PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>\</b> '	PLE CONSTRUCTION  G		SURVEY PLETED
		345543	B. WING _			C / <b>02/2016</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225 SS=D	INVESTIGATE/REPO ALLEGATIONS/INDIV The facility must not elem found guilty of a mistreating residents had a finding entered registry concerning at of residents or misappe and report any knowled court of law against a indicate unfitness for other facility staff to the or licensing authorities.  The facility must ensure including injuries of unmisappropriation of resimmediately to the adto other officials in account of the survey and cert.  The facility must have violations are thorough established postate survey and cert.  The facility must have violations are thorough prevent further potent investigation is in progressentative and to with State law (includicertification agency) vincident, and if the allier that is the survey and if the allier that is the survey incident, and if the allier that is the survey and incident, and if the allier that is the survey incident, and if the allier that is the survey incident.	employ individuals who have busing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a nemployee, which would service as a nurse aide or ne State nurse aide registry s.  The that all alleged violations of the facility and cordance with State law procedures (including to the iffication agency).  The evidence that all alleged hly investigated, and must dial abuse while the gress.  Stigations must be reported	F 2	25		5/24/16
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITLE		(X6) DATE

(X6) DATE

05/24/2016 **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.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE S	
			, a Boilebii			
		345543	B. WING _			) 2/2016
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/0	72/2010
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE
F 225	by: Based on record rev	is not met as evidenced iew and resident and staff	F2	The statements made on this Plan	-	
	the administrator or E an allegation of abuse sampled for abuse (F The findings included Resident #237 was a 04/15/16 with diagnor vertebra, history of faterm use of anticoagu hyperlipidemia.  Review of the compreminimum data set (M indicated that Reside intact and required or with bed mobility, trar personal hygiene. The	Resident #237). I: dmitted to the facility on ses that included fracture of ills, atrial fibrillation, long ulant, diabetes mellitus, and ehensive admission DS) dated 04/22/16 int #237 was cognitively ne person limited assistance insfers, toileting, and e MDS further revealed that		Correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and St. Regulations the facility has taken of take the actions set forth in this Plat Correction. The Plan of Correction constitutes the facility allegation compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indice F225 INVESTIGATE/REPORT ALLEGATION/INDIVIDUALS. Corrective Action:  Resident #237.  Resident #237 was physically asset	ate r will n of be cated.	
	one staff member wit impairment to bilatera Review of a physician Coumadin (medicatio milligrams (mg) by m Review of a physician to draw a prothrombin normalized ratio (INR quickly the blood clot Review of a care plan Resident #237 was of for toxicity and abnor stated care plan stated free from discomfort to anticoagulant use	n order dated 04/15/16 read in time (PT) and international it) (used to evaluate how s) every Monday. In dated 04/18/16 stated that in an anticoagulant with risk mal bleeding. The goal of ed Resident #237 was to be or adverse reactions related through the next review date. uded draw labs as ordered		No injuries, or marks or bruises we noted at that time. Solstas Laborate contacted immediately. Lab Techni was not allowed to return to facility Identification of other residents who be involved with this practice:  All residents have the potential to be affected by the alleged practice. All were interviewed on 5/20/2016 by Keiser SW and asked if they were of any type of Abuse or suspected that had or has occurred /transpire facility that has not been reported. staff were interviewed, no new alle of abuse or suspected abuse were reported. Phlebotomists were also in-serviced about reporting abuse a who to report to. All alert and orien	re pry was cian o may  re I staff Pam aware abuse d in the After all gations	
	•	ent #237 on 04/25/16 at 2:54		residents were also interviewed to	see if	

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE AN OF CORRECTION IDENTIFICATION NUMBER: A PHILIPPING COMPLETED						
			A. BUILDI	NG _		l ,	_
		345543	B. WING_			l	C <b>02/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	02/2010
				31	16 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSIN	G AND REHABILITATION CENTER		Α	DVANCE, NC 27006		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 225	Continued From pa	age 2	F:	225			
	_	to her room to draw her blood.			abuse. No new allegations were report	he	
		ted that when the laboratory			at this time. We also informed residents		
		n the light it startled her from			who to report abuse to.		
		ed the laboratory employee to			Systemic Changes:		
	· •	nt off and the laboratory			Director of Nursing and /or Designee Ir	1	
	employee ignored	her request so Resident #237			serviced all staff (full time, part time, a	nd	
	again asked the lal	boratory employee to please			PRN) to inform them that Abuse will no	t	
		d again the laboratory			be tolerated and if there is any allegation		
		her request. Resident #237			of abuse it must be reported immediate	•	
		e laboratory employee			to the Administrator or Director of Nurs	ing.	
		roughly draw blood from her			All staff should always report any		
	_	nd after applying a cotton ball			witnessed or suspected or reported abo		
		over the site slapped her			promptly to the Administrator or Directo		
		s if "slapping on a Band-Aid." ted she was crying because			of Nursing. Everyone is responsible fo reporting. All reports of resident verbal,		
		y employee turned on the light			sexual, physical and mental abuse,		
		caused her to have a back			corporal punishment, involuntary		
		e behavior and the actions of			seclusion, neglect, or misappropriation	of	
	· ·	loyee added to her stress.			resident property shall be promptly and		
		ted she was afraid of this			thoroughly investigated by facility		
	laboratory employe	ee and did not want her coming			management. It is the responsibility of	our	
	back into her room	. Resident #237 stated she			employees, facility consultants, attendi	ng	
	had reported the in	cident to her nurse.			physicians, family members, visitors, e	tc.	
		se #3 on 4/26/16 at 4:21 PM			to promptly report any incident or		
		1/25/16 at 8:30 AM Resident			suspected incident of neglect or reside		
		that she wanted someone else			abuse, including injuries of an unknown		
		Resident #237 stated to Nurse			source and theft or misappropriation of		
		ory employee that drew her			resident property, to facility manageme		
	_	was really rough while			The facility will not employ individuals we have been found guilty of abusing,	VIIO	
		and then slapped the middle of ping on a Band-Aid." Resident			neglecting, or mistreating residents by		
		to Nurse #3 that the laboratory			court of law; or have had a finding ente		
		her to "stop crying" and that			into the State nurse aide registry	. 50	
		this laboratory employee and			concerning abuse, neglect, mistreatme	nt	
		draw her blood anymore.			of residents or misappropriation of their		
		at she immediately reported			property; and report any knowledge it h		
		ervisor #1 and Supervisor #2			of actions by a court of law against an		
	·	ted Resident #237's room			employee, which would indicate unfitne	ss	
	approximately 5 to				for service as a nurse aide or other fac		

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CENTER	S FOR WEDICARE 6	NIEDICAID SERVICES			OIVID INO. 0930-039 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345543	B. WING		05/02/2016
NAME OF P	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	
DEDMUD		AND DELIABILITATION CENTED	3	16 NC HIGHWAY 801 SOUTH	
BEKMUDA	A COMMONS NURSING	AND REHABILITATION CENTER	4	ADVANCE, NC 27006	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CTION (X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 225	Continued From pag	ae 3	F 225		
		rvisor #1 on 04/26/15 at 4:40		staff to the State nurse aide regist	rv or
		urse #3 reported to her and		licensing authorities. The facility w	-
		proximately 9:00 AM on		ensure that all alleged violations in	
		poratory employee that drew		mistreatment, neglect, or abuse, in	_
		od that morning was really		injuries of unknown source and	10.009
		e needle in her arm and was		misappropriation of resident prope	erty are
		or #1 stated that Nurse #3		reported immediately to the admin	-
	stated that Resident	#237 was uncomfortable and		of the facility and to other officials	in
	did not want the lab	oratory employee back into		accordance with State law through	ı
	her room. Superviso	or #1 stated she could not		established procedures (including	to the
	recall if Nurse #3 sta	ated that Resident #237 was		State survey and certification agei	ncy).
	fearful of the laborat	tory employee and could not		The facility will have evidence that	t all
		ated that the laboratory		alleged violations are thoroughly	
		ped the arm of Resident #237.		investigated, and will prevent furth	
		d she would have to ask		potential abuse while the investiga	
	_	nat she had reported to her.		in progress. Within 24 hours of the	
	1 -	d that she had instructed		reported abuse or suspension of a	
	· ·	I the laboratory and tell them		the Director of Nursing or Adminis	
	1	oloyee back to the facility.  If she did not follow up with		must submit via fax what is called hour report. This report is sent to	
	Supervisor #2 and v			Department of Health and Human	
	· ·	e's name. Supervisor #1		Services Personnel Health Regist	
		not go talk to Resident #237		purpose of the report is to notify the	•
		the resident. Supervisor #1		agency that possible abuse or neg	
		not inform the DON of the		occurred and that the facility is con	
	incident.			an investigation. Within 5 days a	•
		rvisor #2 on 04/26/16 at 4:58		report must also be submitted. Th	-
		urse #3 had reported to her		report will include witness stateme	
	and Supervisor #1 a	at approximately 9:00 AM on		findings and interventions. The re	
	04/25/16 that Reside	ent #237 did not want the		all investigations will be reported t	o the
	laboratory employee	e that drew her blood on		administrator or his designated	
	04/25/16 back into h	ner room, Resident #237		representative and to other official	l□s in
	stated that the labor	atory employee was verbally		accordance with State law (includi	ing to
	-	d slapped her in the arm "as if		the State survey and certification a	
	slapping a Band-Aid	l" on her arm. Supervisor #2		within 5 working days of the incide	ent, and
		3 reported that Resident #237		if the alleged violations verified	
	was fearful of this la			appropriate corrective action must	
	-	d that she had reported this to		taken. This in services was complete	
	the DON and then c	alled the laboratory and told		5/24/2016. Phlebotomists were als	30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG	<del></del>	,	2
		345543	B. WING _			l	02/2016
NAME OF P	ROVIDER OR SUPPLIER	-	_ <b>'</b>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEDMIID	COMMONS NUIDSING	C AND DELIABILITATION CENTED		31	6 NC HIGHWAY 801 SOUTH		
DEKNUU	A COMMONS NURSING	AND REHABILITATION CENTER		Al	DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	their facility. Supervisor allegation of 5:00 PM that the laboratory employe stated that she did around 5:00 PM that the laboratory emplointerview with the Distriction of the incident aware of the incident laboratory employe confirmed that she incident until the su attention. The DON information she corrabuse. The DON st Supervisor #1 and/simmediately report immediately started laboratory of the incomplete working report to the In a follow up intervising from the sattempted to talk to left multiple message DON was still unawe employee's name the on 04/25/16. Interview with the A 2:51 PM revealed the #1 and Supervisor allegation of abuse	was no longer welcome in visor #2 was unaware of the e's name. Supervisor #2 go and talk to Resident #237 at afternoon and apologized for oyee's behavior. ON on 04/26/16 at 5:07 PM of previously been made in with Resident #237 and the e by the facility staff. The DON was not made aware of the recipient with a stated that after hearing the insidered this an allegation of ated she would have expected for Supervisor #2 to this to her so she could have an investigation, notified the cident and filed a 24 hour in e state agency. The investigation is the letted and submitted the 24 tate agency and had the laboratory supervisor and go with no return call. The tare of the laboratory in at drew Resident #237 blood diministrator on 04/28/16 at that she expected Supervisor #2 to immediately report the to the DON or herself so that all be started and the 24 hour letted and the 24 hour was a started and the 24 hour letter to the DON or herself so that all the book or herself so that all the book or herself so that all the started and the 24 hour letter a	F	2225	in-serviced about reporting abuse and who to report to by 5/25/2016 by Phlebotomy Manager/Supervisor. Any staff member (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quest has also incorporated this to their new process for phlebotomist. Monitoring:  To ensure compliance, Administrator of Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by interviewing 5 staff members weekly in reference to: Has anyone reported any abuse allegations, and if so, has it beer reported to the Director of Nursing or Administrator. This will be done on wee basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee the Administrator or designee to assure corrective action initiated as appropriate Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing prograr reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director of Director of Director Director.	at hire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345543	B. WING _			05/0	02/2016
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		316	EET ADDRESS, CITY, STATE, ZIP CODE NC HIGHWAY 801 SOUTH VANCE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page				Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016		
F 226 SS=G	483.13(c) DEVELOP ABUSE/NEGLECT, E		F 2	226			5/24/16
	policies and procedu	t, and abuse of residents					
	by: Based on record revinterviews the facility the administrator or Dan allegation of abus sampled for abuse (Fresulted in a delay of abuse to the North C Personnel Registry (Frindings included: Resident #237 was a 04/15/16 with diagnovertebra, history of faterm use of anticoaguly hyperlipidemia. Review of the compreminimum data set (Mindicated that Reside intact and required or with bed mobility, traipersonal hygiene. The Resident #237 required one staff member with the substitution of the compressional hygiene.	Resident #237) which reporting an allegation of arolina Health Care state agency).  dmitted to the facility on ses that included fracture of alls, atrial fibrillation, long alant, diabetes mellitus, and ehensive admission DS) dated 04/22/16 ant #237 was cognitively the person limited assistance			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or wil 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 F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES. Corrective Action: Resident #237. Resident #237 was physically assessed No injuries, or marks or bruises were noted at that time. Quest Laboratory was contacted immediately. Lab Technician was not allowed to return to facility. Identification of other residents who make involved with this practice:	II d. d.	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	
		345543	B. WING _			05/	02/2016
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DEDMUD	COMMONG NUBOING	AND DELIABILITATION CENTED		316	6 NC HIGHWAY 801 SOUTH		
BEKMUDA	COMMONS NURSING	AND REHABILITATION CENTER		AD	OVANCE, NC 27006		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 226	Continued From page	<u> </u>	F 2	226			
			' 2	.20	All regidents have the netential to be		
	read, in part, "It is the	y's abuse policy dated 07/15			All residents have the potential to be affected by the alleged practice. All ale	rt	
	employees, facility co	· · · · · · · · · · · · · · · · · · ·			and oriented residents were interviewe		
		embers, visitors, etc. to			on 5/20/2016 by Pam Keiser SW and	u	
		ncident or suspected incident			asked if they had felt abused by staff,		
		abuse, including injuries of			residents, or anyone else in the facility.		
	_	theft or misappropriation of			We also informed residents of who to		
	resident property, to				report suspected abuse to if need be. N	10	
		n order dated 04/15/16 read,			new allegations were reported.		
		on used to thin the blood) 2			Phlebotomists were also in-serviced ab	out	
	milligrams (mg) by m	•			reporting abuse and who to report to.		
	Review of a physician	n order dated 04/15/16 read,			Systemic Changes:		
	draw a prothrombin to	ime (PT) and international			Director of Nursing and /or Designee In	ı	
	normalized ratio (use	d to evaluate how quickly	serviced all staff (full time, part time, and			nd	
	the blood clots) every				PRN) to inform them that Abuse will no		
		n dated 04/18/16 stated that			be tolerated and if there is any allegation		
		n an anticoagulant with risk			of abuse it must be reported immediate		
		mal bleeding. The goal for			to the Administrator or Director of Nursi	ng.	
		n stated Resident #237 was			All staff should always report any		
		mfort or adverse reactions			witnessed or suspected or reported abo		
	•	ant use through the next rvention included draw labs			promptly to the Administrator or Director of Nursing. Everyone is responsible for		
		t abnormal labs to the			reporting. The facility has developed ar		
	physician.	t abnormal labs to the			implemented written policies and	iu	
		ory report dated 04/25/16			procedures that prohibit mistreatment,		
	read that the collection	- Table - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			neglect, and abuse of residents and		
		and was received in the			misappropriation of resident property. A	AII .	
	laboratory on 04/25/1	6 at 9:12 AM.			reports of resident verbal, sexual, phys		
	-	ent #237 on 04/25/16 at 2:54			and mental abuse, corporal punishmen		
	PM revealed that at 4	1:30 AM on 04/25/16 a			involuntary seclusion, neglect, or		
	laboratory employee	came into her room to draw			misappropriation of resident property sl	hall	
		#237 stated that when the			be promptly and thoroughly investigate	d	
	laboratory employee	turned on the light it startled			by facility management. It is the		
	her from sleep and sl	ne asked the laboratory			responsibility of our employees, facility		
		urn the light off and the			consultants, attending physicians, famil	ly	
		ignored her request so			members, visitors, etc. to promptly repo	ort	
	Resident #237 again				any incident or suspected incident of		
		urn the light off and again			neglect or resident abuse, including		
	the laboratory employ	yee ignored her request.			injuries of an unknown source and thef	t or	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
						С	
		345543	B. WING _		n	5/02/2016	
NAME OF PI	ROVIDER OR SUPPLIER	<b>.</b>		STREET ADDRESS, CITY, STATE, ZIP COD		5/02/2010	
				316 NC HIGHWAY 801 SOUTH			
BERMUDA	A COMMONS NURSIN	IG AND REHABILITATION CENTER		ADVANCE, NC 27006			
(V4) ID	SLIMMAD	/ STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	NDDECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	Continued From p	age 7	F 2	26			
	Resident #237 sta	ted that then the laboratory		misappropriation of resident p	property, to		
	employee proceed	led to very roughly draw blood		facility management. The fac	ility will not		
	from her right ante	ecubital (the region of the arm in		employ individuals who have	been found		
		and after applying a cotton ball		guilty of abusing, neglecting,	or		
		over the site slapped her		mistreating residents by a co			
		s if "slapping on a Band-Aid."		have had a finding entered in			
		ted she was crying because		nurse aide registry concernin	•		
		ry employee turned on the light		neglect, mistreatment of resid			
		caused her to have a back		misappropriation of their prop	•		
	1 -	ne behavior and the actions of		report any knowledge it has o	-		
		bloyee added to her stress.		a court of law against an emp	•		
		ted she was afraid of this		would indicate unfitness for s			
		ee and did not want her coming		nurse aide or other facility sta			
		ncident to her nurse.		State nurse aide registry or lie authorities. The facility will en	-		
	· ·	se #3 on 4/26/16 at 4:21 PM		alleged violations involving m			
		4/25/16 at 8:30 AM Resident		neglect, or abuse, including in			
		that she wanted someone else		unknown source and misappi	-		
		Resident #237 stated to Nurse		resident property are reported	•		
		ory employee that drew her		immediately to the administra			
		g was really rough while		facility and to other officials in			
		and then slapped the middle of		with State law through establi			
	_	ping on a Band-Aid." Resident		procedures (including to the S			
		d to Nurse #3 that the lab		and certification agency). The			
		I her to "stop crying" and that		have evidence that all alleged	-		
		this laboratory employee and		are thoroughly investigated, a			
		draw her blood anymore.		prevent further potential abus			
	Nurse #3 stated th	at she immediately reported		investigation is in progress. V	Vithin 24		
	the incident to Sup	pervisor #1 and Supervisor #2		hours of the reported abuse of	or		
	as soon as she ex	ited Resident #237's room		suspension of abuse, the Dire	ector of		
	approximately 5 to			Nursing or Administrator mus			
		ervisor #1 on 04/26/15 at 4:40		fax what is called a "24 hour"	•		
		Nurse #3 reported to her and		report is sent to the Departme			
		pproximately 9:00 AM on		and Human Services Personi			
		aboratory employee that drew		Registry. The purpose of the	•		
		lood that morning was really		notify the agency that possibl			
	,	the needle in her arm and was		neglect has occurred and tha	-	<b> </b>	
		risor #1 stated that Nurse #3		is conducting an investigation		<b> </b>	
	stated that Reside	nt #237 was uncomfortable and		days a 5 day report must also	be		

