefits explained to the resident me of side rail assessments in ents should have been done in condition or change in sident #53's bilateral side rail on with bilateral padding was administrator. She additionally is sessment was done to ateral side rails used in the bilateral padding met the ical restraint. She indicated the regulations related to	F	504			

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES FY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA	D 4.T.E.	
F 604	Continued From pag	e 27	F 6	04			
	3/4/17 with diagnose disease, dementia wanxiety, schizophren The quarterly Minimulassessment dated 11 #118 's cognition was had delusions during Resident #118 was a behaviors on 1 to 3 of 6 days, and rejection Resident #118 requires for bed mobility, transand personal hygiene assistance of 2 or motolieting. Resident #10 no indicated Resident #10 indicated Resident #10 indicated Resident #10 restraints (defined as physical or mechanic equipment attached body that the individuation which restricts freedoaccess to one 's book A partially completed Resident #118 dated the Quality Improvent evaluation indicated oriented to person or	am Data Set (MDS) 1/9/17 indicated Resident as severely impaired. She the MDS review period. assessed with physical days, verbal behaviors on 4 to of care on 1 to 3 days. and extensive assistance of 1 asfers, locomotion on the unit as. She required extensive are with dressing and 118 was not steady and was with staff assistance. She aitations with range of motion and the elchair. Resident #118 was a bladder and bowel and she anjury. The assessment 118 had no physical any manual method or and device, material or or adjacent to the resident 's and cannot remove easily or of movement or normal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/16/2018		
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER	•	33	REET ADDRESS, CITY, STATE, ZIP CODE 8426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002	,		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	were assessed as a perimeters, range of muscle weakness, had a history of fall expressed a desire in bed for her own shenefits of side rail Resident #118 to president #118 to president #118 to resitting and/or stand used side rails for cenabled Resident #functional abilities increased potential indicated that an al attempted was phy therapy initiated on or interventions we recommendations of bilateral half rails to promote independentials and hot been due to a cevaluation asked if were explained to trepresentative and not been as the respreviously been awards.	raking. Her functional abilities grasp strength within normal of motion/dexterity adequate, and impaired balance. She is. Resident #118 had not to have side rails raised while safety or comfort. The use were noted as enabling osition self in bed, enabling is from a supine (lying) to a sing position, Resident #118 care with staff cueing, and if the risks included the for injuries. This assessment ternative intervention that was sical and/or occupational 7/6/17. No other alternatives	F	604				
	Resident #118 had identified as a bruis Facility Reported Ir reviewed. It indicates	dated 7/3/18 indicated an injury of unknown origin se to her left eyelid. The acident (FRI) investigation was ted a bruise to Resident #118 ' wered during morning care.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604		e 29 sed as not swollen and pressure related rather than	F 6	04		
	resolving. Resident the investigation and rail on her bed. The to the where Reside side rail. The witnes specific incident, but	d not spread and was #118 was observed during I noted to lay against the side bruised area corresponded int #118 laid her head on the is statements indicated no they had noted Resident e often with her head against				
	indicated Resident # severely impaired. S to 3 days. She requ or more with bed mo extensive assistance the unit. Resident # with toileting and per was not steady on he to stabilize with staff functional limitations she utilized a wheeld falls and was always	assessment dated 10/11/18 if 18's cognition was She had other behaviors on 1 ired extensive assistance of 2 ibility and transfers and the e of 1 with locomotion on/off 118 was dependent on 1 staff rson hygiene. Resident #118 er feet and she was only able assistance. She had no with range of motion and chair. Resident #118 had no is incontinent of bladder and ment indicated Resident #118 raints.				
	focus area of potenti impairment with brui eyelid. This area wa most recently revised care also included the required for transferre indicated Resident # This focus area was recently revised on 1	Resident #118 included the all for skin integrity se noted on 7/3/18 to her left as initiated on 7/5/18 and d on 10/15/18. This plan of the focus of area of assistance ring. The interventions 118 was able to weight bear. Initiated on 3/27/18 and most 10/25/18. This care plan had antion of Resident #118 's				

11/16/2018
(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUC			E SURVEY PLETED	
		345146	B. WING _			11	11/16/2018	
	ROVIDER OR SUPPLIER 'WOODS NURSING A	ND REHABILITATION CENTER		33426 OLD S	RESS, CITY, STATE, ZIP CODE SALISBURY ROAD BOX 1250 LE, NC 28002	·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 604	were added following which Resident #11 eyelid believed to be 11/14/18 at 3:10 PN Resident #118 date complete was review confirmed that she assessment and completed. She explained by her management complete bed rail ethe facility in Nover as she began complete bed rail ethe facility in Nover as she began complete bed rail ethe facility in Nover as she began complete bed rail revealed she was reported she was reported that the she never received education she was further revealed she education on any ocompleted, and this assessments were Nurse indicated this was no longer in place revaluations had reported that the fa assessment, but the	cated she believed the pads and an incident on 7/3/18 in 18 obtained a bruise on her be caused by the side rails. Inducted with the QI Nurse on M. The Bed Rail Evaluation for ed 11/28/17 that was partially swed with the QI Nurse. She partially completed this onfirmed that it was never fully eplained that she was directed at and the corporate office to valuations of every resident in inber 2017. She reported that obleting the assessments she in each assessment that asked en providing to the resident en Party (RP) on the risks and usage. The QI Nurse not sure what was supposed to education, so she asked the estated that the Administrator facility Consultant, but that any direction of what type of supposed to provided any if the bed rail evaluations she is was why none of the marked as complete. The QI is Bed Rail Evaluation form acce in the electronic medical of February 2018. She stated no bed rail evaluations and/or been conducted. She cility did have a restraint at she had not done any into because the facility had no	F	504				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345146	B. WING			11/16/2018		
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002	DDE	1111012010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 604	was asked why Res rails used in conjunct and if these interver determine if they me restraint. She state implemented after F bruise to her eyelid came from the resid the side rail. The Q completed a restrain #118's bilateral sid A Physical Device L for Resident #118 c indicated the device side rails. The specified to consideration movement of leanin was noted to use the the benefit of the principles in the properties of th	the QI Nurse continued. She ident #118 had bilateral side ction with bilateral padding nations had been assessed to let the definition of a physical did that the padding was resident #118 sustained a (7/3/18) that they believed ent placing her head against I Nurse revealed she had not not assessment on Resident	F 60					
	Nurse on 11/15/18 a Physical Device Use for Resident #118 w Nurse. She confirm evaluation. She sta Nurse Consultant la was told to complete	wwas conducted with the QI at 12:00 PM. The 11/15/18 e Evaluation dated 11/15/18 ras reviewed with the QI ed she completed this ted she spoke with the Facility st evening (11/14/18) and she e this assessment. She through the form this morning						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11/16/2018		
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 604	The QI Nurse indica #118 was unable to assistance it was de rails were not a rest padded side rails we from falling out of be specifically was prebody on the side rail moving around in be An interview was conditionally and partial side rail evaluations confirmed she was completed as educated resident and/or the education of the risk been explained to the time of the side rail reassessments shochange in conditionally reassessments shochange in conditionally reassessments adding was added sustained a bruise the been caused by the Resident #118 move padding was to stop the side rails and can adding the	the Facility Nurse Consultant. Inted that because Resident safely get out of bed without etermined the padded side raint. She stated that the ere preventing Resident #118 ed and that the padding venting her from injuring her lis related to the resident ed.	F 6	04				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONST			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		33426 OI	ADDRESS, CITY, STATE, ZIP CODE LD SALISBURY ROAD BOX 1250 ARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE	
F 604	Continued From pag	e 34	F 6	604				
	restraint. She indica	t the definition of a physical ted that she expected the physical restraints to be						
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1)	<u> </u>	F 6	336			12/16/18	
	a comprehensive, ac	ssessment duct initially and periodically ccurate, standardized ment of each resident's						
	§483.20(b)(1) Resid A facility must make assessment of a resignals, life history and resident assessment by CMS. The assess the following: (i) Identification and (ii) Customary routine (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behav (vii) Psychological we (viii) Physical functio (ix) Continence. (x) Disease diagnosi (xi) Dental and nutriti (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmer (xvi) Discharge plant	dent's needs, strengths, depreferences, using the sinstrument (RAI) specified sment must include at least demographic information e. s. ior patterns. ell-being. ning and structural problems. es and health conditions. ional status.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345146	B. WING		11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING ANI	O REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	11/10/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 636	on the care areas trig the Minimum Data S (xviii) Documentation assessment. The as include direct observ with the resident, as licensed and nonlice members on all shifts §483.20(b)(2) When timeframes prescribe chapter, a facility mu assessment of a resitimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmission significant change in mental condition. (For "readmission" means following a temporary or therapeutic leave. (iii) Not less than once This REQUIREMENT by: Based on record revision facility failed to comp Minimum Data Set (Note 1) 156 residents reviewed assessments (Residents findings: 1.Resident #417 was	nal assessment performed agered by the completion of et (MDS). In of participation in sessment process must ation and communication well as communication with used direct care staff is. Irequired. Subject to the ed in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) action. The timeframes 43(b) of this chapter do not are days after admission, and in which there is no the resident's physical or or purposes of this section, are a return to the facility of absence for hospitalization of e every 12 months. If is not met as evidenced assessments for 3 of d for completion of MDS ent #417, #416 and #6).	F 63	F636 Comprehensive Assess and Timing How corrective action will be accomplished for those resident have been affected by the deficipractice The RN Minimum Data Set (MD completed the Minimum Data Set for residents #417, #416, and #6 assessments were submitted an accepted by 11/19/18.	s found to ent S) nurse et (MDS) 5. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 636	An interview on 11/MDS Nurse #2 revadmission MDS as submission on 11/6 further revealed sh List, generated from assist her with keep assessment due downs the only MDS 11/5/2018 through further reported the period to complete failed to complete failed to complete I MDS assessment. An interview on 11/Administrator reveal of the late MDS assimprovement meet Administrator further eached out to the with securing addit assessment on time Administrator report Nurses to complete assessments by the 2. Resident #416 with 10/24/2018. A revia assessment was not	of completed by 11/15/2018. 216/2018 at 10:40 AM with ealed Resident #417's sessment was due for 5/2018. The MDS Nurse #2 e used the MDS in Progress in the electronic software, to ping up with the MDS ates. She reported that she staff working between 11/6/2018. The MDS Nurse at she worked over during this nine pending assessments but Resident #417's admission 216/2018 at 6:13 PM with the aled that she was made aware sessments during the Quality ing held five days ago. The ear revealed that she had corporate consultant to assist ional help to complete MDS e. Additionally, the red she expected the MDS e and submit all the MDS e date due. as admitted to the facility on ew of Resident #416's MDS	F 63	How the facility will identify othe having the potential to be affect same deficient practice Beginning on 11/19/18 the MDS Consultant conducted a 100% current residents most recent Budget Reconciliation Act (OBI Minimum Data Set (MDS) subrithe current residents for timelin audit was completed on 12/11/ revealed all other assessments completed and submitted in a timanner. What measures will be put into systemic changes made to ensithe deficient practice will not receducated regarding the importimely completion and submiss assessments by the MDS Consinurse consultant. The schedul completion dates will be review the morning IDT meeting. How the facility plans to monito performance to make sure that are sustained The Director of Nursing (DON) Quality Improvement (QI) nurse perform a 10% audit of comple Minimum Data Set (MDS)Complements of the review of timely completion and submission of MDS assessments week for 12 weeks; then quarte thereafter. The DON and or RN will share the results of MDS A	ted by the S RN Nurs audit of th c Omnibus RA) mitted for less. The 18 and s had beer imely place or sure that cur S nurses T) were ortance of ion of MDS ved daily ir or its solutions and/or RN e will ted prehensive week for d onts each erly QI nurse	se e e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16	6/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIA	- 1	(X5) COMPLETION DATE
F 636	List, generated from assist her with keepir assessment due date she was the only MD 11/5/2018 through 11 further reported that speriod to complete ni failed to complete Re MDS assessment. An interview on 11/16 Administrator revealed of the late MDS asses Improvement meeting Administrator further reached out to the cowith securing addition assessment on time. Administrator reporte Nurses to complete assessments by the complete assessments by the complete assessments revealed for October 2018 was 11/15/2018. An interview on 11/16 MDS Nurse #1 revealed J, L, M, N, O and P. If revealed she was rescompleted MDS assessmede a list of when the were due and checker #1 further reported R quarterly MDS assessments massessments were second to when the were due and checker #1 further reported R quarterly MDS assessments with the properties of the properties	the electronic software, to any up with the MDS as. She further reported that S staff working between 76/2018. The MDS Nurse she worked over during this are pending assessments but sident #416's admission 87/2018 at 6:13 PM with the add that she was made aware assments during the Quality and five days ago. The revealed that she had revealed that she	F 6	the interdisciplinary team (I weekly for 12 weeks. Any electric by the MDS Restrated by the MDS Restrated by the procedures outlined in the Assessment Instrument (Roman Procedures outlined at the MDS RN consultant. The DON and/or MDS RN corrective actions to the mainprovement (QI) committed months for review, identificated additional corrective actions recommendations. The additional corrective actions recommendations. The additional corrective actions recommendations, and to committee recommendation quarters to the quarterly quand performance improvemended for continued monitor continued compliance in the accuracy of assessments. The administrator consulted medical director and the nuregarding the plan of correct 12/11/18 with no changes of recommendations noted.	errors noted value of the Resident AI) Manual a as needed by will present I onthly quality ee for 12 ration of trends, and Iministrator ends and QI ns for four uality assurament (QAPI) tional determine the ring to ensure e area of d with the urse practition ction on	to : : : : : : : : : : : : : : : : : : :	

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		345146	B. WING		11	1/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	O REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
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F 636	MDS Nurse #1 revea	nave been done. Additionally, alled that as of 11/15/2018, y assessments and 3	F 63	56		
F 637 SS=D	Administrator revealed of the late MDS asset Improvement meeting Administrator further reached out to the country with securing additional assessment on time. Administrator reported Nurses to complete a assessments by the	ed she expected the MDS and submit all the MDS date due. essment After Signifcant Chg	F 63	57		12/16/18
	determines, or should there has been a sign resident's physical or purpose of this section means a major declir resident's status that itself without further inplementing standa interventions, that had one area of the resid requires interdiscipling care plan, or both.) This REQUIREMENT by: Based on observation record review, the face	hin 14 days after the facility d have determined, that nificant change in the mental condition. (For on, a "significant change" ne or improvement in the will not normally resolve ntervention by staff or by rd disease-related clinical is an impact on more than ent's health status, and hary review or revision of the		F637 Comprehensive Asses Significant Change How corrective action will be	ssment after	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		345146	B. WING _			11/	16/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S1	TREET ADDRESS, CITY, STATE, ZIP CODE		10:20:10
				33	3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AN	D REHABILITATION CENTER		Α	LBEMARLE, NC 28002		
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F 637	Continued From pag	ne 39	F 6	337			
	(weight loss and skir	with two areas of decline n) for 1of 1 resident (Resident changes. The findings			accomplished for those residents found have been affected by the deficient practice The Minimum Data Set (MDS) for residents #165 was completed for a	d to	
		3/12/14 with cumulative al Palsy and Dysphasia.			significant change on 11/16 /18. How the facility will identify other residential to be affected by the significant control of the significant change of the significant chang		
	Review of Resident #165 electronic medical record revealed her weight was 91 pounds in June 2018 with no weight obtained in July 2018 and August 2018.				same deficient practice Beginning on 11/19/18 the MDS (Minir Data Set) RN consultant conducted a 100% audit of the current residents□ conditions for the past 30 days to	num	
		#165's quarterly MDS dated r weight was 91 pounds and			determine if significant change MDS assessments were appropriately completed for those residents having decline in the areas of weight loss and		
	#165's diet (ordered mechanical soft with	Il record revealed Resident 6/29/18) was upgraded from nectar thick liquid, to a pped meats with thin liquids			skin integrity. The audit was complete on 12/11/18 and revealed that no other significant change assessments were needed. What measures will be put into place of systemic changes made to ensure that	d r or	
	9/29/18 indicated Re	d Ulcer Flowsheet dated esident #165 had a sue Injury to her left hip.			the deficient practice will not recur Beginning on 12/7/18 and completed by		
	Review of Resident record revealed her	#165 electronic medical weight was 72 pounds in d her weight was 76 pounds			12/16 /18, The MDS nurses and Interdisciplinary Team (IDT) were re-educated by the MDS consultant/RI consultant regarding the importance of completing a significant change of condition Minimum Data Set (MDS)	N	
	10/1/18 and dischard 10/5/18 with a new o	•			assessment for a resident with two are of decline. Residents with significant changes in condition will be reviewed on the morning IDT meeting with	daily	
	indicated a diet dow	#165's readmission orders ngraded to mechanical soft on 10/6/18 and orders for			recommendations to the MDS nurse for the need for a significant change assessment.	or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			1 11	/16/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DETHAND	/ WOODO NII IDOINO AA	ID DELIA DII ITATIONI OFNITED		3	3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AN	ND REHABILITATION CENTER		-	ALBEMARLE, NC 28002		
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F 637	Continued From page	ge 40	F 6	637			
	Speech Therapy.				How the facility plans to monitor its		
	'				performance to make sure that solution	ns	
	Review of Resident #165's quarterly MDS dated				are sustained		
		her weight at 72 pounds and			The Director of Nursing (DON) and or	RN	
	as having an unstag	geable pressure ulcer.			QI nurse will perform a 10% audit for		
	Davison of Davidson	#405 last assissed assaults			significant changes and completion of		
		#165 last revised care plan cated her at risk for weight			MDS significant change assessments each week for 12 weeks in the IDT		
		ed for the presence of an			meeting; then quarterly thereafter on		
			resident significant changes and the				
	appropriate.				completion of significant change MDS		
					assessments.		
	Review of Resident #165's Wound Ulcer				The DON will share the results of MDS		
		1/5/18 indicated the area to her			Audits with the interdisciplinary team (IDT)	
	left hip was describe	ed as unstageable.			at least weekly for 12 weeks.	IDT	
	Pavious of Posidont	#165's Wound Ulcer			The DON and/or MDS RN will present corrective actions to the monthly qualit		
		1/31/18 indicated the area to			improvement (QI) committee for review	-	
	her left hip was reso				identification of trends, additional	٧,	
					corrective actions, and recommendation	ons.	
	In an observation or	n 11/14/18 at 10:30 AM with			The administrator and/or DON will pres	sent	
		e, the area to Resident #165			trends and QI committee		
	-	d. The Treatment Nurse			recommendations to the quarterly qua	•	
		story of the area to her left hip			assurance and performance improvem		
		s had and overall gradual			(QAPI) committee for review, additiona		
	eating well.	months and she was not			recommendations, and to determine the need for continued monitoring to ensure		
	eating well.				continued compliance in the area of	· C	
	In an observation or	n 11/16/18 at 8:40 AM,			accuracy of assessments.		
		approximately 25% of her					
		Assistant (NA) #10 stated she			The administrator consulted with the		
		nuch and had a gradual			medical director and the nurse practition	oner	
	aecline in her condi	tion in recent months.			regarding the plan of correction on 12/11/18 with no changes or		
	In an interview on 1	1/16/18 at 9:30 AM, the Nurse			recommendations noted.		
		ated Resident #165 had an			Todominonations noted.		
		she was in talks with the					
		about Hospice Services.					
		,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER	•	33	TREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 SS=D	Director of Nursing (Dexpectation that a sign completed when therefunctional or medical considered self-limiting an interview on 11/Nurse #1 stated sheet change MDS was ind MDS was completed reason as Resident # and the pressure ulce Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revisite interview the facility family Minimum Data Set (Mor the areas of physicand #118), discharge tube feed (Resident # reviewed for MDS assessment must findings included: 1. The resident was admadeled to the diagram of the diagram	16/18 at 4:50 PM, the DON) stated it was her nificant change MDS be a were two areas of decline that were not leg. 16/18 at 6:10 PM, MDS did not feel a significant icated when the quarterly on 10/12/18. She stated her 165's weight had gone uper had healed. The ents of Assessments. It accurately reflect the list is not met as evidenced lew, observation, and staff ailed to complete the lDS) assessment accurately cal restraints (Residents #53 status (Resident #80), and le168) for 4 of 38 residents		637	F641 Accuracy of Assessments How corrective action will be accomplished for those residents found have been affected by the deficient practice The Minimum Data Set (MDS) for residents #53, #118, #80 and #168 were assessed for accuracy by the MDS nurr and corrections were resubmitted on 11/16/18 and 12/4/18 by RN MDS nurs How the facility will identify other reside having the potential to be affected by the same deficient practice Beginning on 11/19/18 the MDS (Minim Data Set) RN Consultant conducted a 100% audit of the current residents in recent Omnibus Budget Reconciliation	re rse e. ents ne num	12/16/18
	Data Set dated 9/20/7	o revealed the resident was			recent Omnibus Budget Reconciliation	ACI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		345146	B. WING		1	1/16/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1/10/2010
				33426 OLD SALISBURY ROAD BOX		
BETHANY	WOODS NURSING ANI	REHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From pag	e 42	F 64	41		
	extensive assistance living. The resident of needs known. "Physused" was coded. A review of the reside 10/4/18 revealed a p	mpaired and required for all activities of daily was unable to make her ical restraints bed rail not ent 's care plan updated roblem for skin tears which if padding added to the side		(OBRA) Minimum Data Se submitted for the current re accuracy related to physic discharge status, and tube audit was completed on 12 revealed no further negative What measures will be put systemic changes made to the deficient practice will negative.	esidents for al restraints, be feeding. The 2/11/18 and we findings. It into place or o ensure that	
	winged mattress was On 11/13/18 at 9:30	am an observation was done m and bilateral padded side		On 12/7/18 the MDS nurse Interdisciplinary Team (ID re-educated regarding the accurate submission of MI assessments by the MDS	F) were importance of OS Consultant.	
	Improvement (QI) Nu and she was asked we bilateral side rails use bilateral padding and been assessed to dedefinition of a physical padded side rails we Resident #53 sustain (December 2017). Thad not completed a	aducted with the Quality arse on 11/14/18 at 3:20 pm why Resident #53 had ed in conjunction with if these interventions had termine if they met the al restraint. She stated that re implemented after led a skin tear to her arm he QI Nurse revealed she restraint assessment on eral side rails with padding.		How the facility plans to m performance to make sure are sustained The Director of Nursing (D QI RN will perform a 10% accuracy in the areas of pl restraints, discharge status feedings each week for 12 quarterly thereafter on the submitted assessments. The DON will share the readults with the interdisciple at least weekly for 12 weekly	that solutions ON) and /or the audit for hysical s, and tube weeks; then accuracy of sults of MDS inary team (IDT) ks.	
	on 11/14/18 at 3:30 F asked what informati MDS for physical res record review, staff in were utilized to code restraints. She repor Restraint Assessmer QI Nurse if there was	educted with MDS Nurse #1 PM. MDS Nurse #1 was on was utilized to code the traints. She stated that nterview, and observation the MDS for physical ted that there was a out that was completed by the se a physical restraint in use, estraints were currently used		The DON and/or MDS RN corrective actions to the m improvement (QI) committed identification of trends, additional corrective actions, and recommends and QI committee recommendations to the quassurance and performance (QAPI) committee for review recommendations, and to	ee for review, ditional commendations. DON will present uarterly quality ce improvement ew, additional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345146	B. WING _		11/16/2018
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 33426 OLD SALISBURY ROAD BO ALBEMARLE, NC 28002	P CODE
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION DATE
F 641	that indicated Res restraints was rev observations of Reinterviews that indicated padding to reviewed with MD revealed she had was in place on the no one had inform been implemented she had observed completed the 9/2 stated that she had have been out of I noticed the bilater padding. An interview was a Administrator on that she expected physical restraints to be accurately concept to be accurately concept and the detection of the restraints of the restraint	e quarterly MDS dated 9/20/18 ident #53 had no physical iewed with MDS Nurse #1. The esident #53 as well as staff icated Resident #53 had in place in conjunction with o the rails since 12/17/17 was S Nurse #1. MDS Nurse #1 not known bilateral padding e bilateral rails. She stated that led her that the padding had d. MDS Nurse #1 was asked if Resident #53 when she 0/18 MDS assessment and she d, but that the resident may bed at that time, so she had not al side rails with bilateral conducted with the 1/1/14/18 at 4:15 pm who stated the regulations related to to be followed and for the MDS oded. s admitted to the facility on iagnoses dysphagia and	F	need for continued monicontinued compliance in accuracy of assessment. The administrator consumedical director/attendin the nurse practitioner reof correction on 12/11/18 or recommendations not	the area of s. Ited with the g physician and garding the plan B with no changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, 3 33426 OLD SALISBURY I ALBEMARLE, NC 280	STATE, ZIP CODE ROAD BOX 1250		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 641	and off at 5 am. The resident 's qu (MDS) dated 10/2/ an intact cognition. assistance for all A dysphagia, CVA wigastrostomy. The mechanically alterecoded "no." A review of the res 10/2/18 revealed p feeding to assist the improving nutrition. weight loss second January 2018 tube mouth during the date of the resident administration administration and the feeding as ordered on 11/13/18 at 10: done of the resider pump that was inful bag was dated for was not discarded of the resident 's 1 discarded by night completed. No Tresident the opporte eat meals.	arterly Minimum Data Set 18 revealed the resident had The resident required total DLs. Active diagnoses were thout residual deficits, and resident required a and diet. Tube feeding was dident 's care plan dated lan for gastrostomy tube are resident in maintaining or al status characterized by dary to dysphagia. Start afeeding at night and eats by lay. dident 's October 2018 astration record (MAR) revealed at the resident received her tube are ach night shift. On am an observation was ant 's tube feeding (TF) bag and ased on the night shift. The and 10/12/18 from night shift and	F	341			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11/16/2018		
	ROVIDER OR SUPPLIER WOODS NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 641	the TF was documer received, the quarter Resident #168 was feeding and would have a considered and would have a considered and a cordingly that she expected	S Nurse #1 who stated that if ented on the MAR as resident enty MDS dated 10/2/18 for inaccurately coded for tube be corrected. Inducted with the //14/18 at 4:15 PM who stated the MDS to be accurately on the resident 's plan of care as admitted to the facility on es that included Alzheimer 's with behavioral disturbance,	F 6	41				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		,	I1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	11/13/18 at 12:35 Pl Resident #118 had to padding. She stated as Resident #118 m tended to roll over to place her head on the Resident #118 was her own safely and to #7 was asked if the prevented Resident bed and she indicate An interview was co 11/14/18 at 11:15 Al was familiar with Re why Resident #118 padding. She stated she believed the pad because Resident # she was able to lear reported she though side rails so Resided didn't get caught in asked when the pad reviewed the record the pads were adde 7/3/18 in which Resion her eyelid believe rails. An interview was co Improvement (QI) N She was asked why side rails used in co padding and if these assessed to determ a physical restraint.	nducted with NA #7 on M. NA #7 was asked why he bilateral side rails with d that they were for protection oved around in bed and o the side of the bed and he side rail. She stated that hot able to get out of bed on hat she was a fall risk. NA bilateral side rails had #118 from falling out of the	F 6	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1.	1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	AND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE		
(X4) ID PREFIX TAG	(EACH DEFICI	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	came from the rest the side rail. The completed a restra #118's bilateral s An interview was on 11/14/18 at 3:3 asked what inform MDS for physical record review, sta were utilized to co restraints. She re Restraint Assessm QI Nurse if there whout that no physical in the building. The that indicated Res restraints was reviobservations of Reinterviews that indibilateral side rails bilateral padding to reviewed with MD revealed she had was in place on the no one had inform been implemented she had observed completed the 10/1 she stated that she had observed completed the she had obser	elid (7/3/18) that they believed ident placing her head against QI Nurse revealed she had not aint assessment on Resident ide rails with padding. conducted with MDS Nurse #1 OPM. MDS Nurse #1 was ation was utilized to code the restraints. She stated that if interview, and observation de the MDS for physical corted that there was a nent that was completed by the was a physical restraint in use, al restraints were currently used a quarterly MDS dated 10/11/18 ident #118 had no physical ewed with MDS Nurse #1. The esident #1 as well as staff in place in conjunction with the trails since 7/3/18 was S Nurse #1. MDS Nurse #1 not known bilateral padding to bilateral rails. She stated that ed her that the padding had I. MDS Nurse #1 was asked if Resident #118 when she 11/18 MDS assessment and the had, but that the resident may be at that time, so she had not all side rails with bilateral conducted with the 1/14/18 at 4:15 PM. Resident ide rail usage in conjunction ing was reviewed with the	F	341			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 641	was added after Rebruise to her eyelid by the side rails. Shift 118 moved around to stop her from hitti and causing an injurexpected the regular restraints to be follocoded accurately. 4. Resident #168 w 8/17/18 with diagnoembolism, anemia, mellitus. She was considered the resideracute care hospital. A review of the Disch revealed the resideracute care hospital. A review of the resideracute care hospital. A review of a physiciar evealed an order to completed with the light that the Resident Loby the Social Worked discharge indicated	indicated that the padding sident #118 sustained a believed to have been caused ne explained that Resident I in bed and the padding was ing her head on the side rails ry. She indicated that she tions related to physical wed and for the MDS to be was admitted to the facility on ses that included pulmonary left hip pain and diabetes discharged home on 8/23/18. IDS (Minimum Data Set) was me of her discharge. Inarge MDS dated 8/23/18 and was coded as discharged to dent's baseline care plantaled she was care planned for	F 6	41			
	completed with the	MDS nurse who was able to dent was marked as					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _		11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 641	Continued From pag	e 49 spital instead of the home	F 6	641	
	Setting. She stated the On 11/16/18 at 4:45 conducted with the Dit was her expectation be coded correctly.	nat it was a typing error. pm an interview was birector of Nursing who stated n for all Discharge MDS's to			
F 644 SS=D	CFR(s): 483.20(e)(1)		F 6	344	12/16/18
	pre-admission scree (PASARR) program of this part to the ma	tion. nate assessments with the ning and resident review under Medicaid in subpart C ximum extent practicable to ting and effort. Coordination			
	from the PASARR le PASARR evaluation	orating the recommendations well II determination and the report into a resident's anning, and transitions of			
	all residents with new serious mental disord related condition for a significant change	ing all level II residents and vly evident or possible der, intellectual disability, or a level II resident review upon in status assessment. T is not met as evidenced			
	Based on observation medical record review resident with newly emental illnesses for Fand Annual Resident	on, staff interview, and w, the facility failed to refer a evident diagnoses of serious Pre-Admission Screening Review (PASARR) Level II dents reviewed for PASARR		F644 Coordination of PASAA Assessments How corrective action will be accomplished for those resident have been affected by the defici practice Resident #106 was referred for	ts found to ient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345146	B. WING _		11/16/2018
NAME OF PI	ROVIDER OR SUPPLIER	-	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIF	•
				33426 OLD SALISBURY ROAD BO	X 1250
BETHANY	WOODS NURSING	AND REHABILITATION CENTER		ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION OF THE APPROPRIATE COMPLETION DATE
F 644	4/8/16. Resident in diagnosis at the till depression and she screening and An (PASARR). The quarterly Minicassessment dated #106 's cognition was administered antianxiety medication on 7 or included schizoph depression. An observation was on 11/13/18 at 3:3 behavioral issues An interview was a (SW) #2 on 11/14, was aware that will diagnosed with a sign of present on admeeded to be refe PASARR. SW #2 responsible for material residual sign of the sign of th	ded: as admitted to the facility on #106 's only mental health me of admission was he had a level I Pre-Admission nual Resident Review imum Data Set (MDS) In 10/3/18 indicated Resident was severely impaired. She antipsychotic medication, ation, and antidepressant In 7 days. Her active diagnoses renia, psychotic disorder, and as conducted of Resident #106 In PM. There were no observed	F	Pre-admission screening resident review (PASARF the Admissions Coordina How the facility will identi having the potential to be same deficient practice Beginning on 11/19/18 ar 11/20/18the MDS (Minim License Nurses conducte of any new psychiatric dia residents for the past 30 determine if referrals for screening are indicated. residents were identified II screenings. What measures will be prosystemic changes made the deficient practice will Beginning on 12/7/18 and 12/16/18, the care plan to facility MDS nurse, Socia and Admissions Coordina re-educated by the RN faregarding the process for residents for the need for Pre-admission screening resident review (PASARF Residents with new psychiatric will be reviewed daily in the meeting with recommendassigned SW to make approximate the sidents of the meeting with recommendassigned SW to make approximate the sidents with make approximate the sidents with make approximate the sidents with recommendassigned SW to make approximate the sidents with recommendassigned SW to make approximate the sidents with recommendassigned SW to make approximate the sidents with recommendassigned sidents with recommendassigned SW to make approximate the sidents with recommendassigned sidents with recommendations and sidents with recommendations	and annual R) screening by tor on 12/3/18. fy other residents affected by the ad completed on um Data Set) ad a 100% audit agnosis for days to Level II PASARR No other as needing Level ut into place or to ensure that not recur d completed by eam including the I Workers (SW) ator were acility consultant identifying a Level II and annual R)screening. hiatric diagnoses the morning IDT lations to the
	been herself or the revealed there wa this issue. This interview with confirmed that Re	e Admissions Director. She is no clear process in place for a SW #2 continued. She is sident #106 had a level I lent #106 's admission		referrals for Level II PAS/ How the facility plans to r performance to make sur are sustained The RN Quality Improver will perform a 10% audit psychiatric diagnoses an	ARR screenings. monitor its e that solutions nent (QI) nurse for new

