PRINTED: 01/14/2025 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345146	B. WING		C <b>12/19/2024</b>
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 000	Initial Comments		E 00	0	
F 000	investigation survey through 12/19/24. The compliance with the i	certification and complaint were conducted on 12/16/24 ne facility was found in requirement CFR 483.73, dness. Event ID# T9Z011.	F 00	0	
	investigation survey v 12/16/24 through 12/ The following intakes NC00216144, NC002 NC00220268, NC002 NC00223540, NC002	19/24. Event ID# T9Z011.			
F 658 SS=D	deficiency.	allegations resulted in eet Professional Standards (i)	F 65	8	1/16/25
	The services provide as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on record rev (NP), Medical Director interviews, the facility errors when Nurse # to Resident #23 pres which included fish oreducing triglycerides	rehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality.  T is not met as evidenced riews, and Nurse Practitioner or, family member, and staff or failed to prevent medication 1 administered medications cribed for Resident #240 il (used to promote health by s) and famotidine (decreases ed to treat heart burn and		1. The medication errors for Reside #23 on 7/30/24 and #55 on 8/30/24 we reported to the provider, and nursing carried out given orders with no sign of symptom of adverse effects noted.  2. The Licensed Nursing Home Administrator is ultimately responsible will ensure that this plan of correction	ere staff or e and

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

TITLE (X6) DATE

Electronically Signed 01/12/2025

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			C <b>2/19/2024</b>	
NAME OF PE	ROVIDER OR SUPPLIER	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		STREET ADDRESS, CITY, STATE, ZIP COI	•	2/13/2024	
				33426 OLD SALISBURY ROAD BOX 12			
BETHANY	WOODS NURSING ANI	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From pag	e 1	F 65	58			
	also failed to prevent medications were no the physician (Reside practice affected 2 of medications were rev #55).	viewed (Residents #23 and		implemented and followed.  3. This deficient practice of affect all residents.  On 1/1/2025, the Director of initiated a 100% audit of all oresident s Medication Admir Records compared to physic since 12.16.24 (Consults, ad written orders). This audit en medications are transcribed and administered per the phyorder. The Director of Nursin provider of any identified are	Nursing current nistration cian orders lmission, asures that appropriately ysician's g notified the as of concern		
	Resident #240 was a 02/08/21.	admitted to the facility on		during the audit, and those e corrected immediately. All a orders will be verified by 2 nu ensure compliance.  4. On 1/3/2025, the Director	admission urses to		
	scheduled for 9:00 A had orders for: - Famotidine 20 millig	cian orders dated July 2024, M, revealed Resident #240 grams (mg) by mouth one gastroesophageal reflux		initiated 100% medication pa observations with all nurses medication aides and agency utilizing the Medication Pass This observation ensures tha medications are administered physician's orders. All nurses	ass to include y nurses Audit Tool at all d per the		
	mouth one time a da support/supplementa	ition for heart health.		agency nurses and medication be retrained during the observation identified areas of concern. To be completed on 1/10/2025. 1/10/2025, any medication are including agency nurses, who	on aides will rvation for all This audit will After ide or nurse, o have not		
	07/30/24 indicated the received the wrong in Resident #23 had no medications that were A phone interview on	norning medications. t shown any affects from the		worked and completed the mass observation will comple their next scheduled shift. An licensed nurses to include agand medication aides will be upon hire.  On 1/1/2025, the Director of initiated and completed the assertion and several completed the mass of the several completed the mass observation.	ete it upon ny newly hired gency nurses educated Nursing		

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 _				C 1 <b>19/2024</b>	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	19/2024	
					3426 OLD SALISBURY ROAD BOX 1250			
BETHANY	WOODS NURSING AN	D REHABILITATION CENTER			LBEMARLE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658		d at the facility but recalled	F6	658	incident reports for the past 30 days to			
	with Resident #23 or on the morning of 07 medications for Resi	dication error that occurred n 07/30/24. She stated that 1/30/24 she was preparing dent #23 but inadvertently medications. Nurse #1			identify trends and identify any incident related to medication administration to ensure appropriate interventions were initiated, the physician notified, and the resident assessed as indicated.			