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OLIVILIV	OT OIL WILDIO, WE G	WEDIO/ ND OLITATOLO				<u> </u>	<del>7. 0000 000 1</del>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
			, BOILDI	_		,	С
		345543	B. WING				02/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				3′	16 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		Α	DVANCE, NC 27006		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 226	Continued From page	e 8	F	226			
		ratory employee back into			submitted. This report will include witn	<b>ess</b>	
		#1 stated she could not			statements, findings and interventions.	000	
		ted that Resident #237 was			The results of all investigations will be		
		ory employee and could not			reported to the administrator or his		
		ted that the laboratory			designated representative and to other		
		ed the arm of Resident #237.			official's in accordance with State law		
		she would have to ask			(including to the State survey and		
	Nurse #3 exactly wha	at she had reported to her.			certification agency) within 5 working d	ays	
	Supervisor #1 stated	that she had instructed			of the incident, and if the alleged		
	Supervisor #2 to call	the laboratory and tell them			violations verified appropriate correctiv	е	
	to not send that empl	loyee back to the facility.			action must be taken. This in service w	as	
	· ·	she did not follow up with			completed by 5/24/2016. Any staff		
	Supervisor #2 and wa				member (full time, part time, and PRN)		
		s name. Supervisor #1			who did not receive in-service training	will	
		ot go talk to Resident #237			not be allowed to work until training is		
		ne resident. Supervisor #1			completed. Phlebotomists were also		
		ot inform the DON of the			in-serviced about reporting abuse and		
	incident.	: #0 04/00/40 -t 4:50			who to report to by 5/24/2016 by	_	
		visor #2 on 04/26/16 at 4:58			Phlebotomy Managers/Supervisor. Any	/	
		rse #3 had reported to her			Phlebotomists (full time, part time, and		
	-	approximately 9:00 AM on nt #237 did not want the			PRN) who did not receive in-service training will not be allowed to work in the	10	
		that drew her blood on			facility until the training is complete. The		
		er room, Resident #237			information has been integrated into th		
		itory employee was verbally			standard orientation training and in the		
		slapped her in the arm "as if			required in-service refresher courses for		
	, -	on her arm. Supervisor #2			all employees and will be reviewed by		
		reported that Resident #237			Quality Assurance Process to verify that		
	was fearful of this lab				the change has been sustained. Quest		
		that she had reported this to			has also incorporated this to their new		
		illed the laboratory and told			process for phlebotomist.		
	them the employee w	vas no longer welcome in					
		sor #2 was unaware of the			Monitoring:		
		s name. Supervisor #2			To ensure compliance, Administrator o	r	
		and talk to Resident #237			Director of Nursing or designee will		
		afternoon and apologized for			monitor this issue using the QA survey		
	the laboratory employ				tool. Facility will monitor compliance by		
		ON on 04/26/16 at 5:07 PM			interviewing 5 alert and oriented reside	nts	
	revealed she had not	previously been made			weekly in reference to: Have they felt		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.455.40				С
		345543	B. WING		05/	02/2016
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DEDMUDA (	COMMONE NUIDEING	AND DELIABILITATION CENTED		316 NC HIGHWAY 801 SOUTH		
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
# F 241 4 SS=G III	aboratory employee confirmed that she wancident until the survice tention. The DON states aboratory of the incident and supervisor #1 and/or mmediately report the management of the incidence of the investigation of abuse to the investigation of abuse to the investigation coulleport filed with the set investigation of abuse to the investigation	with Resident #237 and the by the facility staff. The DON as not made aware of the reyor brought it to her stated that after hearing the idered this an allegation of ted she would have expected a Supervisor #2 to a sis to her so she could have an investigation, notified the dent and filed a 24 hour state agency.  We will be be be a started the sted and submitted the 24 te agency and had a submitted the 24 te agency and had a with no return call. The re of the laboratory supervisor and a with no return call. The re of the laboratory at drew Resident #237 blood ministrator on 04/28/16 at at she expected Supervisor 2 to immediately report the to the DON or herself so that all do be started and the 24 hour tate agency timely.  AND RESPECT OF	F 22	abused by staff, residents, or anyone in the facility, and if yes did they report to staff. This will be done on weekly be for 4 weeks then monthly for 3 months the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropria Any immediate concerns will be broug the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director Nursing, MDS Coordinator, Unit Mana Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.  Date of Compliance: 5/24/2016	t it asis by  te. ht to or l be am ing of ger,	5/24/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDII			С
		345543	B. WING _			5/02/2016
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/02/2010
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
	OU MAA DV OT	ATEMENT OF REFIGIENCIES	<u></u>		OTION!	245
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	Continued From page	e 10	F 2	241		
		iew and resident and staff		The statements made on this Pla	ın of	
		failed to treat a resident with		Correction are not an admission t		
	_	hen a laboratory employee		not constitute an agreement with		
		manner that caused a		alleged deficiencies. To remain in		
	resident to be fearful			compliance with all Federal and S		
	residents sampled for	r respect and dignity		Regulations the facility has taken		
	(Resident #237).			take the actions set forth in this P		
	The findings included	l:		Correction. The Plan of Correction	n	
	Resident #237 was a	dmitted to the facility on		constitutes the facility's allegation	of	
		ses that included fracture of		compliance such that all alleged		
	vertebra, history of fa	ills, and long term use of		deficiencies cited have been or w	ill be	
	anticoagulant.			corrected by the date or dates inc	licated.	
	Review of the compre			F241 DIGNITY AND RESPEC	T OF	
	minimum data set (M	The state of the s		INDIVIDUALITY.		
		nt #237 was cognitively		Corrective Action:		
	1	ne person limited assistance		Resident #237.	_	
	with bed mobility, trai	<del>-</del>		Resident #237 was physically ass		
		e MDS further revealed that		No injuries, or marks or bruises w		
		ed extensive assistance of		noted at that time. Solstas Labora	-	
	I .	h dressing and had no		contacted immediately. Lab Tech		
	1	al upper or lower extremities.		was not allowed to return to facilit	•	
		ent #237 on 04/25/16 at 2:54		Identification of other residents w	no may	
	PM revealed that at 4	<u> </u>		be involved with this practice:	ho	
	1 -	her room to draw her blood.  I that when the laboratory		All residents have the potential to affected by the alleged practice. A		
		the light it startled her from		and oriented residents were interv		
	, , ,	the laboratory employee to		on 5/20/2016 by Pam Keiser SW		
	please turn the light of			asked if all staff treated them with		
	1 *	r request so Resident #237		and dignity. No new allegations w	•	
		ratory employee to please		reported.		
	turn the light off and a			Systemic Changes:		
		red her request. Resident		Director of Nursing and /or Design	nee In	
		the laboratory employee		serviced all staff (full time, part tin		
	I .	ughly draw blood from her		PRN) to inform them that, all staff		
	1 *	after applying a cotton ball		promote care for residents in mar		
	_	er the site slapped her		in an environment that maintains		
	1	"slapping on a Band-Aid."		enhances each resident's dignity		
	I .	I she was crying because		respect in full recognition of his or		
		emplovee turned on the light		individuality. This in service was		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _		l ,	_
		345543	B. WING			1	C 02/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	02:20:0
				3′	16 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSIN	G AND REHABILITATION CENTER		Α	DVANCE, NC 27006		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 241	Continued From pa	age 11	F:	241			
	· ·	caused her to have a back		_ ' '	completed by 5/23/2016. Any staff		
		e behavior and the actions of			member (full time, part time, and PRN)		
	-	loyee added to her stress.			who did not receive in-service training		
		ed the laboratory employee			not be allowed to work until training is		
		" Resident #237 further stated			completed. This information has been		
		nis laboratory employee and			integrated into the standard orientation		
		ming back into her room.			training and in the required in-service		
	Resident #237 stat	ed she had reported the			refresher courses for all employees and	d	
	incident to her nurs	se.			will be reviewed by the Quality Assurar	ice	
	Interview with Nurs	e #3 on 4/26/16 at 4:21 PM			Process to verify that the change has		
		1/25/16 at 8:30 AM Resident			been sustained.		
		that she wanted someone else					
		Resident #237 stated to Nurse			Monitoring:		
		ory employee that drew her			To ensure compliance, Administrator of	r	
	_	was really rough while			Director of Nursing or designee will		
		and then slapped the middle of bing on a Band-Aid." Resident			monitor this issue using the QA survey tool. Facility will monitor compliance by		
		to Nurse #3 that the lab			interviewing 5 alert and oriented reside		
		her "stop crying" and that she			weekly in reference to: Does staff treat		
		aboratory employee and did			them with dignity and respect. This will		
		w her blood anymore. Nurse			done on weekly basis for 4 weeks then		
		dent #237 was no longer			monthly for 3 months by the Support		
		ported the incident but was			Nurse, Unit Manager, or designee.		
	visibly shaken up b	y the event. Nurse #3 stated			Reports will be presented to the weekly	,	
	that she apologized	d for the behavior of the			QA Committee by the Administrator or		
	laboratory employe	e behavior and reassured her			designee to assure corrective action		
		e care of the situation. Nurse			initiated as appropriate. Any immediate		
		immediately reported the			concerns will be brought to the Director		
		sor #1 and Supervisor #2 as			Nursing or Administrator for appropriate		
		Resident #237's room			action. Compliance will be monitored a		
	approximately 5 to				ongoing auditing program reviewed at t		
	•	view with Resident #237 on			Weekly Quality of Life Meeting. Weekly	′	
	04/26/16 at 6:35 Pt				QA Committee meeting is attended by		
		had come and talked to her ident and informed her that the			Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support	>	
		e would not be allowed back			Nurse, Therapy, HIM, Dietary Manager		
		esident #237 stated she			Wound Nurse.	,	
	_	relief" when she heard this			Date of Compliance: 5/24/2016		
	_	ent #237 further stated that she			2 3.0 0. 00. phanos. 0/24/2010		

