(X4) ID PREFIX TAGSUMMAR (EACH DEFIC REGULATORYF 253 SS=B483.15(h)(2) HOU MAINTENANCEThe facility must maintenance service sanitary, orderly,This REQUIREM by: Based on observice	SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior. ENT is not met as evidenced	B. WING ID PREFIJ TAG	STREET ADDRESS, CITY, STATE, ZIP CC 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	ODE CORRECTION ON SHOULD BE HE APPROPRIATE	R-C 06/23/2016
BERMUDA COMMONS NURSI         (X4) ID       SUMMAR         PREFIX       (EACH DEFIC         TAG       483.15(h)(2) HOU         SS=B       A83.15(h)(2) HOU         MAINTENANCE       MAINTENANCE         The facility must maintenance service       This REQUIREM         by:       Based on observice	NG AND REHABILITATION CENTER Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) USEKEEPING & SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior. ENT is not met as evidenced	ID PREFIJ TAG	STREET ADDRESS, CITY, STATE, ZIP CC 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 X PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ODE CORRECTION ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
BERMUDA COMMONS NURSI         (X4) ID       SUMMAR         PREFIX       (EACH DEFIC         TAG       483.15(h)(2) HOU         SS=B       A83.15(h)(2) HOU         MAINTENANCE       MAINTENANCE         The facility must maintenance service       This REQUIREM         by:       Based on observice	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) USEKEEPING & SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior.	PREFI	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	CORRECTION ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
(X4) ID       SUMMAR         PREFIX       (EACH DEFIC         TAG       483.15(h)(2) HOU         SS=B       MAINTENANCE         The facility must       maintenance servers anitary, orderly,         This REQUIREM       by:         Based on observer       Based on observer	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) USEKEEPING & SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior.	PREFI	ADVANCE, NC 27006 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
(X4) ID PREFIX TAGSUMMAR (EACH DEFIC REGULATORYF 253 SS=B483.15(h)(2) HOU MAINTENANCEThe facility must maintenance service sanitary, orderly,This REQUIREM by: Based on observice	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) USEKEEPING & SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior.	PREFI	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 253 SS=B F 253 SS=B F 253 The facility must maintenance serv sanitary, orderly, This REQUIREM by: Based on observ	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) USEKEEPING & SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior. ENT is not met as evidenced	PREFI	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
SS=B MAINTENANCE The facility must maintenance serves anitary, orderly, This REQUIREM by: Based on observe	SERVICES provide housekeeping and vices necessary to maintain a and comfortable interior. ENT is not met as evidenced	F	253		7/6/16
maintenance service sanitary, orderly, This REQUIREM by: Based on observice	vices necessary to maintain a and comfortable interior. ENT is not met as evidenced				
by: Based on observ					
address a foul sm The findings inclu 1. On 06/22/16 a the facility that re were carpeted. T black splattered s the hallway. One was noted to cove inches by 12 inch During the tour th in appearance an dried spills scatte hallway. The 400 and 500 at 8:30 AM and th dingy in appearar On 06/22/16 at 9: supervisor was in housekeeping sta able to start clear morning. She ex on the 100 and 20 She added that h visited the facility	ility failed to keep carpeted and or 5 of 6 halls and failed to hell on 1 of 6 halls. ded: t 8:20 AM a tour was made of vealed the 100 and 200 halls he carpet was noted to have tains throughout the length of stained area on the 200 hall er an area approximately 18		The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies. To rem compliance with all Federal Regulations the facility has take the actions set forth in Correction. The Plan of Con constitutes the facility's alleg compliance such that all alle deficiencies cited have beer corrected by the date or dat F253 HOUSEKEEPING & MAINTENANCE SERVICES Corrective Action: Carpets were cleaned, hallw stripped and waxed, and 40 deep cleaned to address the Contract was terminated with housekeeping company. Identification of other reside be involved with this practice All residents have the poten affected by the alleged prac hallway floors were observe attention. Systemic Changes: Nursing Home Administrator	sion to and do t with the pain in and State taken or will this Plan of prection gation of eged n or will be es indicated. S vay floors were 0 hall was e foul smell. th contracted nts who may e: tial to be tice. All d to need	

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.

