PRINTED: 07/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345416	B. WING _				C 06/2016
	ROVIDER OR SUPPLIER	NT CEN		STREET ADDRESS, C 142 BERMUDA VILL BERMUDA RUN, N		1 04/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 157 SS=D	was provided to the additional SOD was 07/05/16 regarding to Resolution (IDR) processing the reduced the scope at IDR panel also reduced the scope at IDR panel also reduced the scope at IDR panel also reduced the scope and F-224 and F-309 to written. A review by Medicaid Services of F-157 with the delet scope and severity of severity for tags F-2 G, and F-514 remain 483.10(b)(11) NOTILI (INJURY/DECLINE/	ment of Deficiencies (SOD) facility on 06/06/16 and an provided to the facility on the results of Informal Dispute Decess. The IDR panel deleted F-157, kept example B and and severity from G to D. The ced the scope and severity of a D and upheld F-514 as the Centers for Medicare and esulted in the following: ion of example A and the reduced to D, the scope and 24 and F-309 were kept at a nded upheld as written at a D. FY OF CHANGES ROOM, ETC) diately inform the resident; dent's physician; and if	F 0				4/28/16
ADODATORY	or an interested fam accident involving the injury and has the printervention; a signift physical, mental, or deterioration in heal status in either life the clinical complication significantly (i.e., a rexisting form of trea consequences, or to treatment); or a decithe resident from the §483.12(a).	sident's legal representative illy member when there is an ne resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial nreatening conditions or s); a need to alter treatment need to discontinue an tment due to adverse o commence a new form of ision to transfer or discharge e facility as specified in			TITI E		(X6) DATE

Electronically Signed 04/28/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345416	B. WING		C 04/06/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 142 BERMUDA VILLAGE DRIVE	04/06/2016	
				BERMUDA 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 157	Continued From page		F 157	7		
	or interested family m change in room or roo specified in §483.15(resident rights under	ident's legal representative ember when there is a ommate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of				
	the address and phor	rd and periodically update number of the resident's r interested family member.				
	This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review the facility failed to notify the family when the physician ordered the resident to receive a mood stabilizer for 1 of 3 sampled residents (Resident #3). Resident #3 was diagnosed with a fractured hip. The findings included: Resident #3 was admitted to the facility on 02/10/16 diagnosed with heart failure, dementia with behavior disturbances, Alzheimer's disease and hypertension. The most recent Minimum Data Set (MDS) dated 02/17/16 specified she had short and long term memory impairment and moderately impaired cognitive skills for daily decision making, she also had physical and verbal behaviors directed towards others. The MDS also specified the resident required extensive assistance with activities of daily living and the resident had no complaints of pain and had not fallen prior to admission. Review of Resident #3's medical record revealed a new order dated 02/16/16 for Valproic acid (mood stabilizer) twice daily. The order was			This Plan of Correction constitutes th facility's written allegation of complian for the deficiencies cited in the CMS-2567. However, the submission this plan is not an admission that a deficiency exists. The Plan of Correcti is prepared and executed solely becait is required by federal and state law. response and Plan of Correction does constitute an admission or agreement the provider of the facts alleged or conclusions set forth in the Statement Deficiencies F157 A) Physician Notification 1. Corrective actions taken for resider found to have been affected by allege deficient practice. Resident #3 discharged from the facili on 3/25/2016. 2. Corrective actions taken for other residents having the potential to be	of on use This not by of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD)E	0-110012010	
