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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345416	A. BUILDING _____ B. WING _____	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	142 BERMUDA VILLAGE DR. ADVANCE, NC 27006

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to notify the physician of a change in	F 157	F 157 Resident #11 was discharged from facility on 5/19/13, however any resident having the potential to be affected by the same deficient proctice will be identified on their admission. Admission assessments documenting skin risk potential are in place (ie, MDS, 5-day - 14-day -30-60-90 day). Records kept in Resident files and monitored by DON. The medical records of current residents has been reviewed to identify potential risk for facility acquired pressure ulcers. No new pressure areas were accessed and no new residents have been admitted since survey. A system is in place whereas Bermuda Village communicates with each shift and utilizes 1 24 hour nursing report form that allows for notable changes to be identified. Each charge nurse for each shift signs this report and it is monitored by the DON. This record is daily and ongoing and kept in facility for one year. Notable changes are transferred to nurses notes on resident files as daily documentation. A faxed report is sent to physician with follow up phone calls at time of incident. Drs. Offices are preferring fax communication.	7-24-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Ellen Foley RN	Director of Nursing	7-24-2013

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.

Received Black Mountain SRO
JUL 25 2013
by: PAM

Original signature 7-16-13 mh

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F 157	Continued From page 1 a resident's condition for 1 of 3 sampled residents with pressure ulcers (Resident #11). The findings included: Resident #11 was admitted to the facility on 04/10/13 with diagnoses that included a stage 2 pressure ulcer, acute respiratory failure, right hemiparesis and weakness. The admission Minimum Data Set (MDS) dated 04/23/13 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for decision making was totally dependant on staff for activities of daily living (ADL) and had an unhealed stage 2 pressure ulcer. Review of Resident #11's medical record revealed a skin assessment sheet. An entry made by Nurse #1 dated 05/07/13 specified that the Resident had a new open area, "Stage 2 ulcer about 2 centimeters (cm) in diameter." Further review of the medical record revealed no documentation that the physician was notified of the new pressure ulcer. On 06/26/13 at 1:15 PM Nurse #1 was interviewed and reported that she was trained to notify the physician to obtain orders for treatment when a resident developed a pressure ulcer. She stated that she would notify the physician for treatment orders the same day when the pressure ulcer was indentified to prevent the area from getting worse. Nurse #1 explained that during a skin assessment she identified Resident #11 had a newly developed stage 2 pressure ulcer on the back of her leg. She stated that she	F 157	On discovery of new facility acquired pressure ulcer, the charge nurse will fax the physician immediatly. The change nurse will follow up with a phone call to the physicians office along with the fax or immedicatly after to acknowledge the receipt of the information provided. The charge nurse is to ask for expected response time to this fax or phone call from the answering party at the physicians office. Our expectation would be to the hear from the doctors office by the end of their business day and state as such in the follow up phone call. Repeat calls may be necessary and speaking with the doctor on call may occur. Nurses are to document correspondence in resident charts and communicate with each shift as designated. The communication of the process will be done by charge nurses to each other daily. Instruction of the new system is to be preformed by the Director of Nursing monitoring the medical records to ensure that changes in residents conditions were properly identified and communicated to physician will be done by the Director of Nursing on going.	7-24-13

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F 157	Continued From page 2 did not notify the physician because she decided to monitor the area and if it did not improve then she would have notified the physician. On 06/26/13 at 1:20 PM the Director of Nursing (DON) was interviewed and stated that if a nurse identified a newly developed pressure ulcer it would be reasonable for the nurse to monitor the area for 24-48 hours and if there was no improvement then she'd expect the nurse to notify the physician. Resident #11's physician was not able to be reached for an interview. On 06/26/13 at 2:15 PM the facility's Medical Director was interviewed on the telephone and stated that he would expect the facility to notify the physician immediately to initiate treatment for any newly developed pressure ulcer. He added that there would not be any exceptions.	F 157	A memo has been issued to staff reviewing existing "tools" in place followed by inservice. Calling physicians after survey reveals their expectation to be notified immediately on a change of status to initiate treatment for any newly developed pressure ulcer. Bermuda Village has weekly Care Plan meeting with the Rehab Director, Director of Social Services, DON, Nurse Coordinator and Activity Director. These meetings have often been most effective in recognizing needs, changes and implementing corrective practices. Discussion and trends are submitted to Quality Assurance that meets quarterly.	
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that discharge summaries, including a recapitulation of the resident's stay	F 283	F283 Resident #2 was discharged 2/24/23, Resident #12 was discharged 6/18/13. No recapitulation of stay was done. No residents have been discharged since survey/ When the facility anticipates discharge of a Resident, there will be a discharge summary that includes a recapitulation of the Residents' stay and a final summary of the Residents' status. The new form is titled RECAPITULATION OF RESIDENT STAY AND DISCHARGE SUMMARY.	7-24-13