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 07/12/2016 RM APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	E SURVEY IPLETED
		345543	B. WING			R-C 5/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	5/23/2016
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 253	conducted with the Ad Administrator reporte concerns with the fac trying to work with the to make the facility di- explained that the hor a contracted service. the stained carpet and to be deep cleaned. observed the tiled had halls stating they app mopped the day prior and appearance. Du Administrator noted a the 500 hall that cove 24 inches by 36 inches tracks were noted to the 500 hall. During the Administrator stated s assist with cleaning s housekeeping. She s facility to be cleaner. On 06/22/16 at 1:18 F visiting and interviewed daily and her only cor the cleanliness. The the floors as "horrend floor outside her mott look like they ever mot this." The floor was r and spills splattered of On 06/22/16 at 3:30 F started mopping the 4	AM a second tour was dministrator present. The d that she had identified ility's cleanliness and was e housekeeping department eaner. The Administrator usekeeping department was The Administrator observed d stated the carpet needed The Administrator also llways on 300, 400 and 500 eared that they had not been based on their condition ring the observations, the black, dried sticky spill on ored an area approximately es. Footprint and wheelchair have spread the stain along this observation, the she would expect nursing to imple spills and alert stated she expected her PM a family member was family member described lous" and pointed to the tiled neer's room stating, "It doesn't opped. And it's always like noted to have dried debris on the floor. PM the housekeeping staff 400 Hall and were able to	F 25		urveyors vith the the facility ed and all carpets 00 halls. vere 100 and al also g of the seted on us 600 hall And the 6, 2016. make and the . The 400 ddress the trator or will survey ance by insure on weekly for 3 Jnit s will be mmittee by o assure propriate. brought to	
	Hall was observed an foul smell.	id noted to have a strong		for appropriate action. Complian monitored and ongoing auditing		

Facility ID: 20070039

If continuation sheet Page 2 of 18

		ID HUMAN SERVICES			FOR	D: 07/12/2016 M APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	<u>D. 0938-0391</u> E SURVEY PLETED
		345543	B. WING			R-C / <b>23/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	123/2010
				316 NC HIGHWAY 801 SOUTH		
BERMUD	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)	LD BE	(X5) COMPLETION DATE
F 253 F 282 SS=D	On 06/22/16 at 9:15 / interviewed on the tel facility as "filthy" and family member stated because the smell at described the odor as urine and mold. She to the nurses about th On 06/22/16 at 9:30 / conducted with the Ar Administrator reporte concerns with the fac trying to work with the to make the facility cl toured the 400 hall ar hall had a foul odor. facility to be cleaner. On 06/22/16 at 11:23 was observed again a smell. On 06/22/16 at 1:13 F was observed and no been sprayed to mas was still detected. On 06/23/16 at 9:52 / was observed and no the odor was not noti aide was interviewed at the end of the hall she had to "really mo smell in the resident's 483.20(k)(3)(ii) SERV PERSONS/PER CAF	AM a family member was lephone and described the "reeked of urine." The d she dreaded visiting the end of the 400 Hall and is being a combination of stated she had complained he facility's cleanliness. AM a second tour was dministrator present. The d that she had identified ility's cleanliness and was e housekeeping department eaner. The Administrator hd noted that the end of the She stated she expected her AM the end of the 400 hall and noted to still have a foul PM the end of the 400 hall bted that air freshener had k the foul odor but the odor AM the end of the 400 hall bted to have clean floors and ceable. The housekeeping and reported that the odor "was bad." She explained p hard" to try to get rid of the s rooms. //CES BY QUALIFIED RE PLAN	F 25	reviewed at the Weekly Quality of L Meeting. Weekly QA Committee mu is attended by Administrator, Direct Nursing, MDS Coordinator, Unit Ma Support Nurse, Therapy, HIM, Diet Manager, Wound Nurse. Date of Compliance: 7/6/2016	eeting tor of anager,	7/6/16

