STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345543

DATE SURVEY COMPLETED

04/27/2011

MULTIPLE CONSTRUCTION B. WING _____________________________

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

BERMUDA COMMONS NURSING AND REHABILITATION CENTER

316 NC HWY 801 SOUTH
ADVANCE, NC 27006

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

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provider's plan of correction

(each corrective action should be cross-referenced to the appropriate deficiency)

COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies cited as a result of this complaint investigation on 04/27/11. Event ID # DDXD11.

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

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.