	medications to Residual stated, "yuk!" and the	administered the crushed dent #23 that the resident at's when she suspected she se #1 indicated she did not			The Staff Development Coordinator, Director of Nursing, or Assistant Direct of Nursing will initiate an in-service with 100% of all nurses and medication aide	า		
	immediately and not the Director of Nursi	ed, but she realized it ified the unit manager and ng. Nurse #1 went on to say NP of the error, and she			to include agency nurses on 1/3/2025 regarding the six rights of Medication Administration, which included reading Medication Administration Record and	the		
		to monitor Resident #23.  Practitioner (NP) # 1's acute			accurately administering medications p physician order. The in-services will b completed on 1/10/2025. After 1/10/20 all nurses and medication aides, include	e 25,		
	visit note dated 07/3 was seen due to rep medication on 07/30	1/24 revealed Resident #23 orts of receiving the wrong /24. Nurse #1 informed the			agency staff, who have not worked and have not received the in-service will receive it upon their next scheduled sh	d/or ift.		
	medications in error: Essentially, Residen	3 received the following fish oil and famotidine. t #23 ended up receiving rning medications instead of			All newly hired licensed nurses, to incluagency nurses and medication aides we be educated upon hire.			
	her prescribed media reports of adverse ef received on 07/30/24 any adverse effects,	cations. There were no ffects from medications 4. Will continue to monitor of			An in-service was initiated with 100% of nurses to include agency nurses and medication aides on 1/3/2025 by the S Development Coordinator or Director of Nursing regarding transcription of orde including clarifying discrepancies with the physician. The in-services will be	taff f rs,		
	12/18/24 at 5:08 PM notified of the medic 07/30/24 with Reside she evaluated Resid	and she stated she was ation error that occurred on ent #23. NP #1 further stated ent #23 the following day and adverse outcomes from the			completed on 1/10/2025. After 1/10/20 all nurses and medication aides, includ agency staff, who have not worked and have not received the in-service will receive it upon their next scheduled sh All newly hired licensed nurses and medication aides to include agency	ing I/or		

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		345146	B. WING		C 12/19/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/19/2024	
				33426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 658	9:34 AM and explained pass, Resident #23 with medications. Nurse # medications and admitive #23. The Administrator longer was employed Administrator also stated they should have donoccurred. The Administrator to the confusion to the confusion to the confusion for anxiety.  The quarterly Minimula indicated she was confused to the confusion to the confusion to the confusion for anxiety.	s interviewed on 12/19/24 at ed that during a medication was given the incorrect 1 prepared the wrong sinistered them to Resident for stated that Nurse #1 no at the facility. The sated the staff did everything the after the incident strator further stated that have provided the correct	F 65	,	tion ne to to ician tion sing dit nce. be tern. sing h all e per Pass	
	03/22/24 included a complete behaviors in which should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be be behaviors in the should be be behaviors. It is not should be be behaviors in the should be behaviors in the should be be behaviors in the s	255's revised care plan dated care area for problematic ne exhibited ineffective iety in which she got upset nand screaming at others.  In order dated 07/12/24 read escribed Ativan (antianxiety rams (mg) three times a day usness.		immediately addressed during the observation, including staff retraining. Any concerns during any of the audits be addressed and corrected immediat 6. The Administrator or Director of Nursing will review and initial the audit weekly for four weeks to ensure that a areas of concern are addressed appropriately. The Administrator or Director of Nursing will present the Autorols' findings to the Quality Assurance Performance Improvement committee monthly for two months. The Quality Assurance Performance Improvement committee will meet monthly for 2 monand review the Audit Tools to determine	will tely.  ts till dit tee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _				C 19/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
DETHANY	WOODS NUBSING AND	DELIA DII ITATIONI CENTED		33	426 OLD SALISBURY ROAD BOX 1250		
DETHANT	WOODS NURSING AND	REHABILITATION CENTER		Al	LBEMARLE, NC 28002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T			(X5) COMPLETION DATE
F 658	Continued From page dated 08/30/24 timed Resident #55 her 8:0 popped her morning medication card, but medication was still scard pack and did no This was not noticed the medication count my Nurse #2.  During an interview w 10:30 AM, she stated #1 so she pulled the #55 for Nurse #1 to a that when she poppe narcotic medication of fallen into the pill cup plastic bubble on the and later during medication of the interview was con PM with NP #2. She in the facility on 08/30 the omission of Resid dose on 08/30/24. She concern for harm to F	e 4 I 3:12 PM read while giving 0 AM medications, Nurse #2 dose of Ativan out of the she did not notice that the stuck in the backside of the t fall into the medication cup. until the shift change during . The report was completed  with Nurse #2 on 12/18/24 at d she was precepting Nurse medications for Resident administer, she did not notice d the Ativan out of her eard, that the Ativan had not but was still stuck inside the back of the medication card ication count, it was  inpleted on 12/18/24 at 1:15 confirmed she was working 0/24 and was made aware of dent #55's morning Ativan he stated there was no Resident #55.		658	trends and/or issues that may need further interventions and the need for additional monitoring. 7. Date of compliance: 1/16/25.		