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345543	B. WING			C
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	] 5:	STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	1 05/	02/2016
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241 F 242 SS=G	crack open not knowi employee was coming Interview with Supervia AM revealed Nurse # approximately 9:00 A with Resident #237 at Supervisor #2 stated and apologized for the behavior, Supervisor that all employees we to the residents and rincluded laboratory ele Interview with the DO revealed that she expincluding laboratory ethe residents and not certainly not make the The DON stated she and made them awar informed them that the allowed back into the Interview with the Adr 2:51 PM revealed that employees including respectful to the resident to them and absolute fearful of them. The allaboratory employee back into the facility. 483.15(b) SELF-DET MAKE CHOICES  The resident has the schedules, and health her interests, assessinteract with members interests.	r" every time her door would ng if the laboratory g back into her room. isor #2 on 04/27/16 at 10:55 and reported at M on 04/25/16 the incident and the laboratory employee. She went to Resident #237 are laboratory employee's #2 reassured Resident #237 are expected to be respectful to talk harshly to them, this imployees.  N on 04/27/16 at 12:00 PM lected all employees mployees to be respectful to speak harshly to them and are resident fearful of them. In the dontacted the laboratory end of the incident and end employee is no longer facility.	F2	241		5/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON: IDENTIFICATION NUMBER:  A. BUILDING		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		1	C / <b>02/2016</b>
NAME OF PR	ROVIDER OR SUPPLIER	ı	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	02/2010
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242	Continued From page	e 13	F 24	42		
	about aspects of his or are significant to the	or her life in the facility that resident.				
	by: Based on record revinterviews the facility request to not have he for 1 of 1 residents sa #237) when a laborate permission or explain obtaining the blood from The findings included Resident #237 was a 04/15/16 with diagnosy vertebra, history of fatterm use of anticoagul hyperlipidemia. Review of the compreminimum data set (Mindicated that Reside intact and required or with bed mobility, train personal hygiene. The Resident #237 requirement to bilaterate to the facility of the comprementation of t	dmitted to the facility on ses that included fracture of alls, atrial fibrillation, long allant, diabetes mellitus, and sehensive admission DS) dated 04/22/16 and #237 was cognitively the person limited assistance the mestive assistance of the dressing and had no all upper or lower extremities.		The statements made on this Plan Correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken of take the actions set forth in this Plate Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indice F242 SELF-DETERMINATION-TO MAKE CHOICES Corrective Action:  Resident 237.  The care plan for resident #237 was immediately updated to reflect residence for preferred time for getting drawn for laboratory. Facility In sensitive and the development of the sensition of the sensitio	te te will of be ated. RIGHT sent's blood iced PNs, on	
	Coumadin (medication milligrams (mg) by makeview of a physician draw a prothrombin to normalized ratio (use the blood clots) every Review of a care plant Resident #237 was of for toxicity and abnormalized ratio (use the blood clots) every Review of a care plant acres the second resident #237 was of toxicity and abnormalized rational resident #237 was of toxicity and abnormalized rational resident with the second resident r	n order dated 04/15/16 read, me (PT) and international d to evaluate how quickly		the updated care plan for resident areference to her preferred time for go blood drawn for laboratory. Identification of other residents who be involved with this practice: All residents have the potential to be affected by the alleged practice. All and oriented residents were intervier reference to the alleged practice or 5/20/2016 by Pam Keiser SW. Reswere asked if they have a choice of	etting may e alert wed in dents	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
			71. 501251			، ا	2
		345543	B. WING			1	02/2016
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		02/2010
				31	16 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER			DVANCE, NC 27006		
	CUMMADVCT	TATEMENT OF DEFICIENCIES			·		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Continued From page	e 14	F	242			
	to be free from discor	mfort or adverse reactions			they have their labs drawn, do they hav	∕e a	
	related to anticoagula	ant use through the next			choice when they go to sleep, do they		
	_	rvention included draw labs			have a choice when they want to get u	ο,	
	as ordered and repor	t abnormal labs to the			do they have a choice to have a bed ba		
	physician.				or shower, and do have a choice to ref	use	
	Review of PT laborat	ory report dated 04/25/16			treatment or lab draws.		
	read that the collection				Systemic Changes:		
		and was received in the			Director of Nursing and /or Designee in	1	
	laboratory on 04/25/1				serviced all nursing staff (RNs, LPNs,		
		n order dated 04/25/16 read			CNAs full time, part time, and PRN) on		
		04/26/16 and recheck PT on			the fact that each resident has the right		
	04/27/16.				choose activities, schedules, and healt		
		ory report dated 04/27/16			care consistent with his or her interests		
	read that the collection				assessments, and plans of care; intera	Ct	
		and was received in the			with members of the community both		
	laboratory on 04/27/1	ent #237 on 04/25/16 at 2:54			inside and outside the facility; make choices about aspects of his or her life	in	
	PM revealed that at 4				the facility that are significant to the	""	
		her room to draw her blood.			resident. Each resident has a right to		
		I that the lab employee never			choose the preferred time to getting		
		n to draw her blood, the lab			laboratory blood work done. Education		
		plain what she was going to			also included on what to do when a		
		byee stated "I am going to			resident refuses to get a laboratory blo	od	
		sident #237 stated she was			work done or treatment. This in service		
		d to wake her up at 4:30 AM			was completed by 5/24/2016.		
	to draw her blood. R	esident #237 further stated			Phlebotomists were also in-serviced th	at	
	each time that the lat	ooratory employee had			the residents have the right to refuse		
	drawn her blood which	ch had been 2 times, it had			treatment and lab draws on 5/24/2016	by	
		morning hours around 4:00			Phlebotomy Managers/Supervisor. It is		
		he did not like not having a			expected the phlebotomist will ask		
		Resident #237 also stated "I			permission from each resident before la	ab	
		ey could just do it then."			draw. If the resident refuses the		
		it Director on 04/27/16 at			phlebotomist will not draw labs but will		
		at the laboratory employees			notify the nurse immediately. Each		
		tween 4:00 AM and 5:00 AM			nursing staff will review the Kardex of	ul.	
	-	ursday's because they travel			every resident they are assigned to wo	rk	
	_	in the area. The Unit Director			with prior to start of assignment. Any		
		ent #237 blood had been 00 AM and 5:00 AM on			nursing staff member (RNs, LPNs, Medication Aides, CNAs full time, part		
	LUUJAINEU DEIWEEN 4.U	O CIVI ALIU J.UU AIVI UII	1		i iviculcation Alucs. CNAS IUII IIIIE. Dati		1

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AND LEAR OF CONNECTION   IDENTIFICATION NOWIDER.   A. BUILDING	(X3) DATE SURVEY COMPLETED	
345543 B. WING	C	
	05/02/2016	
BERMUDA COMMONS NURSING AND REHABILITATION CENTER  316 NC HIGHWAY 801 SOUTH		
ADVANCE, NC 27006		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345543	B. WING		C <b>05/02/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/02/2016
				316 NC HIGHWAY 801 SOUTH	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 242	Continued From pag	ne 16	F 2	reviewed at the Weekly Quality Meeting. Weekly QA Committee is attended by Administrator, Di Nursing, MDS Coordinator, Unit Support Nurse, Therapy, HIM, I Manager, Wound Nurse. Date of Compliance: 5/24/2016	e meeting frector of t Manager, Dietary
F 312 SS=E	483.25(a)(3) ADL CA DEPENDENT RESID	ARE PROVIDED FOR DENTS	F3	-	5/24/16
	daily living receives	able to carry out activities of the necessary services to on, grooming, and personal			
	by: Based on observation interviews, the facility with the care of finger residents dependent living (Residents #36). The findings included 1. Resident #36 was 04/20/15 with diagnor dementia, osteoarthy stiffness, and depression The annual Minimum 03/14/16 indicated Rimpaired for daily defected extensive assistance living (ADL) including	admitted to the facility on oses which included ritis, hand contractures, joint		The statements made on this F Correction are not an admission not constitute an agreement wit alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correctionstitutes the facility's allegatic compliance such that all alleged deficiencies cited have been or corrected by the date or dates in F312 ADL CARE PROVIDED DEPENDENT RESIDENTS Corrective Action:  Resident #36, #121, #10 and # were cleaned and trimmed. Identification of other residents be involved with this practice:	n to and do th the in I State en or will Plan of tion on of d will be ndicated. D FOR

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345543	B. WING			С
NAME OF B		343343	D. WING_	OTDEET ADDRESS SITV STATE TO SE	<u> </u>	05/02/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
BERMUD	A COMMONS NURSIN	IG AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
				ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From p	age 17	F 3	12		
F 312	MDS further reveal range of motion to extremities.  The current care prevealed Resident performance deficing assistance with AL was for the Reside of function with perplan included appropriate and clean as infurther included strain and clean as infurther included straining, grooming.  A review of the animal dated 03/14/16 review of the animal care with the performance of care, in and required exterincluding nail care.  A review of the fact Resident #36 was Tuesday and Fridat PM to 11 PM.  A review of documental daily report revealed.	led Resident #36 had impaired both sides ' upper and lower lan last reviewed 03/14/16 #36 had a self-care it which required total DLs. The ADL care plan goal ent #36 to improve current level resonal hygiene. The ADL care toaches to assist Resident #36 ds, and check nail length and necessary. The care plan eff to provide assistance with and personal hygiene.  Inual summary nurses notes realed Resident #36 was ed cognitively, had no signs of that contractures to her hands insive assistance for all ADLs	F3	All residents have the potent affected by the alleged pract resident's nails (fingers and assessed on 5/19 by Debi F for cleanliness to provide contheir physical and mental new prevent spread of infection, cleanliness and to prevent shall long and dirty finger nails trimmed and cleaned. Systemic Changes:  Director of Nursing and /or I serviced all nursing staff (RI Medication Aides, CNAs full time, and PRN) that a residu unable to carry out activities must receive the necessary maintain good nutrition, groupersonal and oral hygiene. If fingers and toes has to be presidents to provide comfort physical and mental needs, spread of infection, to provide and to prevent skin problem service was completed by 5 nursing staff member (RNs, Medication Aides, CNAs full time, and PRN) who did not in-service training will not be work until training is compleinformation has been integrated.	tice. All toes) were flinchum RN pmfort, to meet beds, to to provide skin problems. So were  Designee in Ns, LPNs, I time, part ent who is sof daily living services to oming, and Nail care of provided to the top revent de cleanliness is. This in 1/24/2016. Any LPNs, I time, part is receive en allowed to the total to the deted. This part is redefined to the deted. This atted into the	
	care task informati dependent on staf The NA care task included nail care	ent #36's nursing assistant (NA) ion specified she was if for showers and grooming. further specified grooming every shift. ition on 04/25/16 at 1:08 PM		required in-service refreshe all employees and will be re Quality Assurance Process the change has been sustai Monitoring: To ensure compliance, Dire or designee will monitor this	r courses for eviewed by the to verify that ned.	