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F 157	revealed no documindicated the family medication. On 04/05/16 at 9:30 was interviewed on member explained the resident was so difficult to arouse. that the resident was medication ordered On 04/06/16 at 10:0 interviewed and repractice to notify famedications. She enotify families via tenotification in the necord. Nurses #4 Valproic acid and the family but was unal to or why she had neconversation in the On 04/06/16 at 1:50 (DON) was interviewed expect nurse of medication chan Resident #3's famil	entation was made that had been notified of the new O AM the family of Resident #3 the telephone. The family that during a visit to the facility bund asleep in her chair and A nurses reported to the family as sleeping as result of a new by the physician. O AM Nurse #4 was corted that it was routine milies of new orders including explained that she tried to elephone and documented the curses' notes of the medical recalled receiving the order for hought she had notified the cole to explain who she spoke of the documented the medical record. The Director of Nursing wed and explained that she est to notify interested families ges. The DON stated that by was very interested in her we been notified when the	F 1	affected by alleged deficient particles and a scheduled or PRN pain medic completed on 4/20/2016 by the Results of the audit revealed resident has either a schedule a standing Physician order for medication. On 4/22/16 physician orders work obtained for every resident to assessment completed by the nurse every shift and docume including any interventions for who had pain. A one-time pain assessment resident was completed on 4/pain was noted, the interventif documented in the clinical recommendation. 3. Measures taken and system to prevent repeat of alleged depractice: Licensed nurses were in-service beginning on 4/22/16 by DON Coordinator to notify the Physical residents change in condition warrant an alteration in treatment including accident involving the which results in injury and has potential for requiring physicial intervention; a significant charesident's physical, mental, or psychosocial status (i.e., a definite threatening condition complications); a need to diexisting form of treatment due consequences or to comment	MARs for cation was the ADON. that every led, PRN, or or pain were to have a pain the licensed ent results, or residents on every /28/16 and if ion was cord. ms changed deficient viced N and MDS sician of that may ment the residents at the an ange in the reterioration in its status in ons or clinical or treatment is continue and to adverse		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 157	Continued From page	ge 3	F 15	form of treatment). As of 4/27/16 all licensed nursing staff had been in-serviced. On 4/28/2016, in-servicing began for a licensed nurses that any resident who a fall are to be assessed each shift for pain x 72 hours. If a resident complair pain and is medicated and pain is not relieved, the nurse is to call to notify the physician for further instructions. The nurse is to then notify the resident and legal representative or interested famin member. Any new orders and notificar is to be documented in the clinical reconservicing will continue thru 5/5/16. 4. How the corrective actions will be monitored to ensure the deficient practival will not reoccur, i.e. quality assurance measures implemented: The DON/ADON and MDS Coordinate will review the 24 hour report and chase 5 residents and any resident who experiences a fall, each week for 4 weeks, then every 2 weeks for 4 weeks, then every 2 weeks for 4 weeks, then every 2 weeks for 4 weeks to determine if the nurse contacted the Physician for the following if they occurred: Accident involving the residential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status either life threatening conditions or clin complications); a need to discontinue existing form of treatment due to adveconsequences, or to commence a new consequences, or to commence and the consequences are to commence and the consequences, or to commence and the consequences are to commence and t	all has r has r hs of he d d dily tion ord. etice or rt for e dent he an erse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
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F 157	Continued From page	÷ 4	F	157	form of treatment). Compliance will be monitored by the Dor designee. Audit tools will be collecte and reviewed by the DON weekly and reported to the QA committee for one quarter and will assess and modify the action plan as needed to ensure continued compliance. F 157 B) Notifying the interested family member 1. Corrective actions taken for resident found to have been affected by alleged deficient practice Resident #3 was discharged on 3/25/16 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: On 4/28/2016 the DON and MDS Coordinator audited all resident's physician orders and nurses notes for documentation of notification of change in condition/treatment to resident, legal resident representative or interested family member in the past 90 days (i.e. deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatmer significantly (i.e., a need to discontinue existing form of treatment due to adversonsequences, or to commence a new form of treatment). 3. Measures taken and systems change to prevent repeat of alleged deficient	d / S. , a nt an se	

		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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			BERMUDA RUN, NC 27006				
