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 _____	09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	142 BERMUDA VILLAGE DRIVE BERMUDA RUN, 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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		10/3/16

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal

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

Electronically Signed | 09/28/2016

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F 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post contact information for individuals wishing to file a complaint. The findings included: On 09/08/16 at 9:13 AM observations were made of the facility's centrally located bulletin board. Observations of the bulletin board did not included contact information for individuals wishing to file a complaint with the State agency. Observations were made throughout the facility and the contact information was unable to be located. On 09/08/16 at 1:56 PM the Social Services Coordinator (SSC) was interviewed and explained she was new in her role but was responsible for maintaining the facility's bulletin board for required posting of information. She was not aware the contact information for filing a complaint was missing. She explained that they had residents that removed papers and that it might have been taken down by accident. On 09/08/16 at 2:00 PM the Assistant Administrator was interviewed and reported the contact information should be posted.	F 156	1- Complaint phone number list was replaced on board during the survey when issue was brought to our attention. 2- To ensure that the phone list remains listed it has been placed in our shadow box which is out of reach from residents but still visible. 3- Social Services coordinator is responsible to ensure phone numbers remain in shadow box by checking weekly 4- DON to check behind the Social Services Coordinator to ensure information is posted according to the following schedule: a. Month One- Weekly b. Month Two- Bi-Weekly c. Month Three to Six- Monthly Audit will be reviewed during the monthly QA meeting. This will be an on-going process.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by	F 167		10/3/16

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F 167	Continued From page 3 Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide results of the most recent survey results conducted by Federal and State Surveyors. The findings included: On 09/08/16 at 9:10 AM the facility's "survey results" notebook was reviewed. The last survey event was dated 09/16/15. Review of the facility's survey history revealed an investigation dated 04/06/16. On 09/08/16 at 1:58 PM the Assistant Administrator was interviewed and reported all survey results were to be posted for review. She was not sure if the Social Service Coordinator (SSC) knew to have all survey results available. On 09/08/16 at 2:02 PM the SSC was interviewed and did not know results from a survey were not	F 167	1- April 2016 Complaint Survey was posted on the board when the issue was brought to our attention. 2- To ensure that survey remains posted it has been placed in our shadow box which is out of reach from residents but still visible. 3- Social Services Coordinator is responsible to ensure that the most recent survey remains in the shadow box by checking it weekly. 4- DON will check behind the Social Services Coordinator to ensure information is posted according to the following schedule a. Month One- weekly b. Month Two- Bi-weekly c. Month Three to Six- Monthly Audit will be reviewed during the monthly QA meeting. This will be an on-going process.	

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F 167	Continued From page 4 included in the "survey notebook."	F 167		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a plan of care with measurable goals and interventions for 1 of 1 resident receiving diuretic and anticoagulant medications (Resident # 27). The findings included:	F 279	1- Resident #27 care plan was reviewed and corrected on September 9th 2016 2- DON and MDS Coordinator will complete an audit of all residents care plans by October 6th 2016 to ensure that all care plans reflect resident□s needs. 3- New, experienced MDS Nurse has been hired to ensure accurate completion	10/6/16

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F 279	Continued From page 5 Resident #27 was admitted to the facility on 04/29/16 with diagnoses which included atrial fibrillation and fluid retention in lower extremities. A review of a quarterly Minimum Data Set (MDS) dated 06/07/16 indicated Resident #27's cognition was intact. The MDS specified the resident had received an anticoagulant for the past 7 days of the assessment period. A review of Resident #27's physician monthly orders dated 09/01/16 through 09/30/16 revealed orders for the following medication: Lasix 60 milligrams (mg) two times a day and Coumadin 2.5 mg Tuesday, Thursday and Saturday and 5 mg Monday, Wednesday, Friday, and Sunday. A review of Resident #27's medical record revealed no care plans with measurable goals and interventions for preventing and monitoring for side effects of Lasix that can lead to dehydration and Coumadin that can cause bleeding. An interview with the MDS Coordinator was conducted on 09/08/16 at 1:41 PM. She confirmed Resident #27 did not have care plans for anticoagulant and diuretic medications. She stated that she completes new care plans and updates care plans when the next MDS is due which is 09/07/16. She stated that she did not have a care plan for Lasix and has never completed a care plan regarding Lasix.	F 279	of resident care plans. Training has been scheduled for October 4th 2016 for DON and MDS Coordinator to learn the facilities MDS/Care Plan system by attending a webinar offered our MDS computer software provider. A daily morning meetings has been implemented between DON, MDS Coordinator and Social Services coordinator to ensure all new orders are reflected in the care plan. 4- DON to perform the resident care plan audit according to the following schedule: Month One- weekly Month Two- bi weekly Months Three-Six- monthly Audits will be reviewed at the monthly QA meeting. This is an on-going process.	