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		345543	B. WING _				C <b>02/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER	1	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	02.20.0
				31	6 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ΑI	DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	e 18	F3	312			
F 312	Resident #36 was obroom. The skin betwhands were observed all the fingernails had skin around the fingernails of both had that same as the prevol/25/16.  During an observation Resident #36 was in fingernails of both had that same as the prevol/25/16.  During an observation Resident #36 was in fingers of both hands flaky skin and all the and crusty skin arourd During an observation Resident #36 was in her bed bath and fee Resident #36 fingers observed and remain between all the finger fingernails with all the On 04/27/16 at 5:54 care for Resident #36 stated Resident #36 assistance with all All grooming and person stated Resident #36 Tuesday and Friday of PM to 11 PM and that washing, shaving, and did not provide nail contents.	served in a Geri chair in her een the fingers of both divith crusty flaky skin and dirough edges and crusty rnails.  In on 04/26/16 at 12:22 PM bed and the fingers and nds were again observed vious observation of  In on 4/26/16 at 4:44 PM bed. The skin between the ewere observed with crusty fingernails had rough edges and the fingernails.  In on 04/27/16 at 1:22 PM bed and stated she just had als like a new woman, and fingernails were ed with crusty flaky skin are and around all the enails with rough edges.  PM NA #1, who provided was interviewed. NA #1 required extensive DLs including, showers, all hygiene. NA #1 further received her showers on on the 2nd shift between 3 t showers included hair d nail care. She stated she are for Resident #36.		312	the QA survey tool. Facility will monitor compliance by observing 5 residents requiring assistance with ADLs. This w be done on weekly basis for 4 weeks the monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Directo Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager Wound Nurse.  Date of Compliance: 5/24/2016	ill nen	
	Tuesday and Friday of PM to 11 PM and that washing, shaving, and did not provide nail c	on the 2nd shift between 3 t showers included hair d nail care. She stated she are for Resident #36.  PM the Director of Nursing					

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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	Resident #36 's nail The DON stated it we care and shaving we and more frequently were dirty. The DON responsible for nail clean and neat.  On 04/28/16 at 3:08 care and supervised Resident #36 resider revealed residents in showers or baths ar Nurse #3 verified na Resident #36. Nurse expectation that the for the residents and clean, well groomed trimmed and cleane On 04/28/16 at 4:26 interviewed. The Ad should be clean and Administrator verifier residents to have dat trimmed and cleane appropriately.  2. Resident #121 was 11/25/14 with diagnoof the nervous system of the nervous system of the guarterly Minim 02/26/16 revealed Filling (ADLs) including the MDS filling.	I care was not completed.  Vas her expectation that nail ere completed with showers between showers if they I stated that the NA's were care and keeping residents  PM Nurse #3, who provided I the NAs on hall where d was interviewed. Nurse #3 eccived nail care during their and as needed in between.  I care was not provided for e #3 explained it was her NAs were to provide nail care d ensure the residents were d, and fingernails were d.  PM the Administrator was ministrator stated all residents	F 3	12		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345543	B. WING			C <b>5/02/2016</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	•	5/02/2016
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 312	or rejection of care.  The current care plar revealed Resident #1 the performance of A diagnosis of nervous plan goal was for the free of discomfort or disease diagnosis. The approaches to provid Resident #121, to checlean as needed.  A review of the facility Resident #121 was soon Tuesday and Friday of AM to 3PM.  A review of Resident (NA) care information dependent on staff for Further review of Hos 02/01/16, and 01/15/staff were to anticipate and required total care.  A review of the facility 02/24/16 at 8:16 PM staff were to anticipate and required total care.  A review of the Hosping 3/28/16 12:30 PM review of the Hosping 3/28/16	not coded for any behaviors  I last reviewed on 02/26/16 21 required assistance with DLs due to the effects of the disorder. The ADL care Resident #121 to remain complications related to the he ADL care plan included e extensive assistance for eck nail length, and trim and  y shower schedule indicated cheduled for showers on on the 1st shift between 7  #121's nursing assistant in sheet specified she was in showers and grooming.  spice nurses notes dated 16 indicated Resident #121 the Resident #121 's needs the from staff for all ADLs.  y nurses notes dated indicated Resident #121 the Resident #121 's needs the from staff for all ADLs.  ice nurses note dated wealed Resident #121 ance with transfers and ed weakness and was totally	F 3 <sup>-</sup>			

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		1 1	PLE CONSTRUCTION  G		CX3) DATE SURVEY COMPLETED C	
		345543	B. WING _			05/02/2016
	ROVIDER OR SUPPLIER	G AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	· · ·	00/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	A review of the Ho at 10:09 AM revea assistance with all dependent of staff  A review of docum revealed Resident Tuesday 04/26/16  During an observa Resident #121 was room. Resident #1 were observed to with jagged edges and a tan colored substance as previous on 04/27/16 at 1:4 care for Resident #1 assistance with all grooming and persistated Resident #1 Tuesday 04/26/16 the hours of 7 AM included hair wash	spice nurses note dated 4/7/16 led Resident #121 required ADLs and was totally for her care.  entation for bath and hygiene #121 received her shower on during the 1st shift.  tion on 04/26/16 at 12:12 PM is up in her wheel chair in her 21 's fingernails to both hands be approximately ½ inch long in old chipped pink nail polish, substance under all the nails.  tion on 04/27/16 at 1:22 PM is in her wheel chair and her is deling with jagged edges and ince under all the nails the	F3	12		
	(DON) was intervie Resident #121 's r The DON stated it	6 PM the Director of Nursing ewed. The DON verified nail care was not completed. was her expectation that nail were completed with showers				

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		345543	B. WING		C <b>05/02/2016</b>	
	ROVIDER OR SUPPLIER	G AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 312	Continued From pa	ge 22	F 31:	2		
	were dirty. The DOI responsible for nail clean and neat.  During an observati Resident #121 's fi jagged edges and t all the nails the sam  On 04/28/16 at 3:08 care and superviser Resident #121 resident #121 resident #121 resident #121. Nurse #3 verified na Resident #121. Nur expectation that the for the residents and	y between showers if they N stated that the NA's were care and keeping residents  ion on 04/28/16 at 8:45 AM ingernails remained long with an colored substance under the as previous observations.  B PM Nurse #3, who provided d the NAs on hall where ded was interviewed. Nurse #3 received nail care during their and as needed in between. ail care was not provided for ise #3 explained it was her be NAs were to provide nail care d ensure the residents were d, and fingernails were				
	interviewed. The Ac should be clean and Administrator verific residents to have distrimmed and cleaned appropriately.  3. Resident #10 wa 04/02/10 with diagnal Alzheimer 's, and control to the current care played revealed Resident # assistance with ADI dementia. The ADL	an last reviewed 01/11/16 #10 required extensive L due to diagnosis of				

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		345543	B. WING			C 5/02/2016	
	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	length and trim and The quarterly Minim 04/12/16 revealed F impaired for making required extensive a daily living (ADL) in personal hygiene are bathing.  A review of the active 4:08 PM revealed F confused, and receive with red nail polish.  A review of the nurs revealed Resident # with confusion and needs and she required for Daily living (ADLs).  A review of docume daily report revealed shower on Wedness shift.  A review of the facil Resident #10 was so Wednesday and Sabetween 7 AM to 3  A review of Resider care information she grooming daily which needed and further	clean as necessary.  Jum Data Set (MDS) dated Resident #10 was severely decisions of daily living and assistance with all activities of cluding assistance for nd total assistance with  Lesident #10 was pleasantly ved and accepted a manicure  Lesident #10 was pleasantly ved and accepted a manicure  Lesident #10 was pleasant staff were to anticipate her uired total care for all Activities as).  Intation for bath and hygiene d Resident #10 received her day 04/27/16 during the 1st  Lety shower schedule indicated cheduled for showers on turday on the 1st shift	F 31	2			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345543	B. WING _	B. WING			05/02/2016	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	,	316 N	EET ADDRESS, CITY, STATE, ZIP CODE NC HIGHWAY 801 SOUTH NANCE, NC 27006	, 00.	<u> </u>	
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ION SHOULD BE THE APPROPRIATE		
F 312	Continued From page		F;	312				
	Resident #10 's finge old chipped red nail ppast the cuticle. All the were ½ inch long with colored substance under the substa	on 04/26/16 at 4:58 PM emails remained with the old inch long with jagged edges ader all of the nails.  on 04/27/16 at 1:14 PM ing transported in her wheel wher family representative to ident #10 's fingernails on erved the same as previous days 04/25/16 &  PM the Director of Nursing ed. The DON verified care was not completed. Its her expectation that nail the completed with showers between showers if they stated that the NA's were						
	clean and neat. On 04/27/16 at 3:11 F	PM NA #3, who provided was interviewed. NA #3 required extensive						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345543	B. WING		C 05/03/2016		
	NAME OF PROVIDER OR SUPPLIER  BERMUDA COMMONS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		05/02/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 312	grooming and perso stated Resident #10 Wednesday and Sat between 7 AM to 3 F hair washing, shavir revealed she provide today (04/27/16) and On 04/27/16 at 5:54 care for Resident #1 on 04/25/16 & today NA #1 stated Reside on day shift and that washing, shaving, a stated that sometime provided manicures their nails. NA #1 remail care for Resident #10 reside revealed residents in showers or baths and Nurse #3 verified nad Resident #10. Nurse expectation that the for the residents and clean, well groomed trimmed and cleaned on 04/28/16 at 4:26 interviewed. The Ad should be clean and Administrator verified residents to have day	DLs including, showers, nal hygiene. NA #3 further received her showers on surday on the 1st shift PM and that showers included ag, and nail care. NA #3 and Resident #10 her shower and did not provide her nail care.  PM NA #1, who provided 0 on the 3 PM to 11 PM shift (04/27/16) was interviewed. And that received her shower as showers included hair and nail care. NA #1 further are the activities department to residents and polished wealed she did not provide and #10 during her shift.  PM Nurse #3, who provided the NAs on hall where down was interviewed. Nurse #3 are eceived nail care during their das needed in between. It care was not provided for a #3 explained it was her NAs were to provide nail care down and fingernails were down.  PM the Administrator was ministrator stated all residents	F 31	2			

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED  C 05/02/2016	
		345543 B. WING					
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	· ·	33/02/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	04/19/13 with diagnous non-Alzheimer's designation.  The quarterly Minimum 03/29/16 indicated impaired in cognition skills and was totally activities of daily living indicated Resident # motion to both sides extremities.  The current care planevealed Resident # assistance with ADL dementia and debilities efficare performance contractures which in ADLs. The ADL care Resident #112 to make function with person plan included approauling and person are with the Hospic included staff to proving and person and person are with the facilities resident #112 was some and person and person and person and person and person and person are with the facilities and person and person and person and person and person and person are with the facilities and person and person and person are with the facilities and person and person and person are with the facilities and person and person are with the facilities and person and person and person are with the facilities and person and person are with the facilities and person are with the facilities and person and person are with the facilities are with the facilities and person are with the facilities and person are with the facilities and person are with the facilities are with the facilities and person are with the facilities are with the facilities and person are with the facilities are with the facili	as admitted to the facility on obses which included ementia, anxiety, and are plantially decision making of dependent on staff for any (ADLs). The MDS further end (ADLs). The MDS further end (ADLs) are plantially decision making of dependent on staff for any (ADLs). The MDS further end (ADLs) are plantially decision making of the plantial impaired range of the upper and lower.  In last reviewed 03/29/16 and the decision of the plantial decisi	F 31				
	daily bed baths for F hair washing and na	A) from Hospice provided Resident #112 which included il care.  t #112's Nursing Assistant					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 312	was dependent on s grooming. The NA ca specified grooming in During an observation Resident #112 was of fingernails were obselving with jagged edg substance under all During an observation Resident #112 was of	mation sheet specified she taff for showers and are task sheet further included nail care every shift.  On on 04/26/16 at 11:21 AM observed in her bed and all erved approximately ¼ inch ges and a brownish tan the fingernails.  On on 04/26/16 at 4:40 PM observed in bed, dressed in a	F 31	2		
	fingernails were obsethis morning 's obsethis morning an observation Resident #112 was or oom with all 10 fingunchanged from the (04/26/16).  On 04/27/16 at 1:17 Resident #112 with a interviewed. NA #4 Resident #112 with a through Friday and thair 2 times a week #4 stated she had cowas awaiting assistated washing. During the Resident #112 's fin have brown colored fingernails and had rexplained she did not attempted to use a not state of the state	on on 04/27/16 at 9:23 AM observed in her chair in her ernails of both hands observation of yesterday  PM the NA #4, who provided her bed baths, was revealed she provided a bed bath daily Monday he bath included washing and nail care as needed. NA ompleted the bed bath and ince for completing her hair interview NA#4 verified gernails were observed to substance under the				