	PM with the Medical was no harm to Resid						
		rses to provide all prescribed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  WOODS NURSING AN	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002	<u> </u>	12110/2024	
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From pa medications to Resi doses.	ge 5 ident #55 and not omit any	F 6	58			
	read Resident #55 (antianxiety medica	vsician order dated 07/12/24 was prescribed Ativan tion) 0.5 milligrams (mg) three ety and anxiousness.					
	dated 08/30/24 time read she was given 2:00 PM. Instead of received 1 mg. The	ont report (medication error) and 2:47 PM for Resident #55 the wrong dose of Ativan at receiving 0.5 mgs, she report indicated NP #2 and This report was completed by					
	at 5:40 PM with Numedication error with she did not pull the rather Nurse #2 did administer to Resid Resident #55 did not tablets in the narcot have pulled the 1 m	ew was completed on 12/18/24 rse #1. She recalled the th Resident #55. She stated Ativan for Resident #55 but and handed it to her to ent #55. Nurse #1 stated of have any 1 mg Ativan tic box and that Nurse #2 must rig of Ativan from another bill card. Nurse #1 stated she					
	10:30 AM, she state #1 at the time of this Resident #55 at 2:0 stated she was not time of this medicat #1 was not checking	with Nurse #2 on 12/18/24 at ed she was precepting Nurse is medication error on 0 PM on 8/30/24. Nurse #2 standing over Nurse #1 at the ion error, but she felt Nurse ig the computer when she Ativan dose and administered					

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		345146	B. WING _			C <b>12/19/2024</b>	
	ROVIDER OR SUPPLIER WOODS NURSING AND	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002		12/13/2024	
(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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658	with Nurse #1 since so Nurse #2 stated she beside her, but she dand make her more read and make her was administrated there was no control of the stated state	hen asked why she was not she was precepting her, should have been right lid not want to hover over her	F 6	58			
F 677 SS=E	Another interview wa Administrator on 12/3 she would expect numedications to the rigand right dose. ADL Care Provided fr CFR(s): 483.24(a)(2) §483.24(a)(2) A residuation out activities of daily services to maintain personal and oral hys	as completed with the 19/24 at 9:34 AM. She stated reses to provide the 19/14 person, the right route 19/14 person are right route 1	F 6	77		1/16/25	

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		345146	B. WING _			C 12/19	9/2024
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIF	P CODE	1 12/1	3/ <b>2</b> 024
				33426 OLD SALISBURY ROAD BO			
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		ALBEMARLE, NC 28002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 677	Continued From page	e 7	F6	577			
F 677	Based on record revinterviews with reside failed to provide routi for 4 of 6 residents reliving (ADL) (Resident The findings included 1. Resident #36 was 11/09/23.  An annual Minimum I dated 8/9/24 indicate cognitively intact.  During an interview a Resident #36 on 12/1 expressed that he wo as it was longer than explained he had not in four months since anyone available to p #36 was unable to re about getting his hair was long on the sides ears.  On 12/18/24 at 10:41 Director was interview not aware that Reside She added she was unterview n	iews, observations and ents and staff, the facility ne hair trimming. This was eviewed for activities of daily its #36, # 50, #53, and #77).  Eadmitted to the facility on  Data Set (MDS) assessment defended Resident #36 was  Individual observation with 8/24 at 10:00 AM, he old like to have his hair cut he liked to wear it. He been able to get his hair cut the facility no longer had provide this service. Resident call the staff that he talked to cut. Resident #36's hair is and was long around the  AM, the Social Services wed and stated that she was ent #36 wanted his hair cut. Insure whose role it was to	F	1. By 1/14/25, a license provide hair services to F 50, 53, and 77. 2. The Licensed Nursir Administrator is ultimately will ensure that this plan implemented and followe 3. This deficient has the affect all residents. 4. Social Services or E will interview 100% of res Brief Interview for Mental 13 or greater and the res residents with a BIMS 12 regarding preferences for services by 1/10/25. 5. Beginning 1/14/25, a needing hair care service provided with them interriby a licensed beautician, will provide transportation 6. The Registered Nurs Development Coordinato of Nursing will in-service including any agency stated Activities of Daily Living, on hair care services by not educated to include a 1/14/25 will not work untinewly hired staff member the education by their first shift.  The Nursing managers we walking rounds on 10 res 30 days to observe their care to ensure compliance.	Residents #36, and Home by responsible and correction is add. The potential to Director of Nursidents with a language Status (BIMS apponsible party to below and the facility or below and the facility or the Director all nursing staff, on providing with an emphasistation of the Director all nursing staff, on providing with an emphasistation of the Director all nursing staff, on providing with an emphasistation of the Director all nursing staff, on providing with an emphasistation of the Director all nursing staff, and providing will complete state of the did not be stated and hair will complete sidents weekly ADLs and hair	and sing sing of of of ally y or of staff y ull e	