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F 279	Continued From page 6 An interview was conducted with the Director of Nursing (DON) on 09/08/16 at 3:17 PM. The DON stated that the resident should have an anticoagulant and dehydration care plan.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep side rails secured putting residents at risk for entrapment for 2 of sampled residents (Resident #12 and #15). The findings included: 1. Resident #12 was admitted to the facility on 08/31/15 with diagnoses that included dementia, fractures and falls. The most recent quarterly Minimum Data Set (MDS) dated 06/30/16 specified the resident's cognition was moderately impaired, she required limited assistance with activities of daily living such as bed mobility and transfers. On 09/07/16 at 10:46 AM Nurse #1 reported Resident #12 used upper half side rails for bed mobility.	F 323	1- Side rails were repaired with-in one hour of issue being reported. 2- All bed rails were checked by Maintenance Assistant on September 9th 2016 to ensure there were no loose rails. 3- On 9/9/2016 Maintenance Director and DON educated Maintenance Assistant on how to properly check the bed rails and document. Maintenance Assistant will perform weekly checks on the bed rails and document appropriately. 4- Maintenance director will audit Side Rail documentation completed by the Maintenance Assistant. Maintenance Director will check according to the following schedule: a. Month One- Weekly	9/12/16

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F 323	Continued From page 7 On 09/08/16 at 9:38 AM observations were made of Resident #12's half side rails. The resident's bed was against the wall but the left half side was tested for security. The rail was loose and able to be pulled 3 to 4 inches away from the bed. On 09/08/16 at 10:08 AM nurse aide (NA) #1 was interviewed and explained Resident #12 used her side rails daily. The NA added Resident #12 was impulsive and attempted to get out of bed unassisted and was at risk for falls. The NA was not aware if the rails needed repair. On 09/08/16 at 10:15 AM the Maintenance Assistant was interviewed and reported he was responsible for safety checks on residents' beds including sided rails. He added he did performed checks weekly but did not physically go to each bed and check the security of side rails. The Maintenance Assistant stated if side rails were loose or broken he would expect the nurse aides or the Social Service Coordinator (SSC) to report issues to him immediately for repair. On 09/08/16 at 10:20 AM the Maintenance Assistant observed Resident #12's side rails and stated they were loose and needed to be tightened. 2. Resident #15 was admitted to the facility on 11/06/15 with diagnoses that included dementia, history of falls and fracture. The most recent Minimum Data Set (MDS) dated 08/29/16 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making and required extensive assistance with bed mobility and transfers.	F 323	b. Month two- Bi- Weekly c. Month Three to Six - Monthly Audit will be reviewed at the monthly QA meeting. This is an on-going process.	

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F 323	Continued From page 8 On 09/07/16 at 10:30 AM Nurse #1 reported that Resident #15 used half side rails and had fall mats at her bedside for safety. On 09/08/16 at 10:22 AM observations were made of Resident #15's side rails, the Maintenance Assistant was present of the observations. The left side of Resident #15's bed the side rail when engaged, the rail was able to swing forward and down in a 90 degree angle. The Maintenance Assistant was not aware if the rail should swing down. On 09/08/16 at 10:25 AM the Social Service Coordinator (SSC) observed Resident #15's side rail and reported the rail was broken and missing a "wing nut." She added the problem should have been reported to the Maintenance Assistant for repair.	F 323		
F 371 SS=E	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 store ice scoops in a sanitary	F 371	1-Ice scoop was properly stored immediately when pointed out during the	10/6/16

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F 371	Continued From page 9 environment and prevent rust build-up in the walk-in cooler. The findings included: 1. On 09/07/16 at 9:00 AM an initial tour of the facility's kitchen was made with the Food Service Director (FSD). During the tour, observations were made of the ice machine. Two metal ice scoops were laying on top of the ice machine uncovered. The top of the ice machine when wiped with a bare hand, had sticky greasy dust build-up. The FSD was present for the observation and stated the scoops should not be stored on top of the ice machine in direct contact with the top of the machine. 2. On 09/07/16 at 9:10 AM the walk-in cooler unit was observed with the Food Service Director (FSD). The floor of the walk-in cooler was rusted. Condensation was noted to be dropping from the ceiling of the walk-in cooler and there was no drain to collect the water. The FSD was interviewed and reported that the rust had been an ongoing concern that he was unable to remove.	F 371	survey. Maintenance Director completed a walk-through of areas where Rust was noted on September 9th 2106. It was determined that the condensation issue was caused by the drain line being plugged thus causing the condensation to spread through -out the cooler. Maintenance Director cleaned out the line and condensation pan to allow proper draining to avoid moisture buildup. 2- On 9/8/2016 Food Service Director checked other ice machines to ensure other scoops were being properly stored. Maintenance Director did a walk- through of other areas that had the potential to be affected by rust to ensure no other areas need attention. 3- On 9/14/2016 Food Service Director performed In-service with kitchen staff members on proper storage of ice scoop. On 9/28/2016 Maintenance Director contacted an outside provider to inquire on what would be compatible to the current deck in the walk-in cooler to repair the floor and remove the rust. 4- Food Service Director will do on going checks to ensure the ice scoop is stored properly according to the following schedule: a. Month One- weekly b. Month Two- Bi-weekly c. Month Three-Six- Monthly	

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F 371	Continued From page 10	F 371	Maintenance director going forward will do weekly checks of the walk-in coolers checking for condensation build up or other potential rust causing issues. Maintenance Director will clean the drain line and pan quarterly to avoid build up. Director of Operations will monitor the logs filled out by the Maintenance Director according to the following schedule: a. Month One- weekly b. Month Two- Bi-weekly c. Month Three-Six - Monthly Both audits will be reviewed at the monthly QA meeting to ensure that the weekly checks are being done in the fridge and that the ice scoop is being stored properly. A schedule for the quarterly cleaning will be kept up with and reviewed for completion at the monthly QA meeting as well. We will work with an outside provider to determine best route to fix issue and make necessary repairs.	