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		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		334	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 BEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 644	mental health relate with SW #2. Reside assessment that in of schizophrenia ar reviewed with SW Resident #106 was with the diagnoses psychotic disorder. referred Resident # for a re-evaluation diagnoses. An interview was concept Director (AD) on 11 that she was aware newly diagnosed was not present on needed to be referred PASARR. The AD responsible for malindicated that she where herself or SW no clear process in This interview with confirmed that Rese PASARR. Resident diagnoses that inclimental health relate with the AD. Resident assessment that in of schizophrenia ar reviewed with the AD and not been award diagnoses of schizof disorder were not prevealed she had not prevealed she had not seen assessment that in the AD and the seen award diagnoses of schizof disorder were not prevealed she had not seen award diagnoses of schizof disorder were not prevealed she had not seen award diagnoses of schizof disorder were not prevealed she had not seen award diagnoses of schizof disorder were not prevealed she had not seen award diagnoses of schizof disorder were not prevealed she had not seen award diagnoses of schizof disorder were not prevealed she had not seen assessment that in the schizophrenia are reviewed with the AD and not seen award diagnoses of schizof disorder were not prevealed she had not seen assessment that in the schizophrenia are reviewed with the AD and not seen award diagnoses of schizof disorder were not prevented the schizophrenia are reviewed she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented she had not seen award disorder were not prevented	uded depression and no other ed diagnoses were reviewed ent #106 's 10/3/18 MDS dicated the active diagnoses of psychotic disorder were #2. SW #2 confirmed into admitted to the facility of schizophrenia and She revealed she had not end to the PASARR authority related to these new conducted with the Admissions /15/18 at 6:44 PM. She stated in the thing that we have a resident was eith a serious mental illness that admission that the resident red for evaluation for level II was asked who was king this referral. She was not sure if it would have #2. She revealed there was place for this issue. The AD continued. She ident #106 had a level I to the thing that it is admission unded depression and no other red diagnoses were reviewed ent #106 's admission unded depression and no other red diagnoses were reviewed ent #106 's 10/3/18 MDS dicated the active diagnoses of psychotic disorder were with the AD stated that she is that Resident #106 's phrenia and psychotic oresent on admission. She ot referred Resident #106 to rity for a re-evaluation related	F 6	644	follow up PASAAR screenings each we for 12 weeks; then quarterly thereafter the need for follow up for Level II PASA screenings. The QI nurse will share the results of the PASAAR Audits with the interdisciplinate team (IDT) at least weekly for 12 week. The QI nurse will present IDT corrective actions to the monthly quality improvement (QI) committee for review identification of trends, additional corrective actions, and recommendation. The administrator and/or DON will prestrends and QI committee recommendations to the quarterly qual assurance and performance improvem (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensur continued compliance in the area of accuracy of assessments. The administrator consulted with the medical director/attending physician are the nurse practitioner regarding the plas of correction on 12/11/18 with no change or recommendations noted.	on AAR ne ry s. e /, ns. sent ity ent I e e		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		,	11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 644	Nursing on 11/16/18 she was not very fam	ducted with the Director of at 4:43 PM. She stated that illiar with the regulations but that she expected the	F 6	44			
F 656 SS=D	Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each resident rights set for §483.10(c)(3), that in objectives and timeframedical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, including treatment under §483. (iii) Any specialized services provide as a result of recommendations. If findings of the PASAI rationale in the reside	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive inprehensive care plan must g- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized is the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the	F6	56		12/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1	1/16/2018	
	ROVIDER OR SUPPLIER ' WOODS NURSING A	AND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	desired outcomes. (B) The resident's future discharge. F whether the reside community was as local contact agen entities, for this pu (C) Discharge plar plan, as appropriar requirements set f section. This REQUIREME by: Based on observation interview, the facilic comprehensive ca wandering (Resider eviewed for wand (Residents #118, # reviewed for physit The findings included the findings incl	goals for admission and preference and potential for Facilities must document ent's desire to return to the essessed and any referrals to cies and/or other appropriate rpose. In in the comprehensive care te, in accordance with the borth in paragraph (c) of this entity failed to have re plans in the areas of ent #163) for 1 of 2 residents ering and physical restraints ering and physical restra	F	F 656 Develop/Impleme Comprehensive Care Plar How corrective action will accomplished for those re have been affected by the practice The comprehensive care president #163 was reviewed for accuracy on 7/23/18 Cresidents #118, and #53 wand revised for accuracy k Minimum Data Set (MDS) 12/11/18 with #163's care reviewed by the MDS nurselow the facility will identify having the potential to be same deficient practice. An audit of the compreher was assessed by the Qual (QI) nurse on 12/12/18 for assessed to be at risk for those residents assessed restraints. Any adverse fin corrected.	be sidents found to deficient plans for ed and revised Care plans for vere reviewed by the RN nurse on plan also se at that time. You other residents affected by the nsive care plans lity Improvement all residents wandering and to have physical adings will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	/16/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	111/	10/2010	
					426 OLD SALISBURY ROAD BOX 1250			
BETHANY	WOODS NURSING AND	REHABILITATION CENTER			LBEMARLE, NC 28002			
(V4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	e 54	F	356				
	difficulty in new situat	ions. The assessment			systemic changes made to ensure that			
	indicated Resident #1				the deficient practice will not recur			
	statements of desire	or intent to leave the facility.			MDS nurse was re-educated 12/7/18 b	٧		
		ns were for Resident #163 to			the MDS/RN consultant regarding			
	reside on the locked	memory care unit and for a			accuracy and completion of			
	wanderguard (an elec	ctronic alert system that			comprehensive care plans in the areas	of		
		facility exit doors when			wandering and physical restraints. The			
		esidents with wandering		education included the importance of				
	-	exit the building) to be		accuracy to ensure that information is				
	placed on his person.				available to provide appropriate care a			
	The UD:-	Desired to the distance of the second			interventions. The Interdisciplinary Tea	m		
		Guide" indicated an alarm			(IDT) team will review comprehensive	- al		
	, ,	d) was initiated for Resident e Resident Care Guide had			care plans in the areas of wandering a physical restraints for completion and	ıu		
		sident #163 had wandering			accuracy in the daily IDT meeting.			
	behaviors.	sident # 100 flad wandering			How the facility plans to monitor its			
	The Admission Minim	um Data Set (MDS)			performance to make sure that solution	าร		
		19/18 indicated Resident			are sustained			
	#163' s cognition was	moderately impaired.			The QI nurse will review the IDT tools t	or		
					wandering and restraints weekly for 4			
	The quarterly MDS as	ssessment dated 7/2/18			weeks to track and trend results for			
	indicated Resident #1	63 's cognition was			inclusion in comprehensive care plans.			
	severely impaired.				The audits will be performed weekly fo			
					weeks, then bi-weekly for 2 months, the	en		
	.	7/12/18 indicated Resident			quarterly thereafter.			
	•	exit door on the 100 hall			The results of the audits will be			
	•	n). Staff were present at			communicated to the DON. The QI nur	se		
		nt #163 had not exited the			will share the results of audits with the	12		
	building.				interdisciplinary team (IDT) weekly for weeks.			
		d 7/21/18 indicated Resident			The DON and/QI nurse will present ID	Γ		
		vandering in and out of other			findings to the monthly quality			
	residents ' rooms.				improvement (QI) committee for review identification of trends, additional	/ ,		
	An incident report dat	ed 7/22/18 indicated			corrective actions, and recommendation	ns.		
		n unsupervised exit from the			The administrator and/or DON will pres	ent		
	-	d by two staff members			trends and QI committee			
	_	acility unsupervised around			recommendations to the quarterly qual	ity		
	12:00 PM (7/22/18).	Resident #163 had been			assurance and performance improvem	ent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		11	/16/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	ODE	. 10/2010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	lot of the facility. Resident #163 ' s 7/23/18 with the in "Problematic manicharacterized by in and at risk for uns related to: cognitive exit from facility 7/ was no care plant Resident #163. An interview was on 11/16/18 at 8:3 completed Reside revealed she mad wandering to Resider his 7/22/18 uffacility. An interview was on Nursing (DON) on stated that she excomprehensive bassessed needs. #163 had been as on his 6/13/18 wall wandering care place at that time. 2. Resident #118 valuations and the sale, demential anxiety, schizophren. A Bed Rail Evaluations and the sale in the sale i	care plan was updated on ditiation of the focus area, mer in which resident acts meffective coping: Wandering upervised exits from facility re impairment. Unsupervised 22/18." Prior to 7/23/18, there related to wandering for conducted with MDS Nurse #2 8 AM. She indicated she mt #163's care plan. She e an error and had not added dent #163's care plan until insupervised exit from the conducted with the Director of 11/16/18 at 4:43 PM. She pected care plans to be used on the resident's She indicated that Resident sessed as a wander risk based ander risk evaluation and that a an should have been put into	F6	(QAPI) committee for review recommendations, and to contend for continued monitor continued compliance in the developing and implementic comprehensive care plans. The Administrator consulter Medical Director and nurse regarding the plan of correct changes or recommendation	determine the ing to ensure e area of ng d with the practitioner etion with no		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Resident #118 had a identified as a bruise Facility Reported Increviewed. It indicates eyelid was discovered Resident #118 was investigation and no on her bed. The bruthe where Resident side rail. The plan of care for focus area of potent impairment with bruite eyelid. This area was most recently revises #118 's care plan in rails. The quarterly Minimassessment dated 1 #118 's cognition was assessment indicate physical restraints (of method or physical or equipmeresident 's body that remove easily which movement or normal An observation was on 11/13/18 at 12:30 bed being assisted was expected.	ated 7/3/18 indicated an injury of unknown origin to to her left eyelid. The cident (FRI) investigation was ad a bruise to Resident #118 ' tered during morning care. beserved during the ted to lay against the side rail uised area corresponded to #118 laid her head on the Resident #118 included the ial for skin integrity ise noted on 7/3/18 to her left as initiated on 7/5/18 and d on 10/15/18. Resident cluded no mention of side	F 6	56			
	was not interviewab	le. She had bilateral side 30 ¾ inches in length, as well					

AND DLAN OF CORRECTION IN IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _		1.	1/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	An interview was of 11/13/18 at 12:35 if Resident #118 had padding. She state as Resident #118 if tended to roll over place her head on An interview was of 11/14/18 at 11:15 if was familiar with R why Resident #118 padding. She state she believed the proported she though side rails so Resident she was able to lear reported she though side rails so Reside didn't get caught asked when the paindicated that she find the answer. So revealed that the swere not noted in the reviewed the record the pads were add 7/3/18 in which Reform her eyelid believed with the intervention. The care plan relate #118 was updated with the intervention. An interview was of on 11/14/18 at 3:30.	onducted with NA #7 on PM. NA #7 was asked why the bilateral side rails with ed that they were for protection moved around in bed and to the side of the bed and	F6	956		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	D REHABILITATION CENTER		STREET ADDRESS, CITY, 33426 OLD SALISBURY ALBEMARLE, NC 280	ROAD BOX 1250			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	bilateral padding. She bilateral side rails used bilateral padding to be she revised Resident 11/14/18 after staff in was in use. An interview was con Administrator on 11/14 #118 's bilateral side with bilateral padding Administrator. She in was added after Resulting been caused by the seen caused by the seen caused by the seed after #118 movement of the side rails and cau Administrator indicated.	s used in conjunction with the reported she expected and in conjunction with the care planned. She stated is #118's care plan on formed her that the padding adducted with the 14/18 at 4:15 PM. Resident a rail usage in conjunction is was reviewed with the indicated that the padding ident #118 sustained a in 7/3/18 believed to have side rails. She explained that id around in bed and the her from hitting her head on	F	556				
		mitted to the facility on nosis of non-Alzheimer's						