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F 157 F 224 SS=G	l 	GLECT/MISAPPROPRIATN	F 15	practice: In-servicing to licensed nurses began of 4/22/2016, by DON instructing nurses any change in a resident's condition/treatment requires notification the resident and the resident's legal representative or interested family member. Examples given in the in-servincluded a deterioration in health, mentor psychosocial status in either life threatening conditions or clinical complications); a need to alter treatme significantly (i.e., a need to discontinue existing form of treatment due to adverconsequences, or to commence a new form of treatment). As of 4/27/16 all licensed nursing staff been in-serviced. 4. How the corrective actions will be monitored to ensure the deficient pract will not reoccur, i.e. quality assurance measures implemented: DON/ADON or MDS Coordinator will review all physician orders and or med record daily five times weekly for changin condition/treatment and documentat of notification to the resident, residents legal representative or interested family member. Review will be on-going. Results of the audits will be reviewed a discussed in the quarterly QA meeting one quarter and will assess and modify the action plan as needed to ensure continued compliance.	that in to vice tal, int an se has ice ical ges ion y and for		

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F 224	policies and procedu mistreatment, neglec and misappropriation	elop and implement written res that prohibit t, and abuse of residents of resident property.	F 22	4	
	by: Based on staff and rand record review the physician orders to o tomography (CT) scawaited 7 days before revealed the residents The findings included Resident #3 was adn 02/10/16 diagnosed with behavior disturb and hypertension. The Data Set (MDS) date short and long term randerately impaired decision making, she verbal behaviors dire MDS also specified the extensive assistance and the resident had had not fallen prior to facility the resident fer 03/02/16 with no inju Resident #3's care pl specified the resident psychotropic medication 03/02/16 at 8:08	In for a resident in pain and obtaining the CT scan which had a fractured hip for 1 of (Resident #3). It is nitted to the facility on with heart failure, dementia ances, Alzheimer's disease the most recent Minimum d 02/17/16 specified she had the mory impairment and cognitive skills for daily also had physical and cted towards others. The the resident required with activities of daily living no complaints of pain and admission. While in the all on 02/16/18, 02/18/16 and the resident required with activities of daily living no complaints of pain and admission. While in the all on 02/16/18, 02/18/16 and the resident required with activities of daily living no complaints of pain and admission. While in the all on 02/16/18, 02/18/16 and the resident required with activities of daily living no complaints of pain and admission. While in the all on 02/16/18, 02/18/16 and the resident required with activities of daily living no complaints of pain and admission. While in the all on 02/16/18, 02/18/16 and the resident required was at risk for falls and on		F224 PROHIBIT MISTREATMENT/NEGLECT 1. Corrective actions taken for residence found to have been affected by alled deficient practice No immediate corrective action countaken. CT scan was scheduled on completed on 3/17. Resident #3 discharged from the facility on 3/25. 2. Corrective actions taken for othe residents having the potential to be affected by alleged deficient practice. On 4/22/2016 a 100% resident chains was completed by the DON and MI Coordinator for residents with an or a CT scan. The results of the audit that no orders were found to have be written. 3. Measures taken and systems chains to prevent repeat of alleged deficient practice: On 4/22/2016 in-servicing began for licensed nurses. Nurses were in-se that when an order for a diagnostic scan was given, it is the responsibility.	ged Ild be 3/15, /2016. r ie: rt audit DS rder for were been anged int r all rviced CT

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				142 BERMUDA VILLAGE DRIVE			
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F 224	of the activity room at wheelchair. Nurse #*	7 PM in front of her	F 22	the nurse receiving the order to ca schedule the CT at the time the or given. If the order is given after 5:3	der is		
	complain of pain. On 03/09/16 the phys treating Resident #3 of that read in part resid extremity discomfort	sical therapy assistant (PTA) documented a progress note ent "complained of left lower pointing along her lateral leg and resisted standing."		the CT cannot be scheduled and the nurse must notify the on-call proving further instructions and document instructions in the medical record at the nursing 24 hour nursing report	ne der for the and on		