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/12/2016 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DA COM	TE SURVEY MPLETED
		345543	B. WING			R-C 6/23/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•	
BERMUDA		AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
BERMODI				ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION YE ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page	e 3	F 2	282		
	by: Based on observatio record review the faci plan that specified the rolls for her hand con resident (Resident #3 The findings included Resident #36 was ad 04/20/15 with diagnos of hands, Alzheimer's most recent Minimum 03/14/16 specified the intact, she had no bel but required extensive bed mobility, persona impaired range of mo upper and lower extre A care plan revised o Resident #36 was to cloths) placed in both On 06/22/16 at 11:00 made of Resident #36 #1 was present for th Resident #36's contra- indentions in the Res fingernails. The NA v explained that she wa for Resident #36 but hand rolls placed in th there were no cloths I they had fallen out. On 06/22/16 at 11:10 Resident #36 was ma answer questions. On 06/22/16 at 11:37	mitted to the facility on ses that included contracture disease and others. The Data Set (MDS) dated e resident's cognition was haviors, did not reject care e 2 person assistance with I hygiene, eating and had tion on both sides of her emities. n 05/16/16 specified have hand rolls (wash hands. AM observations were 5's hands. Nurse Aide (NA) e observations and uncurled acted fingers that revealed ident's palm from her		The statements made Correction are not an a not constitute an agree alleged deficiencies. T compliance with all Fe Regulations the facility take the actions set fo Correction. The Plan constitutes the facility' compliance such that deficiencies cited have corrected by the date F282 SERVICES BY O PERSONS/PER CAR Corrective Action: Hand rolls were placed hands. Identification of other r be involved with this p All residents have the affected by the alleged Plans were reviewed to on July 6, 2016 to insu- managing devices were implemented. Systemic Changes: Director of Nursing an serviced all nursing sta Medication Aides, CN/ time, and PRN) that th Care Plans of their res assignment to insure to items they need in pla This in service was co 6/22/2016. Any nursin	admission to and do ement with the foremain in ederal and State y has taken or will rth in this Plan of of Correction s allegation of all alleged e been or will be or dates indicated. QUALIFIED E PLAN d in resident #36 residents who may practice: potential to be d practice. All Care by MDS Coordinator ure all contracture re care planned and d /or Designee in aff (RNs, LPNs, As full time, part hey must review sidents on their they know what ce for contractures. mpleted by	

Facility ID: 20070039

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY
				·		R-C
		345543	B. WING	B. WING		6/23/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		GAND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
		S AND REHADILITATION CENTER		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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 282	282 Continued From page 4 and was assigned to Resident #36 today but had not provided care since starting her shift at 7 AM. The NA stated she was unaware Resident #36 was to have hand rolls or cloths in her hands.		F 28	2 (RNs, LPNs, Medication Aides, time, part time, and PRN) who c receive in-service training will no allowed to work until training is o	lid not ot be	
	On 06/23/16 at 8:38	3 AM the MDS Coordinator d stated nurse aides were		This information has been integrated the standard orientation training required in-service refresher control all employees and will be review Quality Assurance Process to version of the standard standa	rated into and in the urses for ved by the erify that	
				the change has been sustained. Monitoring: To ensure compliance the MDS DON or designee will monitor th using the QA survey tool. Facilit monitor compliance by observin residents to insure any newly or	Nurse, is issue y will g 5 dered	
				device for contracture managern being implemented. This will be weekly basis M-F for 4 weeks th monthly for 3 months by the MD DON or designee. Reports will presented to the weekly QA Cor the Administrator or designee to corrective action initiated as app	done on len IS Nurse, be nmittee by assure	
				Any immediate concerns will be the Director of Nursing or Admir for appropriate action. Complian monitored and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly QA Committee is attended by Administrator, Dir Nursing, MDS Coordinator, Unit Support Nurse, Therapy, HIM, D Manager, Wound Nurse. Date of Compliance: 7/6/2016	brought to nistrator program of Life meeting rector of Manager,	
{F 312} SS=D	483.25(a)(3) ADL C DEPENDENT RES	ARE PROVIDED FOR	{F 312	-		7/6/16