(X3) DATE SURVEY COMPLETED		
11/16/2018		
DDE 250		
CORRECTION (X5) ON SHOULD BE COMPLETION HE APPROPRIATE DATE (Y)		
1		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG	(X3) DATE COMP	
		345146	B. WING _		11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 656 F 677 SS=D	on 11/14/18 at 3:30 F asked about Resider side rails. MDS Nurs for side rails when in they were a restraint were not considered were for safety to pre Nurse #1 revealed sl padding were in place further stated that if the for the side rail 's new An interview was con Administrator on 11/2 #53's bilateral padd these interventions were reviewed with the Ad Administrator indicated MDS Nurse to care printerventions provided ADL Care Provided for CFR(s): 483.24(a)(2) A residual to the side out activities of daily	anducted with MDS Nurse #1 PM. MDS Nurse #1 was in #53 's bilateral padded se #1 stated that she coded structed by nursing when and the resident 's side rails a restraint. The side rails a restraint. The side rails event falling out of bed. MDS the had not known bilateral the on the bilateral rails. She there was no focus or goal the ed, it was missed. Inducted with the 14/18 at 4:15 PM. Resident the did rail usage and that there not care planned was ministrator. The the did that she expected the tolan for any care or the form of the resident. The resident who is unable to carry living receives the necessary good nutrition, grooming, and	F 6	56		12/16/18
	This REQUIREMEN by: Based on record rev interviews, the facility for 2 of 2 dependent	riews, observations and staff failed to provide nail care residents reviewed for ing (Residents #123 and		F 677 ADL Care Provided for Dependent Residents How corrective action will be accomplished for those residents fo have been affected by the deficient practice The resident #123 and #20 were presidents.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345146	B. WING			11/	16/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
					3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER			LBEMARLE, NC 28002		
0411.1=	CLIMMADY CT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 61	F	677			
					with nail care immediately on 11/16/18	by	
		is admitted to the facility			a Certified Nursing Assistant (CNA).		
		es that included Rheumatoid			How the facility will identify other reside		
	Arthritis.				having the potential to be affected by the	ne	
	The most recent MD	C (Minimum Data Cat) anded			same deficient practice		
		S (Minimum Data Set) coded essment and dated 10/16/18			All residents that require assistance hat the potential to be affected. On 11/17/		
	assessed the resider				the nursing supervisor initiated an audi		
	oriented, able to make her needs known and				resident requiring assistance with nail	. 01	
	understood others. T				care. The audit was completed on		
		he required total assistance			11/20/18 with 36 residents requiring fol	low	
	from 1 to 2 staff mem	bers for all her Activities of			up nail care. Any issues with resident		
	Daily Living (ADL's).				nails were resolved immediately by the		
					hall nurse and/or certified nursing		
		nt's active care plan dated			assistant.		
		esident #123 was dependent			What measures will be put into place of		
	on others for ADL's a	nd personal care.			systemic changes made to ensure that		
	.				the deficient practice will not recur		
	-	g notes revealed no refusals			Re-education for all CNA s to include	_	
	of nail care documen	tea.			fulltime, part time, and agency staff wa		
	Davious of a purging s	note dated 10/18/18 revealed			initiated on 11/19/18 to be completed by 12/16/18 regarding following the Resid		
		teral hand contractures due			Care Guide to include nail care.	ent	
		tis and was dependent on			Re-education was conducted by the St	aff	
	staff for all ADL's.	and was dependent on			development coordinator and/or the D0		
					(Director of Nursing). For staff not		
	During observations	for 4 days (11/13/18,			re-educated by 12/16/2018 they will be		
	11/14/18, 11/15/18 ar	nd 11/16/18) the resident			in-serviced prior to working on the floor		
	was observed with lo	ng nails to both of her			New hires and agency staff will receive		
	contracted hands and	d a dark substance under			this education during orientation to the		
	both thumb nails.				facility.		
					The RN supervisors and assigned		
	On 11/14/18 at 2:30p				Department Heads will continue to	- 0	
	•	#123. She stated that she			perform Compliance Monitoring Round		
		ner hands due to severe			(three) times per week. The rounds will	be	
	about cleaning under	and had not been asked			performed at random times, and days		
	about cleaning under	or cutting ner rialis.			including weekends. How the facility plans to monitor its		
	On 11/14/18 at 4:05p	m an interview was			performance to make sure that solution	16	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1	1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·		
(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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 677	She stated that the ai administrative nurses needed. She stated the schedule to do nail care added that the aides oneed for nail care if the conducted with NA # aides and nurses consisted that the personal care and we assistance or alert and indicated. NA #1 state routine schedule for not completed with LPN # provided nail care who aides the residents or floor was not a routine school of the aides of the stated that the aides of the stated that the reformal care. The DO expectation for the aidetrim nails during daily	cility's Treatment Nurse. des, nurses and completed nail care as nat there was not a formal are on a routine basis. She would alert a nurse of the ne resident was a diabetic. In an interview was I who stated that both the nelete nail care as needed. The aides observe nails during build provide the needed nurse if the resident was a d that there was not a nail care. The am an interview was The third the needed nurse if the resident was a d that there was not a nail care. The third the needed shade a diabetic. She added shave nail care provided by nurse. She stated that there needule for nail care. The third the needed shade and	F6	are sustained The RN supervisor will perform observation of 5 residents with 5 times a week for 1 week, ther week for 3 weeks and then week thereafter for Activities of Daily (ADL) care to include nail care. The results of the ADL observat will be shared with the QI nurse The Director of Nursing (DON) and trend the results and re-edi initiate counseling for nursing si indicated. The DON will share to faudits with the interdisciplina (IDT) weekly for 12 weeks. The DON and/or QI nurse will p Interdisciplinary Team (IDT) cor actions to the monthly quality improvement (QI) committee fo identification of trends, addition corrective actions, and recomm The administrator and/or DON trends and QI committee recommendations to the quarte assurance and performance im (QAPI) committee for review, as recommendations, and to deter need for continued monitoring the continued compliance in the are providing ADL care. The Administrator consulted with Medical Director and nurse pracent regarding the plan of correction changes or recommendations or recommendat	daily audits a 3 times a ekly Living tion audits a and DON. will track ucate or taff as he results ry team oresent rective r review, al lendations. will present ditional mine the o ensure ea of th the ctitioner with no		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	was aware Resident dirty and that she had resident's nails or ale care. She denied any	m an interview was 2 who confirmed that she #123's nails were long and d not cleaned under the rt a nurse to the need for y refusals from the resident ted that there was not a	F	677			
	cumulative diagnoses Accident (CVA) and He Resident #20's quarte (MDS) dated 8/8/18 in impairment and he will behaviors. He was all assistance of one star Review of Resident # dated 8/22/18 for perrequired staff assistant Hemiplegia. There was of showers, turning, rincontinence care. In an observation and 9:40 AM, Resident #2 right arm under his shooperative. He remounder the sheet to all nails. They appeared brown substance under	erly Minimum Data Set indicated moderate cognitive as coded as exhibiting no so coded for extensive iff person for hygiene. 20 last revised care plan sonal hygiene read he ince due to his CVA and ere care plans for his refusal					
	time." It was noted th	at his Hemiplegia affected was able to open his hand					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345146	B. WING		1	/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	Resident #20 was a sitting up eating bre hands reveals long dark brown substar In an interview on a Treatment Nurse stassistants, nurses a provided nail care a In another observar Resident #20 was a received a shower both hands reveale nails. He stated the his nails and stated cut them. In an interview on a Assistant (NA) #15 experienced any re #20 but she knew had activities of daily live. In an interview on a stated Resident #20 activities of daily live.	tion on 11/14/18 at 8:30 AM, again lying in bed. He was eakfast. Observation of both, jagged finger nails with a nee under them. 11/14/18 at 4:05 PM, the tated that the nursing and administrative nurses as needed. 15/18 at 8:10 AM, sitting up in bed. He stated he this morning. Observation of ad long, jagged clean finger a staff member cleaned under a she would come back later to 11/15 at 8:20 AM, Nursing stated she had not a fusals of care from Resident ne liked to be left alone.	F 67	,		
	In an interview on a stated the aides an added that she look if needed. In an interview on a #1 stated she comp	11/15/18 at 9:50 AM, NA #1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING		11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 677	Director of Nursing s was provided by nur- nails as needed duri	e 65 /15/18 at 11:15 AM, the tated that diabetic nail care ses. The aides trim and clean ng personal care. She stated al schedule for nail care but	F 67	7	
F 684 SS=G	that it was her expec	tation for the aides to ails during daily personal	F 684	4	12/16/18
	applies to all treatmet facility residents. Base assessment of a resithat residents received accordance with protopractice, the comprescare plan, and the restriction of the resident facility. Based on observation of the practitioner (NP) and interviews and recomprovide timely evaluate pain following a fall of complaints of pain. To obtain a diagnostic x requested one on 10 dated 10/30/18 reveathrough 7th ribs on the Resident #30. The faddress a resident's suicidal ideations an symptoms for 52 day	andamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure entereatment and care in fessional standards of hensive person-centered esidents' choices. To is not met as evidenced ons, resident, staff, Nurse of Medical Director (MD) of review, the facility failed to eation of a report of immediate on 10/17/18 and continued on the facility also failed to eated fractures to the 3rd one left side. This was for acility also failed to promptly expression of passive		F684 Quality of Care How corrective action will be accomplished for those residents foun have been affected by the deficient practice Resident #30 has had decreased complaints of left side rib pain and is receiving scheduled pain medication along with an additional order for PRN pain management. Resident #163 received a psychiatric review on 11/8/ which revealed no suicidal ideations. continues to receive psychiatric service as needed. How the facility will identify other resident	18 He es

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11,	/16/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				33	426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING A	AND REHABILITATION CENTER		ΑI	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	age 66	F 6	584			
	-	vas for 2 of 2 residents			having the potential to be affected by t	he	
		eing. The findings included:			same deficient practice		
		3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			An audit was conducted by the RN Qu	ality	
	1. Resident #30 w	as admitted on 5/15/18 with			Improvement (QI)nurse all incident	•	
	cumulative diagnoses of Atrial Fibrillation,				reports from November from 11/1/18		
	_	Failure, Osteoarthritis, Restless			through 11/16/18 for any unresolved		
	Leg Syndrome and	d Delusional Disorder.			complaints of pain or expressions of		
	D				suicidal ideations. A review of progres		
		arterly Minimum Data Set			notes was completed for any expression		
		18 indicated moderate ent with a Brief Mental Status			of suicidal ideations not resolved with a negative findings noted.	10	
		2. She was coded with no			The Interdisciplinary Team will review a	all	
	, ,	ted assistance with ambulation.			residents with incidents, including falls		
		coded with no impairments to			and changes of condition, and any		
		extremities. She was coded for			behavior notes indicating suicidal		
	scheduled and as	needed (PRN) pain			ideations in morning IDT meeting. The		
	medications. Resid	dent #30 was coded as			review will include completion of		
	1	and as having no falls since			assessment, evaluation, monitoring, a	nd	
	previous MDS ass	essment.			treatment of complaints of pain; and		
	Daview of the survey	ing 24 Hour Danast dated			assessment, evaluation, completion of		
		sing 24 Hour Report dated sident #30 slid to the floor on			psychiatric referrals, and monitoring of follow up for suicidal ideations.		
		Physician and Responsible			What measures will be put into place of	ır	
		. The 24-Hour Report indicated			systemic changes made to ensure that		
		ived Tylenol 2 tablets on			the deficient practice will not recur		
	second shift.	,			·		
					The Nursing staff will be re-educated		
	Review of an incid	ent report and nursing note			beginning 11/20/18 by the DON and/or	•	
		10:43 AM read Resident #30			SDC on assessment, evaluation,		
		ed fall in her room. She was			monitoring, and physician notification of		
		own from her wheelchair to her			residents with continued complaints of		
		ell. The report and nursing note			pain and/or suicidal ideations.		
	left rib pain. The n	Resident #30 complained of			Re-education will be completed by 12/16/18. Any staff members not		
		ras left for the NP and Medical			receiving re-education by 12/16/18 will	not	
	· ·	rvention was a therapy screen.			be allowed to work until education is	1101	
	Shootor. The inter	Tondon was a therapy sorcen.			completed. New hires and agency sta	ff	
	Review of a Physic	cian Fax Communication sheet			will receive this education during		
		ad Resident #30 did not fall but			orientation to the facility.		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′			(X3) DATE SURVEY COMPLETED	
	345146	B. WING _			11/	16/2018
ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
WOODS NUBSING AND	DELIABILITATION CENTED		33	3426 OLD SALISBURY ROAD BOX 1250		
WOODS NURSING AND	D REHABILITATION CENTER		Α	LBEMARLE, NC 28002		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE
sat on the floor and of walker and recliner. If left rib pain. The Nurs the word "monitor" w documentation was to Review of the nursing 10/17/18 read Reside tablets at 6:00 PM. Review of the Octobe and Medication Admiread Resident #30 w (treats nerve pain) the and Ultram (synthetic twice daily scheduled Norco (opioid used to needed for pain. Review of the Octobe #30 received no as not received not received not received not received no as not received no	raught herself using her Resident #30 complained of se Practitioner (NP) wrote ith her initials. The NP undated. g 24 Hour Report dated ent #30 received Tylenol 2 er 2018 Physician Orders inistration Record (MAR) as receiving Neurontin ree times daily scheduled copioid used to treat pain) d. There were also orders for o treat pain) 1 tablet as er 2018 MAR read Resident leeded doses of her Norco. er 2018 MAR read a standing milligrams (mg) 2 tablets by as needed for pain for 48 cated Resident #30 received 0/17/18, 10/23/18, 10/24/18 dilitation screen dated ent #30 was not interested in one. g 24 Hour Report dated ent #30 complained of rib	F	584	Abuse, Neglect, and Misappropriation of Property that includes assessment, evaluation, monitoring, and notification physician of residents with continued complaints of pain and/or suicidal ideations. Training will be provided by the Staff Development Coordinator or the Director of Nursing. Residents exhibiting complaints of pain and/or suicidal ideations will be discuss in the daily interdisciplinary team (IDT) meeting after the occurrence. Discussion will include notification of attending physician, Resident Representative and whether interventions implemented are effective. How the facility plans to monificate to make sure that solutions are sustained. The QI Nurse will review the IDT form for pain and/or behaviors for trending and tracking of residents with repeat complaints of pain and/or suicidal ideations on a weekly basis for 12 weet. The QI Nurse will present IDT corrective actions and reported abuse/neglect, suicidal actions to the monthly quality improvement (QI) committee for review identification of trends, additional corrective actions, and recommendation. The administrator and/or DON will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure	of of he sed on d tor ks. e , ns. ent	
Review of a nursing	24 Hour Report dated				6.	
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR SAT ON THE NUMBER OF THE NUMBE	Ad5146 ROVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 sat on the floor and caught herself using her walker and recliner. Resident #30 complained of left rib pain. The Nurse Practitioner (NP) wrote the word "monitor" with her initials. The NP documentation was undated. Review of the nursing 24 Hour Report dated 10/17/18 read Resident #30 received Tylenol 2 tablets at 6:00 PM. Review of the October 2018 Physician Orders and Medication Administration Record (MAR) read Resident #30 was receiving Neurontin (treats nerve pain) three times daily scheduled and Ultram (synthetic opioid used to treat pain) twice daily scheduled. There were also orders for Norco (opioid used to treat pain) 1 tablet as needed for pain. Review of the October 2018 MAR read Resident #30 received no as needed doses of her Norco. Review of the October 2018 MAR read a standing order for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain for 48 hours. The MAR indicated Resident #30 received Tylenol 650 mg on 10/17/18, 10/23/18, 10/24/18	ROVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 sat on the floor and caught herself using her walker and recliner. Resident #30 complained of left rib pain. The Nurse Practitioner (NP) wrote the word "monitor" with her initials. The NP documentation was undated. Review of the nursing 24 Hour Report dated 10/17/18 read Resident #30 received Tylenol 2 tablets at 6:00 PM. Review of the October 2018 Physician Orders and Medication Administration Record (MAR) read Resident #30 was receiving Neurontin (treats nerve pain) three times daily scheduled and Ultram (synthetic opioid used to treat pain) twice daily scheduled. There were also orders for Norco (opioid used to treat pain) 1 tablet as needed for pain. Review of the October 2018 MAR read Resident #30 received no as needed doses of her Norco. Review of the October 2018 MAR read a standing order for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain for 48 hours. The MAR indicated Resident #30 received Tylenol 650 mg on 10/17/18, 10/23/18, 10/24/18 and 10/26/18. Review of the Rehabilitation screen dated 10/18/18 read Resident #30 was not interested in participating in therapy. Review of the nursing 24 Hour Report dated 10/22/18 read Resident #30 complained of rib pain and received Tylenol on third shift.	A BUILDING 345146 B. WING SOVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 sat on the floor and caught herself using her walker and recliner. Resident #30 complained of left rib pain. The Nurse Practitioner (NP) wrote the word "monitor" with her initials. The NP documentation was undated. Review of the nursing 24 Hour Report dated 10/17/18 read Resident #30 received Tylenol 2 tablets at 6:00 PM. Review of the October 2018 Physician Orders and Medication Administration Record (MAR) read Resident #30 was receiving Neurontin (treats nerve pain) three times daily scheduled and Ultram (synthetic opioid used to treat pain) twice daily scheduled. There were also orders for Norco (opioid used to treat pain) 1 tablet as needed for pain. Review of the October 2018 MAR read Resident #30 received no as needed doses of her Norco. Review of the October 2018 MAR read a standing order for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain for 48 hours. The MAR indicated Resident #30 received Tylenol 650 mg on 10/17/18, 10/23/18, 10/24/18 and 10/26/18. Review of the Rehabilitation screen dated 10/18/18 read Resident #30 was not interested in participating in therapy. Review of the nursing 24 Hour Report dated 10/122/18 read Resident #30 complained of rib pain and received Tylenol on third shift.	NOWDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEDICENCIES ELECAN PROFICIENCY WISTER PROFICE PROFILE PROFI	A BUILDING STREETADDRESS, CITY, STATE, 2IP CODE

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345146	B. WING _			11/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
DETUANV	WOODS NUBSING AND	REHABILITATION CENTER		33	3426 OLD SALISBURY ROAD BOX 1250		
DETHANT	WOODS NURSING AND	REHABILITATION CENTER		Α	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 68	F 6	84			
	10/23/18 read Resident #30 went out of the facility with her RP on first shift. Review of a Physician Fax Communication dated				The Administrator consulted with the Medical Director and nurse practitioner regarding the plan of correction with nuchanges or recommendations noted.		
	10/23/18 read Reside complain of left upper going to have her RP for evaluation if some	ent #30 continues to r rib pain and stated she was drop her off at the hospital ething was not done. The NP se #4, "no complaints" with			changes of recommendations noted.		
	PM read Resident #3 soreness to her left s	note dated 10/29/18 at 4:56 0 was complaining of ide and left arm. Resident ay and the NP was notified.					
	follows: Minimal displ through seventh post	eport dated 10/30/18 read as aced fractures of the third erior lateral ribs left side was undated but initialed by					
	Review of Resident # dated 10/30/18 for Bi reliever) four times da	· · ·					
	read in part as follow: approximately 2 weel have left lower rib cay coughing, deep breat bed. Resident #30 stately alleviate the pair very concerned since	dated 10/30/18 at 2:11 PM, s: Resident #30 had a fall ks ago and continues to ge pain that worsens with this or with repositioning in ated her pain medications do n somewhat, but she is still to it is ongoing. Resident #30 is doing okay and has no					
	Review of the Novem Resident #30 receive	ber 2018 MAR read d no as needed doses of her					

AND DI AN OF CORRECTION IN IMPER		' '	TIPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1.	1/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 33426 OLD SALISBURY ROAD BO ALBEMARLE, NC 28002	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 684	#30 reported she fexperienced left sicher ribs and she re NP or MD until two stated the pain was tated she continuin bed and on transher left side with farmal ner left side and left armal ner left side ner left side pain management in an interview on stated she was assand assigned to he the NP was in the the NP about Resiside pain. She stated assess Resident #her to monitor Responsible pain. She stated about a week complaining of pain supervisor #3 requences and supervisor #3 requences ner left side with side with side ner left side with si	11/13/18 at 4:49 PM, Resident ell in October and immediately de pain. She stated she broke received no x-ray and saw no weeks after the fall. She is bad but has improved. She es to have pain with movement efers. She reached to guard ricial grimacing. The plan last revised on 11/14/18 at risk for pain related to mess and discomfort to her left in 10/29/18. The care plan also read her x-ray dated fractures of her left 3rd interventions included listening of pain, medications as ting verbal and non-verbal and notification of the physician in the was not effective. 11/14/18 at 2:35 PM, Nurse #4 signed Resident #30 most days er the day she fell. She stated building that day and spoke to dent #30's complaints of left ed she did not recall if the NP 30 on 10/17/18 but the NP told ident #30 and administer the needed it for pain. Nurse #4 ex later, Resident #30 was still in to her left side so Nurse needed it not report in tinued complaints of pain until	F	584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 33426 OLD SALISBURY ROAD BALBEMARLE, NC 28002			
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F 684	Assistant (NA) #10 complained of left s reported it to Nurse #30 continues to co transfers. In an interview on 1 Supervisor #3 state Resident #30 had a side pain. She state to monitor her for co pain. She stated she 10/29/19 and reque Resident #30 reque In an interview on 1 stated Resident #30 had a side pain. She stated she 10/29/19 and reque Resident #30 reque In an interview on 1 stated Resident #30 compreport it to her assign In an interview on 1 stated it was her ex directed the nursing #30, they would have worse, but she was the fall. The NP con Resident #30 until 1 reported to her that	n dated 10/23/18. 1/14/18 at 2:45 PM, Nursing stated Resident #30 ide pain after the fall and she #4. She confirmed Resident implain of occasional pain with 1/14/18 at 3:05 PM, Nurse id she was aware that fall and was experiencing left id the NP wanted nursing staff ontinued or worsening of the experience contacted the NP on sted an x-ray because sted it. 1/15/18 at 8:50 AM, NA #11 in has complained of pain to re. NA #11 stated when lained of pain, she would	F	584	iENCY)		
	her on 10/23/18, sh #30, but she was ou and she was not no Nurse Supervisor #3	ated when the Nurse #4 faxed e stopped in to see Resident at of the facility with her RP tified again until 10/29/18 by 3. The NP stated that was ne x-ray. The NP confirmed					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING			1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 684	NP confirmed she duntil 10/30/18. She additional treatment already taking Ultra Tylenol as needed. routinely review the relied on the staff ca Physician Commun confirmed she was through Friday and was not at the facilit In a second intervie Resident #30 was s NA #11 present in the complained of left s ribs. She was guard grimacing. NA #11 complaint of pain ar nurse. In an interview on 1 confirmed she was had cared for her si AM on 11/15/18. She inform her that Resi earlier today after b #30 had not complawas due her schedu Resident #30. A telephone call was	of fractured left side ribs. The id not assess Resident #30 stated there was no need for and that Resident #30 was m twice daily for pain and The NP stated she did not nursing notes but rather alling her for sending her a fication Fax form. The NP at the facility daily Monday available by phone when she by. W on 11/15/18 at 10:40 AM, itting up in her wheelchair with the room. Resident #30 ide pain where she broke her led of her left side with facial heard Resident #30's and stated she would notify her 1/15/18 at 5:40 PM, Nurse #6 assigned Resident #30 and noce beginning her shift at 7:00 e stated NA #11 did not dent #30 voiced left side pain reakfast and that Resident ined of pain to her, but she alled Ultram and would assess	F 68	34			
	to call surveyor. At the return call from RP. In an interview on 1	pers listed with messages left ime of exit, there had been no 1/16/18 at 8:20 AM, Resident feeling better today. She					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 684	In a second interview the NP stated it was NA #11 heard Reside pain on 11/15/18, she Resident #30's nurse. A telephone call was at 11:18 AM with a m surveyor regarding not complaints of pain or exit, there had been in a telephone call or #12 confirmed she whom 10/19/18 and 10/2 stated she recalled Releft rib pain especially could not use her left pain. NA #12 stated she recalled Resident #30's nurse. In a telephone call or #13 confirmed she whom 10/18/18 for third Resident #30 stated but NA #13 could not anything to the nurse. In a second interview NA #10 confirmed she whom 10/18/18, 10/21/18, 10/20/18, 10/20	on 11/16/18 at 10:20 AM, her expectation that when ent #30 complain of left side e would have reported it to e. made to NA #11 on 11/16/18 dessage left to call the ot reporting Resident #30's in 11/15/18. At the time of no return phone call. 11/16/18 at 11:35 AM, NA has assigned Resident #30 complaining of when toileting and that she arm to reach due to the she reported the pain the e on both days. 11/16/18 a 11:42 AM, NA has assigned Resident #30 shift. She stated she recalled she was sore from the fall, it recall if she reported	F6	84				
	In an interview on 11.	/16/18 at 12:30 PM, Nurse						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1.	1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING	AND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIF 33426 OLD SALISBURY ROAD BO ALBEMARLE, NC 28002			
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F 684	10/19/18, 10/26/18 stated he worked 7:00 PM. Nurse #1 notification that Re and that she neve went in to give her In a telephone into the MD stated it would have been and NP at the time who complained of pair have been ordered He further stated it continued pain and rule out injury, it would have concerned the further stated in t	vas assigned Resident #30 on 8, 10/27/18 and 10/28. He those days from 7:00 AM to 7 stated he received no esident #30 complained of pain r complained of pain when he medications. erview on 11/16/18 at 5:00 PM, ras his expectation that there assessment completed by the en Resident #30 first n on 10/17/18 and x-ray would d at that time to rule out injury. If Resident #30 reported d the NP did not assess her to ras expectation that the nursing contacted him for orders. dical record indicated new 6/18 for Resident #30 to have a completed three times daily weeks and to administer the	F	584			
	6/12/18 with diagn without behaviors, encephalopathy, a Pulmonary Diseas A review of the me #163 was initially a the facility (700 ha	edical record indicated Resident admitted to an unlocked unit of all) on 6/12/18 but was relocated nory care unit on the 500 hall					