	hair. She stated she	e in and cut their loved ones' didn't know how other ir cut. She indicated that		of Nursing will review the and present findings to the Assurance Performance	ne Quality	8	

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 _				C <b>19/2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 126 OLD SALISBURY ROAD BOX 1250 BEMARLE, 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	The Activities Director facility did not have to take residents out for clarified the facility do take residents to med.  An interview occurred (DON) on 12/18/24 as she had only been in October 2024. She so informed that she was someone to cut their that the NAs could be part of routine activiti but they were not allow there had been cand position of hairstylist, hired to her knowledge.  An interview was con Administrator on 12/2 stated she was unaw haircut. She stated she hairstylist for the facility appointments to take trimming due to being wanted.  2. Resident #50 was 6/9/23.	ts (NAs) could not cut hair. In further stated that the ransportation available to hair trimming, but she bes have transportation to dical appointments.  It with the Director of Nursing at 11:04 AM. She stated that the DON position since tated she had not been is responsible for finding esidents' hair. She stated rush the residents' hair as es of daily living (ADL) care, bewed to trim it. She relayed idates interviewed for the but that no one had been ge.  Inpleted with the 18/24 at 11:10 AM. She ware Resident #36 wanted a she had been recruiting for a lity. The Administrator further of had not been making a residents out for hair gunaware this service was admitted to the facility on  Data Set assessment dated at Resident #50 was	F6	377	Committee to ensure compliance. 7. Date of compliance: 1/16/25.		
		18/14 at 10:00 AM, she					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 677	as it was longer tha stated she had to re her hair since the fat to perform this serv. She explained she about getting her ha which staff. Resider in the back and was On 12/18/24 at 10:4 Director was intervinot aware that Resi She added she was cut residents' hair.  The Activities Direct 12/18/24 at 10:47 A staff did not trim residents got their hair. She stated she residents got their hair. She stated that the transportation availabair trimming, but shave transportation appointments.  An interview occurre (DON) on 12/18/24 she had only been informed that she was meene to cut the that the NAs can brof routine ADL care trim it. She relayed	would like to have her hair cut in she liked to wear it and ely on family members to trim acility did not have anyone able ice for the last four months. Had asked staff several times air cut but was unable to recall int #50's hair touched her collar is long around the sides.  If AM, the Social Services ewed and stated that she was dent #50 wanted her hair cut. It is unsure whose role it was to to the was interviewed on the wast interv	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			C <b>12/19/2024</b>		
	ROVIDER OR SUPPLIER  Y 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 LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COI  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 677	An interview was co Administrator on 12/stated she was unaw haircut. She stated shairstylist for the facistated that the facilit appointments to take trimming due to bein wanted.  3. Resident #53 was 2/14/23.  An annual Minimum 11/25/24 indicated the cognitively intact.  During an interview Resident #53 on 12/stated that she would it was longer than she the facility did not have the facility did not have the facility to get here was past her should around her head.  On 12/18/24 at 10:4 Director was intervien not aware that Resident was unawer that Resident was unaw	mpleted with the 18/24 at 11:10 AM. She ware Resident #50 wanted a she had been recruiting for a ility. The Administrator further y had not been making e residents out for hair ag unaware this service was admitted to the facility on  Data Set assessment dated nat Resident #53 was  and observation with 18/14 at 10:00 AM, she d like to have her hair cut as ne liked to wear it and stated are anyone able to perform	F	577				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			C <b>12/19/2024</b>	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002		12/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	12/18/24 at 10:47 AM staff did not trim resifamily members camhair. She stated she residents got their hat the NAs could not cut further stated that the transportation availa hair trimming, but sh have transportation trappointments.  An interview occurre on 12/18/24 at 11:04 has only been in the 2024. She stated she was responsible the residents' hair. Shough the residents' care, but they were relayed there had be for the position of habeen hired to her known and the country light of the facility appointments to take trimming due to bein wanted.	or was interviewed on M and stated that nursing dents' hair, but that some ie in and cut their loved ones' didn't know how other air cut. She indicated that it hair. The Activities Director is facility did not have ble to take residents out for it clarified the facility does to take residents to medical in did with the Director of Nursing AM. She stated that she DON position since October is had not been informed that for finding someone to cut the stated that the NAs could thair as part of routine ADL and allowed to trim it. She is en candidates interviewed in the stated that the no one had owledge.	F	677			
