STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Woods Nursing and Rehabilitation Center	33426 Old Salisbury Road Box 1250 Albemarle, NC 28002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record reviews, and Nurse Practitioner (NP), Medical Director, family member, and staff interviews, the facility failed to prevent medication errors when Nurse #1 administered medications to Resident #23 prescribed for Resident #240 which included fish oil (used to promote health by reducing triglycerides) and famotidine (decreases stomach acid and used to treat heart burn and gastroesophageal reflux disease). The facility also failed to prevent medication errors when medications were not administered as ordered by the physician (Resident #55). This deficient practice affected 2 of 8 residents whose medications were reviewed (Residents #23 and #55). The findings included: 1. Resident #23 was admitted to the facility on [DATE]. Resident #240 was admitted to the facility on [DATE]. A review of the physician orders dated July 2024, scheduled for 9:00 AM, revealed Resident #240 had orders for: - Famotidine 20 milligrams (mg) by mouth one time a day related to gastroesophageal reflux disease. -Fish Oil (reduces triglycerides) 1000 mg by mouth one time a day for nutritional support/supplementation for heart health. A progress note written by Nurse #1 dated 07/30/24 indicated that Resident #23 had received the wrong morning medications. Resident #23 had not shown any affects from the medications that were given. A phone interview occurred with Nurse #1 on 12/18/24 at 5:40 PM. She explained that she no longer was employed at the facility but recalled the details of the medication error that occurred with Resident #23 on 07/30/24. She stated that on the morning of 07/30/24 she was preparing medications for Resident #23 but inadvertently used Resident 240's medications. Nurse #1 explained when she administered the crushed medications to Resident #23 that the resident stated, [NAME]! and that's when she suspected she made the error. Nurse #1 indicated she did not know how it happened, but she realized it immediately and notified the unit manager and the Director of Nursing. Nurse #1 went on to say she also notified the NP of the error, and she received new orders to monitor Resident #23. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse Practitioner (NP) # 1's acute visit note dated 07/31/24 revealed Resident #23 was seen due to reports of receiving the wrong medication on 07/30/24. Nurse #1 informed the NP that Resident #23 received the following medications in error: fish oil and famotidine. Essentially, Resident #23 ended up receiving Resident #240's morning medications instead of her prescribed medications. There were no reports of adverse effects from medications received on 07/30/24. Will continue to monitor of any adverse effects, today she was hemodynamically stable and in no acute distress. A phone interview occurred with the NP #1 on 12/18/24 at 5:08 PM and she stated she was notified of the medication error that occurred on 07/30/24 with Resident #23. NP #1 further stated she evaluated Resident #23 the following day and Resident #23 had no adverse outcomes from the medication error. The Administrator was interviewed on 12/19/24 at 9:34 AM and explained that during a medication pass, Resident #23 was given the incorrect medications. Nurse #1 prepared the wrong medications and administered them to Resident #23. The Administrator stated that Nurse #1 no longer was employed at the facility. The Administrator also stated the staff did everything they should have done after the incident occurred. The Administrator further stated that nursing staff should have provided the correct medication to the correct resident. 2a. Resident #55 was admitted on [DATE] with a diagnosis of anxiety. The quarterly Minimum Data Set, dated dated dated [DATE] indicated she was cognitively intact, and she did not exhibit any behaviors. Resident #55 was coded for the use of antianxiety medication. Review of Resident #55's revised care plan dated 03/22/24 included a care area for problematic behaviors in which she exhibited ineffective coping related to anxiety in which she got upset easily yelling, cursing, and screaming at others. Review of a physician order dated 07/12/24 read Resident #55 was prescribed Ativan (antianxiety medication) 0.5 milligrams (mg) three times a day for anxiety and anxiousness. Review of an incident report (medication error) dated 08/30/24 timed 3:12 PM read while giving Resident #55 her 8:00 AM medications, Nurse #2 popped her morning dose of Ativan out of the medication card, but she did not notice that the medication was still stuck in the backside of the card pack and did not fall into the medication cup. This was not noticed until the shift change during the medication count. The report was completed my Nurse #2. During an interview with Nurse #2 on 12/18/24 at 10:30 