	progress note. The p the resident's compla toe and the PTA notif On 03/10/16 at 6:00 A Resident #3 was awa The nurse administer at 12 AM with little eff for 'Joe' very agitated	to complete a sitting 4 minutes according to the progress note also specified int of pain was also in her fed "nursing" of the pain. AM Nurse #2 documented like and yelling out loudly. ed Ativan gel (anti-anxiety) fect. "Resident screaming until 4:30 AM. Will continue		4. How the corrective actions will be monitored to ensure the deficient put will not reoccur, i.e. quality assurate measures implemented: DON/ADON or MDS Coordinator or review all physician orders and or record daily five times weekly for 4 then once weekly for 2 weeks to a any ordered diagnostic test(s) were scheduled and completed timely. If the guidit will be reviewed and	oractice nce vill medical weeks, ssure		
	PTA read in part, "Pt encouragement to pa including forward lear extremities with facial passive attempts call. She does complain o sitting, however no fawhen weight bearing. pressure to left knee abduction. Conveyed practitioner who was motion assessment." On 03/10/16 at 10:00 progress note that sp Resident #3 on site for documented, "Obserworking with the paties."	rticipate with any movement of or movement of lower grimacing following all ing out 'no more, no more.' If lateral thigh pain from cial grimacing or complaints Also, grimacing with resisting motion into left hip diconcerns to nurse present for passive range of		of the audit will be reviewed and discussed in the quarterly QA mee assess and modify the action plan needed to ensure continued comp	as		

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F 224	PTA how long patient reported 2 days. She coming to the facility, say exactly where the the most when her le cannot give good his dementia." On 03/10/16 the nurs order for portable x-rato left leg pain and hi Tylenol (pain medicar five days and as neeresident's pain was not not be given as needed but review of the Med Record (MAR) reveal as needed pain medion 03/10/16 the mobreceived by the facilit "an occult femoral neexcluded. CT (compimaging with sedation The documented was the NP was notified of 4:50 PM. On 03/10/16 at 5:05 scan of Resident #3's administer antianxiet prior to scan. On 03/10/16 at 6:40 she informed Reside and new orders for for documented that the pain or discomfort. Review of Resident #a CT scan was not per second of the scan was not per sec	left leg. When questioned with this acute pain has history of falls since Patient when asked cannot e pain is but she complained ft leg was abducted. Patient tory as she has severe he practitioner (NP) wrote an any of left knee/femur/hip due ppain. The NP also ordered tion) three times a day for ded pain medication if the ot relieved with the Tylenol. In 50mg (pain medication) diff the resident was in pain dication Administration led she did not receive the cation.	F 2:	24			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345416	B. WING	B. WING		04/	06/2016
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F 224	Continued From page	2 Q		224			
1 221				4			
		/17/16 and indicated the					
	resident had a fractur	•					
	On 03/17/16 at 9:30 /						
		quest of staff for "yelling out					
		The NP also documented					
		t the CT scan that was					
	-	y (03/10/16) and the patient					
		today (03/17/16). The					
	patient was still complaining of left hip and leg pain."						
	On 03/17/16 at 3:10 PM the NP ordered Resident						
		Emergency Department for					
		nent of a fractured hip.					
		t #3 was evaluated in the					
		ent and the family declined					
		or an orthopedic referral.					
	_	to the facility on 03/17/16					
	with orders for Roxan						
		AM the Director of Nursing					
		ed and explained that on					
	I *	11/16 she was out of the					
		She added that when she					
		on 03/14/16 she became					
	1	esident #3's CT had yet to					
		tated she instructed staff to					
	get the CT scheduled						
	•	AM the Assistant Director of					
	Nursing (ADON) was	interviewed and explained					
	at the time the order	was written for the CT scan					
	for Resident #3 the fa	amily had considered moving				ĺ	
	her to another facility	. The ADON stated that the				ĺ	
	nurses waited a day of	or two to see if the family				ĺ	
	was going to move th	e resident and the order for				ĺ	
		e sent with the resident for				ĺ	
	the new facility to per	form. The ADON added that				ĺ	
		amily did not move Resident				ĺ	
	#3 and that was wher	n the facility realized they				ĺ	
	needed to proceed w	ith scheduling the CT scan.				ĺ	
	The ADON stated that	t the scan should not have				ĺ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345416	B. WING				06/2016	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	00/2010	
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F 224	Continued From page	e 10	F	224	4			
	been delayed for 7 da							
		PM the NP was interviewed						
		reported that she was in the						
		Resident #3 in pain while						
	_	The NP stated she first						
		Resident's pain on 03/10/16						