Facility ID: 20070039

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	-	D HUMAN SERVICES MEDICAID SERVICES	1		PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345543	B. WING		06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.20.2010
BERMUD	A COMMONS NURSING A	AND REHABILITATION CENTER		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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
{F 312}	A resident who is una daily living receives th maintain good nutritic and oral hygiene.	e 5 ble to carry out activities of ne necessary services to n, grooming, and personal	{F 31	12}	
	Based on observatio record review the faci dependent resident's residents (Resident # The findings included Resident #36 was ad 04/20/15 with diagnos of hands, Alzheimer's most recent Minimum 03/14/16 specified the intact, she had no bel but required extensive bed mobility, persona impaired range of mo upper and lower extre A care plan revised of Resident #36 had an deficit related to impat to check nail length a On 06/22/16 at 11:00 made of Resident #36 #1 was present for the Resident #36's contra- right hand revealing 1 The NA was interview was routinely assigned but not today. The N- were long and should and as needed.	nails for 1 of 3 sampled 36). : mitted to the facility on ses that included contracture disease and others. The Data Set (MDS) dated e resident's cognition was haviors, did not reject care e 2 person assistance with I hygiene, eating and had tion on both sides of her emities. n 05/16/16 specified activity of daily living (ADL) ired cognition and staff were		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 St Regulations the facility has taken of take the actions set forth in this Plan 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 F312 ADL CARE PROVIDED F DEPENDENT RESIDENTS Corrective Action: Resident #36, were trimmed. Identification of other residents who be involved with this practice: All residents have the potential to be affected by the alleged practice. All resident's nails (fingers and toes) we assessed on July 5, 2016 by DON, Manager, and Wound Nurse for cleanliness to provide comfort, to re their physical and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin pro- All long and dirty finger nails were trimmed and cleaned. Systemic Changes:	and do ne ate or will an of of l be cated. OR o may be l vere , Unit neet

Facility ID: 20070039

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		ND HUMAN SERVICES			FORM	: 07/12/201 APPROVEI
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
		345543	B. WING		R-	
	ROVIDER OR SUPPLIER	545545			06/2	23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH		
BERMUD	COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 312}	Continued From page	e 6	(F 312	2}		
	Resident #36 was ma answer questions. On 06/22/16 at 11:37 again and reported th and was assigned to not provided care sin On 06/22/16 at 11:40 interviewed and repo Resident #36's nails AM but did not trim th seem long to her. On 06/23/16 at 10:32 (DON) was interviewed fingernail length was stated if Resident #36 short, the length coul severity of her hand of	ade but she was unable to 7 AM NA #1 was interviewed nat she had gotten confused Resident #36 today but had ce starting her shift at 7 AM.		Director of Nursing and /or Design serviced all nursing staff (RNs, LF Medication Aides, CNAs full time, time, and PRN) that a resident wh unable to carry out activities of da must receive the necessary servic maintain good nutrition, grooming personal and oral hygiene. Nail ca fingers and toes has to be provide residents to provide comfort, to m physical and mental needs, to pre spread of infection, to provide clea and to prevent skin problems. Thi service was completed by 7/1//20 nursing staff member (RNs, LPNs Medication Aides, CNAs full time, time, and PRN) who did not receiv in-service training will not be allow work until training is completed. T information has been integrated in standard orientation training and i required in-service refresher cour- all employees and will be reviewe Quality Assurance Process to ver the change has been sustained. Monitoring: To ensure compliance, Director of or designee will monitor this issue the QA survey tool. Facility will me compliance by observing all resid- requiring assistance with ADLs. T be done on weekly M-F basis for then monthly for 3 months by the Nurse, Unit Manager, or designee Reports will be presented to the w QA Committee by the Administrat designee to assure corrective acti- initiated as appropriate. Any imme concerns will be brought to the Di-	PNS, part no is ily living ces to , and are of ed to eet their event anliness s in 16. Any s, part ve ved to his nto the n the ses for d by the ify that f Nursing e using ponitor ents his will 4 weeks Support e. veekly or or ion ediate	

Event ID: SJGJ12

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/12/20 <sup>7</sup> MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		PLETED
		345543	B. WING				-C / <b>23/2016</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 16 NC HIGHWAY 801 SOUTH DVANCE, NC 27006	<u>  00</u> ,	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
{F 312}	Continued From page	e 7	{F 3	12}	Nursing or Administrator for appropriat 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, MD Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager Wound Nurse. Date of Compliance: 7/6/2016	ind the y S	
F 314 SS=D	resident, the facility n who enters the facility does not develop pre individual's clinical co they were unavoidab pressure sores receiv	ESSURE SORES thensive assessment of a nust ensure that a resident without pressure sores ssure sores unless the indition demonstrates that le; and a resident having ves necessary treatment and healing, prevent infection and	F	314			7/6/16
	by: Based on observatio record review the fac rolls to prevent a pres with a history of a pres 1 of 1 sampled reside The findings included Resident #36 was ad 04/20/15 with diagnos of hands, Alzheimer's most recent Minimum 03/14/16 specified the	· · · · · · · · · · · · · · · · · · ·			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 wi 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	ll f	