	An annual Minimum	Data Set assessment dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345146	B. WING _			C 12/19/2024		
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002				
(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 677	cognitively intact.  During an interview Resident #77 on 12/ expressed that he was it was longer than stated he had to rely his hair since the fact to perform this servi. He explained he had know he wanted a hair was long on the On 12/18/24 at 10:4 Director was intervien to aware that Resident's hair.  The Activities Direct 12/18/24 at 10:47 A staff did not trim resfamily members can hair. She stated she residents got their hair. She stated that the transportation availabair trimming, but shave transportation appointments.  An interview occurre (DON) on 12/18/24 she had only been in October 2024. She	and observation with 18/14 at 10:00 AM, he would like to have his hair cut in he liked to wear it and won family members to trim cility did not have anyone able one for the last four months. It asked his son to let the staff aircut, but he was not sure spoke with. Resident #77's	F	577				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345146	B. WING		C <b>12/19/2024</b>	
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002	12.10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 677	Continued From page	e 13 esidents' hair. She stated	F 67	7		
	of routine ADL care, I trim it. She relayed th	sh the residents' hair as part but they were not allowed to ere had been candidates sition of hairstylist, but that d to her knowledge.				
	stated she was unaw haircut. She stated sl hairstylist for the facility stated that the facility appointments to take trimming due to being wanted.	8/24 at 11:10 AM. She are Resident #77 wanted a ne had been recruiting for a lity. The Administrator further had not been making residents out for hair gunaware this service was				
F 760 SS=E	CFR(s): 483.45(f)(2)  The facility must ensity \$483.45(f)(2) Resider medication errors.  This REQUIREMENT by:  Based on record rev Medical Director, faminterviews, the facility	f Significant Med Errors  ure that its- nts are free of any significant  is not met as evidenced  iews, and Nurse Practitioner, ily member, and staff failed to prevent significant en Nurse #1 administered	F 76	The medication errors for Reside #23 on 7/30/24 and #55 on 8/30/24 w reported to the provider, and nursing carried out given orders with no sign.	vere staff	
	Resident #240 which prevent blood from cl treat anxiety disorder epilepsy), isosorbide pressure), metoprolo pressure), spironolac blood pressure), cital depression). In additi			symptom of adverse effects noted.  2. The Licensed Nursing Home Administrator is ultimately responsible will ensure that this plan of correction implemented and followed.  3. This deficient practice can potent affect all residents. On 1/1/2025, the Director of Nursing initiated a 100% audit of all current resident's Medication Administration	e and is	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII		CONSTRUCTION	COMF	E SURVEY PLETED
		345146	B. WING _				C / <b>19/2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		33	REET ADDRESS, CITY, STATE, ZIP CODE 8426 OLD SALISBURY ROAD BOX 1250 LBEMARLE, NC 28002	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	#191 which included	ge 14 I Aricept (used to treat (used to treat depression)	F	760	Records compared to physician orders since 12.16.24 (Consults, admission,		
	and Tramadol (used practice affected 2 c	to treat pain). This deficient			written orders). This audit ensures that medications are transcribed appropriat and administered per the physician's order. The Director of Nursing notified provider of any identified areas of concerns.	ely	
	The findings include  1. Resident #23 was 12/13/22.	d: admitted to the facility on			during the audit, and those errors were corrected immediately. All admission orders will be verified by 2 nurses to ensure compliance.  4. On 1/3/2025, the Director of Nursi	•	
	scheduled for 9:00 A had orders for: - Ingrezza 40 milligra a day for tardive dys	ician orders dated July 2024, AM, revealed Resident #23 ams (mg) by mouth one time kinesia. lepressant medication) 50			initiated 100% medication pass observations with all nurses to include medication aides and agency nurses utilizing the Medication Pass Audit Too This observation ensures that all medications are administered per the	l.	