		1 1			(X3) DATE SURVEY COMPLETED		
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A Nurse Practitione indicated Resident of COPD, alcohol a encephalopathy, and to the locked memor NP indicated that Register and year, but was and stated that being at the "here". The Admission Minital assessment dated 6 #163 's cognition working assessment dated 6 for the state of the sta	r (NP) note dated 6/13/18 #163 had a significant history buse, metabolic d dementia. He was admitted ry care unit of the facility. The esident #163 was oriented to at he was not certain where he he was quite anxious about mum Data Set (MDS) 6/19/18 indicated Resident ras moderately impaired. The terview revealed he felt peless 12-14 days, had p/staying asleep/or sleeping rs, feeling tired or having little feeling bad about himself ble concentrating on things is assessed with no behaviors. administered antidepressant r days. Resident #163 indicated the gs of sadness, emptiness, depression characterized by; ow self-esteem, tearfulness, ndrawal from care/activities in to facility, loss of ge in lifestyle. This focus in 6/22/18. The interventions depression ones to keep in ation as ordered, offer	Fé	684				
,	Continued From para A Nurse Practitione indicated Resident; of COPD, alcohol al encephalopathy, and to the locked memon NP indicated that person and year, but was and stated that being at the "here". The Admission Miniassessment dated 6 #163's cognition were ident's mood in down/depressed/hotrouble falling aslee too much 12-14 days, 7-11 days, and troul 12-14 days. He was resident #163 was medication on 7 of 7 The plan of care for focus area of feeling anxiety, uneasiness ineffective coping, lemotor agitation, with related to: admission independence/chan area was initiated of included: convey accomprovide repeated hos strengths, discuss for resident, encourage contact/visit, medical activities that reside provide emotional signal in the provide emotional	TOORNECTION IDENTIFICATION NUMBER: 345146 ROVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 A Nurse Practitioner (NP) note dated 6/13/18 indicated Resident #163 had a significant history of COPD, alcohol abuse, metabolic encephalopathy, and dementia. He was admitted to the locked memory care unit of the facility. The NP indicated that Resident #163 was oriented to person and year, but he was not certain where he was and stated that he was quite anxious about	ROVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 A Nurse Practitioner (NP) note dated 6/13/18 indicated Resident #163 had a significant history of COPD, alcohol abuse, metabolic encephalopathy, and dementia. He was admitted to the locked memory care unit of the facility. The NP indicated that Resident #163 was oriented to person and year, but he was not certain where he was and stated that he was quite anxious about being at the "here". The Admission Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #163 's cognition was moderately impaired. The resident 's mood interview revealed he felt down/depressed/hopeless 12-14 days, had trouble falling asleep/staying asleep/or sleeping too much 12-14 days, feeling bad about himself 7-11 days, and trouble concentrating on things 12-14 days. He was assessed with no behaviors. Resident #163 was administered antidepressant medication on 7 of 7 days. The plan of care for Resident #163 indicated the focus area of feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by; ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/activities related to: admission to facility, loss of independence/change in lifestyle. This focus area was initiated on 6/22/18. The interventions included: convey acceptance of resident and provide repeated honest appraisals of resident 's strengths, discuss feelings about placement with resident, encourage loved ones to keep in contact/visit, medication as ordered, offer activities that resident has shown interest in, and provide emotional support to resident/family as	ROVIDER OR SUPPLIER 7 WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (#ACH DEFICIENCY MUST BE PRECEDED BY PULL (#CACH DEFICIENCY MUST BE PRECEDED BY PRETX TAG Continued From page 74 A Nurse Practitioner (NP) note dated 6/13/18 indicated Resident #163 had a significant history of COPD, alcohol abuse, metabolic encephalopathy, and dementia. He was admitted to the locked memory care unit of the facility. The NP indicated that Resident #163 was oriented to person and year, but he was not certain where he was and stated that he was quite anxious about being at the "here". 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The interventions included: convey acceptance of resident and provide emolorage loved ones to keep in contact/visit, medication as ordered, offer activities that resident has shown interest in, and provide emotional support to resident/family as	ROWIDER OR SUPPLIER 7 WOODS NURSING AND REHABILITATION CENTER 8 SUMMARY STATEMENT OF DEPICIENCIES (REACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) COntinued From page 74 A Nurse Practitioner (NP) note dated 6/13/18 indicated Resident #163 had a significant history of COPD, alcohol abuse, metabolic encephalopathy, and dementia. He was admitted to the locked memory care unit of the facility. The NP indicated that Resident #163 was oriented to person and year, but he was not certain where he was and stated that he was quite anxious about being at the "here". The Admission Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #163' so cognition was moderately impaired. 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		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	O REHABILITATION CENTER	•	33426 OI	ADDRESS, CITY, STATE, ZIP CODE LD SALISBURY ROAD BOX 1250 ARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	were all initiated on 6 A Social Work (SW) by SW #2 indicated a assessment was con and he reported "thoughts #2 indicated she ask made him feel that w wanted a beer and w that he had not liked care unit as he was, people back there". The quarterly MDS a indicated Resident # severely impaired. Trevealed he had felt 12-14 days, trouble ff asleep/or sleeping to tired or having little e thoughts that he wou or thoughts of hurting days. He had no bel administered antidep days. The plan of care rela (initiated 6/22/18) was specific date noted) to reported feeling down sleeping, feeling tired thoughts of harming initiated on 6/22/18 or revisions.	ssion. These interventions 6/22/18. Inote dated 7/2/18 completed a mini-mental status ducted for Resident #163 ughts he ' d be better off s of harming himself". SW ed Resident #163 what ay and he stated that he ras unable to get it and also being on the locked memory "not like the other crazy ssessment dated 7/2/18 163 's cognition was the resident mood interview down/depressed/hopeless alling asleep/staying o much 12-14 days, feeling nergy 12-14 days, and had lid have been better off dead ghimself in some way on 2-6 naviors. Resident #163 was ressant medication on 7 of 7 ted to feelings of sadness is updated in July 2018 (no o indicate Resident #163 in and depressed, trouble it without energy, and having	F6	584				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		,	I1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 1 ALBEMARLE, NC 28002	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	's family members keep Resident #16 unit or to move him This was noted to Resident #163 and move off of the loc noted to be moved unit and onto the 1 (7/10/18). An NP note dated #163 was evaluate somewhat upset be were touching his but otherwise he high pleased to be mov NP indicated Residential unlocked unit for care unit on this said exit from the facility hall unlocked unit for care unit on this said after Resident #163. after Resident #164. after Resident #165. after Resident #166.	had spoken with Resident #163 several times about whether to it is on the locked memory care in to one of the unsecured units. The been discussed with the reported that he wanted to ked unit. Resident #163 was out of the locked memory care 00 hall (unlocked) on this date with the dand stated that he was ecause he believed people things and stealing his things and no complaints and was ed off of the locked unit. The dent #163 needed close he was developing paranoia ocked unit. The was moved from the 100 to the 500 hall locked memory ame date (7/22/18). Interest 7/28/18 indicated Resident values since returning to the two was unable to hold his eriod of time, and he had ting on one task. The Was was ordered This 8/1/18 order was 30 days 3's report of passive thoughts	F	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345146	B. WING _			11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	initial psychiatric ev management. Staff intermittent confusic increased anxiety, a care. He was noted elevated/expansive. concentration, restle combativeness, and suicidality was note This 8/23/18 PNP in was 52 days after in passive thoughts of An observation was was attempted with 7:45 AM. Resident to self only. He was An interview was confused a self only. He was a stempted with 7:45 AM. Resident to self only. He was An interview was confused in thoughts of suicide reviewed with SW ##163 reporting this in that Resident #163 wanted to leave the she had not complete assessment for Resconfirmed he had not harming himself. Sind done after Resident management for the confused one of the of Nursing (DON) of She reported that the when an issue of	desident #163 was seen for his aluation and medication reported Resident #163 had on, difficulty redirecting, and some combativeness with a with agitation, firritable mood, poor ressness, physical aggression, a resistance to care. No don this PNPs assessment. The physical psychiatric evaluation resident #163 's report of suicide on 7/2/18. conducted, and an interview Resident #163 on 11/16/18 at #163 was alert and oriented	F6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page		F 6	84				
	consultation. She sta was to pass the inform #2 indicated that Res suicidal thoughts to h							
	11/16/18 at 9:41 AM. which Resident #163 thoughts to SW #2 w. She stated she was u	ducted with the DON on The note dated 7/2/18 in reported passive suicidal as reviewed with the DON. unable to recall with any						
	SW #2. She reported on with Resident #16 that on 7/10/18 Resid	een told this information by If that there was a lot going If in July 2018. She stated If it is in the stated If it is in the stated in the state in						
	on 7/22/18 Resident a exit from the facility, a was moved back to the confirmed SW #2 's s	#163 had an unsupervised and on that same date he ne locked unit. The DON statement that she was not						
	or the NP to request and that her responsi information to the nur	dently contact the physician a psychiatric consultation bility was to pass the rsing staff. She indicated the btebook at the nurse 's						
	station where they ke whom she was support to the facility. The Do and stated that there	ept a list for the PNP of osed to see when she came ON reviewed this notebook was not any information in to Resident #163 's report						
	This interview with th asked what her expe- timely psychiatric cor reported multiple dep passive suicidal thou	e DON continued. She was ctation was related to a insultation for a resident who irressive symptoms as well as ghts. The DON indicated ent with voiced passive						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	notebook to alert her next scheduled visit to the PNP came to the weeks. An interview was conditional to the seeks. An interview was conditional to the weeks.	red for a psychiatric e documented in the PNP to see the resident on her o the facility. She stated that facility about once every 2 ducted with the NP on 1. The note dated 7/2/18 in reported passive suicidal as reviewed with the NP. unable to recall with certainty med of Resident #163 's thoughts, but she felt he ng that she believed, "he just say 'oh I'd rather be dead oday'." She indicated that order dated 8/1/18 for a on that it wasn 't even 163 's depressive thoughts. She indicated esident #163 's increased	F 6	84		
F 689	thoughts to SW #2 w physician. He stated if he had been inform to Resident #163. He expectation was for a thoughts to be taken psychiatrist to be condetermination of the expressed thoughts a	as reviewed with the that he was unable to recall led of this information related e indicated that his any statement of suicidal	F 6	89		12/16/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 33426 OLD SALISBURY ROAD ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIAT ICIENCY)	(X5) COMPLETION DATE	
F 689 SS=J	Continued From page CFR(s): 483.25(d)(1) §483.25(d) Accidents		F 6	89			
	The facility must ensu §483.25(d)(1) The resast free of accident has \$483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on record revobservation, the facility supervision to prevent impaired residents will behaviors from exiting unsupervised (Reside	are that - sident environment remains azards as is possible; and asident receives adequate stance devices to prevent is not met as evidenced aiew, staff interview, and ty failed to provide at 1 of 2 sampled cognitively and displayed wandering		F 689 Free of Accid Hazards/Supervision/How corrective action accomplished for those have been affected by practice " On 7/22/18, Resident Hazards/Supervision of Accident Hazards/Supervisio	Devices will be se residents found the deficient	to	
	Immediate Jeopardy Resident #163 was for without supervision be Housekeeper #2. Rea picnic bench under to the rear parking of 12:00 PM. Immediate 11/16/18 when the fair implemented an accell Immediate Jeopardy remains out of compliseverity of "D" (no has more than minimal has	began on 7/22/18 when bund outside of the facility by Housekeeper #1 and sident #163 was seated on a covered shelter adjacent the facility at approximately be Jeopardy was removed on cility provided and eptable credible allegation of removal. The facility lance at a lower scope and rm with the potential for arm that is not immediate monitoring systems put in		found, by two membe staff, sitting outside in adjacent to the rear paresident was assisted by the two members of staff at 12:00pm.	rs of housekeeping the picnic area arking lot. The back into the facili of housekeeping hall Nurse confirmed are guard was in ard bracelet was not to 5 pm, Resident y the Hall nurse with a Director of Nursing vised exit of Reseas transferred to the mentia) unit. The rearing a Wander	ed ot ith	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO	•		
				33426 OLD SALISBURY ROAD BOX	1250		
BETHANY	WOODS NURSING A	AND REHABILITATION CENTER		ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From p	age 81	F 6	89			
F 689	6/12/18 with diagn without behaviors, disease (COPD), a encephalopathy, a A review of the me #163 was initially athe facility (700 hat to the locked mem the same day (6/1 A Nursing Admissi Resident #163 ind no help required for He ambulated indo Resident #163 was behaviors. A nursing note dat #163 was alert and some confusion and about the facility. of sun-downing and evenings. A Nurse Practition indicated Resident of COPD, alcohol encephalopathy, a be a poor historiam to the locked mem the continued on Normedication) relate be alcohol induced Resident #163 was distributed and with the locked mem the continued on Normedication) relate the alcohol induced Resident #163 was distributed and with the locked mem the continued on Normedication) relate the alcohol induced Resident #163 was distributed and with the locked mem the continued on Normedication) related the locked mem the continued on Normedication induced Resident #163 was distributed to the locked mem the continued on Normedication induced Resident #163 was distributed to the locked mem the continued on Normedication induced Resident #163 was distributed to the locked mem the continued on Normedication induced Resident #163 was distributed to the locked mem the continued on Normedication induced Resident #163 was distributed to the locked mem the continued to the	s admitted to the facility on loses that included dementia chronic obstructive pulmonary alcoholic abuse, metabolic and anxiety. Redical record indicated Resident admitted to an unlocked unit of lill) on 6/12/18 but was relocated fory care unit on the 500 hall 2/18). On Evaluation dated 6/12/18 for icated he was independent with or bed mobility and transfers. Rependently with supervision. It is assessed with wandering led 6/12/18 indicated Resident doriented to situation with and was observed wandering. He was noted to have a history and increased wandering in the let (NP) note dated 6/13/18 to the first that a significant history.	F6	for functionality 11/7/18 by and re-checked by the DON functionality on 11/15/18. "On 7 /22 /18 at 12:16p #1□s physician was notified administrator of the resident unsupervised exit. "On 7/22 /18, at 12:16p #163□s Resident Represer was notified by the staff nurtunsupervised exit. "On 7/24 /18, the Minit (MDS) nurse confirmed Reswas already assessed for A Wandering, wander guard was functional when checked by admissions director 6/13/18 was admitted to the facility resident was assessed for a wandering on 6/13/18, the arevealed a score of 6 out of points. The Wandering Risk assessment was completed Registered Nurse QI Nurse "On 7/24 /18, Resident wandering assessment was on by the QI nurse and resure of 10 out of 21 total points. #163□s care plan and care reviewed and updated as a 7/23/18 by the MDS nurse. "On 7/22/18 at 12:10 pr Nurse documented the War was intact to right lower leg "On 7/22/18 at 12:05 pr Supervisor on duty conduct observation audit of all exit	m, Resident d by the it s m Resident ntative (RR) rese of the mum Data Set sident #163 at Risk of was on and y the B. The resident on 6/12/18, the risk for assessment f 21 total a evaluation d by the series as re-assessed ulted in a score Resident guide were ppropriate on m the RN Staff nder guard . m The RN ted 100%		
		luation dated 6/13/18 indicated		result of this audit showed in findings. The audit included	no negative		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED			
		345146	B. WING			11/16/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
RETHANY	WOODS NURSING AN	D REHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX 125	60	
DEITIANT	WOODO NONOINO AIN	D REHADIEHATION GENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pag Resident #163 was a	ge 82 at risk for wandering. He was	F 68	exit doors for functionality of a	alarms and /	
	noted with cognitive remembering where difficulty in new situa indicated Resident #	loss, occasional problems he was at, and had some ations. The assessment 163 had made verbal or intent to leave the facility.		or locks. The RN Supervisor was reported the completion and redoor audit to the Director of N 7/22/18. The RN Supervisor of the audit in the written statem.	verbally esults of the ursing on locumented	
	Follow up intervention reside on the locked wanderguard (an elealarms and locks the cognitively impaired	ons were for Resident #163 to memory care unit and for a extronic alert system that a facility exit doors when residents with wandering exit the building) to be		11/15/18. " The Maintenance Directo weekly the functionality of the system on all exit doors. The Director documents the result weekly checks in the TELS co	or checks locking Maintenance s of all	
	placed on his persor The "Resident Care bracelet (wandergua #163 on 6/14/18. Th not indicated that Re	- -		system. On 11/16/18 the Assis Administrator printed from the computer system of the Logbo of the Resident Monitoring Sy 6/2/18 through 11/10/18. The reveals that weekly door checoccurred since 6/2/18.	stant TELS pok Report stems from Report	
	focus area of the pobreathing pattern rel on 6/14/18. There w	Resident #163 indicated the tential for/actual ineffective ated to COPD was initiated vas no initiated focus area #163 's wandering behaviors at that time.		" On 11/7/18 the QI nurse of functionality of Res # 163 □s N guard. On 11/15/18 at 8:55 pr performed an observation aud 163 □s Wander guard for functioning with an expiration	Wander In the DON It on Res # Itionality and Ity	
	assessment dated 6 #163 's cognition wa was assessed with r care, and no wander the supervision of 1 and locomotion on/o supervision with no s room and corridor. If was assessed as un without staff assistar	mum Data Set (MDS) /19/18 indicated Resident as moderately impaired. He no behaviors, no rejection of ring. Resident #163 required for bed mobility, transfers, off the unit. He required set up help for walking in Resident #163 's balance steady but able to stabilize nce. He had no functional e of motion and utilized no		10/2020. The wanderguard had expired and was functional. " During the investigation of unsupervised exit that was initervised from two housekeep observed the resident in the owarea and the RN Staff Nurse. Was interviewed and was una verbalize the exit path that was RN supervisor interviewed of the inability to determine that	of the tiated on were ers that outside picnic Res # 163 ble to as taken. The ner staff to the DON	

Facility ID: 923032

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1' '	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11	/16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
DETHANN	WOODO NUDOINO AND	DELIABILITATION OF NEED		33426 OLD	SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		ALBEMA	RLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Cognitive Loss/Demeror Resident #163 's 6/1 to a diagnosis of demalcohol abuse. He will deficits requiring reor familiar with his surrous had a history of alcohapproximately 2 monuse. He had diagnost dementia without behalt metabolic encephalor required very minimal supervision and cuein was noted as essential admission with noted sometimes sleeping in A Care Plan Return to 6/19/18 completed by indicated Resident #1 community but that his woods up until his hoo his admission to the face of the	esment (CAA) related to entia was triggered for 9/18 Admission MDS related mentia associated with as noted with cognitive itentation until he was fundings. Resident #163 and abuse which he was this post ceasing alcohol ses of COPD, alcohol abuse, navioral disturbance, and pathy. Resident #163 I assistance, mainlying to complete tasks. He ally homeless prior to stays in hotels and in the woods of a local park. To Community note dated by Social Worker (SW) #2 163 wanted to return to the e had been living in the spitalization that resulted in facility. Note dated 6/27/18 re plan meeting was ent #163. Two of his family I to be in attendance. On attended the meeting, that Resident #163 had a hospital Against Medical ey wished for him to remain term care as they felt he ted living facility AMA if he	F6	path of in the by the notified MD of Democration of Democration of the more and part of the more and part of the p	of Res #163. Res #163 was place secured dementia unit at 12:1 er RN supervisor. The RN Staffed the Resident Representative of placement in the Secured centia Unit. The resident has ined in the Secured Dementia 17/22/18 without any further pervised exits. On 11/15/18 at 8:30 pm the Quovement Action Team met to perform the Unsupervised Exit of dent # 163 on 7/22/18. The QL consisted of the Regional Vice dent, Administrator, Director of Ing. Social Services, Admission for, Nursing Supervisor, MDS in Payroll and Accounts Rece keepers, Assistant Administrator, The QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in Res #163 could have taken on 18. Those paths included the exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the QL Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine were only three probable exit in the Action Team determine and the Action Team determine were action in the Action Team determine and the Action Team d	O pm Nurse e and Unit ality erform sis Action e ins ivable or and of the d that paths exit ce hall door g lot. ed ined ems. TIAL	
	A SW note dated 7/2	/18 completed by SW #2			re all other residents were acco o negative findings, all present		

Facility ID: 923032

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	,			33	3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AN	D REHABILITATION CENTER		Α	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	conducted for Resider passive thoughts of or reported desire to indicated she asked him feel that way are beer and was unable had not liked being of unit as he was, "not back there". The quarterly MDS a indicated Resident # severely impaired. Find with no behaviors, where equired supervisibed mobility and loce Resident #163 required or physical help for locomotion on the uncorridor. Resident #163 required supervisibed mobility and loce Resident #163 required indicated that she had not range of motion and An Admissions Directing indicated that she had seep Resident #163 unit or to move him to this was noted to have Resident #163 and him wow off of the locked moved out of the locked moved out of the locked indicated that she had to the total that the locked indicated that she had to the locked indicated that she had to the locked indicated that she had the locked indicated that	antal status assessment was ent #163 and expressed death with no active thoughts harm himself. SW #2 Resident #163 what made do he stated that wanted a ent to get it and also that he on the locked memory care like the other crazy people assessment dated 7/2/18 ends of second was assessed andering, or rejection of care. Sion with set up help only for comotion off the unit. The supervision with no set from staff for transfers, hit, and walking in room and and walking in room and and was steady on his feet at functional limitations with utilized no mobility devices. Stor note dated 7/10/18 and spoken with Resident #163 everal times about whether to on the locked memory care to one of the unsecured units. The save been discussed with the reported that he wanted to end unit. Resident #163 ked memory care unit and	F	689	" On 11/15/18 at 6:55 pm the Director of Nursing completed a 100% audit of placement and functionality, utilizing the Secure Care Products 707 Tester, of alwander guards currently in use and documented the expiration dates of each wander guard currently in use. Results the audit determined that all wander guards were in place and functional for the 37 residents identified at risk for wandering. Wanderguards are placed or residents that are identified at risk for elopement. These 37 residents were identified as wanderers by results of the completion of the Wandering Risk Evaluation. " On 11/15/18 the Nursing Supervise was in-serviced by the Administrator and Director of Nursing that when initiating investigation for an unsupervised exit, to promptly check the resident wander gustor placement and functionality as well checking all exit doors for functionality. The in-service included the use of the Action Checklist for Unsupervised Exit form. " On 11/15/18 at 5:45 pm the administrator in-serviced the department heads regarding the Action Checklist for Unsupervised Exit, processes for notification of Administrator and Director of Nursing. The Action Checklist for Unsupervised Exits is a guideline that directs actions to be taken by facility stand administration when an incident of Unsupervised Exits occurs including checking the functionality of the wander the sand administration when an incident of Unsupervised Exits occurs including checking the functionality of the wander the sand administration when an incident of Unsupervised Exits occurs including checking the functionality of the wander the sand administration when an incident of Unsupervised Exits occurs including checking the functionality of the wander the sand administration when an incident of Unsupervised Exits occurs including checking the functionality of the wander the sand administration when an incident of Unsupervised Exits occurs including checking the sand administration when an incident of Unsupervised Exits occurs including checking the sa	e II ch of on e or nd the to ard as	
F 689	indicated a mini-mer conducted for Reside passive thoughts of or reported desire to indicated she asked him feel that way and beer and was unable had not liked being ounit as he was, "not back there". The quarterly MDS a indicated Resident # severely impaired. Fwith no behaviors, whe required supervisibed mobility and loce Resident #163 required or physical help for locomotion on the uncorridor. Resident #163 required supervisibed mobility and loce Resident #163 required supervisibed mobility and loce Resident #163 required indicated that she had not range of motion and An Admissions Directing indicated that she had in separate to the separate that she had not remove of motion and the separate that she had not remove of motion and the separate that she had not remove of the locked moved out of the locked moved out of the locked moved out of the locked indicated Resident #163 and had had had had had had had had had ha	antal status assessment was ent #163 and expressed death with no active thoughts harm himself. SW #2 Resident #163 what made do he stated that wanted a ent to get it and also that he on the locked memory care like the other crazy people assessment dated 7/2/18 ends 's cognition was resident #163 was assessed andering, or rejection of care. Sion with set up help only for comotion off the unit. The area supervision with no set from staff for transfers, and, and walking in room and least was steady on his feet at functional limitations with utilized no mobility devices. Stor note dated 7/10/18 and spoken with Resident #163 everal times about whether to on the locked memory care to one of the unsecured units. The area one of the unsecured units are been discussed with the reported that he wanted to end unit. Resident #163 ked memory care unit and allocked) on this date	F	689	of Nursing completed a 100% audit of placement and functionality, utilizing th Secure Care Products 707 Tester, of all wander guards currently in use and documented the expiration dates of ear wander guard currently in use. Results the audit determined that all wander guards were in place and functional for the 37 residents identified at risk for wandering. Wanderguards are placed or residents that are identified at risk for elopement. These 37 residents were identified as wanderers by results of the completion of the Wandering Risk Evaluation. "On 11/15/18 the Nursing Supervise was in-serviced by the Administrator ar Director of Nursing that when initiating investigation for an unsupervised exit, a promptly check the resident wander gu for placement and functionality as well checking all exit doors for functionality. The in-service included the use of the Action Checklist for Unsupervised Exit form. "On 11/15/18 at 5:45 pm the administrator in-serviced the department heads regarding the Action Checklist for Unsupervised Exit, processes for notification of Administrator and Director of Nursing. The Action Checklist for Unsupervised Exits is a guideline that directs actions to be taken by facility stand administration when an incident of Unsupervised Exits occurs including	e II ch of on e or nd the to ard as	