Facility ID: 20070039

If continuation sheet Page 8 of 18

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/12/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345543	B. WING		R-C 06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	н
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION (X5) IVE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE FICIENCY)
F 314	bed mobility, personal impaired range of mo- upper and lower extra pressure ulcers or sk On 04/27/16 a physic place wash cloths in 1 wound care to a stag the 3rd and 4th right On 05/02/16 the MDS Resident #36 was red 4th finger and had co- hands and hand rolls On 05/11/16 Residen finger resolved. A care plan revised o Resident #36 was to cloths) in place to bot On 06/22/16 at 11:00 made of Resident #31 #1 was present for th Resident #36's contra indentions in the Res fingernails. The NA v explained that she wa for Resident #36 but hand rolls placed in th there were no cloths they had fallen out. On 06/22/16 at 11:10 Resident #36 was ma answer questions. On 06/22/16 at 11:37 again and reported th and was assigned to not provided care sin The NA stated she way	e 2 person assistance with al hygiene, eating and had otion on both sides of her emities and she had no in breakdown. tian's order was written to bilateral hands daily for e 3 pressure ulcer between fingers. S Coordinator documented ceiving treatment to her right intractures to fingers on both were placed in them. t #36's pressure ulcer to her n 05/16/16 specified have hand rolls (wash th hands. AM observations were 6's hands. Nurse Aide (NA) e observations and uncurled acted fingers that revealed ident's palm from her	F 3	F314 Treatment /SVP Pressure Sores Corrective Action: Resident #36 pressur on 5/11/2016. Hand of as ordered. Identification of other be involved with this All residents have the affected by the allege residents who have f meet their physical a prevent/heal pressur by DON on 7/5/2016 Systemic Changes: Director of Nursing a serviced all nursing s CNAs full time, part t the facility must ensu who enters the facilit sores does not devel unless the individual' demonstrates that th and a resident having receives necessary t services to promote I infections and prever developing on 6/22/2 staff member (RNs, I part time, and PRN) in-service training wi work until training is information has been standard orientation required in service ref	re ulcer was healed rolls placed to hands r residents who may practice: e potential to be ed practice . All hand rolls ordered to ind mental needs and e areas were audited and /or Designee in staff (RNs, LPNs, time, and PRN) that are that a resident y without pressure lop pressure sores 's clinical condition ey were unavoidable; g pressure sores reatment and healing, prevent int new sores from 2016. Any nursing LPNs, CNAs full time, who did not receive II not be allowed to completed. This in integrated into the training and in the effesher courses for ill be reviewed by the rocess to verify that

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	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345543	B. WING		R-C 06/23/2016
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		816 NC HIGHWAY 801 SOUTH 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET
F 314	Continued From pag	e 9	F 314		
	Resident #36's nails AM and Resident #30 placed in her hands. did not put hand rolls after she finished cle was not aware the re hand rolls in place. On 06/23/16 at 9:57 interviewed and state #36 was noted to hav on her right 4th digit 3rd and 4th finger. To obtained orders for the the use of hand rolls with wound healing, were to be in place a the pressure to the fin The wound nurse rep	rted that she had cleaned that morning around 9:30 6 did not have hand rolls The Nurse also stated she in the Resident's hands aning her nails because she sident had an order to keep AM the wound nurse was ed that on 04/27/16 Resident ve a stage 3 pressure ulcer between the knuckles of the he wound nurse stated she reatment and implemented to open the hands to assist She added the hand rolls II day, every day to relieve ngers and absorb moisture. ported that the stage 3 ed but she would expect the		To ensure compliance the Unit Man Wound Nurse, Director of Nursing of designee will monitor this issue usin QA survey tool. Facility will monitor residents weekly for prevention/hea pressure sores. This will be done we M-F basis for 4 weeks then weekly in months by the Unit Manager, Woun Nurse, DON or designee. Reports we presented to the weekly QA Commit the Administrator or designee to ass corrective action initiated as approp Any immediate concerns will be bro the Director of Nursing or Administrat for appropriate action. Compliance we monitored and ongoing auditing pro reviewed at the Weekly Quality of L Meeting. Weekly QA Committee me is attended by Administrator, Director Nursing, MDS Coordinator, Unit Ma Support Nurse, Therapy, HIM, Dieta Manager, Wound Nurse. Date of Compliance: 7/6/2016	or ng the 5 ling eekly for 3 d will be ttee by sure riate. ught to ator will be gram ife setting or of nager,
{F 431} SS=D		RUG RECORDS, GS & BIOLOGICALS bloy or obtain the services of	{F 431]		7/6/16
	a licensed pharmacis of records of receipt controlled drugs in su accurate reconciliation records are in order a	t who establishes a system			
		s used in the facility must be e with currently accepted			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/12/20 FORM APPROV OMB NO. 0938-03	/ED
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		R-C 06/23/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BERMUD		AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
BEIGHOD				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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC	N
{F 431}	Continued From page	e 10	{F 43 <sup>-</sup>	1}		
	appropriate accessor instructions, and the applicable.	5				
	facility must store all locked compartments	tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys.				
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu	ide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit tion systems in which the imal and a missing dose can				
	by: Based on observatio facility failed to secure unattended for 1 of 1 and left medications u station at 1 of 2 nurse The findings included 1. On 06/22/16 at 10 made of the nurses' s intersection of the 400 the desk were three b medications were pos desk less than an arm There was no one att during the observatio	: :00 AM observations were		The statements made on this F Correction are not an admissior 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 Correc constitutes the facility's allegatio compliance such that all alleged deficiencies cited have been or corrected by the date or dates in F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS	n to and do h the in I State en or will Plan of tion on of d will be	

