STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	C 05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, facility records and staff interviews, the facility failed to clean the heating and air conditioning systems in twelve out of twelve of the residents' rooms observed (room numbers 202, 203, 204, 205, 405, 407, 408, 501, 504, 507, 508 and 601) . These rooms were located on the 200, 400, 500 and 600 hall. The facility also failed to clean oxygen concentrator filters in four portable oxygen concentrators. Findings Included: On 5/4/15 at 10:20am during the initial tour of the facility, room numbers 202, 203, 204, 205, 405, 407, 408, 501, 504, 507, 508 and 601 were found to have dust, dirt, and debris such as large dust balls, large pieces of black dirt, and food crumbs in the grill of the Thru the Wall Air Conditioner Units and dusty filters. Additionally, four oxygen concentrator filters were found to have significant amount of dust build up on them. The concentrators were in use and located at the nursing station where residents were sitting. These concentrators were used by residents in room numbers 508B, 504, 405 and 601. An interview with the Maintenance Director on 5/7/15 at 12:09pm revealed that the nurses were responsible for cleaning the filters on the oxygen concentrators. Further discussion with the	F 253	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F253 Housekeeping & Maintenance Services Corrective Action: The air conditioners (A/C) located in rooms 202,203,204,205,405,407,408,501,504,507,508, and 601 were cleaned by the Maintenance Director on 5/15/15. The Concentrator Oxygen filters in rooms 508B, 504,405, and 601 were cleaned on 5/7/15 by the Dir. of Nursing(D.O.N.)and the Unit Director. Identification of other residents who may be involved with this practice: All A/C units and residents using oxygen have the	5/17/15

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

Electronically Signed | 05/22/2015

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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F 253	Continued From page 1 Maintenance Director revealed that the Thru the wall Air Conditioner Units should be cleaned quarterly. The Logbook Documentation revealed that the last time the units were clean was on January 23, 2015. According to the facility's policy, the units next cleaning should have been in April, 2015. An observation in room numbers 507, 508, 601, 407, 408, and 405 with the Maintenance Director on 5/7/15 at 12:25pm revealed the Thru the wall Air Conditioner units in these rooms were noted to have dust, dirt and debris in the grills and filters. An interview with the Unit Coordinator on 5/7/15 at 12:20pm revealed it is the facility's policy that the nurses on the 3rd shift were responsible for cleaning the oxygen concentrator filters, changing the oxygen tubing and humidified bottles weekly on Tuesdays. The Unit Coordinator reported that the oxygen tubing and humidified bottles were changed but was not sure if the filters were cleaned. During an observation with the Unit Coordinator on 5/7/15 at 12:40pm, it was noted that the 4 oxygen concentrators in question were noted to have the same significant amount of dust on the filters as noted on 5/4/15. During an interview with the Director of Nursing (DON) on 5/7/15 at 2:30pm, she stated that it was her expectation that the oxygen filters be cleaned weekly. The DON further added that the filters were old and they do get cleaned, they just don't look it. Additionally, the DON reported that it was her expectation that the Thru the Wall Air Conditioner Units were cleaned on a quarterly	F 253	potential to be affected. On 5/15/15 all AC units and filters were checked for dirt, debris and dust. This audit revealed 15 A/C units requiring cleaning which was completed 5/15/15. All residents using oxygen and concentrators in use were inspected for cleanliness on 5/7/15. This inspection revealed that no additional concentrator filters required cleaning. Systemic changes: Maintenance developed the A/C Unit Inspection Form for review of the A/C units to include filter checks which will be documented and completed to assure compliance. Oxygen filters will be cleaned and documented on the MAR weekly. All nurses, full and part time, were in-serviced 5/7/15-5/17/15 by the D.O.N. on the use of oxygen and care of concentrators including filters. Any in-house staff who did not receive in-service training will not be allowed to work until training has been completed. Monitoring: To ensure compliance, the Unit Director/designee will observe oxygen concentrator filters for cleanliness using the O2 Concentrator Filter Audit with 3 residents and MAR documentation will be reviewed to verify oxygen filters are clean. This will be done five times per week for four weeks and then monthly for three months. Identified issues will be reported to the D.O.N. or Administrator for appropriate action. A/C units will be checked weekly for cleanliness of units and filters by the Maintenance Director	

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F 253	Continued From page 2 basis according to the facility's policy.	F 253	weekly for four weeks and monthly for three months. Any issues will be reported to the Administrator for follow up. Compliance will be monitored and the auditing program reviewed at the weekly QA meeting attended by the D.O.N., Wound Nurse, MDS Nurse, Unit Director,Support Nurs, Dietary Manager, Maintenance Director,Soc. Serv. Dir, and Administrator. Date of Completion: 5/17/15	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, records review, staff and family interviews, the facility failed to apply the splint for a left hand contracture as ordered by the physician (MD) and as indicated on the care plan for 1 of 1 resident (Resident #92). Findings included: Resident #92 was admitted on 12/11/14 with diagnoses including arthritis, Alzheimer disease, dementia and depression. The most recent Minimum Data Set (MDS), dated 3/10/15,	F 318	F318 Increase/Prevent Decrease in Range of Motion Corrective action: Resident # 92 was discharged on 5/7/15 with splint applied properly. C.N.A's including # 1 and # 2 were in-serviced and educated 5/7/15 to 5/17/15. Identification of other residents who may be involved with this practice: All residents requiring assistance with ADL's	5/17/15