AM, she stated she was precepting Nurse #1 so she pulled the medications for Resident #55 for Nurse #1 to administer, she did not notice that when she popped the Ativan out of her narcotic medication card, that the Ativan had not fallen into the pill cup but was still stuck inside the plastic bubble on the back of the medication card and later during medication count, it was discovered. An interview was completed on 12/18/24 at 1:15 PM with NP #2. She confirmed she was working in the facility on 08/30/24 and was made aware of the omission of Resident #55's morning Ativan dose on 08/30/24. She stated there was no concern for harm to Resident #55. An interview was completed on 12/18/24 at 1:00 PM with the Medical Director. He stated there was no harm to Resident #55. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Administrator on 12/19/24 at 9:34 AM. She stated she would expect nurses to provide all prescribed medications to Resident #55 and not omit any doses. 2b. Review of a physician order dated 07/12/24 read Resident #55 was prescribed Ativan (antianxiety medication) 0.5 milligrams (mg) three times a day for anxiety and anxiousness. Review of an incident report (medication error) dated 08/30/24 timed 2:47 PM for Resident #55 read she was given the wrong dose of Ativan at 2:00 PM. Instead of receiving 0.5 mgs, she received 1 mg. The report indicated NP #2 and Resident #55's RP. This report was completed by Nurse #1. A telephone interview was completed on 12/18/24 at 5:40 PM with Nurse #1. She recalled the medication error with Resident #55. She stated she did not pull the Ativan for Resident #55 but rather Nurse #2 did and handed it to her to administer to Resident #55. Nurse #1 stated Resident #55 did not have any 1 mg Ativan tablets in the narcotic box and that Nurse #2 must have pulled the 1 mg of Ativan from another resident's narcotic pill card. Nurse #1 stated she resigned that day. During an interview with Nurse #2 on 12/18/24 at 10:30 AM, she stated she was precepting Nurse #1 at the time of this medication error on Resident #55 at 2:00 PM on 8/30/24. Nurse #2 stated she was not standing over Nurse #1 at the time of this medication error, but she felt Nurse #1 was not checking the computer when she pulled the incorrect Ativan dose and administered it to Resident #55. When asked why she was not with Nurse #1 since she was precepting her, Nurse #2 stated she should have been right beside her, but she did not want to hover over her and make her more nervous. An interview was completed on 12/18/24 at 1:15 PM with NP #2. She confirmed she was working in the facility on 08/30/24 and was made aware of the double dose of Resident #55's Ativan on 08/30/24 was administered at 2:00 PM. She stated there was no concern for harm, but Nurse #1 and Nurse #2 were instructed to observed for increased sedation. An interview was completed on 12/18/24 at 1:00 PM with the Medical Director. He stated there was no harm to Resident #55. Another interview was completed with the Administrator on 12/19/24 at 9:34 AM. She stated she would expect nurses to provide the medications to the right person, the right route and right dose.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415 Based on record reviews, observations and interviews with residents and staff, the facility failed to provide routine hair trimming. This was for 4 of 6 residents reviewed for activities of daily living (ADL) (Residents #36, # 50, #53, and #77). The findings included: 1. Resident #36 was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #36 was cognitively intact. During an interview and observation with Resident #36 on 12/18/24 at 10:00 AM, he expressed that he would like to have his hair cut as it was longer than he liked to wear it. He explained he had not been able to get his hair cut in four months since the facility no longer had anyone available to provide this service. Resident #36 was unable to recall the staff that he talked to about getting his hair cut. Resident #36's hair was long on the sides and was long around the ears. On 12/18/24 at 10:41 AM, the Social Services Director was interviewed and stated that she was not aware that Resident #36 wanted his hair cut. She added she was unsure whose role it was to cut residents' hair. The Activities Director was interviewed on 12/18/24 at 10:47 AM and stated that nursing staff did not trim residents' hair, but that some family members came in and cut their loved ones' hair. She stated she didn't know how other residents got their hair cut. She indicated that the Nursing Assistants (NAs) could not cut hair. The Activities Director further stated that the facility did not have transportation available to take residents out for hair trimming, but she clarified the facility does have transportation to take residents to medical appointments. An interview occurred with the Director of Nursing (DON) on 12/18/24 at 11:04 AM. She stated that she had