	but was told this was	day 2 of pain for the						
	resident. The NP exp	plained she reviewed the						
	resident's history and noted that the resident fell							
	on 03/02/16 and ordered x-rays. The NP added							
	that the x-rays were inconclusive and a CT scan was ordered to rule out a fracture. On 03/17/16							
		cility for her weekly visit and						
		Its of Resident #3's CT scan ot been done. The NP						
		t appropriate" to wait to get						
		e was "shocked" on 3/17/16						
		otten the CT scan. The NP						
		e would have expected to be						
		time of onset especially for						
	Resident #3 because							
	needed" pain medica	tion ordered for her pain she						
	developed on 03/09/1	16. The NP stated she						
	reviewed the internal	phone-log and no calls were						
	received from the fac	ility regarding Resident #3						
	_	10/16. The NP reviewed						
	I .	ults and reported that the						
		red non-pathological (did not						
	spontaneously happe							
	On 04/06/16 at 3:50 F							
	· ·	ained that she had received it #3 to have a CT scan but						
		tal to schedule the procedure						
		nd she didn't think anyone						
	I .	cheduling a CT scan would						
		M. The nurse added that						
		off in report. The nurse						
	1 -	esident was in pain and						
		anxiety and velling at night						

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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		C 04/06/2016	
	ROVIDER OR SUPPLIER	T CEN	1	STREET ADDRESS, CITY, STATE, ZIP CODE 42 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006	1 04/06/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 224 F 309 SS=G	provide the necessar or maintain the higher mental, and psychoso accordance with the cand plan of care. This REQUIREMENT by: Based on staff and not	are secive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment is not met as evidenced urse practitioner interviews a facility failed to identify a or a resident with a history of psychoactive medications is yelling out rather than in. When the facility it was in pain they waited 7 is a physician ordered aphy (CT) scan that had a fractured hip for 1 of (Resident #3). In itted to the facility on with heart failure, dementia ances, Alzheimer's disease the most recent Minimum in the most	F 224		ion	

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930-0391
The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345416	B. WING _			04/	06/2016
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BEDMUD	A VII I ACE DETIDEMEN	T CEN		14	12 BERMUDA VILLAGE DRIVE		
DEKINUU	A VILLAGE RETIREMEN	ICEN		В	ERMUDA RUN, NC 27006		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 12	F 3	809			
		no complaints of pain and			obtained for every resident to have a p	ain	
		admission. While in the			assessment completed every shift.		
		ell on 02/16/18, 02/18/16 and			On 4/22/2016 in-servicing began with		
	03/02/16 with no inju				full-time, part-time, and PRN nurses th	at	
		an was dated 02/26/16 that			included the location of the blue binder		
	specified the resident			that would have pain assessment shee	ts:		
	psychotropic medicat			for every resident would be located at	:he		
	On 03/02/16 at 8:08			nurses station, each resident is to have			
	Nurse #1 specified th			the assessment completed each shift,			
	of the activity room a			directions if residents were noted to ha	-		
	wheelchair. Nurse #			pain when the assessment was comple	e.		
	injuries were "observ			A sample MAR was attached to the in-service sheet			
	complain of pain. On 03/08/16 nurse #			A pain assessment was completed on	ااد		
	Resident #3 slept we				residents on 4/28/16 by DON and MDS		
		AM nurse #2 documented			Coordinator and the results of the audi		
	that Resident #3 was	awake at 11:48 PM and			found no residents with a compliant of		
	given a hypnotic med	dication with "some effect"			pain.		
	but the resident woul	d call out loudly with					
		eded" antianxiety medication			3. Measures taken and systems chang	ed	
	_	given at 3:05 AM that was effective and the			to prevent repeat of alleged deficient		
		nained awake but quiet."			practice:		
		sical therapy assistant (PTA)			Licensed nursing staff was in-serviced	on	
		documented a progress note			"Recognizing signs/symptoms of pain"	_	
		dent "complained of left lower pointing along her lateral leg			and "assessing for pain when residents	3	
		ind resisted standing."			exhibit behaviors such as yelling out". In-services were completed by the DO	NI	
	1	e to complete a sitting			on 4/27/16.	•	
		4 minutes according to the			DON/ADON or MDS Coordinator will a	udit	
		progress note also specified			all resident pain assessments for		
	. •	aint of pain was also in her			completion 5 times a week for 3 weeks	,	
		ied "nursing" of the pain.			three times a week for 2 weeks, twice		
		al record revealed there were			weekly for 2 weeks, weekly for 2 week	3,	
		03/09/16 that addressed pain			and monthly for one month.		