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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		
		345543	B. WING _			C <b>05/02/2016</b>	
NAME OF PROVIDER OR SUPPLIER  BERMUDA COMMONS NURSING AND REHABILITATION CENTER		AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	1 00	02/2010	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	(DON) was interviewed Resident #112 's nail The DON stated it was care was completed with frequently between shiften DON stated that for nail care and keep neat.  On 04/28/16 at 3:08 Find care and supervised to Resident #112 resider revealed residents residents and Nurse #3 verified nail Resident #112. Nurse expectation that the Nor the residents and clean, well groomed, trimmed and cleaned.  On 04/28/16 at 3:34 Finterview with NA #5, Resident #112. A return on 04/28/16 at 4:26 Finterviewed. The Admishould be clean and with Administrator verified.	PM the Director of Nursing ed. The DON verified care was not completed. It is her expectation that nail with showers and more nowers if they were dirty. It is the NA's were responsible by the NA's were responsible by the NA's who provided the NA's on hall where down was interviewed. Nurse #3 deived nail care during their is as needed in between. It is care was not provided for the HA's were to provide nail care the residents were and fingernails were the residents were and fingernails were.  PM attempted a telephone who provided care for the CAM's and the Administrator was the providents.	F3	12			
F 364 SS=D	appropriately. 483.35(d)(1)-(2) NUT PALATABLE/PREFER	RITIVE VALUE/APPEAR, R TEMP es and the facility provides	F 3	64		5/24/16	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/02/2010	
				316 NC HIGHWAY 801 SOUTH			
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 364	Continued From page	e 29	F 3	64			
	food prepared by me	thods that conserve nutritive bearance; and food that is					
	by: Based on observation record review the fact to preserve the nutrition bread stuffing for 1 of the pureed food was. The findings included The facility provided apureed corn bread stream of the pureed stuffing to read on 04/28/16 observation meal service. On 04/28/16 at 12:00 pureeing corn bread stuffing to read desired amount of stuturned the machine of the cook poured hot with During this observation and stated he it was apureed food with water consistency. The coapproximately 2 cups stuffing. He added the water would dilute or composition.  On 04/28/16 at 12:15 stuffing was placed or residents.  On 04/28/16 at 2:58 if	a recipe (not dated) for uffing instructed to use low when pureeing the corn h desired consistency. tions were made of the  PM the cook was observed stuffing. The cook placed a uffing into a food processor, in and while it was running water into the mixture. On the cook was interviewed in its usual practice to "thin" er to reach a mashed potato ook reported he poured of water into the corn bread hat he was not concerned the change the food's  PM the pureed corn bread in the tray line and served to the copy water into the date of water into the corn bread hat he was not concerned the change the food's  PM the Dietary Manager dand explained that water		The statements made on this pleasure correction are not an admission not constitute an agreement with alleged deficiencies.  To remain in compliance with alleged deficiencies the facility or will take the actions set forth in plan of correction. The plan of constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or corrected by the dates indicated.  Corrective Action for Resident Aran audit tool was put into place to utilization of recipes by all production and adily basis. The manager at initiated practice of conducting distand-up meetings with dietary suboth shifts.  Corrective Action for Resident Plasfected. All residents have the potential to affected by this alleged deficient Recipes were reprinted and made available to all staff. The audit to on May 9, 2016 to monitor recipe compliance with established recipes.	federal has take in this correction of will be to monitoriction statistics at aff on the total practice to be to practice de to be garden use an enter the total practice to the	en or aff  y	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345543	B. WING	B. WING		C <b>05/02/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	02/2010	
REDMIID	A COMMONS NUIDSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH			
BERIVIODA	4 COMMONS NORSING	AND REHABILITATION CENTER		ADVANCE, NC 27006			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		) BE	(X5) COMPLETION DATE	
F 364		s specified in a recipe. He ted cooks to follow recipes	F	Systemic Changes An in-service was conducted on Ma 2016 by the Dietary Manager. Those attended were all dietary production The in-service topic included followistandardized recipes and proper preparation of pureed foods. The malso addressed the initiation of daily stand-up meetings for both Dietary of A follow-up in-service was conducted Gallins Corporate Registered Dietitic May 20, 2016. Those who attended all dietary staff. Any in-house staff member who did not receive in-servitraining will not be allowed to work utraining has been completed. Inform presented included following standarecipes, preparation of pureed foods monitoring of nourishment food storareas, maintenance of ingredient bim monitoring of refrigerated storage temperatures and food safety storage temperatures and food safety storage practices.  All monitoring tools/audits will be completed and findings will be report the weekly/monthly QA meeting. This information has been integrated the standard orientation training and required in-service refresher course all Dietary employees and will be reby the Quality Assurance Process to that the change has been sustained Quality Assurance  The Dietary Manager or Consultant Dietitian for Gallins Dining and Nutriwill monitor this issue using the "Die QA Audit" tool. All areas will be mordaily. See attached monitoring tool.	e who staff.  ang		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUIL		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		B. WING		C 05/02/2016	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	1 00/02/2010
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 364 F 371 SS=F	F 371 483.35(i) FOOD PROCURE,		F 36	will be completed 5 days/week for for weeks and then weekly times two mor until resolved by QOL/QA comming Reports will be given to the weekly of Life- QA committee and corrective action initiated as appropriate. Resulter audits will then be shared by the Administrator in the Quarterly QA Mowith the Medical Director with verification of his attendance along with all mention of the QA Team and Department Heep Date of Compliance: 5/24/2016	nonths ttee. Quality e ults of e eeting cation nbers
	This REQUIREMEN by: Based on observati record review the far food items at safe te Fahrenheit (F) or be bins clean and failed use by date for 1 of The findings include 1. On 04/28/16 obs	T is not met as evidenced ons, staff interviews and cility failed to store perishable emperatures of 41 degrees low, failed to keep ingredient it to store food items past the 2 nourishment rooms.		The statements made on this plan of correction are not an admission to a not constitute an agreement with the alleged deficiencies.  To remain in compliance with all fed and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of corrections	eral s taken nis