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		345146	B. WING _			11/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	D REHABILITATION CENTER		,	ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 85	F 6	589			
	redirected but was se	een shortly after ambulating			" On 11/15/18 at 6:15pm the RN		
	out of another reside	-			Supervisor #1 and RN #2 began		
					in-services to all nursing staff members	S	
	A nursing note dated	7/12/18 at 11:30 AM			on duty regarding the Action Checklist		
	completed by Nurse	#2 indicated Resident #163			Unsupervised Exits for Nursing Staff.	Γhe	
	•	loor on the 100 hall (the hall			facility will utilize the current personnel		
	T	f were present at that time			roster to ensure that all staff members		
	and Resident #163 h	ad not exited the building.			in serviced by the RN Staff Developme		
	A ND (1 (1 = (40/40: 1: 4 15 :1 4			Coordinator on actions to be taken wh		
		12/18 indicated Resident			an Unsupervised Exit occurs. The Acti	on	
		and stated that he was ause he believed people			Checklist for Unsupervised Exits for	_	
	•	ngs and stealing his things			Nursing Staff is a guideline of tasks for staff to perform when a door alarm is		
		I no complaints and was			sounding, if a resident is missing or ex	ite	
		off of the locked unit. The			without supervision.	113	
	•	nt #163 needed close			" 100% of staff members from all		
		e was developing paranoia			departments will be in serviced starting	ו	
	since leaving the lock	·			11/15/18 to determine the exit door that	•	
	•				sounding, and the appropriate respons	se .	
	A behavior note date	d 7/21/18 at 1:28 PM			to the alarm including, going outside a	nd	
		#2 indicated Resident #163			check the area to include the perimete	r to	
		ering in and out of other			assure that a resident has not exited		
		throughout the first shift			unsupervised, notification of Nursing		
	(7:00 AM - 3:00 PM)				Supervisor or Unit Nurse of resident □s		
	A				unsupervised exit if resident is observe	∌d	
		ited 7/22/18 completed by			outside, completion of a 100% head		
		assigned to Resident #163 on 7/22/18) was informed by			count of all current residents. If a resid is observed outside staff member should be counted as a count of all current residents.		
	the 200 hall nurse (N	•			remain with resident and escort reside		
	housekeeping staff (I				back into the facility. All staff were made		
		and Resident #163 sitting			aware of their responsibility to follow th		
		unsupervised around 12:00			care plan and care guide for residents		
	_	a adjacent to rear parking lot			risk for wandering, including heightene		
		s brought back into the			awareness of those resident □s' location		
	_	per #1 and Housekeeper #2.			The inservice will be completed for all		
		inderguard was noted to be			facility staff by 12/16/18.		
	intact to his right lower	er leg. (There was no			" Any staff who have not been		
		er or not the wanderguard			re-educated by 12/16/18 must receive		
	was functioning.) Re	esident #163 was alert but			education prior to working their assign	ed	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
345146	B. WING _		11/16/2018		
	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•	,,	
		33426 OLD SALISBURY ROAD BOX 12	50		
ND REHABILITATION CENTER		ALBEMARLE, NC 28002			
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
age 86	F 6	689			
nes three (person, place, and no injuries, pain, or shortness predisposing factor to the to be Resident #163 's recent ty. ted 7/22/18 completed by she was informed by Nurse 163 was found sitting outside by Housekeeper #1 and Nurse Supervisor #1 was eported to the Director of text message. Resident #163 of the 500 hall locked memory to the #163 's family member was as the NP. ather conditions per Weather ebsite and complete for the temperature on M was 78 degrees Fahrenheit, y, and there was no the Wandering Review dated by the Quality Improvement and Resident #163 had an from the facility on 7/22/18 at an the #163 was assisted back are sident #163 's wanderguard ed to be confirmed when he he building. (The anctioning was not noted to be	F	shift. All new hires including will be educated during their orientation. "On 11/15/18 at 7:35 pm Maintenance Director and Mithematical Assistant completed 100% at doors for functionality, 100 % were functional. The facility Indoors that are all equipped with Care automatic locking / alar The Maintenance Director ar Maintenance Assistant visual manually checked the function exit doors. "As a result of the RCA contine 11/15/18, it was determined to the alarm. These three door visitors, staff and vendors. The automatically resets each time closed requiring the code to to open the door again. The lare only communicated to state The solution implemented by included written signage at a that states For our residents please do not assist resident door without notify staff first. The facility mailed a letter on all Families and Resident Representatives. "On 11/15/18 at 7:00 pm nurse #1 completed a 100% residents that have been idearisk for unsupervised exits, he	facility the aintenance udit of all exit of doors has 10 exit with a Secure ming system. Ind the ally and conality of all completed on that there are by code is he sare used by he door he the door is he re-entered Door codes aff members. If the facility and the safety, outside the Additionally and the safety, and the safety are safety and the safety are safety and the safety and the safety are safety ar		
	IDENTIFICATION NUMBER:	A BUILDIN 345146 ND REHABILITATION CENTER STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) age 86 nes three (person, place, and no injuries, pain, or shortness predisposing factor to the to be Resident #163 's recent tty. ted 7/22/18 completed by she was informed by Nurse 163 was found sitting outside by Housekeeper #1 and Nurse Supervisor #1 was aported to the Director of text message. Resident #163 of the 500 hall locked memory tf #163 's family member was as the NP. ather conditions per Weather expisite inducom) for Albemarle 's licitated the temperature on M was 78 degrees Fahrenheit, y, and there was no be Wandering Review dated by the Quality Improvement and Resident #163 had an from the facility on 7/22/18 at int #163 was noted to be found ared picnic area by the staff ent #163 was assisted back Resident #163 's wanderguard end to be confirmed when he he building. (The inctioning was not noted to be lent #163 was relocated to the	A BUILDING 345146 B. WING STREET ADDRESS, CITY, STATE, ZIP COI 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002 STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PRESIX TAG CROSS-REFERENCED TO THINDER LOST OF CROSS-REFERENCED TO THE CROSS TAGE TO THE CROSS TAGE TO THE CROSS-REFERENCED TO THE CROSS TAGE TO THE C	A BUILDING 345146 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002 STATEMENT OF DEFICIENCIES NOR MUST BE PRECEDED BY FULL TAG RESCHIPTIVING INFORMATION) ABGE 86 Bes three (person, place, and no injuries, pain, or shortness predisposing factor to the to be Resident #163 's recent by. 40 40 411/16/ 411/	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345146	B. WING			11/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2010
TO UNE OF TH	NOVIBER OR COLL FIER				3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER					
				А	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 87	F	689			
	An observation was o	conducted on 11/15/18 at			identified 13 residents with evaluation		
		where Resident #163 was			assessments dates older than 3 month	S.	
		ouilding unsupervised on			" On 11/15/18 at 8:51 pm The QI nu	_	
		ad a concrete pad, picnic			completed the Wandering Risk		
		g that provided shade and			Evaluations on those residents identified	ed	
		oking area for residents and			from the MDS Nurse #1 audit.		
		it to the rear parking lot that			" On 11/15/18 at 7 pm the MDS nur	se	
	_	by staff. The area Resident			#2 completed a 100% Audit of current		
		s approximately 167 feet			pictures in the Wander guard Notebool	(
	away from the neares	st facility exit.			for residents that have been identified	at	
					risk for Unsupervised Exits and require	а	
	An observation was of	conducted, and an interview			wander guard monitor. The audit revea	led	
	was attempted with F	Resident #163 on 11/16/18 at			2 residents did not have current photos	; .	
	7:45 AM. Resident #	163 ambulated			The Social Worker #1 obtained and		
		as alert and oriented to self			printed photos for these 2 residents an		
		oout his unsupervised exit			placed them in the appropriate noteboo	ok.	
	_	7/22/18 he reported that he					
		ay". He was unable to			WHAT MEASURES WERE PUT INTO		
	·	on related to the 7/22/18			PLACE OF SYSTEMIC CHANGES MA	νDE	
	incident.				" To prevent reoccurrence, starting		
					11/15/18 the bracelet placement of the		
		ten statement completed by			wander guard will be documented daily	-	
		cated he had exited the			the licensed nurse on 11-7 shift assign		
		PM to go to his car that was			to the resident. The licensed nurses or		
		s rear parking lot to eat his			-7 shift will be educated by the Director		
		he saw Resident #163 get			Nurses starting 11/15/18 and complete by 12/16/18 on the process of checking		
		ples underneath the shelter				j	
	I .	car. Housekeeper #1 noted eper #2 coming outside and			the placement and documenting the placement on the MAR (Medication		
	I .	lent #163 was supposed to			Administration record).		
		sed and she said he was			" Beginning 11/15/18, the QI nurse	A/ill	
	1	1 indicated he took Resident			be responsible for documenting weekly		
	#163 back inside of the				the functionality of the wander guards.		
					The QI nurse will document the		
	A phone interview wa	as conducted with			functionality on the Transmitter Tester	_oa	
	Housekeeper #1 on 1				form. Each resident will have an individ	_	
		ed he had exited the building			Transmitter Form. The QI nurse will be		
	•	or to eat his lunch in his car			responsible for tracking the expiration		
		e rear parking lot. He			dates of individual wander guards and		

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES			OIVID INC	J. 0930-039 i	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING		11/	16/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
				33426 OLD SALISBURY ROAD BOX 1250			
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		ALBEMARLE, NC 28002			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
F 689	Continued From page	e 88	F 689	9			
		as the parking lot the staff		replacing the wander guard price	or to the		
	I -	0 hall door required a		expiration date. On 11/15/18, the			
		ode to unlock. Housekeeper		educate the QI nurse on the pro			
		moving his car from an		document the weekly functiona			
		lot to a shaded spot as it		wander guard and tracking the	-		
	-	stated that this was when he		date and replacing the wander			
	saw Resident #163 s	itting at the picnic tables		prior to expiration.			
	under the shelter. He	e revealed that Resident		" The Maintenance Director	will be		
		sed. He stated that he		responsible for weekly checking	g of the		
	_	33 "looked tired and was		functionality of the Secure Care			
	-	usekeeper #1 reported that at		system. The documentation wil			
		sekeeper #2 exiting the		uploaded into the TELS compu	•		
		700 hall door. He stated that		The TELS computer system is			
		lent #163 was supposed to		Maintenance Communication T	•		
	I	f and she told him that he		system for work orders and Pre			
		be outside unsupervised. cated he and Housekeeper		Maintenance. The QI Nurse wil monthly the weekly door check	•		
	-	#163 back to the 700 hall		from the TELS computer system	•		
		curity code, and brought him		share it with the QI Committee.			
		J. He reported that as he		" On 11/15/18 the Social Wo			
		with Resident #163 when he		completed education with the re			
		ne took the resident from		that are currently unsupervised			
	there.			on the importance of not assist	ing other		
				residents through the locked do	ors.		
		ousekeeper #1 continued.		" On 11/16/18, the administr			
		Resident #163 got out of the		hold an adhoc QI meeting, part	•		
	_	hat he did not know how		include the medical director/res			
		otten out. He was asked if		physician, to review the unsuper			
		en made to the utilization of		root cause analysis, identified is			
		quired a numerical security		in-services, and systematic cha	inges.		
		hat the numerical code was ut that the new code was		HOW THE FACILITY PLANS T	0		
		t heads and then distributed		MONITOR MEASURES TO MA			
		staff still utilized these exit		SOLUTIONS ARE SUSTAINAE			
	doors.	otali otili dilii200 tilogo otil		" The Administrator and/or E			
				review new behaviors, incident			
	An undated handwrit	ten statement completed by		reports in the morning Interdisc			
		cated she had exited the		Team (IDT) meeting to ensure			
		ound 12:00 PM and was		unsupervised exits have an ass			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345146	B. WING _			11/	16/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u>	
				3	3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		A	ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 89	F 6	889			
F 689	walking to her car. S Housekeeper #1 get of her if Resident #163 of the building and shindicated she and Ho #163 back inside the A phone interview wa Housekeeper #2 on 1 Housekeeper #2 state building through the 7 something from her colot/rear parking lot. Sentered the numerica door. She indicated to much about the incide Resident #163 outsid unsupervised and she supposed to be outsid Housekeeper #2 report Housekeeper #1 whill stated that she went I through 700 hall door security code and she that Resident #163 w She indicated that Horesident back inside to This interview with Housekeeper #1 whill stated that she went I through 700 hall door security code and she that Resident #163 w She indicated that Horesident back inside to the was asked how I building. She stated Resident #163 had go any changes had been the exit doors that recode. She indicated changed regularly, bu given out department	the noted that she saw out of his car and he asked was supposed to be outside e told him he was not. She usekeeper #1 took Resident building. Is conducted with 1/15/18 at 1:20 PM. ed that she had exited the 1/00 hall door to get ar in the staff parking he reported that she I security code to exit the hat she couldn't recall ent. She stated she saw e at the picnic tables e knew he was not de without staff supervision. Orted she ran into e she was outside. She	F	589	incident report with a root cause analysis and care plans are updated accordingl." The Administrator and/or DON will report their findings and subsequent corrective actions to the monthly Quali Improvement Committee for any recommendations, recommended action and monitoring for continued compliant in this area. "The Administrator will monitor the weekly door checks through the TELS program bi-weekly for completion for 3 months then monthly thereafter. The Quire will monitor the documentation of checking placement of wander guards weekly for 3 months then monthly thereafter. "The Administrator will be responsifor implementation of this plan. The Director of Nursing will monitor the documentation of functionality checks bi-weekly for 3 months then monthly thereafter. The results of the findings were reported to the QI committee month by the Administrator, QI Nurse and DO respectively. The administrator consulted with the medical director and the nurse practition regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	y. I ty ons ce ble vill nly oN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345146	B. WING _		1	1/16/2018	
NAME OF PROVIDER OR SUPPLIER BETHANY WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 1 ALBEMARLE, NC 28002	ODE		
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assigned to Resider of his unsupervised confirmed Resident wanderguard, had be and was cognitively she was unable to reabout the incident. On her lunchbreak a found outside unsup (Housekeeper #1 are indicated that Nurse informed her that Resoutside. She stated when she had last is the time he was four indicated that once incident she checked wanderguard for plarecall if she had chee #2 stated she change wanderguard as a prinformed Nurse Supshe called the Direct indicated that Resid locked memory care the incident. This interview with Nested how Resident #163 exited asked if any change utilization of the exit numerical security of the sident she called the called the under the saked if any change utilization of the exit numerical security of the sident she called the called the saked if any change utilization of the exit numerical security of the sident she called the called the called the saked if any change utilization of the exit numerical security of the sident she called the called the called the saked if any change utilization of the exit numerical security of the called the ca	Inducted with Nurse #2 on M. She confirmed she was Int #163 on 7/22/18 at the time exit. She additionally #163 was wearing a Ideen an identified wanderer, Impaired. She reported that Idecall very many specifics Nurse #2 stated that she was It the time Resident #163 was Identified wanderer, Impaired. She reported that Identified wanderer, Impaired. She was Interest was unable to recall Identified was unable to recall Identif	F	589			

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345146	B. WING			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		3342	EET ADDRESS, CITY, STATE, ZIP CODE 6 OLD SALISBURY ROAD BOX 1250 EMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	visitors. Nurse #2 re utilized these exit dod An interview was con Supervisor #1 on 11/confirmed she was w Resident #163 's unsbuilding on 7/22/18. that Resident #163 whe was wearing a wa cognitively impaired. wandered into other throughout the facility was on the unlocked spoke about the incidental Housekeeper #1 outside of the building adjacent to the rear puthat he was disorient brought inside the busidents were in the wanderguard was chasted she had not rewasted she had not rewasted that all of checked to ensure the found no problems. #163 was moved to that same afternoon. Nurse #2 when she had she thought it was about 15 minutes. This interview with N	and was sometimes given to vealed staff and visitors still ors. Iducted with Nurse 15/18 3:23 PM. She orking at the time of supervised exit from the She additionally confirmed ras an identified wanderer, inderguard, and he was She stated that he residents ' rooms and all or during the time when he unit. Nurse Supervisor #1 lent on 7/22/18. She stated found Resident #163 g at the picnic tables parking lot. She reported the det times 3 when he was silding. She indicated that a seconducted to ensure all building. Resident #163 's ecked for placement. She recalled if his wanderguard estioning. Nurse Supervisor of the exit doors were ey were locked and they She reported that Resident the locked memory care unit She stated she asked and last seen Resident #163 as about 10 minutes prior to indicated it was estimated autside unsupervised for	F	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/16/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 0 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	out of the building know if he slipped visitor when they e reported that Resi independently, he like he could have rather than a residual stated that another #163 to have exite who was deemed knowledge of the unlock the dining that safe smokers so that they could through the dining smoking area indetended the numerical securegularly, but that staff, visitors, and Supervisor #1 revichanges with the staff, visitors, or the incident. She continued to be ut An interview was a 11/16/18 at 10:25 working at the time unsupervised exit. She additionally cowas an identified wanderguard, and She indicated that came in and told in found outside unsupervised exit. Housekeeper #1 wastated that she infinite was an interview was an identified wanderguard, and she indicated that came in and told in found outside unsupervised exit.	how Resident #163 had gotten . She stated that they didn't out behind a staff member or a exited the building. She dent #163 ambulated walked fast, and he also looked been a visitor at the building dent. Nurse Supervisor #1 or possibility was for Resident ed the building behind a resident as a safe smoker and had numerical security code to room exit door. She explained were given the security code enter and exit the building room exit door to access the expendently. She reported that curity code was changed the new code was given out to the safe smokers. Nurse ealed that there had been no security code being provided to the safe smoking residents since e stated that these exit doors	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING		11	/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		, 10, 20 10	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 689	Supervisor #1 verbal Resident #163 was no care unit shortly after. This interview with N asked how Resident She stated that it was Resident #163 exited asked if any changes utilization of the exit on numerical security conumerical code was given the new code was given distributed to staff, any visitors. Nurse #3 resulting the security of the new code was given the staff, and visitors. Nurse #3 resulting the security of the security of the security was not 11/16/18 at 8:56 AM. reached for interview was 11/15/18 at 2:30 PM. working on Resident time of his unsupervity was not able to recal incident. NA #4 state known wanderer and eye on him at all time wandered in and out throughout the day a of the facility. An interview was continued the security of the securit	ak. She then informed Nurse by. She reported that moved to the locked memory being brought back inside. She was #163 got out of the building. In the building. She was a had been made to the doors that required a lock. She indicated that the changed regularly, but that wen out department heads, and was sometimes given to wealed staff and visitors still lors. The statempted with Nursing 11/15/18 at 1:57 PM and She was unable to be and the NA #3 was assigned to time of his unsupervised was was #163's unit (100 hall) at the sed exit on 7/22/18. She are any specific details of the exit that the staff had to keep an the sed exit on the staff had to keep an the sed exit on the staff had to keep an the sed exit on the staff had to keep an the sed exit on the staff had to keep an the sed exit on the staff had to keep an the staff had t	F 68	9			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		ATE SURVEY DMPLETED	
		345146	B. WING	· · · · · · · · · · · · · · · · · · ·		11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 1 ALBEMARLE, NC 28002		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	s unsupervised exit and he had not beer of the incident. He re that a resident had exit unsupervised. The provided information He reported that the for the wanderguard could have potential The distances from shelter area where Franged from 167 fees he changed the numexit doors about oncodes were provided changed as the staff through a variety of that there had been usage of any of these Maintenance Director monitoring was concensure they were fureported he checked doors locking system TELS (The Exported he checked doors locking system system TELS (The Exported he TELS log to from July 2018 through a variety of the TELS log to the system of the TELS log to from July 2018 through a variety of the telestronically logs. Maintenance Director from the TELS log to from July 2018 through a variety of the variety was collapsed to be checked that the total supposed to the checked that the total supposed	at the time of Resident #163 ' from the building on 7/22/18 in involved in the investigation evealed he had no knowledge exited the building Maintenance Director in on all of the buildings exits. It were 10 exits, all equipped system, that Resident #163 Ily exited the building from. Ithe 10 exits to the picnic Resident #163 was found it to 954 feet. He stated that herical security codes for the five a week. He stated that the five to staff each time they were five members exited the building the exit doors. He indicated fino changes made with the five exit doors. The for was asked if any flucted on the exit doors to finctioning properly. He fit the functionality of the exit fins weekly using the computer Equipment Lifecycle System)	F 68	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345146	B. WING		,	11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COI 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	recall how she identibut she acknowledgresponsibility for enscompleted and that a wanderguard monitoresidents with wander An interview was considered. An interview was considered and the Arrivian was considered at the Arrivian was the Arrivian and unable to offer an expostem failure relate had occurred. On 11/16/18 at 9:20 Administrator provided log dated June 2018 is wanderguard had and placement on 10 days in June that ha #163 is wanderguar and placement (6/17 and 6/28/18 through An interview was considered where the modern	of the residents with QI Nurse was unable to ified this lapse in monitoring, ed that it was her suring this task was as of this date (11/15/18) the oring was re-initiated for all erguards. Inducted with the DON on She stated that she was discovered that the third shift of checking wanderguards diplacement. The DON was explanation as to how this d to wanderguard monitoring AM the Assistant ed a wanderguard monitoring that indicated Resident #163 libeen checked for function of 29 days. There were 8 d not indicated Resident d was checked for function 7/18, 6/22/18 through 6/25/18,	F 68				
	She stated that there and placement moni wanderguard from J She revealed the fact failure with wanderg re-initiated the monit	e was no evidence of function toring for Resident #163 's uly 2018 through 11/14/18. cility identified a system uard monitoring and had toring as of 11/15/18 by uard monitoring for function					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Records (MARs). The explained that wanded been documented in 11/15/18. She further monitoring had been form that was kept at that each nursing state who resided on that uplace. An interview was con Administrator on 11/1 confirmed Resident # exit from the facility on She additionally confibeen identified as was behavior, and he had prior to the unsuperving reported that Resider to the locked memory to fluctuating confusic alcohol abuse, and his him on the locked unial cohol seeking. She of the locked unit on was asked what precomove to an unlocked Resident #163 had rebeing on the locked upromote his dignity he unit. This interview with the She stated that when back in the building ounsupervised exit, his for placement, the was seen as the state of the was as the state of th	e Medication Administration e Assistant Administrator rguard monitoring had not the medical record prior to r explained that this documented on a separate the nursing stations and tion had a list of residents init with wanderguards in ducted with the 5/18 at 12:20 PM. She r163 had an unsupervised in 7/22/18 around 12:00 PM. rmed Resident #163 had inderer, he had exit seeking a wanderguard in place sed exit (7/22/18). She int #163 was initially admitted or care unit (500 hall) related on, dementia related to s family 's request to place it as Resident #163 was revealed he was moved off r/10/18. The Administrator injitated Resident #163 's unit. She stated that exported he was not happy init and in an effort to e was moved to an unlocked Resident #163 was brought	F	589			

CENTER	3 FOR MEDICARE &	WEDICAID SERVICES			OIVID IN	0. 0930-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		11	/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 33426 OLD SALISBURY ROAD BO ALBEMARLE, NC 28002	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	if Resident #163 's v checked on 7/22/18 ensure it was proper his exit to rule out im functioning as a root exit. She stated she wanderguard Reside time of his unsupervifor functioning. The there were 9 exit doc equipped for the war each door had a nun required to be enterer revealed that it had rexit Resident #163 u She additionally revealed that it had rexit Resident #163 u She additionally revealed that it had rexit Resident #163 u She additionally revealed that it had revisitors, and safe sm numerical security of the doors. The Additure incident was ghad not determined he building. She staproblem had been ad #163 was moved to the She was asked if the wanderguards who revealed that the with wanderguards with wanderguards with a continuous their residents with won the unlocked units ensure their wanderguards properly.	he Administrator was asked wanderguard had been after his unsupervised exit to by functioning at the time of proper wanderguard cause of the unsupervised	F 6	89			

	G		(X3) DATE SURVEY COMPLETED	
B. WING		1	1/16/2018	
	,-,-,-	DE	,	
	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
by no. nt er d. as he	39			
	F 68	STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 1: ALBEMARLE, NC 28002 PREFIX (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY F 689 F 689 In the cross of the control of the cross of t	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 F 689 In by 100 In by 100 In the per 110 In the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	the assessment revitotal points. The Walassessment was converse QI Nurse. On 7/24 /18, Reside assessment was reand resulted in a scopoints. Resident #1 guide were reviewed on 7/23/18 by the Monon 7/23/18 at 12:1 documented the Walawer leg. On 7/22/18 at 12:0 duty conducted 100 doors, the result of the findings. The audit in doors for functionality The RN Supervisor completion and result of the RN Supervisor completion and results of the Maintenance If functionality of the Iddoors. The Maintenance If Inctionality of the Iddoors. The Maintenance If Inctionality of all weekly system. On 11/16/18	sk for wandering on 6/13/18, ealed a score of 6 out of 21 indering Risk evaluation impleted by the Registered ent #163 's wandering assessed on by the QI nurse ore of 10 out of 21 total 63 's care plan and care d and updated as appropriate DS nurse. O pm the RN Staff Nurse inderguard was intact to right 5 pm The RN Supervisor on 6% observation audit of all exiting audit showed no negative included checking all exiting of alarms and / or locks. Everbally reported the elits of the door audit to the for 7/22/18. The RN inted the audit in the written 18. Director checks weekly the ocking system on all exiting ance Director documents the checks in the TELS computer 8 the Assistant Administrator	F	689			
	Logbook Report of t Systems from 6/2/18 Report reveals that occurred since 6/2/1 · On 11/7/18 the QI functionality of Res 11/15/18 at 8:55 pm observation audit or						

