DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345416	B. WING			09/	09/2014
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				14	2 BERMUDA VILLAGE DRIVE		
BERMUDA	A VILLAGE RETIREMEN	I CEN		в	ERMUDA RUN, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371 SS=F	STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food	F 3	371			9/24/14
	by: Based on observatio facility failed to chang handling food, remov stored ready for use a equipment was clean The findings included 1. Observations of th service were made on AM. The facility's Foo was not present for th breakfast meal prepa wore gloves to prepar The morning cook po waffle and plated it fo 8:00 AM the morning hands into a bucket of removed a dishcloth fo the dishcloth to clean morning cook then re	e expired canned goods and ensure food service ed for use. : e facility's breakfast meal n 09/09/14 starting at 7:50 id and Beverage Director the observations. During the ration the morning cook re chocolate chip waffles. ured the batter into the d the waffle, removed the r meal service repeatedly. At cook submerged his gloved			Tag 0371 - 483.35(i) FOOD PROCURE STORE/PREPARE/SERVE - SANITAR' (LONG TERM CARE FACILITIES) #1 The deficient practice of poor sanitation was discussed with the morning cook (9/09/14) and plans for inservice addressing safe/serve practice initiated Monthly inservices by Food Service Director will continue to address the preparation, distribution and service of food under sanitary conditions. The Food Service Director conducted an inservice (9/20/14). Review with dietary personnel is ongoing, with department training for current and new hires. Continuing education efforts on	Y on f	
					sanitation and kitchen operations will be	e	(X6) DATE
LADUKAIUKI	DIVED I OK 9 OK 5 OK 5 OK 10 DEK/	SUPPLIER REPRESENTATIVE'S SIGNATURE			IIILE		(NO) DATE

Electronically Signed

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.

09/24/2014

PRINTED: 10/28/2014

	S FOR MEDICARE &				OMB NO. 0938-039		
()		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED		
		345416	B. WING		09/09/2014		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
BERMUDA VILLAGE RETIREMENT CEN				142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		HOULD BE COMPLETION		
F 371	Continued From page	- 1	F 37				
	dishroom and was ob ramekins of food place trays wearing the sam the morning cook's gl visibly soiled with rem 8:11 AM the morning chopped into bite size still wearing the soiled pieces in his hands a residents' plates. On morning cook was int he was trained to use meal service and cha completion of a meal he would change his or if he came in conta raw chicken. The mo intended to change h meal preparation was breakfast trays left th	bserved to handle individual sing them on residents' meal ne gloves. Observations of oves revealed they were mants of waffle batter. At cook handled 3 waffles and e pieces. The morning cook d gloves scooped the waffles nd placed the food onto 09/09/14 at 8:13 AM the erviewed and reported that e clean gloves prior to every inge his gloves after the service. He also added that gloves if they became dirty act with raw food such as orning cook reported he is gloves once the breakfast a finished. At 8:22 AM the e kitchen to be served to		<pre>#2</pre>	nd		
	Director was interview were trained to wear completing tasks in th he would expect staff between tasks to pre- food. He stated that t have changed his glo waffles. 2. An initial tour of th on 09/09/14 at 10:25 Beverage Director. O	te kitchen. He explained that to change their gloves vent cross-contamination of he morning cook should ves before he handled the e facility's kitchen was made AM with the Food and bservations of the facility's ea was made and noted to		The outdated pumpkin puree immediately discarded, 9/08/14. The Food Service Director wi a rotation protocol enforced to e utilization of product in a timely the dry storage area. Bermuda Village will continue minimally to avoid overage of st The opening cook will check i and observe dates on canned g dry storage bi-weekly (on currer shipment schedule). Outdated it refused.	Il reinstate ensure manner for e to order cock. in food oods or nt		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 932966

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345416			, ,		COMPLETED		
		B. WING		09/09/2014			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODI		 		
BERMUDA VILLAGE RETIREMENT CEN				142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		ULD BE COMPLETIO		
F 371	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 37	 FIFO method (first in, first out) for food storage. A check list is kept dry storage area. The Food Servir monitor this practice weekly. All practices will be integrated in QA system to ensure effectiveness presented by the dietary represent the QA committee on a quarterly to the QA committee on a quarterly to the QA committee on a quarterly to the kitchen cooks clean equipment each use, up to three times daily, needed. The in-house staff performed deep cleaning on the flat top griddle and burner that presented with build up residue. This deep clean practice done weekly by assigned kitchen personnel. A check list will be maintained for 	In the ce will the sand tative to basis.		

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Event ID: HFT811

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		ND HUMAN SERVICES				FOR	D: 10/28/201 MAPPROVE D. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345416	B. WING			09	/09/2014	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
BERMUDA VILLAGE RETIREMENT CEN				142 BERMUDA VILLAGE DRIVE				
BERMUDA VILLAGE RETIREMENT CEN				В	ERMUDA RUN, NC 27006			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO 1 DEFICIENC		TION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 371	Continued From page 3		F	371	weekly. Investigation for local industrial cleani from outside agencies is underway. The Food Service Director will addres	s		
					cleaning equipment practices at mont inservice meeting. Information and updates presented to committee quarterly or as needed to evaluate the effectiveness of current equipment cleaning and to monitor that this practice is sustained.	QA		
	7(02-99) Previous Versions O	bsolete Event ID: HF			cility ID: 932966 If cou			

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