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		ND HUMAN SERVICES			PRINTED: 07/12/ FORM APPRC OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345543	B. WING		R-C 06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/20/2010
			:	316 NC HIGHWAY 801 SOUTH	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE
{F 431}	observation. On 06/22/16 at 12:04 nurses' station at the 600 Halls were made (DON). The 3 bottles unattended at the nur picked up the medica - 1 bottle of acetar - 1 bottle of a	PM observations of the intersection of 400, 500 and with the Director of Nursing of medications were rses' station. The DON tion bottles that revealed: minophen unopened minophen empty obilus opened and contained he bottles from the nurses' PAM the DON was ed the medications should attended at the nurses' :39 AM observations were medication cart. The cart ay down the hall, unlocked er approximately 5 minutes, sident's room and ication cart. Nurse #2 was ed her medications and apply buttocks." Nurse #2 are her medication cart was	{F 431	Corrective Action: Medication and Treatment carts will locked and secured while the nurse not in attendance. Medication removed from nurses of and stored in secured location. Identification of other residents while be involved with this practice: All residents have the potential to the affected by the alleged practice. And were done 7/1/ 2016 by DON and medication and treatment carts we locked and secured when the nurse not in attendance. All medications stored and secured. All medications treatment carts are locked at all time when not in immediate use by Nurse Medication and treatment carts and any area that medication was secu- stored were checked to ensure that was, no expired, undated or not ini- meds. No medication was unsecur- nurses station. Systemic Changes: Director of Nursing and /or Design serviced all nursing staff (RNs, LPI time, part time, and PRN) that the must store all drugs and biologicals locked compartments under prope temperature controls, and permit of authorized personnel to have acce the keys. The facility must also sep lock, and have permanently affixed compartments for storage of control drugs. Drugs and biologicals used facility must be labeled in accordar currently accepted professional pri and include the appropriate access and cautionary instructions, and th	e was lesk o may be udits all re e was were and nes se. All d also urely t there tialed ed at ee in Ns, full facility s in r nly ss to barately d bled l in the nce with nciples, sory

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		R-C 06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DERIVIOD	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
{F 431}	Continued From page	₽ 12	{F 431	expiration date when applicable. T service was completed by 7/1/2010 nursing staff member (RNs, LPNs, time, part time, and PRN) who did receive in-service training will not the allowed to work until training is cor This information has been integrate the standard orientation training ar required in-service refresher course all employees and will be reviewed Quality Assurance Process to verife the change has been sustained. Monitoring: To ensure compliance, Unit Manage DON or designee will monitor this using the QA survey tool. Facility w monitor compliance by auditing ea medication cart, and treatment car any other areas that medication is to ensure that they are secured pro- at all times. Facility will also observe medication and treatment carts for expired, undated and not initialed, nurse. This will be done on daily M basis for 4 weeks then monthly for months by the Support Nurse, Unit Manager, or designee. Reports will presented to the weekly QA Comm the Administrator or designee to as corrective action initiated as appro- Any immediate concerns will be br the Director of Nursing or Administ for appropriate action. Compliance monitored and ongoing auditing pr reviewed at the Weekly Quality of Meeting. Weekly QA Committee m is attended by Administrator, Direct Nursing, MDS Coordinator, Unit M Support Nurse, Therapy, HIM, Die	6. Any full not be mpleted. ed into hd in the less for d by the fy that ger, issue vill ch t and stored operly ve all by the I-F 3 t ill be hittee by ssure priate. ought to rrator e will be ogram Life leeting ctor of anager,