only been in the DON position since October 2024. She stated she had not been informed that she was responsible for finding someone to cut the residents' hair. She stated that the NAs could brush the residents' hair as part of routine activities of daily living (ADL) care, but they were not allowed to trim it. She relayed there had been candidates interviewed for the position of hairstylist, but that no one had been hired to her knowledge. An interview was completed with the Administrator on 12/18/24 at 11:10 AM. She stated she was unaware Resident #36 wanted a haircut. She stated she had been recruiting for a hairstylist for the facility. The Administrator further stated that the facility had not been making appointments to take residents out for hair trimming due to being unaware this service was wanted. 2. Resident #50 was admitted to the facility on [DATE]. A quarterly Minimum Data Set assessment dated [DATE] indicated that Resident #50 was cognitively intact. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation with Resident #50 on 12/18/14 at 10:00 AM, she expressed that she would like to have her hair cut as it was longer than she liked to wear it and stated she had to rely on family members to trim her hair since the facility did not have anyone able to perform this service for the last four months. She explained she had asked staff several times about getting her hair cut but was unable to recall which staff. Resident #50's hair touched her collar in the back and was long around the sides. On 12/18/24 at 10:41 AM, the Social Services Director was interviewed and stated that she was not aware that Resident #50 wanted her hair cut. She added she was unsure whose role it was to cut residents' hair. The Activities Director was interviewed on 12/18/24 at 10:47 AM and stated that nursing staff did not trim residents' hair, but that some family members came in and cut their loved ones' hair. She stated she didn't know how other residents got their hair cut. She indicated that the NAs could not cut hair. The Activities Director further stated that the facility did not have transportation available to take residents out for hair trimming, but she clarified the facility does have transportation to take residents to medical appointments. An interview occurred with the Director of Nursing (DON) on 12/18/24 at 11:04 AM. She stated that she had only been in the DON position since October 2024. She stated she had not been informed that she was responsible for finding someone to cut the residents' hair. She stated that the NAs can brush the residents' hair as part of routine ADL care, but they were not allowed to trim it. She relayed there had been candidates interviewed for the position of hairstylist, but that no one had been hired to her knowledge. An interview was completed with the Administrator on 12/18/24 at 11:10 AM. She stated she was unaware Resident #50 wanted a haircut. She stated she had been recruiting for a hairstylist for the facility. The Administrator further stated that the facility had not been making appointments to take residents out for hair trimming due to being unaware this service was wanted. 3. Resident #53 was admitted to the facility on [DATE]. An annual Minimum Data Set assessment dated [DATE] indicated that Resident #53 was cognitively intact. During an interview and observation with Resident #53 on 12/18/14 at 10:00 AM, she stated that she would like to have her hair cut as it was longer than she liked to wear it and stated the facility did not have anyone able to perform this service for the last four months. She explained she had asked staff several times about getting her hair cut but was unable to recall which staff. She stated that she had not been offered an appointment with anyone outside of the facility to get her hair cut. Resident #53's hair was past her shoulders and was sticking out around her head. On 12/18/24 at 10:41 AM, the Social Services Director was interviewed and stated that she was not aware that Resident #53 wanted her hair cut. She added she was unsure whose role it was to cut residents' hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Activities Director was interviewed on 12/18/24 at 10:47 AM and stated that nursing staff did not trim residents' hair, but that some family members came in and cut their loved ones' hair. She stated she didn't know how other residents got their hair cut. She indicated that the NAs could not cut hair. The Activities Director further stated that the facility did not have transportation available to take residents out for hair trimming, but she clarified the facility does have transportation to take residents to medical appointments. An interview occurred with the Director of Nursing on 12/18/24 at 11:04 AM. She stated that she has only been in the DON position since October 2024. She stated she had not been informed that she was responsible for finding someone to cut the residents' hair. She stated that the NAs could brush the residents' hair as part of routine ADL care, but they were not allowed to trim it. She relayed there had been candidates interviewed for the position of hairstylist, but that no one had been hired to her knowledge. An interview was completed with the Administrator on 12/18/24 at 11:10 AM. She stated she was unaware Resident #53 wanted a haircut. She stated she had been recruiting for a hairstylist for the facility. The Administrator further stated that the facility had not been making appointments to take residents out for hair trimming due to being unaware this service was wanted. 