	mg, give1.5 tablets, related to generalize depressive disorder - alprazolam (a benz system depressant i	by mouth one time a day and anxiety disorder and major codiazepine-central nervous medication) 0.25 mg tablet by			physician's orders. All nurses, to include agency nurses and medication aides who retrained during the observation for identified areas of concern. This audit who be completed on 1/10/2025. After	/ill all	
mouth two times a day for anxiety.  - Benztropine Mesylate (an anticholinergi medication) 0.5 mg by mouth every 12 hd EPS (extrapyramidal signs or muscle stiffness/rigidity).		ate (an anticholinergic by mouth every 12 hours for I signs or muscle			1/10/2025, any medication aide or nurs including agency nurses, who have not worked and completed the medication pass observation will complete it upon their next scheduled shift. Any newly h	t ired	
	anticonvulsant and r 125 mg, give 2 caps day for schizophreni -Risperdal (an antip	sychotic medication) 0.5 mg ts, by mouth two times a day			licensed nurses to include agency nurse and medication aides will be educated upon hire.  On 1/1/2025, the Director of Nursing initiated and completed the audit of all incident reports for the past 30 days to identify trends and identify any incident related to medication administration to	t	
	The annual Minimur assessment dated 1 #23 had severely im	2/12/24, indicated Resident			ensure appropriate interventions were initiated, the physician notified, and the resident assessed as indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040140		CTDEET ADDRESS CITY STATE ZID CO		2/19/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
BETHANY	WOODS NURSING	AND REHABILITATION CENTER		33426 OLD SALISBURY ROAD BOX	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 ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From p	age 15	F 7	760			
	O2/08/21.  A review of the ph scheduled for 9:00 had orders for:  - Apixaban (an an by mouth two times	s admitted to the facility on  ysician orders dated July 2024, 0 AM, revealed Resident #240  ticoagulant medication) 2.5 mg s a day related to atrial		The Staff Development Coc Director of Nursing, or Assist of Nursing will initiate an in- 100% of all nurses and med to include agency nurses of regarding the six rights of M Administration, which include Medication Administration F accurately administering medication of Nursing Medication Page 1	stant Director service with dication aides n 1/3/2025 Medication ded reading the Record and edications per		
	by mouth three tin anxiety disorderGabapentin (an a mg by mouth two polyneuropathy. D - Isosorbide Mond nitrate with vasod	xiolytic medication) 10 mg HCl nes a day related to generalized inticonvulsant medication) 300 times a day related to no not crush or chew. nitrate Extended Release (a lating properties medication) 30 time a day for hypertension. Do		physician order. The in-se completed on 1/10/2025. At all nurses and medication a agency staff, who have not have not received the in-se receive it upon their next so All newly hired licensed nur agency nurses and medicate be educated upon hire.	fter 1/10/2025, nides, including worked and/or rvice will cheduled shift. rses, to include		
	0.5 tablet to = 12.3 related to primary -Spironolactone (umg by mouth one -Citalopram Hydromedication) 10 mg related to general depressive disord  A progress note w 07/30/24, indicate	used to treat hypertension) 25 time a day for Hypertension. bbromide (an antidepressant g by mouth one time a day zed anxiety disorder and major		An in-service was initiated was nurses to include agency medication aides on 1/3/20. Development Coordinator of Nursing regarding transcriptincluding clarifying discrepa physician. The in-services was completed on 1/10/2025. At all nurses and medication a agency staff, who have not have not received the in-service it upon their next so All newly hired licensed nur medication aides to include	urses and 25 by the Staff or Director of tion of orders, ancies with the will be fter 1/10/2025, aides, including worked and/or rvice will cheduled shift. ses and agency		
	Practitioner #1 wa Resident #23 for 4 shown any affects given.	s notified and stated to monitor 18 hours. Resident #23 had not 18 from the medications that were 18 occurred with Nurse #1 on		nurses will be educated upon 5. The Director of Nursing Director of Nursing will audin Administration records comphysician's orders weekly xensure medications are training tr	on hire. g or Assistant it 5 Medication pared to the 4 weeks to		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			A. BOILDII			، ا	C
		345146	B. WING _				19/2024
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	127	10/2024
				33	426 OLD SALISBURY ROAD BOX 1250		
BETHANY	WOODS NURSING AND	REHABILITATION CENTER		Al	LBEMARLE, NC 28002		
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B)	≡	(X5) COMPLETION
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPRIA		DATE
F 760	Continued From page	e 16	F 7	760			
	12/18/24 at 5:40 PM.	Nurse #1 stated she no			accurately and administered per physic	ian	
	longer was employed	I at the facility but recalled			order utilizing a Medication Administrat	ion	
	the details of the med	dication error that occurred			record (MAR) audit tool.		