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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	
						С	
		345543	B. WING _	B. WING		05/	02/2016
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				316 N	NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADV	ANCE, NC 27006		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 371	Continued From page	e 32	F 3	871			
		s's refrigerator internal	'		constitutes the facility's allegation of		
		degrees Fahrenheit. The			constitutes the facility's allegation of compliance such that all alleged		
	-	I thermometer read 53			deficiencies cited have been or will be		
		Inside the refrigerator were			corrected by the dates indicated.		
	_	eam, eggs, cream cheese			corrected by the dates indicated.		
	and additional perish				Corrective Action for Resident Affected		
		AM a thermometer on the			An audit tool was put into place to mon	itor	
		rator measured the internal			safe food storage practices in refrigeral		
	temperature to be 54				storage areas, ingredient bin storage a		
	On 04/28/16 at 11:41				n the nourishment room areas on a da		
		d salad dressing from the			pasis. The manager also initiated pract	-	
		d used the salad dressing to			of completing a daily manager checklis		
	make a pasta salad s	served to residents.					
	On 04/28/16 at 11:45	AM a staff member			Corrective Action for Resident Potentia	lly	
	removed a 1/4 gallon of	carton of half and half cream		/	Affected		
	for use to make mash	ned potatoes.		/	All residents have the potential to be		
		AM the Registered Dietitian			affected by this alleged deficient praction		
		neck the temperature of the			The audit tool began on May 9, 2016	to	
		n the ¼ gallon carton used to les. The RD poured some of		r	nonitor safe food storage practices.		
	the half and half crea	m into a cup. The RD used		5	Systemic Changes		
	a digital thermometer	that recorded the half and			On 4/25/16 the ingredient bins were		
	half cream temperatu	re in the cup to be 56		i	mmediately removed, product in the		
	degrees Fahrenheit.			0	containers was discarded, the containe	rs	
	On 04/28/16 at 11:48	AM the RD was interviewed		l v	were thoroughly cleaned and sanitized		
	and reported that the	kitchen had a history of			and new product was placed in the bins		
	problems with the co	ok's refrigerator's		li li	ids were labeled appropriately. Also or	1	
	-	served the refrigerator's			1/25/16 the Manager removed the		
		that read 54 degrees			outdated items from the nourishment		
	Fahrenheit.			- 1	refrigerators. The refrigerators were		
		AM the RD tested the			horoughly cleaned and sanitized and		
	-	of cream cheese stored in			re-stocked. On 4/28/16 the dietary		
	the cook's frig that m	easured 53 degrees			manager discarded all items that were		
	Fahrenheit.	A A A A A b a construction of the state of t		- 1	nside the Cook's refrigerator which wa		
		AM the morning cook was			above the required temperature range.		
		rted that he checked the			Γhe refrigeration unit was turned off un		
	-	ook's refrigerator "around 7			repaired by equipment repair personne	I.	
		40 degrees Fahrenheit."			Γhe unit was cleaned and sanitized.	_	
	Review of the kitcher	n' temperature log for the		\	When the temperature range was within	n	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	(X3) DATE SURVEY COMPLETED	
			7 5012511		С
		345543	B. WING _		05/02/2016
NAME OF PI	ROVIDER OR SUPPLIER	1 11 1	1	STREET ADDRESS, CITY, STATE, ZIP CODE	03/02/2010
				316 NC HIGHWAY 801 SOUTH	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 371	Continued From page	e 33	F 3	 	
		vealed that on 04/28/16 it		35-41 degrees F the unit was restoo	ked
	_	internal temperature of the		An in-service was conducted on Apr	
	refrigerator to be 43	•		2016 by the Dietary Manager. Those	
		PM the Dietary Manager		attended were all dietary staff. The	
		d and explained that an		in-service topic included bulk storag	e
		of a refrigerator above 41		sanitation and maintenance of food	
	degrees Fahrenheit s	_		storage areas in the nourishment ro	oms.
	immediately to either	himself and/or the		Another in-service was conducted o	n May
	Maintenance Directo	r. He stated that all items		5, 2016 by the Dietary Manager. The	ose
	inside the refrigerator	r had been discarded and		who attended were all dietary staff.	Γhe
		nd the half and half cream		in-service topics covered the results	from
		n used for the lunch meal.		the Annual Re-certification Survey w	hich
	2. During the initial to			included ingredient bin storage,	
		I, the dry ingredient bins		monitoring of refrigerated storage	
		served to be stored under a		temperatures, maintenance of the	
		e. On top of the table was a		nourishment room areas and failure	to
		table was littered with		follow standardized recipes. The	of o
		redient bins contained (1)		in-service also included the initiation	of a
		anko bread crumbs and (3) the ingredient bins revealed:		manager's daily checklist and daily stand-up meetings for both dietary s	hifte
		M the food thickener bin had		A follow-up in-service was conducte	
	brown food crumbs n			Gallins Corporate Registered Dietitia	
		tated the brown particles in		May 20, 2016. Those who attended	
		ed to be crumbs of food.		all dietary staff. Any in-house staff	
	1	20 AM the panko bread		member who did not receive in-serv	ice
		al flakes mixed in the bin and		training will not be allowed to work u	ntil
	l •	g in the panko. Closer		training has been completed. Inform	ation
	observation revealed	the scoop's handle was		presented included following standa	rdized
	resting in the panko.			recipes, preparation of pureed foods	i,
	- On 04/25/16 at 10:2	21 AM the sugar bin was		monitoring of nourishment food store	age
	clean inside but the s	scoop's handle was resting in		areas, maintenance of ingredient bir	ıs,
	the sugar.			monitoring of refrigerated storage	
	_	ons the Dietary Manager was		temperatures and food safety storage	e
	-	rted that the bins should be		practices.	
		other food particles and the		All monitoring tools/audits will be	
	scoops should not be			completed and findings will be report	ted to
		nourishment room on the		the weekly/monthly QA meeting.	
		5/16 at 12:15 PM revealed 1		This information has been integrated	
	bottle of chocolate m	ilk that had an expiration		the standard orientation training and	in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
<b>345543</b> B. WING			C <b>05/02/2016</b>				
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	02/2010
DEDMUD/	COMMONE NUIDEING	AND DELIABILITATION CENTED		3′	16 NC HIGHWAY 801 SOUTH		
DEKINUUA	BERMUDA COMMONS NURSING AND REHABILITATION CENTER			Α	DVANCE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	371 Continued From page 34		F3	371			
	date of 04/18/16, 3 cups of pudding that were dated 04/16/16 and 5 cups of pudding that were dated 04/19/16 were present in the refrigerator. An interview with the Dietary Manager on 04/25/16 at 1:15 PM revealed that he had just been into that nourishment room and had not seen the expired milk or pudding. The dietary manager stated that the pudding was good for 3 days after being placed in the refrigerator and should have been discarded along with the chocolate milk.  Interview with the Administrator on 04/28/16 at 2:51 PM revealed that she would have expected the dietary manager to be routinely checking the refrigerators in the nourishments rooms and discarding expired items and rotating the other items on a daily basis.			required in-service refresher cours all Dietary employees and will be a by the Quality Assurance Process that the change has been sustained.  Quality Assurance The Dietary Manager or Consultar Dietitian for Gallins Dining and Nu will monitor this issue using the "D QA Audit" tool. All areas will be m daily. See attached monitoring too will be 5 days/week for four weeks then weekly times two months or a resolved by QOL/QA committee. will be given to the weekly Quality QA committee and corrective action initiated as appropriate. Results of audits will then be shared by the Administrator in the Quarterly QA with the Medical Director with verific of his attendance along with all me of the QA Team and Department Hereits and corrective and the partment of the QA Team and Department Hereits and will be a shared by the partment of the QA Team and Department Hereits and will be a shared by the partment of the QA Team and Department Hereits and will be a shared by the partment hereits and th		wed erify n y ored nis orts fe-	
F 431 SS=D	483.60(b), (d), (e) DR LABEL/STORE DRU		F4	131	Date of Compliance: 5/24/2016		5/24/16
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a controlled drugs is ma reconciled.  Drugs and biologicals	aloy or obtain the services of the whole establishes a system and disposition of all officient detail to enable an another in; and determines that drug and that an account of all aintained and periodically as used in the facility must be a with currently accepted					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		C	
NAME OF PROVIDER OR SUPPLIER  BERMUDA COMMONS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	05/02/2016	
(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 IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 431	Continued From page	e 35	F 431			
	professional principle appropriate accessor instructions, and the e applicable.	s, and include the y and cautionary expiration date when				
	facility must store all locked compartments	tate and Federal laws, the drugs and biologicals in under proper temperature only authorized personnel to eys.				
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribution	ide separately locked, ompartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can				
	by: Based on observation interviews the facility NovoLOG insulin Flex when opened and an FlexPen that was not were available for use and failed to ensure a while the nurse was must be findings included:  1. A review of the facility storage and use of included:	lity protocol regarding the		The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or w 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 indicate F431 DRUG RECORDS, LABEL/STORE DRUGS AND	ill f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY PLETED	
						С	
		345543	B. WING _		0	5/02/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
DEDMUD	A COMMONO NUIDOU	NO AND DELIABILITATION CENTED		316 NC HIGHWAY 801 SOUTH			
BEKWUDA	A COMMONS NURSI	NG AND REHABILITATION CENTER		ADVANCE, NC 27006			
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE	
F 431	Continued From p	age 36	F 4	31			
		date and initials of the person		BIOLOGICALS			
		n must be written on the sticker.		Corrective Action:			
	opening the mount	irinasi be willen on the sticker.		Medication and Treatment ca	urte where		
	Resident #123 wa	is admitted to the facility on		locked and secured while the			
		nosis of diabetes mellitus.		not in attendance. Any insulir			
	O/21/10 With diagr	iodio oi diasotos monitas.		dated or initialed when open			
	A physician's orde	er dated 2/23/16 indicated		immediately discarded. Medi			
	1	s to receive NovoLOG insulin		immediately secured properly			
		e before meals and at bedtime		Identification of other residen			
	for diabetes mellit			be involved with this practice	•		
				All residents have the potenti			
	Review of physicia	an's order dated 4/27/16		affected by the alleged practi			
	indicated Residen	t #123 was to receive		were done on 5/16/2016 by L	aurie Hein		
	NovoLOG insulin	10 units via FlexPen before		RN and all medication and tre	eatment carts		
	meals for diabetes	s mellitus.		were locked and secured who	en the nurse		
				was not in attendance. All me	edications		
		:15 AM Resident #123's		were stored and secured. All	medication		
		lexPen was observed on the		and treatment carts are locke			
		on cart ready for use and was		when not in immediate use b	-		
		ted. A yellow sticker was		Medication and treatment car			
		ovoLog FlexPen that stated after		any area that medication was			
		efrigerate and sticker indicated		stored were checked to ensu			
		re in 28 days after opening. The		was, no expired, undated or i	not initialed,		
		FlexPen had no date on the		open insulin by the nurse.			
	sticker label as to	when it had been opened.		Systemic Changes:	::_		
	A review of the Ma	edication Administration Record		Director of Nursing and /or D	•		
				serviced all nursing staff (RN			
	, ,	esident #123 received		time, part time, and PRN) tha	-		
	_	scale insulin from 04/01/16 to hysician's orders as indicated		must store all drugs and biolo locked compartments under			
		entation on the MAR and further		temperature controls, and pe	•		
		esident #123 received 10 units		authorized personnel to have	•		
		n via FlexPen at 4:00 PM and		the keys. The facility must als			
		/16 as indicated per nurses'		lock, and have permanently a			
	documentation on	· · · · · · · · · · · · · · · · · · ·		compartments for storage of			
	a south of tation of	uio ivii u C.		drugs. Drugs and biologicals			
	On 04/28/16 at 11	:25 AM an interview was		facility must be labeled in acc			
		e Unit Director who verified that		currently accepted profession			
		Invol OG insulin FleyPen was		and include the appropriate a	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		DATE SURVEY	
			A. BUILDII	NG		Ι,	•	
		345543	B. WING _				02/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	:		
DEDMID		IO AND DELIABILITATION OFNITED		31	16 NC HIGHWAY 801 SOUTH			
BEKMUD	A COMMONS NURSIN	IG AND REHABILITATION CENTER		Α	DVANCE, NC 27006			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFIX	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Ē	(X5) COMPLETION	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΊΕ	DATE	
F 431	Continued From p	age 37	F4	431				
	on the 500 hallway	y medication cart and was			and cautionary instructions, and the			
		ed and was ready for use. The			expiration date when applicable. This is	1		
	-	d the NovoLOG insulin FlexPen			service was completed by 5/24/2016. A			
		discarded from the 500 hallway			nursing staff member (RNs, LPNs, full	,		
		the beginning of the 7:00 AM to			time, part time, and PRN) who did not			
		ause there was no indication of			receive in-service training will not be			
	when the insulin h	ad been opened and nursing			allowed to work until training is complete	ted.		
		to determine if the insulin had			This information has been integrated in			
	expired. The Unit	expired. The Unit Director stated all nurses had			the standard orientation training and in	the		
	been in-serviced to			required in-service refresher courses for	or			
	when opened to d	etermine the expiration date			all employees and will be reviewed by	:he		
	once the insulin w	as opened. The Unit Director			Quality Assurance Process to verify that	ıt		
	immediately remove	ved the NovoLOG insulin			the change has been sustained.			
	FlexPen from the	500 hallway medication cart.			Monitoring:			
					To ensure compliance, Administrator of			
		:08 PM an interview was			Maintenance Director or designee will			
		e Director of Nursing (DON)			monitor this issue using the QA survey			
		pectation was that nursing staff			tool. Facility will monitor compliance by			
		I the NovoLOG insulin FlexPen			auditing each medication cart, and			
		when it was opened. The DON			treatment cart and any other areas that			
		ation was that nursing staff per			medication is stored to ensure that they			
		ould have checked that Resident			are secured properly at all times. Facili	iy		
		insulin FlexPen was dated			will also observe all medication and	4		
		r to administering the NovoLOG t #123. The DON stated her			treatment carts for expired, undated an			
					not initialed, open insulin's by the nurse This will be done on weekly basis for 4			
		nat nursing staff would clarify init Director if they were unsure			weeks then monthly for 3 months by th			
		col for opening and dating			Support Nurse, Unit Manager, or	5		
	insulin.	cor for opening and dating			designee. Reports will be presented to			
	middin.				the weekly QA Committee by the			
	On 04/28/16 at 2.5	55 PM an interview was			Administrator or designee to assure			
		Administrator who stated the			corrective action initiated as appropriat	e.		
		FlexPen for Resident #123			Any immediate concerns will be brough			
		dated when opened. The			the Director of Nursing or Administrator			
		ed staff should have verified			for appropriate action. Compliance will			
		s dated prior to administering			monitored and ongoing auditing progra			
		ilin to Resident #123.			reviewed at the Weekly Quality of Life			
					Meeting. Weekly QA Committee meeting	ng		
	On 04/28/16 at 2:5	55 PM an interview was			is attended by Administrator, Director of	-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		X3) DATE SURVEY COMPLETED	
		345543	B. WING _			C <b>05/02/2016</b>	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  316 NC HIGHWAY 801 SOUTH  ADVANCE, NC 27006			33/32/23 13	
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F 431	NovoLOG insulin 10 Resident #123 on 0- PM. Nurse #1 stated Resident #123's No- opened date prior to Resident #123 on 0- insulin was required determine when it weresponsibility of the verify that insulin has stated without an op- determine if Resider FlexPen had expired insulin on 04/27/16.  2. A review of facility storage and use of i- indicated insulin mu- attached and the da- opening the insulin in Resident #242 was 04/18/16 with diagner A physician's order of Resident #242 was FlexPen 10 units in mellitus.  On 04/28/16 at 11:4 Levemir insulin Flex hall medication cart opened and undated An interview was co 04/28/16 at 11:45 A 10 units of Levemir	se #1 who administered units via FlexPen to 4/27/16 at 4:00 PM and 8:00 d she had not checked voLOG insulin FlexPen for an administering the insulin to 4/27/16. Nurse #1 stated to be dated when opened to rould expire and it was the nurse administering insulin to d an open date. Nurse #1 sened date she was unable to not #123's NovoLOG insulined prior to administering the resultin dated 02/20/14 st have a date opened sticker the and initials of the person must be written on the sticker.  admitted to the facility on rosis of diabetes mellitus.  dated 04/27/16 indicated to receive Levemir insulin the morning for diabetes  0 AM Resident #242's Pen was observed on the 100 ready for use and was	F 4	Nursing, MDS Coordinato Support Nurse, Therapy, I Manager, Wound Nurse. Date of Compliance: 5/24/	HIM, Dietary		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345543	B. WING _			C 05/02/2016	
	ROVIDER OR SUPPLIER	NG AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		0.00.02.00.00	
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F 431	forgot to check that had an open date insulin to Residen been in-serviced of was required to be opened to determined to the insulin FlexPen should have dated for Resident #242 and the conducted with the conducted with the conducted with the conducted that insulin was opened inmediately remonsulin was opened in the 100 hallow. On 04/28/16 at 12 conducted with the cond	exPen. Nurse #2 stated he at the Levemir insulin FlexPen prior to administering Levemir it #242. Nurse #2 stated he had during orientation that insulin et dated by nursing staff when ine when insulin would expire. Whoever opened the Levemir hould have dated the insulin ed per facility protocol.  252 AM an interview was et Unit Director who verified that exPen was on the 100 hallway and was ready for use for down was not dated when opened. Stated all nurses had been stulin had to be dated when interested all nurses had been stulin had to be dated when interested all nurses had been way medication cart.  208 PM an interview was et Director of Nursing (DON) pectation was that nursing staff of the Levemir insulin FlexPen when it was opened. The DON atton was that nursing staff per ould have checked that Resident stulin FlexPen was dated when alministering the Levemir insulin The DON stated her nat nursing staff would clarify and interview was decolor opening and dating	F 4	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		345543	B. WING _			C / <b>02/2016</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 NC HIGHWAY 801 SOUTH  ADVANCE, NC 27006		<b>VELIZO10</b>
(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 CROSS-REFERENCED TO THE APPROPRIED OF THE	D BE	(X5) COMPLETION DATE
F 441 SS=E	Levemir insulin FlexPhave been dated whe Administrator stated is that the insulin was difference to a cart parker revealed the cart was During the observation visitors were in the hamedication cart. The the medication cart. The the medication cart was approached that lock a cart if the nurse unattended.  483.65 INFECTION Control Programmed the facility must estall infection Control Programmed approached the same cart if the nurse unattended.	dministrator who stated the en for Resident #242 should in opened. The staff should have verified ated prior to administering Resident #242.  202 AM observations of a ed outside room 302 in unlocked and unattended. In residents, staff and allway with the unlocked are was no nurse attending At 10:07 AM Nurse #3 cation cart and was 3 demonstrated that the unlocked and stated that she to get supplies. She offered the failed to secure her  PM the Director of Nursing and stated that the et to be locked when not in a nurse was expected to the had to leave the cart  CONTROL, PREVENT  blish and maintain an gram designed to provide a mifortable environment and evelopment and transmission on.	F 4			5/24/16
		blish an Infection Control				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 05/02/2016
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  316 NC HIGHWAY 801 SOUTH  ADVANCE, NC 27006		05/02/2016
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 441	Continued From page (1) Investigates, continued	e 41 rols, and prevents infections	F 441		
	should be applied to	cedures, such as isolation, an individual resident; and d of incidents and corrective ctions.			
	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact will direct contact will trar (3) The facility must residue.	n Control Program ident needs isolation to infection, the facility must brohibit employees with a se or infected skin lesions th residents or their food, if asmit the disease. equire staff to wash their ct resident contact for which ated by accepted			
		le, store, process and to prevent the spread of			
	by: Based on observatio interviews the facility infections and mainta program to prevent re contracting scabies in	in an infection control esidents and staff from the facility for 4 of 5 r scabies (Residents #231,		The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or witake the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of	11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  G	(X3) DATE SU COMPLET	ETED	
		345543	B. WING		05/02	/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.02		
				316 NC HIGHWAY 801 SOUTH			
BEKMUDA	A COMMONS NURSIN	G AND REHABILITATION CENTER		ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 441	dated 07/01/02 rev to prevent and con read in part: precaidentification of coruntil the first treatm resident's assigned manual further indiapplication of treat laundry and room obelts and blood preupholstered furnitu 7-10 days, and the scabies and atypic isolation until after 3 negative skin scrnot treated effective by crusted thick less Review of the facili May 2015 through residents in different skin tissue (SST) in as follows:  May 2015 revealed and a resident with June 2015 revealed 1 case of scabies of August 2015 revealed 1 case of scabies of Oct 2015 revealed 1 case of scabies of	ilities infection control manual realed the facilities guidelines trol the transmission of scabies utionary measures included ntacts and contact isolation ment had been completed in the diagram orders, cleaning, disinfection control cated general instructions for ment per Physician orders, cleaning, disinfecting of gait essure (B/P) cuffs, remove and cover with plastic for distinction between Norwegian all scabies. Norwegian required the second treatment and until rapings. Norwegian scabies if ely heavier infestation is noted sions.  Ity infection control log from February 2016 revealed int parts of the building with soft critations, rashes and scabies  If 11 cases of SST irritations is a rash on the 200 hall. If a cases of SST irritations, and on the 500 hall. If a cases of SST irritations and on the 500 hall.	F 44	compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic F441 INFECTION CONTROL, PRE SPREAD, LINENS Corrective Action: Resident #231, #36, #121 and #10. Resident #231 expired on 8/27/2018 Resident #36: On 4/27/2016 was tre with Elimite Cream prophylactically scabies. Resident was immediately placed on contact isolation. On 4/28 resident was assessed by attending physician. Skin scrapings done on 4/28/2016 which were sent to Solsta for analysis. Resident was on Contact Isolation from 4/27/2016 and, 5/6/25/13/2016. Resident was on Contact Isolation from 4/27/2016 to 5/14/2018 Resident #121: On 4/27/2016 was to with Elimite Cream prophylactically scabies. Resident was immediately placed on contact isolation. On 4/28 resident was assessed by attending physician. Skin scrapings done on 4/28/2016 which were sent to Solsta for analysis. Resident was treated was treated was on Contact Isolation for 4/27/2016 to 5/14/2016. Resident was on Contact Isolation for 4/27/2016 to 5/14/2016. Resident was on Contact Isolation for 4/27/2016 to 5/14/2016. Resident was immediately placed on contact Isolation for 4/28/2016. Resident was immediately placed on contact Isolation for 4/28/2016. Resident was immediately placed on contact Isolation. On 4/28 assessed by a dermatologist. Skin scrapings were done by the dermation 4/28/2016. Resident was immediately placed on contact isolation. On 4/28 laboratory results were not definitive Resident was treated with Ivermectic	ated. VENT  5. eated for  8/2016  I as Lab with  2016 et  16. reated for  8/2016  I as Lab with  016. rom  ologist iately  8/2016 es. ion on		
	Nov 20 15 revealed 3 cases of scabies	d 7 cases of SST irritations and		-	ion on vas on		