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F 318	Continued From page 3 revealed the resident was severely cognitively impaired. The resident required extensive assistance with such activities of daily living (ADL) as mobility and eating, total assistance with dressing, bathing and toileting. During an interview on 5/5/15 at 3:45 PM, the rehabilitation director stated that the resident was discharged from physical therapy (PT) and occupational therapy (OT) on 4/15/15 with recommendation to use the splint daily for 4-5 hours or as long as tolerated. The restorative aides received training from PT staff and were responsible for splint application. Record review revealed the MD order, dated 4/16/15, to place the left hand splint daily, in afternoons for four-five hours. Monitor the skin condition for signs and symptoms of breakdown. The Plan of Care for resident #92, dated 4/20/15, indicated that the resident had an ADL self care performance deficit and left hand contracture. The goal was to improve current level of function in bed mobility, transfer, eating, dressing, toilet use and personal hygiene. The interventions were to ensure splint was in place on the left hand for four-five hours during the day, to observe the skin before and after splint application and to report the skin breakdown to the nurse. Record review of the care area tasks report for 4/1/15 - 5/5/15 revealed three documented entries of splint application. The rest of the report data was blank. During an observation on 5/4/15 at 10:50AM, the resident was in bed, her left hand was contracted with all the fingers in full flections position, but no hand splint was applied. The left hand was observed clean, with no odor or pressure signs. The splint was observed laying on the nightstand.	F 318	through a restorative or functional maintenance type program have the potential to be affected. An audit of all residents requiring assistance with ADL's through a program was completed on 5/5/15 by the MDS Nurse to ensure the program with instructions was present in the computer system and firing appropriately to the C.N.A's per the care plans. The audit revealed one resident (#92) on splints and 9 others in functional restorative nursing. These residents' care plans were reviewed 5/5/15 to ensure they reflect current ADL needs with no issues being identified. Review of all tasks firing for documentation revealed that those fired to the restorative C.N.A were not firing to the other C.N.A's when restorative was not in the building. Corrections were completed on 5/5/15 so that all ADL tasks involving functional restorative nursing and Range of Motion are firing to the C.N.A's for documentation. Systemic changes: On 5/5/15 - 5/17/15 all nursing staff RN's, LPN's, and C.N.A.'s full and part time were in-serviced by the D.O.N. on ADL needs such as splints, ambulation, wheel chair mobility, range of motion and documentation requirements in the Point of Care computer system. This included a review of the policies and procedures for nursing maintenance and restorative type programs. Any in-house staff members who did not receive in-service training will not be allowed to work until training has been completed. When any resident is identified with an ADL need, nursing will document	

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F 318	Continued From page 4 The resident was unable to answer the questions, related to the splint, based on her cognitive impairment. During an observation on 5/4/15 at 11:30 AM, the resident was observed in wheelchair in the hallway. Her left hand was observed without a splint. During an observation on 5/4/15 at 2:40 PM, the resident was observed in bed, without a splint on her left hand. The splint was observed on the nightstand near the bed. During an observation on 5/5/15 at 9:30 AM, the resident was observed in her wheelchair in activity room, without a splint on her left hand. During the family interview on 5/4/15 at 2:48 PM, the family members of resident #92 stated that they were visiting the resident at the time of breakfast, lunch and dinner every other day and never observed the splint on the resident ' s hand. The family members indicated that the splint was always observed on the nightstand. During an interview on 5/5/15 at 10:15 AM, nurse aide #1 stated that she was aware of resident #92 required having the splint application every morning for 4-5 hours due to her left hand contracture. The restorative aide was responsible for applying the splint. The resident could not apply or remove the splint on her own. The nurse aide #1 did not work weekends and was not sure if the resident #92 received the splint to her left hand on weekends. During an interview on 5/5/15 at 10:30 AM, the restorative aide stated that she was responsible to apply the splint every morning, remove it after few hours and document it in computer system. She was uncertain for how long the splint should be applied. The aide also mentioned: " When we were busy, we could miss the splint application " .	F 318	concerns and refer to the Restorative Nurse to be placed in the appropriate restorative functional maintenance type program with identified goals and methods and schedule established. The care plan is updated and fired to the C.N.A through Point of Care documentation. Monday through Friday the Unit Director/Support Nurse will review recommendations for ADL programs to ensure they are care planned and Point of Care computer system updated to require documentation by the C.N.A. Any issue will be reported to the D.O.N. with appropriate follow up. This will be reviewed at the daily clinical meeting Monday through Friday which includes the D.O.N., Unit Director, Support Nurse, MDS nurse, Wound nurse and other clinical staff as needed. Monitoring: To ensure compliance the Unit Director/designee will observe C.N.A's or conduct interviews with residents using the Functional Maintenance Audit Tool with three residents to verify that ADL services were provided. This will be done five times a week for four weeks and then monthly for three months. Identified issues will be reported and ongoing auditing reviewed at the weekly QA meeting attended by the D.O.N., Unit Director, Support Nurse, MDS Nurse, Dietary Manager, Maintenance Director, Activities Dir, Soc. Serv. Dir,, and Administrator. Date of completion: 5/17/15	

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F 318	Continued From page 5 On the first shift all the aides could help with splint application because they were trained in that procedure. During an interview on 5/5/15 at 10:20 AM, the MDS nurse stated that the staff was responsible to document the splint application in computer system every time the task was performed. During an interview on 5/5/15 at 3:30 PM, nurse aide #2, on 500 hall, where the room of Resident #92 was located, stated that she never applied splint to the resident ' s hand. During an interview on 5/6/15 at 11:10 AM, the nurse #1 stated that she was responsible for transferring the order of splint application from the PT department to restorative book. This book was available for all aides who worked with resident #92. During an interview on 5/5/15 at 3:40 PM, the director of nursing (DON) stated that her expectation was for the staff to follow the MD order for splint application, including the frequency and duration of wearing splint. The restorative aides and the floor aides were responsible for splint application, according to daily assignment.	F 318		