OLIVILIV	O T OIT WILDIO TITLE G	WEDIO/ ND CEITTICE				CIVID ITC	7. 0000 000 I
· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
					3426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		Δ	ALBEMARLE, NC 28002		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	e 100	F	689			
		vith an expiration date of		000			
	10/2020.	with an expiration date of					
		ition of the unsupervised exit					
		7/22/18, witness statements					
		wo housekeepers that					
		t in the outside picnic area					
	and the RN Staff Nur	se. Res # 163 was					
	interviewed and was	unable to verbalize the exit					
	path that was taken.	The RN supervisor					
	interviewed other sta						
	communicated to the						
		exit path of Res #163. Res					
	•	he secured dementia unit at					
		supervisor. The RN Staff sident Representative and					
		he Secured Dementia Unit.					
	The resident has rem						
		7/22/18 without any further					
	unsupervised exits.	,					
	· On 11/15/18 at 8:30	pm the Quality					
	Improvement Action ⁻	Team met to perform a					
	further detailed Root	Cause Analysis (RCA) of the					
		Resident # 163 on 7/22/18.					
		onsisted of the Regional					
		nistrator, Director of Nursing,					
		nissions Director, Nursing					
		rses, Payroll and Accounts					
		pers, Assistant Administrator sultant. As a result of the					
		eam determined that there					
		able exit paths that Res #163					
		7/22/18. The Areas of					
		sed, and possible solutions					
		d goals date were set for					
	action items.						
	CORRECTIVE ACTION	ON FOR RESIDENTS					
	HAVING THE POTE	NTIAL TO BE AFFECTED					
	· On 7/22/18, the RN	Supervisor completed a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			1/16/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE	11/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	residents were act findings, all prese. On 11/15/18 at 6 completed a 100% functionality, utiliz 707 Tester, of all vand documented wanderguard curred determined that a and functional for risk for wandering residents that are These 37 resident by results of the cRisk Evaluation. On 11/15/18 the in-serviced by the Nursing that where an unsupervised or resident wanderguard functionality. The the Action Checklist in-serviced the de Action Checklist for notification of Anursing. The Action Checkling the functional doors for functional ty regarding Unsupervised Exiter States and RN #2 began on duty regarding Unsupervised Exiter States and States and RN #2 began on duty regarding Unsupervised Exiter States and Stat	audit to ensure all other counted for: no negative nt. 2:55 pm the Director of Nursing addit of placement and ing the Secure Care Products wanderguards currently in use the expiration dates of each ently in use. Results of the audit ll wanderguards were in place the 37 residents identified at . Wanderguards are placed on identified at risk for elopement. Its were identified as wanderers ompletion of the Wandering Nursing Supervisor was Administrator and Director of a initiating the investigation for exit, to promptly check the used for placement and ell as checking all exit doors for in-service included the use of its for Unsupervised Exit form. Exit for Unsupervised Exit, processes Administrator and Director of on Checklist for Unsupervised et that directs actions to be aff and administration when an ervised Exits occurs including tionality of the wanderguard and	F	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	•	334	REET ADDRESS, CITY, STATE, ZIP CODE 126 OLD SALISBURY ROAD BOX 1250 BEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	be taken when an U Action Checklist for Nursing Staff is a gu perform when a doo resident is missing of The staff members 11/15/18 to determine sounding, and the a alarm including, goin to include the perime has not exited unsup Nursing Supervisor unsupervised exit if complete a 100% he residents. If a reside member should rem resident back into the aware of their respo and care guide for re- including heightened 's location. The facility staff will working their next as On 11/15/18 at 7:3 Director and Mainter 100% audit of all exi % of doors were fun exit doors that are a Care automatic lock Maintenance Director Assistant visually an functionality of all exi As a result of the R was determined that the security code is does not trigger the are used by visitors,	rs are inserviced on actions to insupervised Exit occurs. The Unsupervised Exits for ideline of tasks for staff to r alarm is sounding, if a prexits without supervision. Will be inserviced starting the the exit door that is appropriate response to the region of the exit	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 ILBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	door again. The Docommunicated to simplemented by the signage at all exit or residents' safety, outside the door wire Additionally, the fact to all Families and II on 11/15/18 at 7:0 completed a 100% been identified as a have a current Wardocumentation on toguide. Results of the with evaluation assimonths. On 11/15/18 at 8:0 completed the Wand those residents ideaudit. On 11/15/18 at 7 completed a 100% Wanderguard Note been identified at rirequire a wandergurevealed 2 resident The Social Worker photos for these 2 in the appropriate not WHAT MEASURES OF SYSTEMIC CHUN Starting 11/15/18 wanderguard will be licensed nurse on resident. The license educated by the Diii	to be re-entered to open the for codes are only taff members. The solution of facility included written loors that states "For our please do not assist resident thout notify staff first". Cility mailed a letter on 11/16/18 Resident Representatives. On pm the MDS nurse #1 audit of residents that have a risk for unsupervised exits, indering Risk Evaluation and the care plan and resident care are audit identified 13 residents resments dates older than 3 residents resments dates older than 3 residents and mitified from the MDS Nurse #1 for the MDS nurse #2 Audit of current pictures in the book for residents that have sk for Unsupervised Exits and first monitor. The audit is did not have current photos. #1 obtained and printed residents and placed them in rebook.	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1.	/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	AND REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	the MAR (Medication - Beginning 11/15/17 responsible for doction functionality of the will document the street Log form. Expensible for transmit responsible for transmit r	cumenting the placement on ion Administration record). 18, the QI nurse will be cumenting weekly the wanderguards. The QI nurse functionality on the Transmitter ach resident will have an iter Form. The QI nurse will be cking the expiration dates of puards and replacing the to the expiration date. On a will educate the QI nurse on ument the weekly functionality and tracking the expiration date wanderguards prior to a Director will be responsible for a functionality of the system. The documentation will be TELS computer system. The issue is a Maintenance acking system for work orders wantenance. The QI Nurse will weekly door check reports from the system and share it with the social Worker completed residents that are currently kers on the importance of not idents through the locked administrator will hold an participants will include the esident 's physician, to review exit, root cause analysis, in-services, and systematic	F	889			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1	1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, 33426 OLD SALISBURY ROAD BALBEMARLE, NC 28002	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE OTO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 689	Continued From particles of the Administrator behaviors, incident meeting to ensure associated incident analysis and care particles of the Administrator findings and subset monthly Quality Imprecommendations, monitoring for contact the Administrator checks through the completion for 3 m. The QI Nurse will rechecking placemer 3 months then more three Administrator implementation of the Nursing will monitor functionality checks monthly thereafter.	age 105 AKE SURE SOLUTIONS ARE and/or DON will review new accident reports in the am IDT all unsupervised exits have an a report with a root cause blans are updated accordingly. and/or DON will report their quent corrective actions to the provement Committee for any recommended actions and inued compliance in this area. will monitor the weekly door at TELS program bi-weekly for boths then monthly thereafter. In the documentation of at of wanderguards weekly for		689	CIENCY)		
	Record review indicated identified as wander residents had updated elopement risk assignment wanderguard expir wanderguard notel function and placed added to their Med The revised Action	ation of Immediate Jeopardy ated on 11/16/18 at 6:10 PM. Cated there were 37 residents ar risks. Each of the 37 ated care plans, care guides, essments, documentation of ation dates, pictures in the book, and wanderguard ment monitoring had been ication Administration Records. Checklist was reviewed, and mily members were verified.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345146	B. WING		11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 689 F 695 SS=D	proper working conditions were changed. The wanderguard not trip security code was elimmediately once clisign in sheets as we education was provion investigating unstrevised action check conducted with the at 6:10 PM confirmed Administrator on 11. Respiratory/Tracheck CFR(s): 483.25(i) § 483.25(i) Respirate tracheostomy care and tracheal stracheostomy care and tracheal stracheostomy care and tracheal stracheostomy care and tracheal stracheostomy care plan, the reside and 483.65 of this strains REQUIREMEN by: Based on observation Practitioner (NP) an interviews and recordarify and implement orders for oxygen with monitoring for a residence respiratory failure for respiratory failure for the security and implement orders for oxygen with monitoring for a residence respiratory failure for the security and implement orders for oxygen with monitoring for a residence respiratory failure for the security of the security and implement orders for oxygen with monitoring for a residence respiratory failure for the security of the security and implement orders for oxygen with monitoring for a residence respiratory failure for the security of t	med the exit doors were in dition and the numerical codes three doors noted as the ggering the alarm when the intered were observed to lock osed. A review of inservice all as staff interviews verified ided on 11/15/18 and 11/16/18 supervised exits and the klist. A phone interview Medical Director on 11/16/18 and his communication with the 1/16/18. Ostomy Care and Suctioning and tracheal suctioning. Sure that a resident who are, including tracheostomy uctioning, is provided such in professional standards of elensive person-centered ents' goals and preferences,	F 68	F695 Respiratory, Tracheotomy Count and Suctioning How corrective action will be accomplished for those residents four have been affected by the deficient practice Resident #113' sorders were clarified the RN supervisor with the attending physician/medical director and	nd to
	monitoring for a resi respiratory failure for residents reviewed finding included:	ident with a diagnosis of or 1 (Resident#113) of 1		practice Resident #113'□s orders were clarifie the RN supervisor with the attending	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		· · · · · · · · · · · · · · · · · · ·	1 11	/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				334	26 OLD SALISBURY ROAD BOX 1250			
BETHANY	WOODS NURSING A	ND REHABILITATION CENTER		AL	BEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 695	Continued From pa	age 107	F 6	695				
	cumulative diagnos Pulmonary Disease respiratory failure. Review of Residen	t #113's August 2018 Physician			How the facility will identify other resident having the potential to be affected by same deficient practice Beginning on 11/19/18 the RN QI nurse conducted a 100% audit of all resident	the se		
	per minute via nasa	as ordered oxygen at 4 liters al cannula (NC) at bed time			currently receiving oxygen therapy to determine that orders were clarified a			
	level on every shift				implemented as written by the physici There were no adverse findings. What measures will be put into place	or		
	Review of Residen Medication Adminis			systemic changes made to ensure the the deficient practice will not recur				
		fying the use of oxygen at 4 I time and monitoring her evels every shift.			All residents with new oxygen orders be reviewed daily in the interdisciplinateam (IDT) meeting to ensure that orders also lightly and implemented.	ıry		
		nology Visit Note dated			are clarified and implemented.			
		o her chronic respiratory failure ntinue her oxygen at 3 liters at night.			How the facility plans to monitor its performance to make sure that solution are sustained The Director of Nursing (DON) and/or			
	monitoring record s	t #113's oxygen saturation stopped on 8/30/18 when she			QI nurse will perform a 10% audit for residents with orders for oxygen			
	documented was woxygen. After 8/30/	Each oxygen saturation level with Resident #113 wearing 118, there was no evidence of monitoring every shift.			saturation levels monthly times three months then quarterly thereafter. The DON and/or QI nurse will share the results of oxygen audits with the interdisciplinary team (IDT) monthly for			
	AM read Resident	g note dated 8/30/18 at 10:46 #113 was sent to the or a change in her mental			three months and then quarterly thereafter. The DON and/or RN QI nurse will pre			
	status She was add ventriculoperitonea replacement and p	mitted to the hospital with a ll (VP) shunt failure with neumonia. A VP shunt is a excessive pressure on the			IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, addition corrective actions, and recommendations.	or nal		
	brain. She was disc 9/13/18. The disch	charged back to the facility on arge summary read Resident e oxygen at 3 liters and then			The administrator and/or DON will pre- trends and QI committee recommendations to the quarterly qua- assurance and performance improver	esent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		-	11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI/ EFICIENCY))N
F 695	dated 9/13/18 did not oxygen except for the 2-3 liters per minute obreath and there were oxygen saturation model. Review of Resident # from 9/13/18 to 9/30/mention of oxygen or monitoring. Review of a NP note read Resident #113 hrespiratory failure and pneumonia. The note higher oxygen concereadmitted on 9/13/1. Review of a NP note read Resident #113 on room air. The note oxygen however at the removed her oxygen wear per prescribed on the Review of Resident # Minimum Data Set (Nashe was cognitively in behaviors. She was of therapy. Review of Resident # did not include any of saturation monitoring.	#113's readmission orders to include any orders for estanding order of oxygen at via NC for shortness of e no orders to resume onitoring. #113's September 2018 MAR 18 did not include any oxygen saturation dated 9/14/18 at 2:41 PM, nad chronic hypoxic d was worsened by eread she was placed on a nitration of 3 liters when 8. dated 9/19/18 at 9:02 AM oxygen saturation was 92% eread she chronically wore ne time, Resident #113 had a She was encouraged to oxygen. #113's quarterly/5-day MDS) dated 9/20/18 indicated intact and exhibited no oxoded for receiving oxygen #113's October 2018 orders orders for oxygen or oxygen	F	(QAPI) committee for recommendations, a need for continued continued continued accuracy of assess. The administrator or medical director/atte the nurse practitions of correction on 12/or recommendations.	and to determine the monitoring to ensure to ensure to ensure the area of ments. Consulted with the ending physician are regarding the plant 11/18 with no change.	e e ad an	

F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			` '	(X3) DATE SURVEY COMPLETED	
	345146	345146 B. WING		11	/16/2018	
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saturation monitorin Review of a NP note read Resident #113' wearing oxygen via documentation of th note read there was orders. Review of Resident dated 10/18/18 read breathing due to her her taking off her ox included administrat Review of a NP note read Resident #113' on 3 liters per minut Resident #113's Pul 8/20/18 which read to have oxygen at 3 liters per minute with Review of Resident orders did not include oxygen saturation monitorin Review of Resident did not include any restriction monitorin In an observation ar 4:33 PM, Resident #via NC. The oxygen	e dated 10/8/18 at 9:17 AM so oxygen saturation was 97% NC. There was no e liter rate in the note. The no changes in her oxygen #113's last revised care plan is she was at risk for ineffective obstruction, sleep apnea and ygen. The interventions ion of her oxygen as ordered. e dated 10/31/18 at 12:39 PM is oxygen saturation was 94% is oxygen saturation was 94% is oxygen saturation was 94% is oxygen saturation for her liters per minute at rest with 5 in any exertion. #113's November 2018 is any orders for oxygen or nonitoring. #113's November 2018 MAR mention of oxygen or oxygen oxygen or oxygen or oxygen or oxygen or oxygen or oxygen or oxygen ox	F 69				
	CORRECTION ROVIDER OR SUPPLIER WOODS NURSING AN SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page saturation monitorin Review of a NP note read Resident #113' wearing oxygen via documentation of the note read there was orders. Review of Resident dated 10/18/18 read breathing due to her taking off her oxincluded administrated to have oxygen at 3 liters per minute Resident #113's Pul 8/20/18 which read to have oxygen at 3 liters per minute with Review of Resident oxygen saturation made and the read state of the resident did not include oxygen saturation made and the resident did not include any resident d	CORRECTION IDENTIFICATION NUMBER: 345146 ROVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 109 saturation monitoring. Review of a NP note dated 10/8/18 at 9:17 AM read Resident #113's oxygen saturation was 97% wearing oxygen via NC. There was no documentation of the liter rate in the note. The note read there was no changes in her oxygen orders. Review of Resident #113's last revised care plan dated 10/18/18 read she was at risk for ineffective breathing due to her obstruction, sleep apnea and her taking off her oxygen. The interventions included administration of her oxygen as ordered. Review of a NP note dated 10/31/18 at 12:39 PM read Resident #113's oxygen saturation was 94% on 3 liters per minute via NC. The note reference Resident #113's Pulmonology Visit Note dated 8/20/18 which read the recommendation for her to have oxygen at 3 liters per minute at rest with 5 liters per minute with any exertion. Review of Resident #113's November 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. In an observation and interview on 11/13/18 at 4:33 PM, Resident #113 was wearing her oxygen via NC. The oxygen concentrator was running at 1.5 liters per minute. She stated she wore her oxygen all the time due to her poor respiratory	A BUILDING 345146 B. WING ROVIDER OR SUPPLIER WOODS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 109 saturation monitoring. Review of a NP note dated 10/8/18 at 9:17 AM read Resident #113's oxygen saturation was 97% wearing oxygen via NC. There was no documentation of the liter rate in the note. The note read there was no changes in her oxygen orders. Review of Resident #113's last revised care plan dated 10/18/18 read she was at risk for ineffective breathing due to her obstruction, sleep apnea and her taking off her oxygen. The interventions included administration of her oxygen as ordered. Review of a NP note dated 10/31/18 at 12:39 PM read Resident #113's oxygen saturation was 94% on 3 liters per minute via NC. The note reference Resident #113's Pulmonology Visit Note dated 8/20/18 which read the recommendation for her to have oxygen at 3 liters per minute at rest with 5 liters per minute with any exertion. Review of Resident #113's November 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. In an observation and interview on 11/13/18 at 4:33 PM, Resident #113 was wearing her oxygen via NC. The oxygen concentrator was running at 1.5 liters per minute. She stated she wore her oxygen all the time due to her poor respiratory	A BUILDING 345146 B. WING STREET ADDRESS, CITY, STATE, ZIP CC 3426 OLD SALUSBURY ROAD BOX A ALBEMARLE, NC 28002 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 109 saturation monitoring. Review of a NP note dated 10/8/18 at 9:17 AM read Resident #113's oxygen saturation was 97% wearing oxygen via NC. There was no documentation of the liter rate in the note. The note read there was no changes in her oxygen orders. Review of Resident #113's last revised care plan dated 10/18/18 read she was at risk for ineffective breathing due to her obstruction, sleep apnea and her taking off her oxygen. The interventions included administration of her oxygen as ordered. Review of a NP note dated 10/31/18 at 12:39 PM read Resident #113's Days note reference Resident #113's Pulmonology Visit Note dated 8/20/18 which read the recommendation for her to have oxygen at 3 liters per minute at rest with 5 liters per minute with any exertion. Review of Resident #113's November 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. In an observation and interview on 11/13/18 at 4:33 PM, Resident #113 was wearing her oxygen is NC. The oxygen concentrator was running at 1.5 liters per minute. She stated she wore her	A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 3426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002 SUMMARY STATEMENT OF DESCRIPTIONS BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 109 Review of a NP note dated 10/8/18 at 9:17 AM read Resident #113's oxygen saturation was 97% wearing oxygen via NC. There was no documentation of the liter rate in the note. The note read there was no changes in her oxygen and her taking off her oxygen. The interventions included administration of her oxygen saturation was 94% on 3 liters per minute via NC. The note reference Resident #113's oxygen saturation was 94% on 3 liters per minute via NC. The note reference Resident #113's November 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. In an observation and interview on 11/13/18 at 4:33 PM. Resident #113's was wearing her oxygen or oxygen saturation monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·		
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F 695	Resident #113 was was wearing her ox concentrator was rushed She was absent of respiratory distress breath. In an interview on 1 Quality Assurance or signed off the readre when Resident #11 She stated she only transcribed correctly medications and tree MAR. The QA Nursho orders for oxygemonitoring when she because the NP and oxygen saturation restated there were sefor oxygen at 2-3 lit	ge 110 ation on 11/14/18 at 8:20 AM, in bed eating breakfast. She ygen via NC and the oxygen unning at 1.5 liters per minute. signs of air hunger or and voiced no shortness of 1/14/18 at 3:02 PM, the (QA) Nurse confirmed she mission orders dated 9/13/18 3 returned from the hospital. It verified the orders were y and did not verify all eatments were on readmission e stated Resident #113 had on or for oxygen saturation he returned from the hospital d MD did not order oxygen of nonitoring. The QA Nurse tanding orders for all residents hers per minutes via NC for and that was what was likely	F 6	,			
	Resident #113 was NC with the concerninute. In an interv (NA) #15 stated Recoxygen. In a telephone call #5 confirmed she would not be dated 9/13/18 #113 was admitted	ion on 11/15/18 at 8:15 AM, observed wearing oxygen via strator running at 3 liters per iew with Nursing Assistant sident #113 always wears on 11/15/18 at 8:55 AM, Nurse worde the readmission nursing at 3:40 PM that read Resident wearing oxygen at 3 liters per hat she only wore the oxygen					

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	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 695	if she needed it. In an interview on 11 stated she had no exto be monitoring Ressaturation because a saturation when she further stated the new have oxygen at 3 lite discharged from the oversight. The NP further was being followed by who made her oxyge was unable to explait recommendation of oxia NC were not imply an observation on Resident #113 was or room wearing oxygen NC with a portable to wheelchair. A review of Resident revealed the NP saw and made no recommoxygen saturation monogen saturation medical in a telephone interview of the MD stated it was Resident #113 return visit in August 2018 ther oxygen would have contacted oxygen orders and ord	/15/18 at 9:00 AM, the NP spectation for the facility staff sident #113's oxygen went in the see her. The NP w orders for Resident #113 to rs per minutes when she was hospital on 9/13/18 was an other stated Resident #113 by a Pulmonologist routinely en recommendation. The NP or why the Pulmonologist oxygen at 5 liters per minute demented in August 2018. 11/15/18 at 10:40 AM, observed in the rehabilitation of at 3 liters per minute via ank attached to her #113's medical record or Resident #113 on 11/16/18 mendations for oxygen or conitoring. iew on 11/16/18 at 5:00 PM, his expectation that when need from her Pulmonology that the recommendations for oxyge been implemented. He	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
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F 697 SS=G	revealed new orders #113 to have oxyger during rest as needed minute via NC during orders also included twice daily. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mar The facility must ensprovided to residents consistent with profet the comprehensive pand the residents' got This REQUIREMEN by: Based on observation Practitioner (NP) and interviews and recorrevaluate and treat a complaints of left rib 10/17/18. A diagnosi revealed fractures to the left side. This was residents reviewed findings included: Resident #30 was accumulative diagnose Congestive Heart Falleg Syndrome and Interview impairment in the comparison of the left side. Resident #30 was accumulative diagnose Congestive Heart Falleg Syndrome and Interview impairment in the comparison of	#113's medical record dated 11/16/18 for Resident at 3 liters per minute via NC d and oxygen at 5 liters per g exertion as needed. The oxygen saturation monitoring magement. For that pain management is so who require such services, resional standards of practice, reson-centered care plan, reals and preferences. T is not met as evidenced cons, resident, staff, Nurse d Medical Director (MD) d review, the facility failed to resident with continued pain following a fall on tic x-ray dated 10/30/18 of the 3rd through 7th ribs on th	F 695		ents ne J	

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BETHANY WOODS	S NURSING AN	ID REHABILITATION CENTER			BEMARLE, NC 28002		
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F 697 Contin	ued From pag	ge 113	F	697			
behav Reside her up sched medica reporti previo Reviev 10/16/ first sh Party (Reside second Reviev dated had ar ambul closet read in left rib corres Directo Reviev dated sat on walker left rib the wo docum	ors and limited ent #30 was or per or lower earlied and as nations. Resideng no pain areas MDS asset who of the nursing 18 read Resident with the Properties of the pain. The nursing on her country of a Physicial 10/17/18 read the floor and and recliner. Pain. The Nursing monitor was the of the nursing work of the nursing was the state of the nursing work of the nursing was the state of the	and assistance with ambulation. Soded with no impairments to extremities. She was coded for eeded (PRN) pain ent #30 was coded as and as having no falls since assment. Ing 24 Hour Report dated dent #30 slid to the floor on eysician and Responsible. The 24-Hour Report indicated ared Tylenol 2 tablets on ent report and nursing note extended and nursing note. The report and nursing note exercise the report and service the report and service the read as a left for the NP and Medical cention was a therapy screen. In Fax Communication sheet the Resident #30 did not fall but caught herself using her Resident #30 complained of the representationer (NP) wrote with her initials. The NP	F	697	appropriate assessment, evaluation, monitoring and treatment administered. All reported improvement in pain levels. What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur. The Nursing staff will be re-educated beginning 11/20/18 by the DON and/or SDC on assessment, evaluation, monitoring, and physician notification or residents with continued complaints of pain. Re-education will be completed to 12/16/18. Any staff not completing education by 12/16/18 will not be allow to work until education completed. Ne hires and agency staff will receive this education during orientation to the facing Residents exhibiting complaints of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial report of pair will be discussed in the next morning limeeting following the initial repo	s. or of of oy wed w lity. n DT ain. the s, d d f the ges	

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F 697	(treats nerve pain) and Ultram (synthetwice daily schedul Norco (opioid used needed for pain.) Review of the Octour #30 received no as Review of the Octour for Tylenol 3 mouth every 4 hou hours. The MAR in Tylenol 650 mg on and 10/26/18. Review of the Reh 10/18/18 read Resparticipating in the Review of the nurs 10/22/18 read Respain and received Review of a nursin 10/23/18 read Respain and received Review of a Physical 10/23/18 read Respain and received Review of a Physical 10/23/18 read Respain and received Review of a Physical 10/23/18 read Respain and received Review of a Physical 10/23/18 read Respain and received Review of a Physical 10/23/18 read Respain of left up going to have her for evaluation if so documented per Note that 10/24/18	was receiving Neurontin three times daily scheduled etic opioid used to treat pain) led. There were also orders for it to treat pain) 1 tablet as ober 2018 MAR read Resident is needed doses of her Norco. ober 2018 MAR read a standing 25 milligrams (mg) 2 tablets by irs as needed for pain for 48 idicated Resident #30 received 10/17/18, 10/23/18, 10/24/18 abilitation screen dated ident #30 was not interested in rapy. sing 24 Hour Report dated ident #30 complained of rib Tylenol on third shift. g 24 Hour Report dated ident #30 went out of the on first shift. cian Fax Communication dated ident #30 continues to per rib pain and stated she was RP drop her off at the hospital mething was not done. The NP urse #4, "no complaints" with	F6	The QI Nurse will present actions and reported abuse suicidal actions to the monimprovement (QI) committed identification of trends, and corrective actions, and recorrective actions, and recommendations to the excommittee for review, addit recommendations, and to need for continued monitor continued compliance in the management. The administrator consulted medical director/attending the nurse practitioner regard for correction on 12/11/18 when or recommendations noted.	e/neglect, athly quality ee for review, ditional commendations. OON will present executive QI tional determine the ring to ensure he area pain ed with the physician and arding the plan with no changes		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
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F 697	soreness to her left #30 requested an x-Review of an x-ray r follows: Minimal disp through seventh possuggested. The x-rathe NP. Review of Resident dated 10/30/18 for Ereliever) four times of Review of a NP note read in part as follow approximately 2 week have left lower rib cacoughing, deep bread bed. Resident #30 shelp alleviate the pavery concerned since stated otherwise, she complaints. Review of the Nover Resident #30 receive Norco or Tylenol. In an interview on 12 #30 reported she fel	30 was complaining of side and left arm. Resident ray and the NP was notified. eport dated 10/30/18 read as placed fractures of the third sterior lateral ribs left side y was undated but initialed by #30's MAR read an order stofreeze (topical pain	F 69	77		
	NP or MD until two v stated the pain was stated she continues	eived no x-ray and saw no veeks after the fall. She bad but has improved. She is to have pain with movement ers. She reached to guard ial grimacing.				