Facility ID: 20070039

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	PLE CONSTRUCTION	(X3) DATE S COMPL	PLETED	
		345543	B. WING		05/0	; )2/2016	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	Feb 2016 reveals 7 Review of the facility March 2016 revealed 1a. Resident #231 v 11/19/12 and expire Review of the medic #231 was admitted heart failure, demendabnormal involuntar neoplasm of the skinguarterly Minimum I 08/15/15 indicated from the impaired for daily deextensive assistance living (ADL) including toileting, dressing at MDS further revealed impairment to her up The MDS also revealed impairment	cases of SST irritations. cases of SST irritations. y infection control log dated d 3 cases of SST irritations.  vas admitted to the facility on d in the facility on 08/27/15. cal record revealed Resident with diagnoses that included dia, anxiety, depression, y movements, malignant n, and insomnia. The Data Set (MDS) dated Resident #231 was severely ecisions making and required e with all activities of daily ag assistance with bathing, and personal hygiene. The ed Resident #231 had no opper and lower extremities. aled Resident #231 had a life than 6 months and received	F 44	· · · · · · · · · · · · · · · · · · ·	out d of tion ation of abies were in s and ion for received . We r letting d for n to ntire atact ors, ing all staff ere milies were eceived deep and any agged 72 so may		
	Review of a medica (MAR) dated 05/01/ no medications adm Review of a treatme	tion administration record 15 through 05/31/15 revealed ninistered for scabies. ent administration record 15 through 05/31/15 revealed		affected by the alleged practice. A residents were treated prophylactic scabies by 4/30/2016. Residents clong term care hall received a secuprophylactic treatment for scabies 5/7/2016.	II cally for on the ond		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345543	B. WING		C <b>05/02/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/02/2010
				316 NC HIGHWAY 801 SOUTH	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER	<b>I</b>	ADVANCE, NC 27006	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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F 441	Continued From pag	ne 44	F 441		
	the cream was admi rash.	nistered 2 times a day for		Systemic Changes: Dr. Auffinger was educated by Dr. Herman, President of Physicians	
	Review of a MAR da	ted 06/01/15 through		Eldercare, Board Member, by 5/24/20	)16.
		o medications for scabies		Director of Nursing and/or Designee in	
	were administered.			serviced all staff (full time, part time, a	
	D	00/04/45 there exists		PRN) about infection control, preventi	ing
	Review of a TAR dat	AC cream as applied to the		spread of infection and CDC scabies education (recognizing, reporting and	
	torso twice a day for			prevention of scabies) and also treatn	
	torso twice a day for	the Chare month.		of scabies with Ivermection, Elimite .A	
	Review of MAR date	ed 07/01/15 through 07/31/15		staff were in serviced about Contact	"
		ions were administered for		precautions and use of PPE. Education	on
	scabies.			provided also included: Clinical and	
				epidemiologic features of scabies, cas	se
		d 07/01/15 through 07/31/15		management of scables, prevention	
		was applied to the torso		measures for scabies, environmental	
	twice a day from 07/	01/15 through 07/06/15		disinfection of scabies. This in service were completed on 5/24/2016. Any	
		dated 08/01/15 through		nursing staff member (RNs, LPNs, ful	
	08/31/15 revealed no			time, part time, and PRN) who did not	t
	administered for sca	bies.		receive in-service training will not be	
	Davious of the TAD d	oted 09/01/15 through		allowed to work until training is complete This information has been integrated	
	08/31/15 revealed no	ated 08/01/15 through		the standard orientation training and i	
	administered for sca			required in-service refresher courses	
		DIGG.		all employees and will be reviewed by	
	An interview with nu	rsing assistant (NA) #3 on		Quality Assurance Process to verify the	
		revealed that she recalled		the change has been sustained.	
		ecalled that she had skin		Monitoring:	
	•	es. NA #3 further stated that		To ensure compliance, Administrator	
		es exposure the nurses		Maintenance Director or designee will	
		o it was and what they were		monitor this issue using the QA surve	
		hat she had went to the		tool. Facility will monitor compliance b	-
		d her doctor completed a skin		auditing weekly skin check assessme	
		ned her suspicions of scables		and ensuring that they are completed	
		ne issue. NA#3 stated that		policy and also ensure that there are	
		ed at the facility had examined #3 that she did not have		new soft skin tissue irritations, rashes scabies. In the event that soft skin tiss	
	i noi ana statea to M	are that one did not have	1	TOGENICO. III UIC CYCIII UICI SOII SKIII US	Juo

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/02/2010	
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
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F 441	she felt like she need did. NA #3 stated that multiple times for sca because of the contine. An interview with Nur 10:36 AM revealed the treated many times we medicines, but it was same issue of a rash further stated she coun scraping was completed was being treated. Nurse #3 stated she have ineffective to the and the Medical Doct. An interview with Nur AM revealed she part assessments of resid Nurse #4 further stated to the MD for further a orders. Nurse #4 explored scabies, how to look to itching that indicate seexplained if treatments.	neat rash but NA #3 stated ed to see her doctor so she it her coworkers were treated bies and most were quitting ued issue.  se #3 on 04/28/2016 at at Resident #231 was ith many different always treatment for the and itching. Nurse #3 uld not recall if a skin ted but stated Resident ed for presumed scabies. had reported the treatments ed Director of Nursing (DON) or (MD) several times.  se #4 on 04/28/16 at 10:43 icicipated in the skin ents and staff for scabies. ed she reported her findings assessment and treatment lained she was in-serviced signs and symptoms of for the rash, tracks and cabies. Nurse #4 further is were ordered for a	F 44'	irritations, rashes and scabies are identified, the facility will follow the appropriate care path. Physician will be immediately notified, Residents will be treated prophylactically for scabies, stawho have been in contact with affected residents will be treated prophylacticall families will be notified to seek medical attention if they've been in contact with affected resident, and residents would put on contact isolation during treatmer or according to CDC guidelines. The facility will also keep apparatus' (scapuland slides) to be used by physician for collecting specimens required to confir scabies. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee the Administrator or designee to assure corrective action initiated as appropriate Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing programate reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting.	aff  y,  be  nt  ala  m  by  e by  e e.  nt to  be  m	
	resident and the treat would report this to the when a suspected careceived she notified assisted with bagging and notified houseked required deep cleaning residents and staff were	ment was not effective she le MD. Nurse #4 revealed se of skin infection was all direct care staff, she li personal items and clothes leping of the room that lig. Nurse #4 further revealed lere treated for suspected li not have scabies but were		is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manag Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	I ` '	ATE SURVEY MPLETED
		0.455.40	D WING			С
		345543	B. WING			05/02/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
BERMUD	A COMMONS NURSI	NG AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
DEININODA	A COMMONO NONON	TO AND REHADILITATION SERVICE		ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 441	Continued From p	age 46	F	441		
	An interview with a AM revealed that the dermatologist scabies which is wand treatment of r DON further state with cream for scaeducated and wer treatment of scabithe residents on the option to receive they were all provide and the prophylactic treprovide additional staff had been treatment of scabithe prophylactic treprovide additional staff had been treatment.	the DON on 04/28/16 at 11:13 on 10/26/15 a resident went to and was diagnosed with what prompted an investigation esidents of the facility. The d that all residents were treated abies and the staff were e provided with cream for es. The DON also stated that he rehab unit were given the reatment or not, but stated that ided with education on the bies. The DON did state that ent on the rehab unit did decline eatment. The DON could not information of when or if the ated at any other times.		***		
	it was an urgent motherwise the resinext visit to the farwere cases of scaland they were treated	e Nurse Practitioners (NP) by agh the communication books, if natter we would call in orders, dent would be seen during the cility. The MD explained there bies in the facility in the past ated and they would be listed on n control log. The MD further				
	explained the typic with Elimite cream mouth, they were some dermatologing 7 to 14 days after used as an adjunct inflammation and condition. The ME medical director sis sort of like an or	cal treatment for scabies was an and Ivermectin tablets by both onetime treatments but sts often recommend retreating the initial treatment. TAC is set treatment for calming the itching related to the skin o stated "in my experience as a cabies is common in facilities, it occupational exposure, and more predisposed to getting				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	G AND REHABILITATION CENTER		1 00/02/2010		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 441	mere cosmetic irritathen have a resurge frequency of scabies than in any other faimportant thing is to associated with scaling the facility and the residents in the patients, it was optionally administrator stated on procedures for is rooms that were affiscables. The administrator stated on procedures for is rooms that were affiscables. The administrator stated on procedures for is rooms that were affiscables. The administrator stated on procedures for is rooms that were affiscables. The administrator stated on procedures for is rooms that were affiscables. The administrator stated on procedures for is rooms that were affiscables. The administrator stated on procedures for including assumed to the facility of	also stated that "scabies is a ant, and it can disappear and ence." "I don't see the as being any different here cility I have been in, the o squash the hysteria bies."  dministrator on 04/28/16 at a there were no confirmed that November 2015 which by to move forward with treating the facility except for the rehabional to them. The at that the staff was in-serviced solation and deep cleaning of licted by scabies or presumed distrator stated that she obe notified of itching or ment that was not effective for the sadmitted to the facility on loses which included diritis, hand contractures, joint ecified disorder of the skin and	F 44			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
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F 441	moderately impaired rejection of care, has and required extense.  Review of a care planevealed Resident # performance deficit with ADLs. The ADL Resident #36 to impute with personal hygie listed in part to assist her needs.  Review of a physici indicated Triamcino and apply to entire and apply to entire apply to enti	ealed Resident #36 was d cognitively, had no signs of id contractures to her hands sive assistance for all ADLs.  an updated on 03/14/16 #36 had a self-care and required total assistance care plan goal was for the prove current level of function the and the approaches were st Resident #36 and provide  an order dated 04/20/16 Hone Acetonide Cream 0/1% poody twice daily for itching.  Inote dated 04/27/16 at 12:48 ent #36 continued to have a body with crusting in skin ingers and a red rash noted to falling out.  In on 0 04/25/16 at 1:08 PM observed in a Geri chair in her ween the fingers of both end with crusty flaky skin and	F 4			
	skin around the fing During an observati Resident #36 was ii dry and crusty looki hand, and between During an observati Resident #36 was ii	on on 04/26/16 at 12:22 PM n bed and observed with very ng skin on her face, arms,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 05/02/2016
	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	1 00/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 441	Aide (NA) #1 who we for Resident #36 state assistance with all A grooming and person and interview on 04/2 revealed she recalled. She explained where the nurses informed residents had scabin NA #3 further explain had scabies because who completed a skew her and treated here Resident #36 had the looked like paste and like other residents with scabies. NA#3 Resident #36 current because she had the before and she had months ago.	tween her fingers.  27/16 at 5:54 PM with Nurse was assigned to provide care ated she required extensive ADLs including, showers, anal hygiene.  27/16 at 3:11 PM with NA #3 and Resident #36 had scabies. In there was scabies exposure at the Nurse Aides (NAs) which	F 4-	,	
	AM revealed the Dir observed Resident: had placed her on of physician assessed scraping and treated scabies pending the was her expectation well groomed, and of it was her expectation daily skin care, and	rector of Nursing (DON) #36 itching and verified they contact precautions after the her and had completed a skin d her prophylactically for e results. The DON stated it n for all residents to be clean, comfortable. The DON verified on for all residents to have nurses to report any skin of for assessment and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		C 05/02/2016
	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	1 03/02/2010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 441	#4 revealed she had to assess for the sign how to look for the rindicated scabies. Not treatments were ordereatment was not exphysician for further orders. Nurse #4 excase of skin infection direct care staff, assubagged personal ite housekeeping when cleaning.  A follow interview or the DON she verifie placed on contact pubeing treated for scale	28/16 at 10:43 AM with Nurse of received in-service training and symptoms of scabies, ash, tracks and itching that lurse #4 further explained if dered for a resident and the effective she reported to the eassessment and treatment plained when a suspected in was received she notified all sisted with medications, in and clothes and notified in the room required deep	F 44	41	
	The DON further ve chairs in the resider be there and all furn be vinyl or leather.  An interview on 04/2 facility Medical Directon for resider Nurse Practitioners the communication an urgent matter the otherwise the reside at the facility either Friday. The MD cor of scabies in the fact treated and were list	e results of a skin scraping. rified the upholstered dining at's room was not supposed to liture in resident rooms was to  28/16 at 2:01 PM with the ctor (MD) revealed typically at swere reported to her or the (NP) by telephone or through books. She explained if it was ey called in orders but ent was seen on the next visit on Tuesday, Thursday or affirmed there had been cases dility in the past and they were ted in the facility infection of further explained the typical			