		view of the Medication					
		d (MAR) for 03/09/16			4. How the corrective actions will be		
		did not have orders for as			monitored to ensure the deficient pract	ice	
		ion or scheduled pain			will not reoccur, i.e. quality assurance		
	medication.				measures implemented:		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7. BOILD			Ι,	c		
		345416	B. WING				06/2016		
NAME OF PI	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00/2010		
				14	42 BERMUDA VILLAGE DRIVE				
BERMUDA VILLAGE RETIREMENT CEN		T CEN		В	ERMUDA RUN, NC 27006				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		· · · · · · · · · · · · · · · · · · ·				
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F 309	Continued From page	e 13	F	309					
		AM Nurse #2 documented	·		The DON and ADON and/or MDS				
		ake and yelling out loudly.			Coordinator will audit to assure nursing	ı			
		red Ativan gel (anti-anxiety)			staff have completed pain assessment				
		fect. "Resident screaming			for residents who have displayed				
	for 'Joe' very agitated	I until 4:30 AM. Will continue			behaviors such as yelling out, through				
	to monitor."				observation during routine daily rounds				
	On 03/10/16 a second	d progress note made by the			and review of 24 hour report. The audit				
	PTA read in part, "Pt	,			will be done daily for 2 weeks, then we	ekly			
		articipate with any movement			for 4 weeks.				
	including forward lear								
	extremities with facial grimacing following all passive attempts calling out 'no more, no more.'				Compliance will be monitored by the D				
	I *	_			or designee. Audit tools will be collecte				
		f lateral thigh pain from icial grimacing or complaints			and reviewed by the DON and reported the QA committee for one quarter. QA	1 10			
	_	. Also, grimacing with			committee will assess and modify the				
		resisting motion into left hip			action plan as needed to ensure				
	abduction. Conveyed				continued compliance.				
	-	present for passive range of			P				
	motion assessment."								
	On 03/10/16 the NP of	documented a progress note			F309 PROVIDE CARE/SERVICES FO	R			
		sessed Resident #3 on site			HIGHEST WELL BEING -				
		NP documented, "Observed							
) working with the patient and femur pain then			B) Waited 7 days to order CT scan.				
	knee pain when the F	PTA would move her left leg.			1. Corrective actions taken for resident				
	When questioned PT	A how long patient with this			found to have been affected by alleged				
		days. She has history of			deficient practice:				
	_	the facility. Patient when			CT scan was scheduled on 3/15,				
	asked cannot say exactly where the pain is but she complained the most when her left leg was completed on 3/17. Resident #3 discharged from the complete on 3/17.		T						
			_	/					
		innot give good history as			on 3/25/2016.				
	she has severe deme	entia." se practitioner (NP) wrote an			2 Corrective actions taken for other				
		ay of left knee/femur/hip due			Corrective actions taken for other residents having the potential to be				
	-	p pain. The NP also ordered			affected by alleged deficient practice:				
		tion) three times a day for			On 4/22/2016 a 100% resident chart at	ıdit			
	, ,	ded pain medication if the			was completed by the DON and MDS				
		ot relieved with the Tylenol.			Coordinator for residents with an order	for			
	On 03/10/16 the mob	_			a CT scan. The results of the audit wer				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345416	B. WING _			04	1/06/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
				142 E	BERMUDA VILLAGE DRIVE			
BERMUDA	A VILLAGE RETIREME	NT CEN		BER	MUDA RUN, NC 27006			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 309	Continued From pa	ge 14	F3	309				
	received by the faci	lity and the impression was		ti	hat no orders were found to have bee	en		
	_	neck fracture cannot be		l v	vritten.			