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F 283	Continued From page 3 and final summary of the resident's status, were completed for 2 of 3 sampled residents discharged from the facility (Resident #2 and #12). The findings included: 1. Resident #2 was admitted to the facility on 1/14/13 and discharged on 2/24/13. His medical record was reviewed in its entirety and no discharge summary was found. On 06/26/13 at 3:40 PM the Director of Nursing (DON) was interviewed and reported that the facility did not document a recapitulation of stay for discharged residents that included the resident's health status at the time of discharge. She stated this was because she was unaware of the requirement. The DON explained that she tried to document a discharge narrative that outlined the resident's discharge plans. 2. Resident #12 was admitted to the facility on 04/23/13 and discharged on 06/17/13. His medical record was reviewed in its entirety and no discharge summary was found. On 06/26/13 at 3:40 PM the Director of Nursing (DON) was interviewed and reported that the facility did not document a recapitulation of stay for discharged residents that included the resident's health status at the time of discharge. She stated this was because she was unaware of the requirement. The DON explained that she tried to document a discharge narrative that outlined the resident's discharge plans.	F 283	It is now available in anticipation of discharges. The form includes diagnosis on admission, course of treatment relevant to discharge or transfer, recently lab findings relevant to discharge, and condition on discharge. There are sections available for rehabilitation, social services, activities and dietary summaries. Current Resident census is reviewed weekly at IDCP meeting. Present at weekly meeting is the Rehabilitation Director, Activities Director, MDS Coordinator, Social Services Director, Nursing Director and Staff member. Recapitulation of stay will be discussed of pending discharge Residents. 7-14 days prior to planned discharge the Resident and/or family representative will be notified. The new form is to be utilized and reviewed with Resident and or representative with signature and date acknowledging same. Notification and overseeing of process will be monitored by Social Services Director during that 7-14 day time period prior to anticipated discharge. Discharge summaries to be part of Care Plan Section of Residents medical record and kept in facility for 7 years. Discharged Residents and status at discharge will be presented to Quality Assurance Committee that meets quarterly.	7-24-13
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 4 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review the facility failed to treat facility acquired pressure ulcers timely for 2 of 3 sampled residents with pressure ulcers (Resident #11 and #12). The findings included: 1. Resident #11 was admitted to the facility on 04/10/13 with diagnoses that included a stage 2 pressure ulcer, acute respiratory failure, right hemiparesis and weakness. A document titled "Norton Plus Pressure Ulcer Scale" dated 04/10/13 specified the resident was at high risk for developing a pressure ulcer. The admission Minimum Data Set (MDS) dated 04/23/13 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for decision making was totally dependant on staff for activities of daily living (ADL) and had an unhealed stage 2 pressure ulcer. Resident #11 had a care plan for pressure ulcers	F 314	F-314 Resident #11 discharged 5/10/13, resident #12 discharged 6/18/13 current resident have no community acquired pressure ulcers after audit of charts (review of nursing documentation, MDS assessments, nursing oral and written commmunication over 24 hour periods. Audit done by DON regularly. Identification assessments done at admission helps define the initial care approaches for the at risk Resident. Interventions are implemented promptly to attempt to prevent pressure ulcers. The assessment tools will identify skin conditions existing pressure sores and areas of skin that are at risk. Several skin assessment tools are used upon admission of a Resident @ Bermuda Village.	7-24-13