	with Resident #23 on	07/30/24. She indicated that			Starting 1/6/2025, the Director of Nursi	ng	
	she was a new nurse	, did not have very much			or Assistant Director of Nursing will aud	lit	
	_	now the residents well. She			the medication audit report five times		
		rning of 07/30/24 she was			weekly for 30 days to ensure compliand		
		s for Resident #23 but			During these audits, the physician will be		
		esident 240's medications.			notified of any identified areas of conce		
	•	when she administered the			Beginning 1/6/25, The Director of Nurs	ng	
		to Resident #23 that the			or Assistant Director of Nursing will		
	_	" and that's when she			complete three medication passes with		
	suspected she made				nurses and medication aides to include		
		know how it happened, but liately and notified the unit			agency nurses weekly x 4 weeks to ensure medications are administered p	er	
	_	ector of Nursing. Nurse #1			physician order utilizing a Medication P		
	· ·	otified the Nurse Practitioner			Audit Tool. Any areas of concern will be	)	
		received new orders to			immediately addressed during the		
	monitor Resident #23				observation, including staff retraining.		
		member was in the room at			Any concerns during any of the audits		
	the time, but she did				be addressed and corrected immediate	ely.	
		rse #1 stated she was new			6. The Administrator or Director of		
	and was unsure what	•			Nursing will review and initial the audits		
		/30/24. She further explained			weekly for four weeks to ensure that all areas of concern are addressed		
		a preceptor with her on					
	cart.	s alone on the medication			appropriately. The Administrator or Director of Nursing will present the Aud	iŧ	
	cart.				Tools' findings to the Quality Assurance		
	Review of the Nurse	Practitioner (NP) #1's acute			Performance Improvement committee		
		1/24 revealed Resident #23			monthly for two months. The Quality		
		orts of receiving the wrong			Assurance Performance Improvement		
		24. Nurse #1 informed the			committee will meet monthly for 2 mon	hs	
		B received the following			and review the Audit Tools to determine		
		ns in error: Eliquis 10mg,			trends and/or issues that may need		
	_	apentin 300mg, isosorbide			further interventions and the need for		
		mg, spironolactone 25mg,			additional monitoring.		
		. The NP noted essentially,			7. Date of compliance: 1/16/25.		
		up receiving Resident #240's			·		
		instead of her prescribed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 501251		С
		345146	B. WING _		12/19/2024
NAME OF PROVIDE  BETHANY WOO		ND REHABILITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP ( 33426 OLD SALISBURY ROAD BOX ALBEMARLE, NC 28002	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETION THE APPROPRIATE
medinclu hour and a her r The signs bruis and i were medi to me heme A ph mem she v medi told I expla #23's furth room vital "oh y "yeal why An ir on 1: reca Resi error Resi had i any I	ded for vital signs x 48 hours, heafternoon routing and symptoming, hypo/hypencreased drown reports of a cations received on the received on t	none call on 07/30/24 orders and to be checked every six old Resident #23's morning the medications and resume ed medications at bedtime. Instructed to monitor for so of increased bleeding, retension, altered mental status siness x 48 hours. There adverse effects from ed on 07/30/24. Will continue elverse effects, today she was table and in no acute distress.  Inccurred with the family 4 at 5:15 PM and she stated try on 07/30/24 when the discourred, however no one are at that time. She the #1 administered Resident cations in her presence. She was the family member stated, the family member stated, the family member stated, the family member stated, the to get them," but never said go them.  The work of the medication error for explained he felt the medication that the event also stated he he medications had caused in the execurred with Nurse the course with Nurse the execurred with Nurse the execution of the exec	F	760	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345146	B. WING _			C <b>12/19/2024</b>	
	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 AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 760	error that occurred of a significant medical gave orders to monitand monitor for sign NP #1 further stated the following day an outcomes from the IThe Administrator w 9:34 AM and explain pass, Resident #23 medications. Nurse medications and ad #23. The Administration stated should have done a Administrator stated should have done a Administrator stated have provided the correct resident.  2. Resident #4 was 7/6/16 with diagnost disorder, congestive type 2.  Review of Resident orders included the medications:	Id consider the medication on 07/30/24 with Resident #23 tion error. She explained she iter Resident #23's vital signs is and symptoms of bleeding. If she evaluated Resident #23 id she had no adverse medication error.  It is interviewed on 12/19/24 at med that during a medication was given the incorrect #1 prepared the wrong ministered them to Resident atter stated that Nurse #1 no end at the facility. The if the staff did everything they fiter the incident occurred. The interviewed that nursing staff should correct medication to the medication to the staff did bipolar included	F 7				