4. Resident #77 was admitted to the facility on [DATE]. An annual Minimum Data Set assessment dated [DATE] indicated that Resident #77 was cognitively intact. During an interview and observation with Resident #77 on 12/18/14 at 10:00 AM, he expressed that he would like to have his hair cut as it was longer than he liked to wear it and stated he had to rely on family members to trim his hair since the facility did not have anyone able to perform this service for the last four months. He explained he had asked his son to let the staff know he wanted a haircut, but he was not sure which staff his son spoke with. Resident #77's hair was long on the sides. On 12/18/24 at 10:41 AM, the Social Services Director was interviewed and stated that she was not aware that Resident #77 wanted his hair cut. She added she was unsure whose role it was to cut resident's hair. The Activities Director was interviewed on 12/18/24 at 10:47 AM and stated that nursing staff did not trim residents' hair, but that some family members came in and cut their loved ones' hair. She stated she didn't know how other residents got their hair cut. She indicated that the NAs could not cut hair. The Activities Director further stated that the facility did not have transportation available to take residents out for hair trimming, but she clarified the facility does have transportation to take residents to medical appointments. An interview occurred with the Director of Nursing (DON) on 12/18/24 at 11:04 AM. She stated that she had only been in the DON position since October 2024. She stated she had not been informed that she was responsible for finding someone to cut the residents' hair. She stated that the NAs can brush the residents' hair as part of routine ADL care, but they were not allowed to trim it. She relayed there had been candidates interviewed for the position of hairstylist, but that no one had been hired to her knowledge. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with the Administrator on 12/18/24 at 11:10 AM. She stated she was unaware Resident #77 wanted a haircut. She stated she had been recruiting for a hairstylist for the facility. The Administrator further stated that the facility had not been making appointments to take residents out for hair trimming due to being unaware this service was wanted.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record reviews, and Nurse Practitioner, Medical Director, family member, and staff interviews, the facility failed to prevent significant medication errors when Nurse #1 administered medications to Resident #23 prescribed for Resident #240 which included Eliquis (used to prevent blood from clotting), buspirone (used to treat anxiety disorders), gabapentin (used to treat epilepsy), isosorbide (used to treat high blood pressure), metoprolol (used to treat high blood pressure), spironolactone (used to treat high blood pressure), citalopram (used to treat depression). In addtion Resident #4 was administered medications prescribed to Resident #191 which included Aricept (used to treat dementia), Lexapro (used to treat depression) and Tramadol (used to treat pain). This deficient practice affected 2 of 8 residents whose medications were reviewed (Residents #23 and #4). The findings included: 1. Resident #23 was admitted to the facility on [DATE]. A review of the physician orders dated July 2024, scheduled for 9:00 AM, revealed Resident #23 had orders for: - Ingrezza 40 milligrams (mg) by mouth one time a day for tardive dyskinesia. - Sertraline (an antidepressant medication) 50 mg, give1.5 tablets, by mouth one time a day related to generalized anxiety disorder and major depressive disorder. - alprazolam (a benzodiazepine-central nervous system depressant medication) 0.25 mg tablet by mouth two times a day for anxiety. - Benztropine Mesylate (an anticholinergic medication) 0.5 mg by mouth every 12 hours for EPS (extrapyramidal signs or muscle stiffness/rigidity). - Depakote Delayed Release Sprinkle (an anticonvulsant and mood stabilizer medication) 125 mg, give 2 capsules by mouth three times a day for schizophrenia. -Risperdal (an antipsychotic medication) 0.5 mg tablet, give 1.5 tablets, by mouth two times a day related to paranoid schizophrenia. The annual Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #23 had severely impaired cognition. Resident #240 was admitted to the facility on [DATE]. A review of the physician orders dated July 2024, scheduled for 9:00 AM, revealed Resident #240 had orders for: - Apixaban (an anticoagulant medication) 2.5 mg by mouth two times a day related to atrial fibrillation. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Buspirone (an anxiolytic medication) 10 mg HCl by mouth three times a day related to generalized anxiety disorder. -Gabapentin (an anticonvulsant medication) 300 mg by mouth two times a day related to polyneuropathy. Do not crush or chew. - Isosorbide Mononitrate Extended Release (a nitrate with vasodilating properties medication) 30 mg by mouth one time a day for hypertension. Do no crush or chew. - Metoprolol Tartrate (a beta blocker medication) 0.5 tablet to = 12.5 mg by mouth two times a day related to primary hypertension. -Spironolactone (used to treat hypertension) 25 mg by mouth one time a day for Hypertension. -Citalopram Hydrobromide (an antidepressant medication) 10 mg by mouth one time a day related to generalized anxiety disorder and major depressive disorder. A progress note written by Nurse #1 dated 07/30/24 , indicated that Resident #23 had received the wrong morning medications. Nurse Practitioner #1 was notified and stated to monitor Resident #23 for 48 hours. Resident #23 had not shown any affects from the medications that were given. A phone interview occurred with Nurse #1 on 12/18/24 at 5:40 PM. Nurse #1 stated she no longer was employed at the facility but recalled the details of the medication error that occurred with Resident #23 on 07/30/24. She indicated that she was a new nurse, did not have very much training and did not know the residents well. She stated that on the morning of 07/30/24 she was preparing medications for Resident #23 but inadvertently used Resident 240's medications. Nurse #1 explained when she administered the crushed medications to Resident #23 that the resident stated, [NAME]! and that's when she suspected she made the error. Nurse #1 indicated she did not know how it happened, but she realized it immediately and notified the unit manager and the Director of Nursing. Nurse #1 went on to say she notified the Nurse Practitioner of the error, and she received new orders to monitor Resident #23. She also explained Resident #23's family member was in the room at the time, but she did not inform her of the medication error. Nurse #1 stated she was new and was unsure what the steps were after notifying the NP on 7/30/24. She further explained that she did not have a preceptor with her on 07/30/24 and she was alone on the medication cart. Review of the Nurse Practitioner (NP) #1's acute visit note dated 07/31/24 revealed Resident #23 was seen due to reports of receiving the wrong medication on 07/30/24. Nurse #1 informed the NP that Resident #23 received the following significant medications in error: Eliquis 10mg, buspirone 10mg, gabapentin 300mg, isosorbide 30mg, metoprolol 25mg, spironolactone 25mg, and citalopram 10mg. The NP noted essentially, Resident #23 ended up receiving Resident #240's morning medications instead of her prescribed meds. During the phone call on 07/30/24 orders included for vital signs to be checked every six hours x 48 hours, hold Resident #23's morning and afternoon routine medications and resume her regular scheduled medications at bedtime. The nurse was also instructed to monitor for signs and symptoms of increased bleeding, bruising, hypo/hypertension, altered mental status and increased drowsiness x 48 hours. There were no reports of adverse effects from medications received on 07/30/24. Will continue to monitor of any adverse effects, today she was hemodynamically stable and in no acute distress. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview occurred with the family member on 12/18/24 at 5:15 PM and she stated she was at the facility on 07/30/24 when the medication error had occurred, however no one told her it had occurred at that time. She explained that Nurse #1 administered Resident #23's morning medications in her presence. She further explained Nurse #1 came back to the room a few minutes later and got Resident #23's vital signs (VS) and the family member stated, oh you're getting her VS? The nurse only said yeah, they want me to get them, but never said why she was getting them. An interview occurred with the Medical Director on 12/18/24 at 1:10 PM and he stated he did not recall being notified of the medication error for Resident #23. He explained he felt the medication error was significant due to the medications that Resident #23 had received. He also stated he had not heard that the medications had caused any harm to Resident #23. A phone interview occurred with Nurse Practitioner (NP) #1 on 12/18/24 at 5:08 PM and she stated she would consider the medication error that occurred on 07/30/24 with Resident #23 a significant medication