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F 314	Continued From page 5 dated 04/30/13 outlining interventions to prevent further skin breakdown that included pressure reducing mattress, change position every 2 hours and others. Review of Resident #11's medical record revealed a skin assessment sheet. An entry made by Nurse #1 dated 05/07/13 specified the Resident had a new open area, "Stage 2 ulcer about 2 centimeters (cm) in diameter." Further review of the medical record revealed no documentation that treatment was initiated on 05/07/13. On 05/10/13 Resident #11 was discharged to the hospital. On 06/26/13 at 1:15 PM Nurse #1 was interviewed and reported that she was trained to notify the physician to obtain orders for treatment when a resident developed a pressure ulcer. She stated that she would notify the physician for treatment orders the same day when the pressure ulcer was identified to prevent the area from getting worse. Nurse #1 explained that during a skin assessment she identified Resident #11 had a newly developed stage 2 pressure ulcer on the back of her leg. She stated that she did not initiate treatment to the area. She added that she thought she had wrapped the area with a dry dressing to monitor it for a couple of days to see if it improved. She stated that if the area had not improved she would have called the doctor for an order to initiate treatment. On 06/26/13 at 1:20 PM the Director of Nursing (DON) was interviewed and stated that if a nurse identified a newly developed pressure ulcer it would be reasonable for the nurse to monitor the	F 314	Direct observation and communication with Resident is our primary source of information. The admission process is conducted by the staff nurse in charge at time of arrival. Skin assessments and tools are completed by RN on duty and closely monitored by DON. On going approaches are outlined in Residents' Care Plan and reviewed and evaluated every 30 days or sooner for significant change or altered Plan of Care. Care planning is coordinated by interdisciplinary team and monitored by DON. Tools used include skin assessments, Norton & Braden Scales, nursing notes, skin diagram & MDS/RAI, Skin Risk assessment form. Care plan for potential risk for pressure ulcer and existing ulcers always include notification of Primary Physician in timely manner - which is "immediate" in an effort to receive prompt treatment. The facility plan is to complete assessments on admission completion by RN charge nurse and monitored by DON -kept in medical file. Updated forms are done quarterly or with significant change. (MDS evaluation 5 day 14day 30day, 60day, 90 day).	7-24-13

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F 314	Continued From page 6 area for 24-48 hours and if there was no improvement then she ' d expect the nurse to notify the physician for treatment orders. Resident #11's physician was not able to be reached for an interview. On 06/26/13 at 2:15 PM the facility's Medical Director was interviewed on the telephone and stated that he would expect the facility to notify the physician immediately to initiate treatment for any newly developed pressure ulcer. He added that there would not be any exceptions. 2. Resident #12 was admitted to the facility on 04/23/13 with diagnoses that included history of skin breakdown, pneumonia, anemia and others. The admission Minimum Data Set (MDS) dated 05/06/13 specified the resident had mild cognitive impairment, required limited assistance with activities of daily living (ADL) and was at risk for skin breakdown but was not admitted with any pressure ulcers. Resident #12's care plan for skin breakdown dated 05/13/13 was reviewed and revealed interventions to prevent breakdown included monitor skin and report changes in a timely manner. Review of Resident #12's included a skin assessment sheet. Further review of the skin assessment sheet revealed a nurse's entry made by Nurse #1 dated 06/07/13 that specified the resident had a "small stage 2 ulcer." A corresponding nurse's entry made by Nurse #1 dated 06/07/13 specified that cream was applied to the area. Review of the physician's orders revealed that no treatment was ordered for the	F 314	In an effort to put in place a change to ensure a non repeatable deficient practice, the nursing communication board used to report one shift to another will include a red dot system that identifies potential risk for skin break down. This alerts nurses to assess to reassess to notify physician and to document in resident file. Monitoring is done by charge nurses on each shift that are aresponsible for follow through and communication. Overall monitoring of system effectiveness by DON weekly. Skin observations done daily - bathtime, dressing, toileting and communicated among staff. 24 hour report completed each shift signed by charge nurse and monitored weekly by DON; addresses notable change and daily/weekly documentation. Noted that physicians polled expect immediate notification to address skin conditions for recommendation and treatment. Memo and Inservice presented to staff outling Bermuda Village Health Care center procedure for facility acquired pressure ulcers. Finds presented to Quality assurance Committee that meets quarterly.	7-24-13