	milligrams (mg) give day for paranoid sch - Haldol (an antipsy mg per milliliters (m every shift for agitat - Fentanyl patch (an	e 1.5 tablet by mouth twice a nizophrenia. chotic medication) injection 5 l). Inject 2 ml intramuscularly					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		345146	B. WING _		,	C <b>12/19/2024</b>		
	ROVIDER OR SUPPLIER WOODS NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 33426 OLD SALISBURY ROAD BOX 125 ALBEMARLE, NC 28002	E			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 760	Continued From page	ge 19	F 7	60				
	assessment dated 8 had moderately imp	num Data Set (MDS) 3/29/24, indicated Resident #4 aired cognition. admitted to the facility on						
	Resident #191 inclumedications: - Aricept 5 mg one to morning Lexapro (an antide by mouth every morning)	treat pain) 25 mg one tablet						
	#2 revealed Reside morning medication was reported to the and the responsible  A nursing progress that Resident #4 ha medications. The pl stated to monitor Resident #4 ha medications.	ated 8/24/24 written by Nurse nt #4 had received the wrong s by Nurse #1. The incident Medical Director at 10:31 AM party (RP) at 7:31 PM.  note dated 8/24/24 indicated d received the wrong morning hysician was notified to and esident #4 for 24 hours. t shown any affects from the ere given.						
	A phone interview of 12/18/24 at 5:40 PM no longer was emple the details of the mewith Resident #4 on the morning of 8/24 medications for Resident #4	ccurred with Nurse #1 on  1. Nuse #1 explained that she oyed at the facility but recalled edication error that occurred 8/24/24. She stated that on /24 she was preparing sident #4 but inadvertently is medications. She stated that						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345146	B. WING _		,	C 1 <b>2/19/2024</b>	
	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 DEFICIENC	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)	SHOULD BE	(X5) COMPLETION DATE	
F 760	nurse and had asked received her Haldol is was identified that R Resident #191's med went on to say that N physician and RP of On 12/18/24 at 10:3 with Nurse #2. She a new nurse and that 8/24/24. She stated Resident #4 had recommorning and Nurse #4 wasn't ordered arto begin asking more that Nurse #1 had gimedications to Resident #4 who was then notified the phystated she should have to Nurse #1 when she medications.  An interview occurre on 12/18/24 at 1:00 notified of the medication Resident #4 would have the medication for the medication Resident #4 would have 9:34 AM and explain pass, Resident #4 would have medications. Nurse #2 but was stamedication cart when	d her if Resident #4 had njection. That was when it esident #4 had received dications in error. Nurse #1 Nurse #2 notified the the error.  1 AM, an interview occurred explained that Nurse #1 was t she was precepting her on that she asked Nurse #1 if eived her Haldol injection that #1 responded that Resident in injection. That prompted her e questions and found out ven Resident #191's dent #4. She went to assess is at her baseline and stable, sician and RP. Nurse #2 have been standing right next he was preparing the  d with the Medical Director PM and stated he was ation error, but didn't feel that his that were received by ave caused any harm.  as interviewed on 12/19/24 at hed that during a medication has given the incorrect #1 was being precepted by handing away from the has Nurse #1 prepared the	F 7	60			
	The Administrator wa 9:34 AM and explain pass, Resident #4 w medications. Nurse # Nurse #2 but was sta medication cart whel medications for Resi the wrong medicatio	as interviewed on 12/19/24 at ed that during a medication as given the incorrect #1 was being precepted by anding away from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		IPLE CONSTRUC	(X3) DATE SURVEY COMPLETED		
		345146	B. WING			C 12/19/2024	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		33426 OLD S	RESS, CITY, STATE, ZIP CODE SALISBURY ROAD BOX 1250 LE, NC 28002	<u>  121</u>	13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	#1 no longer was em Administrator further immediately notified to resident and notified to incident. The Administ everything they should incident occurred. She should have been motive being prepared Administrator stated to	ployed at the facility. The stated that Nurse #2 he physician, assessed the the RP following the strator stated the staff did	F7	60			