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		ND HUMAN SERVICES			PRINTED: 07/12/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345543	B. WING		R-C 06/23/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		16 NC HIGHWAY 801 SOUTH DVANCE, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 431}	Continued From page	e 13	{F 431}	Manager, Wound Nurse.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS		F 520	Date of Compliance: 7/6/2016	7/6/16
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the			
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify o which quality assessment ties are necessary; and nents appropriate plans of tified quality deficiencies.			
		ords of such committee th disclosure is related to the committee with the			
		by the committee to identify efficiencies will not be used as			
	by: Based on observatio interviews the facility' Assurance Committe implemented procedu			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	d do

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 07/12/201 DRM APPROVE NO: 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345543	B. WING				R-C 06/23/2016
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER			6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 14 vo recited deficiencies that	F	520	Regulations the facility has taken or v	will	
	were originally cited i				take the actions set forth in this Plan Correction. The Plan of Correction		
	follow up survey. The	e repeated deficiencies were of care and pharmacy			constitutes the facility's allegation of compliance such that all alleged		
	during two federal su	ued failure of the facility rveys of record show a			deficiencies cited have been or will be corrected by the date or dates indicated		
	pattern of the facility's effective Quality Assu	s inability to sustain an ırance Program.			F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Corrective Action:		
	The tags were cross	referred to:			Quality Committee consisting of the Administrator, Director of nursing, Un	iit	
	1 a. F 312: Provide A Daily Living: Based of	Assistance with Activities of on record review,			Manager, Staff Development coordin MDS coordinators, Support Nurse,		
	the facility failed to tri	terviews and record review m a dependent resident's ed residents (Resident #36).			Therapy, HIM, Dietary Manager, Wou Nurse and Medical Director reviewed implemented procedures and monitor	red	
		ed for failing to provide nail			interventions the committee put in pla on July 5, 2016 on areas of quality of		
	during the May 2016	312 was previously cited recertification survey for			and pharmacy services. Identification of other residents who r	nay	
	residents.	care for 4 of 4 sampled			be involved with this practice: All residents have the potential to be affected by the alleged practice. Qua	litv	
	b. F 431: Labeling an Pharmaceuticals: Ba	d Storage of used on observations and			Committee consisting of the Administrator, Director of nursing, Un		
	medication cart when	cility failed to secure a left unattended for 1 of 1			Manager, Staff Development coordin MDS coordinators, Support Nurse,		
	unattended at 1 of 2 i				Therapy, HIM, Dietary Manager, Wou Nurse and Medical Director reviewed implemented procedures and monito		
	failing to secure a me	ed on the current survey for edication cart that was ng medications unattended			interventions the committee put in pla on July 5, 2016 on areas of quality of	ace	
	at the nurses' station.	F 431was previously cited recertification survey for			and pharmacy services All resident's (fingers and toes) were assessed on	nails	
		edication cart when g to discard expired insulin. AM the Administrator was			5, 2016 by Director of nursing, unit manager and wound nurse for cleanl to provide comfort, to meet their phys		