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F 314	Continued From page 7 stage 2 pressure ulcer. Further review of the medical record for Resident #12 revealed on 06/11/13 the physician was notified of the stage 2 pressure ulcer and ordered treatment. On 06/17/13 Resident #12 was discharged from the facility. On 06/26/13 at 1:15 PM Nurse #1 was interviewed and reported that she was trained to notify the physician to obtain orders for treatment when a resident developed a pressure ulcer. She stated that she would notify the physician for treatment orders the same day when the pressure ulcer was identified to prevent the area from getting worse. Nurse #1 explained that during a skin assessment she identified Resident #12 had a newly developed stage 2 pressure ulcer on his buttock. She stated that for stage 2 pressure ulcers the facility used physician ordered Tegaderm (medical dressing) that covered and protected wounds. She stated that in the case of Resident #12 rather than notifying the physician she used barrier cream to treat the area and decided to monitor the area for a couple of days to see if it improved. On 06/26/13 at 1:20 PM the Director of Nursing (DON) was interviewed and stated that if a nurse identified a newly developed pressure ulcer it would be reasonable for the nurse to monitor the area for 24-48 hours and if there was no improvement then she'd expect the nurse to notify the physician for treatment orders. She added that for stage 2 pressure ulcers the nurses would need to obtain physician orders to initiate	F 314		

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F 314	Continued From page 8 treatment and confirmed that barrier cream was not used to treat stage 2 pressure ulcers. On 06/26/13 at 2:15 PM Resident #12's physician was interviewed on the telephone and stated that he would expect the facility to have notified him on 06/07/13 of the Resident's stage 2 pressure ulcer. He added that barrier cream was not effective in treating a stage 2 pressure ulcer.	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep air circulation vents clean and free of debris and mold in the kitchen. The findings included: On 06/25/13 at 11:35 AM an initial tour was made of the kitchen with the Food Service Director (FSD). The tour included observations of the 4 air circulation vents in the ceiling positioned directly above the food production area. The observation of the 4 vents revealed black debris and water condensation. Droplets of water were	F 371	F371 The 4 air circulating air vents and all remaining air vents have been replaced and air diverters installed to direct air away from food and or food production areas to ensure a safe and clean operation.. All filters have been replaced in air conditioning units to increase air flow. The duct work behind the vents has been cleaned with moldicide and inspected by a heating and air conditioning company.	7-24-13

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F 371	Continued From page 9 observed to dripping from the black debris on the vents into the food production area. Additionally, during the observation the lunch meal service was observed and revealed the lunch meal was plated and left uncovered directly below one of the vents in use. The vent was noted to have heavy growth of black debris being blown into the food left uncovered. On 06/25/13 at 11:40 AM the FSD was interviewed and stated that the air vents were cleaned by maintenance but he was unaware of the last time they were cleaned. He added that he had observed the black debris but had not reported the dirty vents to maintenance for cleaning. The FSD was able to wipe off the black debris with his hand and stated he thought the debris was mold because of the water condensation. On 06/26/13 at 10:40 AM the Maintenance staff member assigned to oversee the kitchen was interviewed and reported that he was unaware of concerns with dirty air vents in the kitchen. He added that he tried to clean them monthly and reported that he last cleaned them on 05/15/13. He confirmed that he had not cleaned them in the month of June because he hadn ' t had time. He stated that he would expect the Food Service Director to report any concerns with the cleanliness of the air vents right away. On 06/26/13 at 10:50 AM the Maintenance staff member observed the 4 air vents on the kitchen and stated they needed to be replaced due to the extent of the debris on them.	F 371	A new monthly check list named "Kitchen air vents" has been posted in the kitchen to inspect and clean all vents to ensure that the deficient practice will not occur. Maintenance personnel is responsible to maintain the monthly check list, to monitor, identify and rectify any problem. The Director of Maintenace assumes the responsibility for the accuracy of the check list. Kitchen and maintenance staff have been inserviced. Visual observation will be made by the kitchen staff for black debris and water condensation on vents. Any findings by the kitchen staff will be reported to Maintenance for immediate response. Findings will be reported to the Quality Assurance Committee that meets quarterly.	7-24-13