	excluded. CT (com	puterized tomography)						
	imaging with sedati	on is strongly recommended."		3	3. Measures taken and systems chang	ged		
	The documented w	as initialed by Nurse #3 and		to	o prevent repeat of alleged deficient			
	the NP was notified			practice:				
	4:50 PM.			On 4/22/2016 in-servicing began for a				
	On 03/10/16 at 5:05			censed nurses. Nurses were in-servi				
	scan of Resident #3			hat when an order for a diagnostic Cl				
	administer antianxie			can was given, it is the responsibility				
	prior to scan. On 03/10/16 at 6:40 PM Nurse #3 documented				he nurse receiving the order to call to			
	she informed Resid			chedule the CT at the time the order given. If the order is given after 5:30pr				
	and new orders for		1 -	per the scheduling department at	.11			
	documented that th			VFUBMC, the CT cannot be schedule	-d			
	pain or discomfort.			and the nurse must notify the on-call	,			
	·	: #3's medical record revealed			provider for further instructions and			
	a CT scan was not	performed on 03/10/16 as			locument the instructions on a physic	ian		
		eview revealed the CT scan			elephone order, in the medical record			
	was performed on 0	03/17/16 and indicated the		a	and on the nursing 24 hour nursing re	port		
	resident had a fract	ured hip.		s	heet.			
	On 03/17/16 at 9:30	AM the NP assessed						
	Resident #3 at the i		1 '	. How the corrective actions will be				
	all night every night			nonitored to ensure the deficient prac				
		out the CT scan that was			vill not reoccur, i.e. quality assurance			
		lay (03/10/16) and the patient			neasures implemented:			
	_	n today (03/17/16). The			OON/ADON or MDS Coordinator will			
	·	nplaining of left hip and leg			eview the nursing 24 hour report shee			
	pain."	DM the ND endered Decident			all physician orders and or medical red			
		PM the NP ordered Resident			laily five times weekly for 4 weeks, the			
		Emergency Department for tment of a fractured hip.			once weekly for 2 weeks to assure an ordered diagnostic CT scan(s) were	у		
		ent #3 was evaluated in the			scheduled and completed timely.			
		ment and the family declined		5	choduled and completed timely.			
		n or an orthopedic referral.		(Compliance will be monitored by the D	OON		
		ed to the facility on 03/17/16			or designee. Audit tools will be collected			
		anol (pain medication).			and reviewed by the DON and reporte			
		elle to be interviewed.			he QA committee for one quarter. QA			
		03 AM the Director of Nursing			committee will assess and modify the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	345416	B. WING _			1	C /06/2016	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 0-1/	00/2010	
DEDMIDA VII I ACE DETIDEMENT CEN			142 BE	RMUDA VILLAGE DRIVE			
BERMUDA VILLAGE RETIREMENT	CEN		BERM	IUDA RUN, NC 27006			
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 309 Continued From page	15	F 3	09				
(DON) was interviewed 03/09/16 through 03/1 building for training. So returned to the facility aware the order for Response the CT scheduled. On 04/06/16 at 11:10 Nursing (ADON) was in at the time the order whom for Resident #3 the far her to another facility. In the CT scan would be the new facility to perfect after a few days the far and that was when needed to proceed with The ADON stated that been delayed for 7 day On 04/06/16 at 12:00 interviewed and report varying abilities to part her impaired cognition progress notes on 03/06 explained that the resist but her resistance to powas not unusual. The 03/09/16 she reported was complaining of part of the NP was at the stat yell. The PTA stated significant in the PTA stated significant in the side of the PTA stated significant in the side of the PTA stated significant in the side of the PTA stated significant in the process of t	d and explained that on 1/16 she was out of the the added that when she on 03/14/16 she became esident #3's CT had yet to ated she instructed staff to 1/14/16 she became at the instructed staff to 1/14/16 she instructed staff to 1	F 3	ac	tion plan as needed to ensure intinued compliance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345416	B. WING _			l	06/ 2016	