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F 697	indicated she was at complaints of sorene side and left arm on revised 11/14/18 also 10/30/18 indicated fra through 7th ribs. Interest to her complaints of produced, documenting indicators of pain and if pain management with 1 man interview on 11 stated she was assig and assigned to her to the NP was in the buth end NP about Reside side pain. She stated Resident #30 and ad she needed it for pair week later, Resident pain to her left side sequested an x-ray of confirmed she did no continued complaints NP the Physician Factoria (NA) #10 strength 11 complained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained of left side reported it to Nurse #30 continues to compained side it to Nurse #30 continues to co	colan last revised on 11/14/18 risk for pain related to ss and discomfort to her left 10/29/18. The care plan oread her x-ray dated actures of her left 3rd erventions included listening pain, medications as go verbal and non-verbal of notification of the physician was not effective. 114/18 at 2:35 PM, Nurse #4 ned Resident #30 most days he day she fell. She stated diding that day and spoke to not #30's complaints of left of the NP told her to monitor minister the prn Tylenol if on. Nurse #4 stated about a #30 was still complaining of on Nurse Supervisor #3 rder from the NP. Nurse #4 to report Resident #30's of pain until she sent the of Communication form dated 114/18 at 2:45 PM, Nursing mated Resident #30 he pain after the fall and she head. She confirmed Resident head plain of occasional pain with	F6	997			

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	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	pain. She stated the monitor her for contibut confirmed there suggest the nurses with the monitor her for contibut confirmed there suggest the nurses with the monitor her for continued comside. She stated she 10/29/18 and request Resident #30 request In an interview on 1° stated Resident #30 her left side with car Resident #30 compliment it to her assiguant In an interview on 1° stated it was her expedirected the nursing #30, they would have worse, but she was the fall. The NP state Resident #30 was given was able to function stated when the Nurshe stopped in to see	ntinued or worsening of the NP wanted nursing staff to nued or worsening of the pain was little documentation to were monitoring Resident aplaints of pain to her left e contacted the NP on sted an x-ray because sted it. 1/15/18 at 8:50 AM, NA #11 has complained of pain to e. NA #11 stated when ained of pain, she would	F 6	,		
	#3. The NP stated the x-ray. The NP confir fractured left side rib need for additional the was already taken and Tylenol as need not routinely review relied on the staff can Physician Communiconfirmed she was a state of the property of th	0/29/18 by Nurse Supervisor nat was when she ordered the med the x-ray results of 5 bs. She stated there was no reatment and that Resident ing Ultram twice daily for pain ed. The NP stated she did the nursing notes but rather alling her for sending her a cation Fax form. The NP at the facility daily Monday available by phone when she				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345146	B. WING	 		11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 697	Resident #30 was s NA #11 present in the complained of left s ribs. She was guard grimacing. NA #11 I complaint of pain an nurse. In an interview on 1 confirmed she was had cared for her si AM on 11/15/18. Sh inform her that Res earlier today after b #30 had not complat was due her schede Resident #30. A telephone call wa at both phone numb to call surveyor. At return call from RP. In an interview on 1 #30 stated she was stated her RP told h In a second intervie	ew on 11/15/18 at 10:40 AM, sitting up in her wheelchair with the room. Resident #30 ide pain where she broke her ded of her left side with facial heard Resident #30's and stated she would notify her 1/15/18 at 5:40 PM, Nurse #6 assigned Resident #30 and not beginning her shift at 7:00 the stated NA #11 did not ident #30 voiced left side pain reakfast and that Resident ained of pain to her, but she called Ultram and would assess as made to Resident #30's RP pers listed with messages left time of exit, there had been no	F 69				
	pain on 11/15/18, si Resident #30's nurs A telephone call wa at 11:18 AM with a	dent #30 complain of left side he would have reported it to se. s made to NA #11 on 11/16/18 message left to call the not reporting Resident #30's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING		11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND) REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 697	exit, there had been in a telephone call or #12 confirmed she w on 10/19/18 and 10/2 stated she recalled R left rib pain especially could not use her left pain. NA #12 stated she resident #30's nurse. In a telephone call or #13 confirmed she w on 10/18/18 for third Resident #30 stated but NA #13 could not anything to the nurse. In a second interview NA #10 confirmed she #30 first shift on 10/1 10/20/18, 10/21/18, 1 and 10/30/18. NA #10 complain of left side palways reported the complaint of left side palways re	a 11/15/18. At the time of no return phone call. a 11/16/18 at 11:35 AM, NA as assigned Resident #30 c2/18 for second shift. She resident #30 complaining of when toileting and that she arm to reach due to the she reported the pain the on both days. a 11/16/18 a 11:42 AM, NA as assigned Resident #30 shift. She stated she recalled she was sore from the fall, recall if she reported a on 11/16/18 at 11:55 AM, where was assigned Resident #30 high the reported and the received resident #30 did to be stated Resident #30 on 0/23/18, 10/24/18, 10/26/18 to stated Resident #30 on 0/27/18 and 10/28. He see days from 7:00 AM to stated he received no dent #30 complained of pain omplained of pain when he	F 69	7		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION 3		SURVEY PLETED
		345146	B. WING		11/	/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698 SS=E	have been ordered a He further stated it w were timely interventi Review of the medica orders dated 11/16/1; pain assessment con while awake for 2 we prn Norco for pain as Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensi require dialysis receiv with professional star comprehensive perso the residents' goals a This REQUIREMENT by: Based on record rev interview, and staff in follow the physician ' (Resident #61) for 1 of dialysis. Findings included: Resident #61 was re- 7/11/08 with the diago disease (ESRD). A review of the last Re-	Resident #30 first in 10/17/18 and x-ray would it that time to rule out injury. as his expectation there ions for pain management. al record indicated new 8 for Resident #30 to have a inpleted three times daily eks and to administer the ordered. are that residents who we such services, consistent indards of practice, the on-centered care plan, and and preferences. T is not met as evidenced iew, observation, resident iterview, the facility failed to s order for fluid restriction of 1 residents reviewed for admitted to the facility on inosis of end-stage renal degistered Dietician (RD) 11/10/16 revealed the	F 69		eviewed by 8. The ng risk fluid intake etician offered in ction removed er residents	12/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345146	B. WING			1/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	'	1/10/2010	
				33426 OLD SALISBURY ROAD BOX 1250			
BETHANY	WOODS NURSING AND	O REHABILITATION CENTER		ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 698	Continued From pag	e 121	F 69	8			
F 698	A review of the reside supervision with set udaily living. Active didiabetes. The reside times a week. A review of the reside gy/24/18 revealed fluid per day and dialysis Friday. A review of the reside order dated 11/1/18 review of the reside November medication (MAR) revealed the review of the reside documentation by the past 30 days revealed to 840 milliliters each Nurse's note look-banot have the total dai the record. On 11/15/18 at 12:15 conducted with Nurse	ent 's annual Minimum Data vealed the resident had an resident required up only for his activities of agnoses were ESRD and ent received dialysis three ent 's care plan dated direstriction of 1500 milliliters on Monday, Wednesday, and ent 's physician monthly revealed fluid restriction of 4-hour period. Four ounces nent were ordered twice a ent 's October and nadministration record resident received his 4 supplement each day.	F 69	same deficient practice To protect residents in similar sit beginning on 11/19/18 the RN C conducted a 100% audit of the r on dialysis including resident #6 other fluid restriction orders are What measures will be put into paystemic changes made to ensure the deficient practice will not recan Any residents with new orders from fluid restrictions will be review morning IDT meeting to ensure orders are carried out and commoders are carried out and commoders are carried out and commoders are carried by the staff development RN on the need to fluid intake for those residents were restriction orders and to provide versus benefits education to the residents who are non-compliant physician orders for fluid restrict Re-education will be completed 12/16/18. No nurses will be allowork after 12/16/18 until education received. Education on fluid reswill be included in new hire educating all licensed nurses including any staff. Certified Nursing Assistant will be instructed to review care any residents with fluid restriction appropriate actions for those residents with fluid restriction con the propriate actions for those residents with fluid restriction appropriate actions for those residents with fluid restriction con the propriate for residents with fluid restrictio	al Nurse residents 1. No in place. place or ure that cur or dialysis ved in the that nunicated ed nurses of monitor with fluid risk se of with ion. by wed to ion is striction cation for y agency s (CNA)'s guides for ons and sidents. 's will be measures ns. All new		
	medication on day sh	480 milliliters of fluids for nift and was not aware of the esident consumed during		restriction during orientation. CN GCA's will receive education be working their assigned shift.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	D REHABILITATION CENTER		33	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	other shifts or the am dietary on the 3 meal Nurse #8 stated that Resident #61's fluid i stated the nursing as they provided to each indicated that Reside of ice this shift, and a pitcher refilled with ic not know how many pitcher. On 11/15/18 at 12:15 conducted with Nursi stated that she was a restriction. NA #9 stated that the GCA (the pitcher of ice to ewhich was not documamount. The NAs we provide the ice and hintake. On 11/15/18 at 12:20 conducted with Resid was not aware he was had drank at least had filled each shift. The melted ice directly from On 11/15/18 at 12:20 done of Resident #61 Styrofoam pitcher had was on the bed-side on 11/15/18 at 12:27 on 11/15/18 at	trays for Resident #61. she did not document ntake for her shift. Nurse #8 sistant documented what n resident. Nurse #8 ent #61 received a full pitcher all residents have their le each shift. Nurse #8 did total milliliters were in a spm an interview was ng Assistant (NA) #9 who laware of Resident #61's fluid lated that Resident #61 would NA would ask the nurse first le requested drink. Nurse #9 (geriatric care aide) provided lach resident each shift mented in the daily intake lere not responsible to lad not documented this spm an interview was lent #61 who stated that he les on a fluid restriction and lift of his water pitcher when resident stated he drank the los on a fluid restriction was lated that he drank the les on a fluid restriction and lift of his water pitcher when resident stated he drank the lated that he lated that	F	698	How the facility plans to monitor its performance to make sure that solution are sustained. The RN QI nurse will perform an audit monthly for three months for all dialysis residents to determine if fluid restriction orders are in place and followed as ordered; then quarterly thereafter on resident on all dialysis residents thereafter. The RN QI nurse will share the results audits with the interdisciplinary team (II at least monthly for 3 months. The DON and/or QI RN will present ID corrective actions to the monthly quality improvement (QI) committee for review identification of trends, additional corrective actions, and recommendation The administrator and/or DON will prestrends and QI committee recommendations to the quarterly quality assurance and performance improvem (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensur continued compliance in the area of accuracy of assessments. The administrator consulted with the medical director and the nurse practition regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	of OT) T y ity ent I e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	· ,	TE SURVEY MPLETED	
		345146	B. WING _			11/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 12 ALBEMARLE, NC 28002	DDE		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 698	the GCA would provided on 11/15/18 12:48 prof Resident #61 's di "Thursday lunch 150 give only what is on to On 11/15/18 at 12:48 conducted with Nurse not provide the reside she administered for On 11/15/18 at 4:25 proconducted with the Distated the Styrofoam of fluid. The DM state Resident #61 's fluid daily allowance was president 's three means tated that she was mursing regarding the required to take medinutritional supplement On 11/16/18 at 12:09 conducted with the Refer was on a 1500 mrestriction which was and the dietary manal of how the total amount provided between the On 11/16/18 at 4:15 proconducted with the Dishe expected staff to	d document fluid intake, and de residents ice each shift. In an observation was done etary ticket that documented 0 cc per day fluid restriction he tray." In property and interview was e #8 who stated that she did ent's fluid intake amount the NA to document. In an interview was ietary Manager (DM) who pitcher holds 600 milliliters ed she was aware of restriction and all of the provided by dietary on the fall trays. The DM further each in communication with the amount of fluid the resident ication, amount given for his each, or from the ice pitcher. In property an interview was D who stated that Resident in illiliter per day fluid managed between nursing eyer. The RD was not aware unt of fluid intake was et two departments or by shift.	F 6	98			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			1 11	/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		33	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 700 F 700 SS=E	alternatives prior to a bed or side rail is a correct installation, a rails, including but n elements. §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Reviet bed rails with the reserves entative and of the installation. §483.25(n)(3) Ensurare appropriate for the second maintaining bed and maintaining bed This REQUIREMENT by: Based on observation interview, the facility assess the need for (Residents #53, #88)	s. empt to use appropriate installing a side or bed rail. If used, the facility must ensure use, and maintenance of bed ot limited to the following as the resident for risk of drails prior to installation. We the risks and benefits of sident or resident obtain informed consent prior that the bed's dimensions the resident's size and weight. We the manufacturers' and specifications for installing arails. To is not met as evidenced on, record review, and staff failed to comprehensively side rails for 4 of 4 residents, #118, and #148) reviewed		700	F700 Bed Rails How corrective action will be accomplished for those residents fou have been affected by the deficient	and to	12/16/18	
	for bilateral side rails The findings include				practice Residents #53, #148, #88 and #118 reassessed beginning 11/15/18 and ending 12/7/18 for the need for side			
	facility on 10/13/17 a on 12/22/17 with dia	as initially admitted to the and most recently readmitted gnoses that included s of one side of the body)			using the Physical Device Use Evalu form. The assessment revealed that side rails for #53 and #118 are used nursing staff for bed mobility while	ation the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345146	B. WING _		11/	/16/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•	10.2010
				33426 OLD SALISBURY ROAD BO	X 1250	
BETHANY	WOODS NURSING	AND REHABILITATION CENTER		ALBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO	CTION SHOULD BE	(X5) COMPLETION DATE
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5 7 00						
F 700	Continued From p	-	F7	700	40/40/40	
	•	kness of one side of the body) ninant side, cognitive		providing care. Beginnir weighted blanket was use		
		eficit and muscle weakness.		#53 and #118 when nurs		
				providing direct care. Th	e weighted	
	A Bed Rail Evalua	tion dated 11/28/17 initiated by		blanket will be trialed for	five days	
		ement (QI) Nurse for Resident		beginning 12/13/18. Sho		
	#148 revealed a b	lank evaluation. There were no		not be effective, a perime	eter mattress will	
	additional evaluations related to side rails in			be trialed. The side rails		
	Resident #148 's	record.		resident #88 as a result of		
				assessment. Resident #1		
		ual Minimum Data Set (MDS)		assessed to use the rail f	•	
		ated Resident #148 's cognition		and positioning. The Res		
	•	npaired. He required the		Representatives for resid		
		nce of 2 or more for bed s were indicated not to have		#148 and #118 were edu 12/16/18 on risks vs. ben		
		e MDS review period.		rails.	ients for the side	
	occurred during ti	ie MD3 review period.		How the facility will identi	ify other residents	
	An observation wa	as conducted of Resident #148		having the potential to be	affected by the	
	on 11/16/18 at 1:4	5 PM. He was in bed sleeping.		same deficient practice		
	Resident #148 ha	d bilateral side rails		An audit was initiated on	11/19/18 and	
	approximately 30	inches in length in place.		completed 11/21/18 by the Director of Nursing (ADO		
	An interview was	conducted with Resident #148 '		resident census from 11/	•	
	s family member of	on 11/16/18 at 1:45 PM. She		determine all residents w	rith side rails in	
	stated that Reside	ent #148 had bilateral side rails		use. Assessments for the	ose residents	
	on the bed since h	nis admission. She stated that		identified as having side	rails in use will be	
	he may have utiliz	ed the bed rails in the past, but		completed by 12/16/18 by	y the Director of	
	she believed he h	ad not used them much now.		Nursing (DON), ADON, O		
		ne had not recalled being		Improvement(QI)nurse, a		
	•	education related to the risks		Nurse Supervisors. Nev		
	and/or benefits of	side rail usage.		were completed for any r		
				side rails in place but did		
		conducted with Nursing		previous assessment. An	•	
	· ,	on 11/16/18 at 1:50 PM. She		requiring extensive assis		
	•	esident #148 had bilateral side		and determined to lack in		
		that she was not sure and that		mobility will have alternat		
	he rarely utilized t	he side rails.		trialed for at least five day	-	
				not limited to weighted bl		
	An interview was	conducted with the QI Nurse on		for positioning, and/or pe	rimeter	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/27/2018 FORM APPROVED

