PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | COME | | DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|---|----------|----------------------------|
| | | 345543 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | I | 05/25/2017 |
| (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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 157 SS=D | (INJURY/DECLINE/F (g)(14) Notification of (i) A facility must immonsult with the residence consistent with his or representative(s) who will be a consistent with his or representative(s) who will be a consistent with his or representative(s) who will be a consistent with his or representative(s) who will be a consistent with his or representative(s) who will be a consistent in high physician intervention (B) A significant charmental, or psychosory deterioration in healt status in either life-the clinical complications (C) A need to alter that the complex in the complex | rediately inform the resident; dent's physician; and notify, refer authority, the resident en there is- ving the resident which has the potential for requiring en; rige in the resident's physical, cial status (that is, a h, mental, or psychosocial areatening conditions or es); reatment significantly (that is, e an existing form of the rese consequences, or to enser or discharge the | F 18 | | | 6/16/17 |
| ARORATODY | | n or roommate assignment | F | TITLE | | (X6) DATE |

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

06/16/2017

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.

Electronically Signed

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | PLE CONSTRUCTION IG | , , | DATE SURVEY COMPLETED |
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| | | 345543 | B. WING _ | | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 00/20/2017 |
| | | | | 316 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 157 | Continued From page | ge 1 | F 1 | 57 | | |
| | as specified in §483 | .10(e)(6); or | | | | |
| | | dent rights under Federal or ons as specified in paragraph n. | | | | |
| | update the address phone number of the This REQUIREMEN | record and periodically (mailing and email) and e resident representative(s). T is not met as evidenced | | | | |
| | and staff interviews physician of a non-p | on, record reviews, physician the facility failed to notify the ressure wound on the for 1 of 1 residents sampled | | The statements made on this Correction are not an admission not constitute an agreement will alleged deficiencies. To remain compliance with all Federal an Regulations the facility has tak | on to and do ith the n in d State | |
| | The findings include | d: | | take the actions set forth in this Correction. The Plan of Correction. | s Plan of | |
| | 05/16/17 with diagnoresistant staphyloco septicemia, acute pudecubitus ulcer of sa on admission, diabe pressure ulcer of this admission, and diab | acral region stage 2 present tic ulcer of right great toe, gh stage 3 present on | | constitutes the facility's allegat compliance such that all allege deficiencies cited have been or corrected by the date or dates F157 NOTIFY OF CHANGE (INJURY/DECLINE/ROOM, ETCORRECTIVE Action: Resident #166. Physician was 5/24/17. New physician orders initiated as ordered. Care plan Resident and Resident's represented. | ion of ed r will be indicated. ES FC). notified on placed and updated. | |
| | between left and rigl were identified on th | nt buttock. No other ulcers e initial nursing assessment. | | notified on 5/24/17. Identification of other residents be involved with this practice: All residents have the potential | who may | |
| | 05/17/17 read in par and sacral decubitus | t, "Stage 3 decubitus to thigh s. Wound doctor to see on the report did not reference a | | affected by the alleged practice 2 to June 16 2017 a skin asses completed on all residents to e all pressure and non-pressure were identified, physician was | e. On June ssment was ensure that wounds | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE COMP | |
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| | | 345543 | B. WING _ | | | 05/2 | 25/2017 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| DEDMIID | COMMONS NUIDSING | AND BEHADII ITATION CENTED | | 31 | 6 NC HIGHWAY 801 SOUTH | | |
| DEKINUUA | COMMONS NURSING | AND REHABILITATION CENTER | | ΑI | DVANCE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA | | (X5) COMPLETION DATE |
| | | | | | DEFICIENCY) | | |
| F 157 | | e 2 d Care Specialist Initial 19/17 read in part, wound of | F 1 | 57 | and physician orders were followed and initiated. All care plans were updated. A | | |
| | the right posterior an | kle was healing and surgical ent of the site was performed. reatment was Santyl | | | pressure and non-pressure wounds we initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was | re | |
| | 05/22/17 at 4:06 PM observed to apply wo | ound care was made on with Nurse #2. Nurse #2 was ound dressing that contained 266's right and left back of | | | held on 6/15/17 by the Nurse Management Team (Director of Nursing MDS, NHA, Unit Manager and Support Nurse). All physician orders were follow and initiated as ordered. | | |
| | _ | urse #2 was observed to Iressing that contained 266's right heel. | | | Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full timpart time, and PRN) on the fact that the | ne, | |
| | 05/24/17 at 2:53 PM. she was the nurse th on 05/16/17 and com assessment. Nurse # #266's right foot was | 7 stated that Resident wrapped with a dressing | | | facility must immediately inform the resident; consult with the resident's physician; and notify consistent with his her authority, the resident's representative(s) when there is, an accident involving the resident which results in injury and has the potential for | s or | |
| | not know what kind of the dressing on admi other foot was fine an was not aware of any | ove the dressing and does of ulcers were present under sission. Nurse #7 stated the and had no ulcers. Nurse #7 of ulcers on the right heel are removed the dressing to ander it. | | | requiring physician intervention; A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); A need to alter treatments | S or | |
| | conducted on 05/24/ confirmed that he had 05/17/17 and was ma Resident #266's right thigh/buttock area. H of this interview, he w wound that Resident that when he visited | Medial Doctor (MD) was 17 at 3:08 PM. The MD d seen Resident #266 on ade aware of the wound to t great toe and to her e added, that up to the time vas not aware of any heel #266 had. The MD stated Resident #266 on 05/17/17 and he did not unwrap it to | | | significantly (i.e., a need to discontinue existing form of treatment due to adversonsequences, or to commence a new form of treatment); The facility must ensure that all pertinent information is available and provided upon request to the physician. The facility must ensure notify the resident and the resident's representative when there is a change room or roommate assignment, a chan | an se to | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | X3) DATE SURVEY COMPLETED |
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| | | 345543 | B. WING _ | | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DDE I | 03/23/2017 |
| | | | | 316 NC HIGHWAY 801 SOUTH | | |
| BERMUD | A COMMONS NURSIN | G AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ON SHOULD BE HE APPROPRIAT | (X5) COMPLETION DATE |
| F 157 | Continued From pa | age 3 | F 1 | 57 | | |
| F 137 | visualize it. He add dry. The MD indica of Nursing (ADON) informed him of the wound to thigh/but recall being inform Resident #266 had notified of any wound. An interview with the 105/25/17 at 10:46 at (DON) was present ADON stated that 105/17/17 and he net with the not say for sure that to Resident #266's have already place he may not have so ADON stated that have been made at Resident #266 had wound. The DON the MD to be made | led the dressing was clean and lated that the Assistant Director had rounded with him and eright great toe wound and the tock area but he could not led of any heel wound that it. The MD stated that if he was land he would go and see the late ADON was conducted on AM. The Director of Nursing the during the interview. The late had rounded with the MD on lotified the MD of Resident lee ADON added that the MD wounds on 05/17/17 but could late he had visualized the wound late he had visualized the wound late he wound that day." The late that meeting the MD should late ware of all the wounds that including the right heel ladded that she expected that le ladded that she expected that le ladded that she expected that le ladded the wound. | F 1 | in resident rights under Fed law or regulations and also must ensure that there is a periodically update the address phone number of the reside representative. All Nurses (RNs, LPNs, full time, and PRN) were also esthe fact that it is the nurse's to follow Physician orders. It is should be called 24 hours as days a week. This process change due to time or day of Physician phone numbers as each nurse's station in their you are unable to reach the physician or the physician of facility medical director with of contacting the primary phattending physician or medical does not provide an approper or does not call back within then the nurse is to contact immediately for further instruction that the nurse is to contact immediately for further instruction. Any Nurse (RN time, part time, and PRN) were ceive in-service training we allowed to work until training this information has been in the standard orientation trainer equired in-service refresher all employees and will be requality Assurance Process the change has been sustain Monitoring: To ensure compliance, Dire or designee will monitor this the QA survey tool. The fac | the facility record and ress and ent's time, part ducated on responsibility hysician day and 7 does not of the week. The fact of the week are located at notebook. If attending on call, call the in 30 minutes hysician. If the cal director riate responsions and minutes the DON for the polyment of the po | t less ne se |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | (X3) DATE COMP | SURVEY PLETED |
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| | | 345543 | B. WING_ | | | C 25/2017 |
| | 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 LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 157 F 224 SS=D | MISTREATMENT/NE §483.12 The resident abuse, neglect, misap property, and exploits subpart. This includes freedom from corpora seclusion and any ph not required to treat the 483.12(b) The facility implement written pole | PHIBIT GLECT/MISAPPROPRIATN Thas the right to be free from propriation of resident ation as defined in this is but is not limited to all punishment, involuntary ysical or chemical restraint the resident's symptoms. | F 1 | compliance by reviewing 5 residents's non-pressure or pressure wounds were to ensure that physician has been not and orders are followed and initiated a ordered. This will be done on weekly the for 4 weeks then monthly for 3 months the Director of Nursing, Support Nurse Unit Manager, or designee. Reports who be presented to the weekly QA Common by the Administrator or designee to as corrective action initiated as appropriate Any immediate concerns will be broughthe Director of Nursing or Administrate for appropriate action. Compliance will monitored and ongoing auditing prograviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meet is attended by Administrator, Director Nursing, MDS Coordinator, Unit Manas Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _Jun 16th, 2017 | ekly ified as pasis by e, vill ittee sure te. th to or I be am ing of ger, | 6/16/17 |