error. She explained she gave orders to monitor Resident #23's vital signs and monitor for signs and symptoms of bleeding. NP #1 further stated she evaluated Resident #23 the following day and she had no adverse outcomes from the medication error. The Administrator was interviewed on 12/19/24 at 9:34 AM and explained that during a medication pass, Resident #23 was given the incorrect medications. Nurse #1 prepared the wrong medications and administered them to Resident #23. The Administrator stated that Nurse #1 no longer was employed at the facility. The Administrator stated the staff did everything they should have done after the incident occurred. The Administrator stated that nursing staff should have provided the correct medication to the correct resident. 40197 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, congestive heart failure and diabetes type 2. Review of Resident #4's August 2024 physician orders included the following morning medications: - Clozaril (an antipsychotic medication) 50 milligrams (mg) give 1.5 tablet by mouth twice a day for paranoid schizophrenia. - Haldol (an antipsychotic medication) injection 5 mg per milliliters (ml). Inject 2 ml intramuscularly every shift for agitation. - Fentanyl patch (an opioid) 12 micrograms per hour. Apply one patch transdermally every 72 hours. The quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #4 had moderately impaired cognition. Resident #191 was admitted to the facility on [DATE]. A review of the August 2024 physician orders for Resident #191 included the following morning medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Woods Nursing and Rehabilitation Center	33426 Old Salisbury Road Box 1250 Albemarle, NC 28002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Aricept 5 mg one tablet by mouth every morning. - Lexapro (an antidepressant) 10 mg one tablet by mouth every morning. - Tramadol (used to treat pain) 25 mg one tablet by mouth twice a day. An incident report dated 8/24/24 written by Nurse #2 revealed Resident #4 had received the wrong morning medications by Nurse #1. The incident was reported to the Medical Director at 10:31 AM and the responsible party (RP) at 7:31 PM. A nursing progress note dated 8/24/24 indicated that Resident #4 had received the wrong morning medications. The physician was notified to and stated to monitor Resident #4 for 24 hours. Resident #4 had not shown any affects from the medications that were given. A phone interview occurred with Nurse #1 on 12/18/24 at 5:40 PM. Nuse #1 explained that she no longer was employed at the facility but recalled the details of the medication error that occurred with Resident #4 on 8/24/24. She stated that on the morning of 8/24/24 she was preparing medications for Resident #4 but inadvertently used Resident 191's medications. She stated that Nurse #2 was her preceptor as she was a new nurse and had asked her if Resident #4 had received her Haldol injection. That was when it was identified that Resident #4 had received Resident #191's medications in error. Nurse #1 went on to say that Nurse #2 notified the physician and RP of the error. On 12/18/24 at 10:31 AM, an interview occurred with Nurse #2. She explained that Nurse #1 was a new nurse and that she was precepting her on 8/24/24. She stated that she asked Nurse #1 if Resident #4 had received her Haldol injection that morning and Nurse #1 responded that Resident #4 wasn't ordered an injection. That prompted her to begin asking more questions and found out that Nurse #1 had given Resident #191's medications to Resident #4. She went to assess Resident #4 who was at her baseline and stable, then notified the physician and RP. Nurse #2 stated she should have been standing right next to Nurse #1 when she was preparing the medications. An interview occurred with the Medical Director on 12/18/24 at 1:00 PM and stated he was notified of the medication error, but didn't feel that any of the medications that were received by Resident #4 would have caused any harm. The Administrator was interviewed on 12/19/24 at 9:34 AM and explained that during a medication pass, Resident #4 was given the incorrect medications. Nurse #1 was being precepted by Nurse #2 but was standing away from the medication cart when Nurse #1 prepared the medications for Resident #4. Nurse #1 prepared the wrong medications and administered them to Resident #4. The Administrator stated that Nurse #1 no longer was employed at the facility. The Administrator further stated that Nurse #2 immediately notified the physician, assessed the resident and notified the RP following the incident. The Administrator stated the staff did everything they should have done after the incident occurred. She added that Nurse #2 should have been monitoring the medications that were being prepared by Nurse #1 closer. The Administrator stated that nursing staff should have provided the correct medication to the correct resident.