F 700 Continued From page 126 11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Rail Evaluations. She stated that she was responsible for Bed Rail Evaluations. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessment she saw the question on each assessment that asked F 700 Continued From page 126 F 700 F 700 F 700 F 700 F 700 Mattresses beginning prior to 12/16/18. Quarterly Re-assessments will be completed for all residents with side rails in use by the Director of Nursing (DON), ADON, Quality Improvement(QI)nurse, and/or the RN Nurse Supervisors. Re-education for residents with side rails in use will be provided to the residents and/or their representatives by 12/16/18 by the nurses assessing the residents and	CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				<u>ON</u>	<u>ив NO. 0938-0</u>	<u>0391 </u>
BETHANY WOODS NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250			` '	I ' '	1 ' '			` '	
BETHANY WOODS NURSING AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 700 Continued From page 126 11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Rail Evaluations. She stated that she was responsible for Bed Rail Evaluations. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessment that asked 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002 D PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION HOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION HOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION HOULD BE (EACH CORRECTIVE ACTION SHOULD BE			345146	B. WING				11/16/2018	
CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 700 Continued From page 126 F 700 11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Rail Evaluations. She stated that she was responsible for Bed Rail Evaluations. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessment she saw the question on each assessment that asked by the nurses assessing the residents and	NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ALBEMARLE, NC 28002 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY F 700					33	3426 OLD SALISBURY ROAD BOX 1250			
F 700 Continued From page 126 11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Rail Evaluations. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessment she saw the question on each assessment that asked F 700 Continued From page 126 11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Quarterly Re-assessments will be completed for all residents with side rails in use by the Director of Nursing (DON), ADON, Quality Improvement(QI)nurse, and/or the RN Nurse Supervisors. Re-education for residents with side rails in use will be provided to the residents and/or their representatives by 12/16/18 by the nurses assessing the residents and	BETHANY	Y WOODS NURSING ANI	D REHABILITATION CENTER		А	LBEMARLE, NC 28002			
11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Rail Evaluations. She stated that she was responsible for Bed Rail Evaluations. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessment that asked mattresses beginning prior to 12/16/18. Quarterly Re-assessments will be completed for all residents with side rails in use by the Director of Nursing (DON), ADON, Quality Improvement(QI)nurse, and/or the RN Nurse Supervisors. Re-education for residents with side rails in use will be provided to the residents and/or their representatives by 12/16/18 by the nurses assessing the residents and	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLET DATE	TION
if education had been provided to the resident and/or Responsible Party (RP) on the risks and benefits of side rail usage. The QI Nurse revealed she was not sure what was supposed to be included in this education, so she asked the Administrator. She stated that the Administrator had contacted the Facility Nurse Consultant, but that she never received any direction of what type of education she was supposed to provide. She revealed she had not provided any education for any of the bed rail evaluations she completed. The QI Nurse indicated this Bed Rail Evaluation form was no longer in place in the electronic medical records system as of February 2018. She stated that since that time no bed rail evaluations and/or re-evaluations had been conducted. A follow up interview was conducted with the QI Nurse on 11/16/18 at 4:40 PM. The blank bed rail evaluation for Resident #148 dated 11/28/17 was reviewed with the QI Nurse. She stated that she was not sure why this assessment was completely blank as she thought she had partially filled it out. She confirmed this was one of the assessment of the need for side rail usage to the	F 700	11/14/18 at 3:10 PM. about the normal pro Rail Evaluations. SI responsible for Bed I explained that she w management and the complete bed rail evaluation that she we management and the complete bed rail evaluation had been and/or Responsible I benefits of side rail under revealed she was not be included in this explained and contacted the Fathat she never received of education she was revealed she had not any of the bed rail explained and/or record that since evaluations and/or reconducted. A follow up interview Nurse on 11/16/18 at evaluation for Reside reviewed with the QI was not sure why this completely blank as filled it out. She contassessments that she she company that she contassessments that she contasses that she contasted the contasted that she contasted that sh	The QI Nurse was asked acess for completion of Bed and stated that she was Rail Evaluations. She as directed by her accorporate office to aluations for every resident in per 2017. She reported that eting the assessments she each assessment that asked an provided to the resident Party (RP) on the risks and sage. The QI Nurse to sure what was supposed to ducation, so she asked the stated that the Administrator acility Nurse Consultant, but are dany direction of what type is supposed to provide. She to provide any education for realuations she completed, and this Bed Rail Evaluation in place in the electronic em as of February 2018. It that time no bed rail everaluations had been was conducted with the QI at 4:40 PM. The blank bed rail and #148 dated 11/28/17 was Nurse. She stated that she is assessment was she thought she had partially firmed this was one of the end not provided education	F	700	mattresses beginning prior to 12/16 Quarterly Re-assessments will be completed for all residents with side in use by the Director of Nursing (D ADON, Quality Improvement(QI)nu and/or the RN Nurse Supervisors. Re-education for residents with side in use will be provided to the reside and/or their representatives by 12/1 by the nurses assessing the reside through written material provided by administrator. What measures will be put into place systemic changes made to ensure the deficient practice will not recur Beginning on 11/19/18 and complet 12/16/18, all licensed nurses were re-educated regarding the assessmented the need for side rails. Education we offered to all new nurses upon orient and no nurses will be allowed to worthey are reeducated. Assessments the need for side rails will be completely a licensed nurse quarterly in conjunction with the MDS assessments the need for side rails will be completely a licensed nurse quarterly in conjunction with the MDS assessments the need for side rails will be completely a licensed nurse guarterly in conjunction with the MDS assessments the need for side rails will be completely a licensed nurse guarterly in conjunction with the MDS assessments the solutions are sustained. To monitor performance to make sure that solutions are sustained, The D of Nursing (DON) will perform a 100 of all residents with side rails in use assessment and risk versus benefit education in the areas of side rail utor 12 weeks; then quarterly thereat	e rails PON), rse, e rails PON), rse, e rails PON (Ponts and Ponts	il it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			1	/16/2018
NAME OF PI	ROVIDER OR SUPPLIER		<u>'</u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DETHANN	/ WOODO NII IDOINO 4	ND DELIABILITATION CENTED		334	26 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING A	AND REHABILITATION CENTER		AL	BEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 700	An interview was of Administrator on 1 Administrator conful Nurse had partiside rail evaluation additionally confirm not fully completed to the resident and education on the rebeen explained to time of the side rail re-evaluations shough in condition determine the conful 2. Resident #118 v 3/4/17 with diagnor disease, demential anxiety, schizophresides and particular confunctions.	conducted with the 1/14/18 at 4:15 PM. The irmed she was aware that the fally completed all residents 'ns in November 2017. She med she was aware these were of as education was not provided allor the RP. She stated that tisks and benefits should have the resident and/or RP at the all evaluations and that full have been done upon any or change in interventions to tinued need of the side rails. The was admitted to the facility on ses that included Alzheimer 's with behavioral disturbance, enia, and insomnia.	F 7	700	the results of the audits with the interdisciplinary team (IDT) at least we for 12 weeks. Any adverse findings related to side rail useage or lack of assessment will be corrected and re-education given as needed by the R Staff Development Coordinator (SDC). The DON and/or QI RN will present ID corrective actions to the monthly quali improvement (QI) committee for review identification of trends, additional corrective actions, and recommendation. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quali assurance and performance improvem (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of assessment of physical restraints. The administrator consulted with the medical director and the nurse practiti regarding the plan of correction on	RN). DT ity w, ons. esent ality ment al he ure	
	Resident #118 dat the Quality Improvevaluation indicate oriented to person long-term memory impaired decision were assessed as perimeters, range muscle weakness, had a history of fal expressed a desire in bed for her own benefits of side rai	ed Bed Rail Evaluation for ed 11/28/17 was conducted by ement (QI) Nurse. This ed that Resident #118 was only with short-term and impairment and severely making. Her functional abilities grasp strength within normal of motion/dexterity adequate, and impaired balance. She lls. Resident #118 had not e to have side rails raised while safety or comfort. The I use were noted as enabling sition self in bed, enabling the			12/11/18 with no changes or recommendations noted.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 700	and/or standing posi- rails for care with sta- resident to maintain. The risks included the injuries. This assess alternative interventing physical and/or occu- 7/6/17. No other alternoted. The recommindicated bilateral hat to promote independing risks and benefits, to Resident #118 and had not been due to comprehension defir risks and benefits, a Resident #118 's reindicated they had in family member had rail usage and was in not signed as complemental to signed as complemental to assistance of 2 or mittransfers. There were no additional conducted for Residual assessment that was an on 11/13/18 at 12:30 bed being assisted was not interviewable.	a supine (lying) to a sitting sition, the resident using side aff cueing, and enabling the physical functional abilities. The increased potential for sment indicated that an on that was attempted was upational therapy initiated on ernatives or interventions were endations of this evaluation aff rails to serve as an enabler dence. The evaluation asked alternatives were explained d the answer indicated they the resident's cit. The evaluation asked if Iternatives were explained to presentative and the answer ot been as the resident's previously been aware of bed in agreement. This form was	F 70				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			11/	16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		33	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 700	Continued From page	e 129	F	700				
	11/13/18 at 12:35 PM #118 moved around i out of bed on her own fall risk. NA #7 was rails had prevented Fof the bed and she in An interview was con 11/14/18 at 3:10 PM. Resident #118 dated complete was review confirmed that she passessment and that She explained that she management and the complete bed rail evathe facility in Novembas she began comples aw the question on if education had beer and/or Responsible Foenefits of side rail us revealed she was not be included in this ed Administrator. She shad contacted the Fathat she never receiv of education she was stated she had not prany of the bed rail evand this was why nor marked as complete. Bed Rail Evaluation fin the electronic med February 2018. She	aluations for every resident in the per 2017. She reported that string the assessments she each assessment that asked in provided to the resident Party (RP) on the risks and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1	1/16/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	ODE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 700	Administrator on Administrator con QI Nurse had partiside rail evaluation additionally confirm not fully complete to the resident an education on the been explained to time of the side rare-evaluations should be a condition of the side rare-evaluation and short-term as a quarterly assumed as a quarterly assumed be a condition of the side rare and short-term and commentation the assistance of 1 st transfers and sup were coded during rails were not code.	conducted with the 11/14/18 at 4:15 PM. The firmed she was aware that the tially completed all residents ' ns in November 2017. She med she was aware these were d as education was not provided d/or the RP. She stated that risks and benefits should have the resident and/or RP at the tial evaluations and that build have been done upon any on or change in interventions to attinued need of the side rails. was admitted to the facility noses that included: Dementia esturbance, Schizophrenia, se and osteoarthritis. MDS (Minimum Data Set) coded the sament and dated 10/5/18, dent as having impaired long temory. The assessment had at she required extensive aff member for bed mobility and tervision for ambulation. No falls to the facility the same that the same that the same that the required extensive aff member for bed mobility and the same that the sa	F	700	· · · · · · · · · · · · · · · · · · ·		
	rails. Review of the Bed 11/28/17 revealed bilateral half rails bed. The person of	d Rail Assessment dated I the resident was to have as an enabler for positioning in who completed the bed rail ot notify resident representative					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			11/16/2018		
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002	E			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 700	3:10pm with the QI of She stated that she assessments in Nov regulations were put 2018 the Bed Rail A from the EHR (Elect by corporate. She arail assessments or done. During an interview the MDS Coordinate Nurse #2 they stated the bed rail assessments or done. During an interview the MDS coordinate Nurse #2 they stated the bed rail assessment some point as direct weren't sure of the pwere not responsible assessments. They use is care planned During an interview the Administrator she change in the bed rail assessment that bed rail assessment by the QI nurse. She were not given any storporate as to what provided so she was not know what type stated that education	assessment. Inducted on 11/14/18 at (Quality Improvement) nurse. started the bed rail rember 2017 when the new at into place but as of February ssessments were removed ronic Health Record) system added that since then no bed reevaluations have been Inducted on 11/14/18 at 3:30pm with provided that since then no bed reevaluations have been Inducted on 11/14/18 at 3:30pm with provided that since then no bed reevaluations have been Inducted on 11/14/18 at 3:30pm with provided that since then at 3:30pm with provided that the QI nurse completed the provided that the QI nurse completed the provided that since they brocess changes since they	F	700				
		the time of the assessments should have been done on tion or change in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		,	11/16/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 33426 OLD SALISBURY ROAD BOX 1: ALBEMARLE, NC 28002	DDE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 700	During an observa Resident #88's be down on the left are Resident was not observation. An interview was 1:50pm with NA # observed the resident was not to the bed. An interview was 2:30pm with NA # was independent bed without the useen the resident up to a standing property of the QI nurse she speaking with Resexplain benefits, rassessment was 1:45pm with the Direction of the Carlon of the	e acknowledged the	F7				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345146	B. WING	 	11/16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION
F 700	evaluation for Reside Quality Improvement resident was oriented short-term and long and severely impair risks included the in The evaluation determined and benefits, alternatesident and the ambeen due to a complewas not signed as of A review of the resident and the resident and the ambeen due to a complewas not signed as of A review of the resident needs known. "Phy used" was coded. A review of the resident needs known. "Phy used" was coded. A review of the resident needs known. "Phy used" was coded. A review of the resident needs known. "Phy used" was coded. On 11/13/18 at 9:30 of the resident 's roralls were noted. The reclining wheel chain her extremities that non-purposeful. On 11/14/18 at 2:15 conducted with Treat assigned to Resident.	lent #53 dated 11/27/17 by the at (QI) Nurse revealed the ed to person only with eterm memory impairment ed decision making. The acreased potential for injuries. It is impaired that the side rails at twee were explained to the swer indicated they had not be or indicated they had not or indicated the resident was impaired and required e for all activities of daily was unable to make her exical restraints bed rail not dent 's care plan updated problem for skin tears which of padded side rails to Padded side rails and winged in 1/11/17.	F 70		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		1	1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING A	AND REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP (33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 700	resident cannot getime. The pads we prevent skin tears that the side rails wassessed. On 11/14/18 at 2:2 of the resident 's rails were noted. An interview was confirmed that she assessment and complete was revicenfirmed that she assessment and completed. She elby her manageme complete bed rail the facility in Nove as she completed question on each a had been provided Responsible Party of side rail usage. was not sure what education, so she stated that the Adr Facility Consultant any direction type Nurse further reve education on any completed, and the assessments were Nurse indicated the was no longer in ustated that since the side rails were that the same policy in the stated that since the side of the pads were not support to the side of the pads were not support to the pads were not	TN commented that the st out of bed on her own at this ere added to the side rails to TN stated she was not aware were required to be periodically so pm an observation was done from and bilateral padded side sonducted with the QI Nurse on m. The Bed Rail Evaluation for d 11/27/17 that was partially ewed with the QI Nurse. She partially completed this onfirmed that it was never fully explained that she was directed int and the corporate office to evaluations for every resident in mber 2017. She reported that the assessment asked if education in to the resident and/or (RP) on the risks and benefits. The QI Nurse revealed she was to be included in this asked the Administrator. She ministrator had contacted the	F7	700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345146 B. WING				11/16/2018		
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	·			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 700	assessment, but that restraint assessment restraints in use. The interview with the she was asked why side rails used in compadding and if these assessed to determ a physical restraint. The rails were implement sustained a skin teal believed the skin teal hitting her arms again repetitive movement. An interview was conditioned and partial side rail evaluations confirmed she was a completed because to the resident and/or education of the risk been explained to the time of side rail asser reassessments shout change in condition.	cility did have a restraint at she had not done any at she had not done any at she had not done any at she cause the facility had no and Resident #53 had bilateral anjunction with bilateral anjunction with bilateral at interventions had been ine if they met the definition of She stated that padded side at the attended after Resident #53 are to her arm (12/17). It was are came from the resident at the side rail from the side at the	F 7	· · · · · · · · · · · · · · · · · · ·				
	conjunction with bila with the Administrate padding was added a skin tear believed side rails. She expla moved her extremiti padding was to stop	ateral padding was reviewed or. She indicated that the after Resident #53 sustained to have been caused by the ained that Resident #53 es around in bed and the ber from hitting the side rails ry. She additionally revealed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			11/	16/2018
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		334	REET ADDRESS, CITY, STATE, ZIP CODE 426 OLD SALISBURY ROAD BOX 1250 BEMARLE, NC 28002		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page	e 136	F7	700			
	bilateral side rails use bilateral padding met restraint. She indica	vas done to determine if the ed in conjunction with the the definition of a physical ted that she expected the physical restraints to be					
	for Resident #53 was who indicated the de padded side rails. Th which led to consider unsafe movement of was noted to use the the benefit of the prerisks noted as none. remove the padded s form indicated, "This resident' s movemen physical limitations the voluntarily getting out	se Evaluation dated 11/15/18 se completed by the QI Nurse vice currently in use was e specific medical symptom ration of device use was extremities. Resident #53 padded side rails daily with evention of injury and the The resident was not able to side rails independently. The device does not impede to be to be the time of the top of the time of bed therefore this device assifications of a restraint".					
	Nurse on 11/15/18 at Device Use Evaluation Resident #53 was resident #53 was resident #53 was resident #53 was resident last even directed to complete indicated she went than dreviewed it with the QI Nurse indicated #53 was unable to satisfact as were not a restray padded side rails were	was conducted with the QI 12:00 pm. The Physical on dated 11/15/18 for viewed with the QI Nurse. completed this evaluation. e with the Facility Nurse ing (11/14/18) and she was this assessment. She irough the form this morning the Facility Nurse Consultant. ed that because Resident afely get out of bed without ermined the padded side eint. She stated that the re preventing Resident #53 d and that the padding					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING		11	1/16/2018	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 761 SS=D	her body on the side moving around in bed moving around in bed An interview was con Administrator on 11/1 Administrator confirm QI Nurse had partially side rail evaluations i additionally confirmed not fully completed as to the resident and/or education on the risk been explained to the time of the side rail ere-evaluations should change in condition of determine the continuabel/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accordance professional principle appropriate accessor instructions, and the applicable.	the resident from injuring rails related to the resident d. ducted with the 6/18 at 4:15 PM. The ed she was aware that the completed all residents' in November 2017. She dishe was aware these were education was not provided the RP. She stated that is and benefits should have excludions and that have been done upon any or change in interventions to used need of the side rails. In displaying the following and Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be existed in the facility must be existed in the facility must be experimently accepted so, and include the yand cautionary expiration date when in the facility must store all drugs and compartments under proper and permit only authorized	F 76			12/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345146	B. WING		11/16/2018	
NAME OF PROVIDER OR SUPPLIER BETHANY WOODS NURSING AND	REHABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	11110/2010	
PREFIX (EACH DEFICIENCY	ATEMENT 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 APPROPR DEFICIENCY)	BE COMPLETION	
storage of controlled of the Comprehensive Dicentrol Act of 1976 and abuse, except when the package drug distributed quantity stored is minimised readily detected. This REQUIREMENT by: Based on observation record review, the face expired insulins, failed inhalers and failed to pouch when opened it carts reviewed for measure findings included: Review of the undated Expiration Dates readed dispensed whose labed expiration date are confrom dispensing with a included exceptions of read as follows: Novolog Insulin Fropening Basaglar Kwik Insultation on 11/16/18 at 3:12 From 1976 and 1976 are serviced in the control of the control	affixed compartments for drugs listed in Schedule II of trug Abuse Prevention and and other drugs subject to the facility uses single unit tion systems in which the smal and a missing dose can is not met as evidenced is not met as evidenced and the facility failed to discard three dots to date when opened two store one inhaler in foil in 1 (300 hall cart) of 4 meds dication storage. The dipolicy titled Medication in part that medications held does not include an insidered expired 1 year reference of a list of atted revised 7/2012 which deep reference of a list of atted revised 7/2012 which deep reference of a list of atted revised 28 days after stulin Pen-discard 28 days	F 761	F 761 Label /Store Drugs and Biologicals How corrective action will be accomplished for those residents four have been affected by the deficient practice The expired medications and undated inhalers identified during the survey with discarded on 11/16/18 by the hall nursely having the potential to be affected by same deficient practice All resident have the potential to be affected. All medication carts were audited by the Nurse Supervisors and DON. There were no other adverse findings. What measures will be put into place systemic changes made to ensure that the deficient practice will not recur All licensed nurses will be re-educated the Director of Nursing and/or staff development RN regarding the process for checking medication carts for expimedications and dating and proper storage of inhalers by 12/16/2018. An nurses not receiving re-education by 12/16/18 will not be allowed to work up aducation is received. New hires and	rere se. dents the liver or at d by ses red	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345146	B. WING _	B. WING		11/16/2018		
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
BETHANY	WOODS NURSING AND	REHABILITATION CENTER			3426 OLD SALISBURY ROAD BOX 1250			
	OUR MAD DV OT	ATEMENT OF REFIGIENCIES			ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	opened 10/10/18. *Basaglar Kwik Insuli dated as opened 10/2 In an interview on 11/2 stated she was not away the Novolog Pen and Pen was to be discard opened. Nurse #1 stated was responsible to characteristics. In an interview on 11/2 Director of Nursing (Expectation that expirany nurse who discovered in the state of the state o	for Resident #90 dated as In Pen for Resident #122 10/18. 116/18 at 3:12 PM, Nurse #1 Ware that Levemir in the vial, the Basaglar Kwik Insulin ded after 28 days once sited she was not sure who necking the medication carts ins. 116/18 at 4:50 PM, the DON) stated it was her red insulins be removed by vers the expired medication audited monthly by the	F 7	761	agency staff will receive this education during orientation to the facility. How the facility plans to monitor its performance to make sure that solution are sustained The RN supervisors will perform observation audits for expired meds an undated or improperly stored inhalers weekly. The QI nurse and/or RN supervisors will ensure all medication carts and medication rooms are audited monthly. The results of the audits will be communicated to the DON. The DON with the interdisciplinary team (IDT) weekly for weeks. The DON and/or nursing unit manager present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, an recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and	d vill 12 will		
					performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance. The administrator consulted with the medical director and the nurse practitio regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	e		
F 804 SS=D	Nutritive Value/Appea CFR(s): 483.60(d)(1)	ar, Palatable/Prefer Temp (2)	F 8	304			12/16/18	

` '		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER WOODS NURSING ANI	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		
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F 804	Continued From pag	e 140	F 80	04		
	§483.60(d) Food and Each resident receive	drink es and the facility provides-				
		prepared by methods that lue, flavor, and appearance;				
	attractive, and at a satemperature. This REQUIREMENT by:	Γ is not met as evidenced				
	interviews, and staff to ensure food was s temperature for 4 of	on, record review, resident interviews, the facility failed erved at an appetizing 4 interviewable residents atability (Residents #45,		F804 ☐ Nutritive value/Appearance Palatable/Preferred Temperature How corrective action will be accomplished for those residents fo have been affected by the deficient practice On 14/20/18 residents #45, #71, #4	und to	
	the facility on 7/22/17	most recently readmitted to 7. His quarterly Minimum essment dated 9/5/18		On 11/20/18, residents #45, #71, #1 and #154 were interviewed by the fa Social Workers regarding meal temperatures. Residents were re-educated regarding requesting the meals be reheated or a replacemen be given when food temperatures a	nat nat tray re not	
	11/14/18 at 2:15 PM. being served at meal the facility. He expla ongoing concern for	ducted with Resident #45 on He reported that "cold food" s continued to be an issue at ined that this has been an this entire year (2018). ed that this was primarily an on the halls.		palatable. A root cause analysis rev that tray delivery was not efficient or the trays were taken to the hall. How the facility will identify other reshaving the potential to be affected be same deficient practice	sidents by the	
	revealed she was aw continued issue. She	ducted with the 14/18 at 4:15 PM. She are that "cold food" was a e reported that this issue was food served on the halls and		All residents have the potential to be effected. On 11/20/18 the facility So Workers interviewed all interviewabl residents (determined by a BIM sco 13 or above) to determine if food is at a palatable temperature. Two of	ocial le are of served	

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		345146	B. WING _			11/16/2018		
NAME OF P	ROVIDER OR SUPPLIER	1	 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2010	
		REHABILITATION CENTER		33	3426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002			
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F 804	stated that the facility meal tray delivery synthe temperature of the more appetizing temperature of the current meal tray working well enough, she was unsure where be implemented. An interview was conditionally manager (DM) on 11 stated that she was uncurrent issue at the fit that she had known so of the residents. She discussed implements system since she becaused implements system was goin. 2. Resident #71 was 8/22/18. His quarter assessment dated 10 #71's cognition was find the first condition was find as a size of PM. The first condition was find the first condition was first condition was first condition was first condition.	rissue with breakfast. She whad been looking into a new stem that would help sustain the food, so it was served at a perature. She revealed that delivery system was not. The Administrator stated in a new system was going to an anew system was going to an anew system was going to an an action of the delivery was a secility. She acknowledged staff reheated items for some the reported that the facility had the answer working as the DM in the was unaware of when a many to be implemented. In the stated that his breakfast in the reported that he was seen and cereal sits, and sausage were cold.	F	304	residents indicated that there are times when the food temperature does not me their personal preference. All residents including the two with concerns, were re-educated that a request can be made to hall staff for a replacement tray or for food to be reheated. A root cause analysis revealed again that tray delive is not always efficient once the trays are taken to the hall. What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur. Beginning on 11/19/18, re-education we given to all nursing and dietary staff by Staff Development Coordinator (SDC) nurse regarding resident preferences for food temperatures and the need to accommodate requests for food to be reheated or a replacement tray given. Re-education will be completed 12/16/18 Any staff not completing education by 12/16/18 will not be allowed to work unthe education is completed. New hirest and agency staff will receive this education during orientation to the facil Beginning 12/12/18, the dietary manage will begin sending test trays weekly at random times to include all three mealst each hall. Temperatures will be taken when the last meal tray is delivered to residents on that hall to ensure that temperatures meet regulatory requirements. A record of the temperatures will be maintained to	eet s, le r ery e as the or 18. til		
	Administrator on 11/1	14/18 at 4:15 PM. She			determine any trends or adverse findin	gs.		

AND PLAN OF CORRECTION ID	ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345146	B. WING _			1/16/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
	DU 17471011 0511755		33426 OLD SALISBURY ROAD BOX 1	250		
BETHANY WOODS NURSING AND REHA	ABILITATION CENTER		ALBEMARLE, NC 28002			
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F 804 Continued From page 142 continued issue. She repor primarily concerning food stended to be a larger issue stated that the facility had be meal tray delivery system the temperature of the food more appetizing temperature the current meal tray delive working well enough. The she was unsure when a new be implemented. An interview was conducted Manager (DM) on 11/15/18 stated that she was unawar current issue at the facility. that she had known staff refor the residents. She report discussed implementing an system since she began wor 2016. She stated she was new system was going to be 3. Resident #154 was admit quarterly Minimum Data Seindicated his cognition was An observation and intervied Resident #154 on 11/16/18 #154 had been served his that and he was eating independent would have preferred his at breakfast. An interview was conducted Administrator on 11/14/18 arevealed she was aware the revealed she was aware the r	erved on the halls and with breakfast. She been looking into a new hat would help sustain, so it was served at a re. She revealed that ry system was not Administrator stated w system was going to ad with the Dietary at 4:00 PM. She re "cold food" was a She acknowledged heated items for some feed that the facility had new meal tray delivery orking as the DM in unaware of when a re implemented. Itted on 2/12/15. His t (MDS) assessment intact. W were conducted for at 7:50 AM. Resident oreakfast in his room dently. He stated that is food to be "warmer"	F 8	How the facility plans to more performance to make sure that are sustained Facility social workers will in residents weekly x12 weeks food temperature palatability the Interdisciplinary Team (I committee and trends or conditional interventions. The Facility social workers were sults of Compliance Round the interdisciplinary team (IE weekly for 12 weeks. The dietary manager will committee that tray temperature two weeks and bill weekly for The results of the test tray that audits will be taken to the Queen Improvement (QI) Committee identification of trends, additicorrective actions, and recomposed that interviews to the main provement (QI) committee identification of trends, additicorrective actions, and recomposed trends and QI committee identification of trends, additicorrective actions, and recomposed trends and QI committee identification of trends, additicorrective actions, and recomposed trends and QI committee identification of trends, additicorrective actions to the quality and present trends and QI committee for additional recommendations to the quality of palatable for compliance of palatable for continuous determine the need for c	hat solutions Interview Interview Interview Interport to DT) Incerns for Incerns for Interport to DT) Incerns for Incerns for Interport to DT) Inter		

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F 804	tended to be a larger stated that the facility meal tray delivery synthe temperature of the more appetizing temperature of the current meal tray working well enough, she was unsure where be implemented. An interview was conditionally manager (DM) on 11 stated that she was unsured that she was unsured that she had known sof the residents. She discussed implement system since she begandless of the system was going at the facility on 9/13/18. Data Set (MDS) asset indicated her cognitionally an interview was conditionally an issue for An interview was condiministrator on 11/1 revealed she was away continued issue. She	food served on the halls and issue with breakfast. She had been looking into a new stem that would help sustain e food, so it was served at a perature. She revealed that delivery system was not. The Administrator stated in a new system was going to ducted with the Dietary 15/18 at 4:00 PM. She maware "cold food" was a acility. She acknowledged staff reheated items for some exported that the facility had ing a new meal tray delivery gan working as the DM in example was unaware of when a leg to be implemented. So most recently readmitted to a most recently Minimum example and the facility Minimum example of the facility had in the faci	F	304	12/11/18 with no changes or recommendations noted.			

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	NAME OF PROVIDER OR SUPPLIER BETHANY WOODS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002			
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F 812 SS=D	stated that the facilit meal tray delivery sy the temperature of the more appetizing tenthe current meal tray working well enough she was unsure who be implemented. An interview was consumed that she was current issue at the that she had known of the residents. She discussed implement system since she be 2016. She stated show system was go Food Procurement, CFR(s): 483.60(i) (1) \$483.60(i) Food safe The facility must - \$483.60(i)(1) - Procurement of the system was go food Procurement, CFR(s): 483.60(i) food safe the facility must - \$483.60(i)(1) - Procurement of the facility must - \$483.60(i)(1) - Procurement	or issue with breakfast. She by had been looking into a new system that would help sustain the food, so it was served at a apperature. She revealed that by delivery system was not an an new system was going to the food with the Dietary 1/15/18 at 4:00 PM. She unaware "cold food" was a facility. She acknowledged staff reheated items for some the reported that the facility had noting a new meal tray delivery the gan working as the DM in the was unaware of when a sing to be implemented. Store/Prepare/Serve-Sanitary 1/2) the product of the food from sources are distributed in the satisfactory by federal, sities. In food items obtained directly	F 8	304		12/16/18	
	and local laws or red (ii) This provision do facilities from using gardens, subject to safe growing and fo (iii) This provision do	s, subject to applicable State gulations. les not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. Des not preclude residents ds not procured by the facility.					

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F 812	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 145 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food items and date food items when stored in the resident nourishment refrigerators for 2 of 2 refrigerators observed. (100/200 hall and 600 hall nourishment room refrigerators) Findings included: 1. Observations of items stored in the facility 's 100/200 hall and 600 hall nourishment room refrigerators revealed the following: a. On 11/14/18 at 3:30 pm it was observed there was a disposable food container with a sandwich in the hall 100/200 nourishment refrigerator that was not dated.		F 8	DEFICIENCY	ry edents found to eficient Director of the rink identified nourishment other residents fected by the completed for s by the		
	100/200 's nouris the Assistant Dire revealed an undar plastic wrap that we disposable contains sandwiches wrap colored drink that There was also a expiration date of and agreed the forwas expired and con 11/15/18 at 12	:49 am observation of hall hment room refrigerator with ctor of Nursing (ADON) ted food item (sandwich with was no longer intact) in a her, several undated bed in plastic, and a blue was half full was undated. sandwich with an expired 11/12/18. The ADON observed od and drink was not dated or discarded them.		there were any other expired undated foods. No expired of foods were found. What measures will be put it systemic changes made to eather deficient practice will not be deficient practice will monitor refr as nourishments are deliver Expired Foods in Nourishments and tool. Any expired or unwill be discarded at that time was re-educated by the Diet (DM) regarding this process	or undated nto place or ensure that t recur rigerators daily ed using the ent Rooms ndated foods e. Dietary staff tary Manager beginning on		

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F 812	Continued From page 146 housekeeping was not responsible to discard or check food stored in nourishment room refrigerators that came from the kitchen. Housekeeping was only responsible to discard resident food items that were brought in from the outside. Housekeeper #3 agreed that the disposable food container that was undated on hall 100/200 could have been brought in from the outside. Co. On 11/15/18 at 11:05 am an observation with the ADON of hall 600 's nourishment room refrigerator revealed multiple food items that were either expired or not dated which included; a gallon of milk with an expired expiration date of 11/9/18 and a disposable food container which contained a sandwich. The ADON stated that housekeeping was responsible to discard expired foods and undated open food items daily from the nourishment room refrigerator. On 11/15/18 at 11:22 am an interview was conducted with the Dietary Manager (DM) who stated that the Dietary Department does not have the responsibility to check the resident hall nourishment room refrigerators for expired food. The DM commented that she did not know who was responsible and would find out. On 11/16/18 at 1:30 pm an interview was conducted with the DM who stated she was informed by the Administrator that housekeeping was responsible to check the nourishment room refrigerators daily for expired and undated food items.		F	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRO		ekly e /, ns. eent	