CENTER	S FOR MEDICARE &	WEDICAID SERVICES			OIVID IN	0. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY PLETED
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		345543	B. WING _		05	5/02/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
BERMODA		AND REMADIEMATION SERVER		ADVANCE, NC 27006		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTOR CROSS-REFERENCED TO		COMPLETION DATE
1710		,		DEFICIENC		
F 441	Continued From pag		F 4	41		
		s was with Elimite cream and				
	_	mouth. She stated both				
		ne time treatments but some				
		nmend retreating. She				
	· ·	lone ointment (a steroid				
	1	ed as an adjunct treatment for				
	_	ation and itching related to further explained scabies				
		ities and some residents				
		sed to getting scables and it				
		irritant issue but it could				
		have a resurgence. She				
	1	rred residents to different				
	dermatologists (skin	specialists) in the area but				
	often treatment was	delayed by 1-3 weeks to				
	schedule the appoin	tments. The MD further				
	· ·	ence as a medical director				
		n facilities, it is sort of like an				
		ire, and some people are				
		getting scabies." The MD				
		abies is a mere cosmetic				
	1	sappear and then have a n't see the frequency of				
	_	fferent here than in any other				
		n, the important thing is to				
	· •	associated with scabies."				
	•	ed Resident #36 was seen				
		orted rashes she determined				
		n exfoliative dermatitis,				
	received a skin scrap	ping test and she would be				
	surprised if the scrap	oing was positive for scabies.				
	On 04/28/16 at 4·26	PM the Administrator was				
		pectation for all residents to				
	1	ned, and comfortable. The				
	_	stated it was her expectation				
	I .	ave daily skin care and				
		any skin conditions to the				
		ment and treatment. She				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		C 05/03/2046
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	05/02/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 441	scabies in the facility they treated all resid was optional for resid hall. She further expl for all resident's skin and the physician or rashes. The Adminis still a problem with ir suspected scabies a had skin issues and treatments had been On 04/29/16 the labor received noting Resitested positive for soc. Resident #121 was 11/25/14 with diagnoof the nervous system. The quarterly Minimo 02/26/16 revealed Rimpaired for daily deextensive assistance living (ADLs) includir bathing. The MDS furthad no skin rashes of A review of a nurse of A review of a care plant of the performance of A diagnosis of a nervolplan goal was for Resident #10 the side of the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the performance of A diagnosis of a nervolplan goal was for Resident #10 the p	e no confirmed cases of until November of 2015 and ents in the facility except it dents who lived on the 100 ained it was her expectation to be cleaned and lotioned NP to be notified of itching or trator confirmed there was affection control regarding and confirmed residents still were itching and their ineffective.  For atory tests results were dent #36's skin scraping abies.  As admitted to the facility on ses which included disease m, kyphosis, and depression.  The part of the p	F 44		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345543	B. WING			05/02/2016	
	ROVIDER OR SUPPLIER	G AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	'	0.02.20.0	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 441	provide extensive all ADLs. A review of physici indicated Triamcini and Eucerin and a A review of a physindicated Benadryl every 6 hours as in A review of a physindicated Zeasorb A review of a nurse 10:30 AM revealed with her shirt lifted covered area. A review of a physindicated Elimite Covered area. A review of a physindicated Elimite Covered area. A review of a physindicated Elimite Covered area. During an observa Resident #121 was on her arms, back  During an observa Resident #121 was room scratching unarms were observed marks.  During an observa Resident #121 was scratching at the industrial puring an observa Resident #121 was scratching at the industrial puring an observa Resident #121 was scratching at the industrial puller with her shirt puller	approaches indicated in part to assistance to Resident #121 for an's order dated 03/12/16 olone Acetonide cream 0.1% pply to pruritic (itchy) rash. ician's order dated 03/09/16 25 milligrams (mg) by mouth eeded for Itching. ician's order dated 04/20/16 powder for itching. e's note dated 04/27/16 at the Resident #121 was observed up and was scratching a rash ician's order dated 04/27/16 aream 5 % (Permethrin) apply to toe once. Ition on 04/25/16 at 4:18 PM is observed scratching a rash and legs.  Ition on 04/26/16 at 12:12 PM is up in her wheel chair in her order her right breast and her ed with red and pink scratch ition on 04/26/16 at 4:49 PM is observed in her room inner sides of her thighs.  Ition on 04/27/16 at 9:15 AM is observed in her wheel chair in dup and was scratching her	F 44	.1			
	Resident #121 was with her shirt pulled abdomen with her During an observa	s observed in her wheel chair d up and was scratching her					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	' '	OMPLETED
		345543	B. WING _			C <b>05/02/2016</b>
	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	<u>'</u>	30/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	verified they had just precautions after the and completed a sk her prophylactically results. The DON st for all residents to be comfortable she expany skin conditions assessment and tree. During an interview Nurse #3, who was #121 explained Rese Benadryl and ointrophysician but the tree for a short time. She #121 had chronic itcher rash and itching physician.  An interview on 04/2 facility Medical Directon concerns for resident Nurse Practitioners the communication was an urgent matter otherwise the resident at the facility either the Friday. The MD control of scabies in the facility results as the facility either the facility in the facility of scabies in the facility results.	#121 was scratching and st placed her on contact e physician had assessed her in scraping and was treating for scabies pending the sated it was her expectation e clean, well groomed, and pected for nurses to report to the physician for	F 4	,		
	treatment for scable lvermectin tablets b medications were o dermatologists reco explained Triamcing	O further explained the typical es was with Elimite cream and y mouth. She stated both ne time treatments but some mmend retreating. She olone ointment (a steroid ed as an adjunct treatment for				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURV	
			7 501251			l c	
		345543	B. WING			05/02/20	<b>)</b> 16
	ROVIDER OR SUPPLIER  A COMMONS NURSING	AND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI IE APPROPRIA		(X5) MPLETION DATE
F 441	skin conditions. The experience as a med common in facilities, occupational exposu more predisposed to also stated that "scairritant, and it can dis resurgence." "I dor scabies being any di facility I have been ir squash the hysteria a The MD also explain today by me for report Resident #121 rashed gets yeasty. Resider scraping test and she scraping was positive they had referred residermatologists (skin often treatment was schedule the appoint During an interview of Administrator stated residents to be clean comfortable. She fur should have daily skinurses to report any physician for assession 0.04/29/16 the labor received noting Resitested positive for scidenase and dementications.	ation and itching related to MD stated " in my lical director scabies is it is sort of like an re, and some people are getting scabies." The MD bies is a mere cosmetic appear and then have a bit see the frequency of fferent here than in any other and, the important thing is to associated with scabies." He de Resident #12 was seen red rashes she determined as related to the fact that she at #121 received a skin are would be surprised if the enteror of the free for scabies. She stated sidents to different specialists) in the area but delayed by 1-3 weeks to sments.  Son 04/28/16 at 4:26 PM the it was her expectation for all and ther stated all residents in care and she expected for skin conditions to the ment and treatment.	F	441			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		345543	B. WING _			C <b>05/02/2016</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	<b>'</b>	33,32,23,10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From pag		F 4	41		
	impaired for daily de	as severely cognitively cision making and required with all ADLs and personal				
	06/08/15 read in part examined and found eruptions to her arms burrowing patterns.	gist consultation report dated t that Resident #10 was to have numerous skin s, back, and legs with several The report further revealed a g for scabies. Resident #10 ies.				
		order dated 06/08/15 read mouth single dose and be implemented.				
	Review of physician TAC 0.1% for itching	order dated 02/14/16 read twice a day.				
		order dated 02/17/16 read n for itching a needed.				
	04/28/16 revealed R and a skin scraping v findings were consisted.	gist consultation report dated esident #10's was examined was completed the clinical tent with scabies. The report was being treated based on and symptoms.				
	Resident #10 was ob	on on 04/25/16 at 3:49 PM oserved scratching her arms. present to both arms.				
	Resident #10 was obwhile being transport	on on 04/27/16 at 1:14 PM oserved scratching her arms ted in her wheel chair down or representative to go to the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345543	B. WING _			C 05/02/2016
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP COD 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Resident #10 scratch verified she was goin with the Family representated it was her explained it was here clean, well groom DON verified it was residents to have dareport any skin conductor assessment and treation of the MD stated Residents morning and was scattered red dry are hand and was noted further stated she be photo dermatitis read explained there was miscommunication with the dermatologis was only treating Reand was also the casexplained there was in June by the dermator was treated for scabe everyone be treated.  On 04/28/16 at 3:08 care for Resident #1 revealed Resident #1 revealed Resident #2 scabies and was not itching as prescribed revealed these treating for short times. The	AM the DON observed hing both of her arms, and and to the dermatologist today esentative (RP) The DON pectation for all residents to add, and comfortable. The her expectation for all illy skin care, and nurses to attend to the MD for atment.  PM the MD was interviewed. It is noted to have some east to her left forearm and have dry skin. The MD elieved this was a kind of cition. The MD and the NP possibly a with the dermatologist and est didn't see anything and sident #10 prophylactically, see in June. The MD further no skin scraping completed atologist and Resident #10 ies and recommended  PM Nurse #3, who provided 0 was interviewed. Nurse #3 10 was treated in the past for w provided ointments for a by the MD. Nurse #3 further ments are effective but only Nurse explained, Resident ing and she had reported the	F 4	41		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345543	B. WING			C 5/02/2016
	ROVIDER OR SUPPLIER A COMMONS NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		3/02/23/10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	interviewed. The Adrexpectation for all regroomed, and comfoverified it was her exhave daily skin care, skin conditions to the treatment.  On 05/02/16 at 4:15 was interviewed. The Resident #10 on 04/2 scraping which was revealed a person coall the symptoms but scraping and in this oclassic skin symptom flaking skin. She was scabies". The DM exalso seen in June 20 scraping for scabies recommended the fatime. The DM further physically go into face resident's reinfection concern. The facility infected resident and would be thorough trareas, staff and visite someone transmitting persons. If there were	PM the Administrator was ministrator stated it was her sidents to be clean, well rtable. The Administrator pectation for all residents to and nurses to report any and possible MD for assessment and and revealed she assessed 28/16 and completed a skin not definitive. The DM further buld have scabies and have still have a negative case Resident #10 had all the past of itching, burrows, and is "a clinical dead ringer for plained Resident #10 was 15 had a positive skin and was treated and cility treat everyone at that explained that she does not illities but based on this there appears to be a may be properly treated the latheir room, but the concern eatment of the common ors in order to prevent git to other areas and other e a suspected rash and bility of being scabies there	F 4-	41		
F 500 SS=B		nsure that it was not spread. PROFESSIONAL ANGE/AGRMNT	F 5	00		5/24/16

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345543	B. WING _			C 05/02/2016
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		03/02/2010
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 500	to be provided by the have that service fur person or agency ou arrangement describ Act or an agreement (2) of this section.  Arrangements as dethe Act or agreement furnished by outside writing that the facilit obtaining services the standards and principrofessionals providing and the timeliness of	to furnish a specific service a facility, the facility must nished to residents by a tside the facility under an ed in section 1861(w) of the described in paragraph (h)  scribed in section 1861(w) of ts pertaining to services resources must specify in y assumes responsibility for at meet professional ples that apply to ng services in such a facility;	F 5	00		
	by: Based on staff interrest facility failed to obtain services provided by 2 residents (Resident dialysis services and dialysis without a contract of the findings included the recertification suthrough 04/28/16. Oprovided a list of 2 receiving outside her the facility provided Services Agreement Dialysis Services Agrefective April 27, 20 On 04/27/16 at 3:46 interviewed and representations. She states	views and record review the n a written agreement for an outside provider for 2 of ts # 39 and 162) receiving the residents received ntract in place. d: ervey was held on 04/25/16 in 04/25/16 the facility esidents in the facility modialysis services. a document titled "Dialysis" that read in part, "This reement is entered into		The statements made on this F Correction are not an admission not constitute an agreement wit alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correctionstitutes the facility's allegatic compliance such that all alleged deficiencies cited have been or corrected by the date or dates in F500 OUTSIDE PROFESSION RESOURCES-ARRANGE/ARG Corrective Action:  Residents #39 and # #162  Residents #39 and # #162  Residents #39 and # #162 recedialysis services from an outsid A Dialysis Service Agreement /6	n to and do th the in d State en or will Plan of tion on of d will be ndicated. AL GMT	

Facility ID: 20070039

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345543	B. WING _				02/2016
NAME OF PROVIDER OR SUPPLIER  BERMUDA COMMONS NURSING AND REHABILITATION CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 500	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULI TAG CROSS-REFERENCED TO THE APPROF		or a hat son g ces rds als d	

Facility ID: 20070039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345543	B. WING _			C <b>05/02/2016</b>	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  316 NC HIGHWAY 801 SOUTH  ADVANCE, 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	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 500	Continued From page	÷ 61	F 5	discussed/ presented to the Committee by the Administrated as appropriate. A concerns will be brought the Nursing or Administrator of action. Compliance will be ongoing auditing program Weekly Quality of Life Med QA Committee meeting is Administrator, Director of Coordinator, Unit Manage Nurse, Therapy, HIM, Die Wound Nurse.  Date of Compliance: 5/24	strator or ctive action Any immediate to the Director for appropriate e monitored an a reviewed at the eeting. Monthly s attended by Nursing, MDS er, Support etary Manager,	of ad ne	