NAME OF PROVIDER OR SUPPLIER BERMUDA VILLAGE RETIREMENT CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 309	and was unable to be On 04/06/16 at 1:15 linterviewed on the te could not recall anytheshe was in pain or no On 04/06/16 at 2:30 lon the telephone and facility and witnessed working with therapy became aware of the but was told this was resident. The NP expresident's history and on 03/02/16 and order that the x-rays were it was ordered to rule of the NP was in the fact asked about the result and was told it had not stated that it was "no the CT and added shout the facility had not go also reported that shoutified of pain at the Resident #3 because needed" pain medicate developed on 03/09/reviewed the internal received from the fact on 03/09 through 03/Resident #3's CT resident	king during the investigation reached for an interview. PM Nurse #1 was dephone and stated she hing about Resident #3 or if bit. PM the NP was interviewed reported that she was in the IR Resident #3 in pain while The NP stated she first Resident's pain on 03/10/16	F3	<u> </u>				
	the order for Residen							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345416	B. WING		C 04/06/2016
	ROVIDER OR SUPPLIER	IT CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006	1 04/00/2010
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F 514 SS=D	be working at 5:05 F she passed the order couldn't recall if the inthought the resident's was behavior related 483.75(I)(1) RES RECORDS-COMPLILE The facility must ma resident in accordant standards and practic accurately document systematically organism. The clinical record minformation to identification resident's assessment services provided; the preadmission screen and progress notes. This REQUIREMENT by: Based on staff interfacility failed to have the closed medical medical residents (Resident The findings include Resident #3 was add 02/10/16 and was di 03/25/16. The facility provided record.	scheduling a CT scan would M. The nurse added that or off in report. The nurse resident was in pain and s anxiety and yelling at night d. ETE/ACCURATE/ACCESSIB Intain clinical records on each ce with accepted professional ces that are complete; ted; readily accessible; and ized. Inust contain sufficient by the resident; a record of the ents; the plan of care and the results of any being conducted by the State; T is not met as evidenced wiews and record review the physician progress notes in ecord for 1 of 1 sampled #3). d: mitted to the facility on scharged from the facility on Resident #3's closed medical	F 30	F514 Maintenance of clinical record 1. Corrective actions taken for reside found to have been affected by alleged deficient practice No immediate action could be taken Resident # 3 since he was discharge from the facility on 3/25/2016.	ent ged for ed
		#3's medical record revealed ohysician documented visits.		Corrective actions taken for other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	00/2010	
					42 BERMUDA VILLAGE DRIVE			
BERMUDA	A VILLAGE RETIREMEN	T CEN			ERMUDA RUN, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 514	progress notes for Rewas for an initial consistency of the was interviewed facility utilized a nurse cross-trained in medical record reported that the NP electronic documenta their progress notes i medical record. The physician had not fax facility for inclusion in	AM the physician faxed esident #3. One faxed copy sult dated 02/16/16 and a //22/16. PM the Director of Nursing ed and explained that the eaide who was cal records to "breakdown" ds for storage. The DON and physician utilized an another to be included in the DON was not aware that the ed progress notes to the Resident #3's medical ded that the medical record	F	514	affected by alleged deficient practice: DON audited all current medical record on 4/28/2016 to determine if the Physic progress notes had been filed onto the medical record. 3. Measures taken and systems chang to prevent repeat of alleged deficient practice: ON 4/19/2016 DON consulted the Medi Director related to the process of progrates after they have been seen by the providers. All provider progress notes were be completed, processed, and faxed to the facility no more than 7 days after being seen by the provider. Prior to the provider leaving the facility on the days resident are seen, the medical records employee will obtain a roster of resident seen on that day to ensure progress not are received for those residents seen. 4. How the corrective actions will be monitored to ensure the deficient pract will not reoccur, i.e. quality assurance measures implemented: DON/ADON/MDS Coordinator will audit records once a week for 4 weeks to assure compliance utilizing the roster of residents seen by Physician's each we Results of the audit will be reviewed and discussed in the quarterly QA Committing and will assess and modify the action plan as needed to ensure continued compliance.	ds cian ded dical dess de will de		