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		ND HUMAN SERVICES			PRINTED: 07/12 FORM APPR	OVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		· , ,	IPLE CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345543	B. WING		R-C 06/23/201	6
NAME OF P	ROVIDER OR SUPPLIER	I	T	STREET ADDRESS, CITY, STATE, ZIP	•	0
				316 NC HIGHWAY 801 SOUTH		
BERMUD	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 PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPL THE APPROPRIATE DAT	ETION
F 520	interviewed and expla facility's recertification 05/02/16 the Quality had implemented new prevent repeat deficie 312 and F 431. The facility had not been meeting but had work the new systems. Th	e 15 ained that following the n survey that ended on Assurance (QA) Committee w systems to correct and ent practice in the areas of F Administrator added that the able to hold a formal QA ked to in-service and audit the Administrator stated that e felt the facility was in	F	and mental needs, to prev infection, to provide clean prevent skin problems. All finger nails were trimmed Audits were done 7/1/ 201 nursing and all medication carts were locked and sec nurse was not in attendam medications were stored a medication and treatment at all times when not in im Nurse. All Medication and and also any area that me securely stored were chec that there was, no expired initialed, open insulin by th Systemic Changes: The Administrator in servic Committee on July 5, 201 the, Director of nursing, U Staff Development coordin coordinators, Support Nur HIM, Dietary Manager, W Medical Director that the f maintain a quality assess assurance committee con director of nursing service designated by the facility; 3other members of the fac quality assessment and a activities are necessary an implements appropriate p to correct identified quality The Director of Nursing ar in serviced all nursing staff Medication Aides, CNAs f	liness and to long and dirty and cleaned. 6 by Director of and treatment sured when the ce. All and secured. All carts are locked mediate use by treatment carts edication was sked to ensure , undated or not ne nurse. ced the Quality 6 consisting of nit Manager, nator, MDS se, Therapy, ound Nurse and acility must ment and sisting of the s; a physician and at least cility's staff. The ssurance quarterly to ct to which ssurance nd develops and ans of actions y deficiencies. nd /or Designee f (RNs, LPNs,	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 07/12/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (. AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			ESURVEY PLETED R-C
		345543	B. WING				/23/2016
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BERMUDA		ND REHABILITATION CENTER		31	16 NC HIGHWAY 801 SOUTH		
				Α	DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 520	Continued From page	- 16	F	520	time, and PRN) that a resident who is unable to carry out activities of daily liv must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Nail care of fingers and toes has to be provided to residents to provide comfort, to meet t physical and mental needs, to prevent spread of infection, to provide cleanlin and to prevent skin problems. This in service was completed by 7/1//2016. Director of Nursing and /or Designee a in serviced all nursing staff (RNs, LPN full time, part time, and PRN) that the facility must store all drugs and biologi in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must also separal lock, and have permanently affixed compartments for storage of controlled drugs. Drugs and biologicals used in the facility must be labeled in accordance currently accepted professional princip and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This service was completed by 7/1/2016. A nursing staff member (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) who did not receive in-service training will not be allowed t work until training is completed. This information has been integrated into th standard orientation training and in the	o d f heir ess also s, icals icals to ttely d the with oles, in ny	
					required in-service refresher courses f all employees and will be reviewed by Quality Assurance Process to verify th the change has been sustained.	the	

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Facility ID: 20070039

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CENTER STATEMENT ( AND PLAN OF NAME OF P	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543 AND REHABILITATION CENTER	A. BUILDING B. WING S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 16 NC HIGHWAY 801 SOUTH NDVANCE, NC 27006	PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED R-C 06/23/2016
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 520	Continued From page	€ 17	F 520	Monitoring: To ensure compliance, Administrator Director of Nursing or designee will monitor this issue using the QA surve tool. Facility will monitor compliance auditing the QA Survey tools for F25 Survey Tool for F282, QA Survey Too F312, QA Survey Tool for F314, and Survey Tool for F431 at the weekly Q meeting. 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 I presented to the weekly QA Committ the Administrator or designee to assi corrective action initiated as appropri Any immediate concerns will be brout the Director of Nursing or Administrat for appropriate action. Compliance w monitored and ongoing auditing prog reviewed at the Weekly Quality of Lif Meeting. Weekly QA Committee meet is attended by Administrator, Directo Nursing, MDS Coordinator, Unit Man Support Nurse, Therapy, HIM, Dietar Manager, Wound Nurse. Quality Committee consisting of the Administrator, Director of nursing, Ur Manager, Staff Development coordin MDS coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Wo Nurse and Medical Director will meet quarterly to identify issues with respect which quality assessment and assura activities are necessary and develop implements appropriate plans of activ to correct identified quality deficiencie Date of Compliance: 7/6/2016	ey by 3, QA of for QA QOL ( be tee by ure iate. light to tor vill be gram ie eting r of hager, ry hit hator, und t ect to ance s and ons

Event ID: SJGJ12

Facility ID: 20070039

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