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| | D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345543 | B. WING | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | STREET ADDRESS, CITY, STATE, ZIP CODE | 03/23/2017 |
| DEDMID | | AND DELIABILITATION OF NITED | 3 | 16 NC HIGHWAY 801 SOUTH | |
| BERMUDA | A COMMONS NURSING A | AND REHABILITATION CENTER | <i>A</i> | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 224 | | e 5 nts and misappropriation of | F 224 | | |
| | resident property, (b)(2) Establish policion investigate any such | allegations, and | | | |
| | §483.95, This REQUIREMENT by: | as required at paragraph is not met as evidenced ns record review, and staff | | The statements made on this Plan of | |
| | interview the facility n orders on admission t and neglected to initia | eglected to initiate treatment for a stage 3 pressure ulcer ate treatment to a | | Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in | do |
| | for 1 of 1 sampled resident was admitted | on the right heel for 8 days sident (Resident #266). The d with a Stage 3 pressure | | compliance with all Federal and State Regulations the facility has taken or wil take the actions set forth in this Plan of | |
| | not initiated for 3 day. admitted with a non-p | ock area and treatment was The resident was also bressure wound to the right te treatment for 8 days. | | Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be | |
| | The findings included | · | | corrected by the date or dates indicated F224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPF | |
| | from the hospital date decubitus ulcer of the | t #266's discharge summary ed 05/16/17 read in part, sacrum stage 2/pressure le 3 present on admission. manage. | | PRIATION. Corrective Action: Resident #266. Physician was notified 5/24/17. New physician orders placed a initiated as ordered. Care plan updated | and |
| | Resident #266 was at 05/16/17 with diagnost ulcer stage 3, diabete hyperlipidemia, and n | dmitted to the facility on ses that included: pressure s mellitus, hypertension, | | Resident and Resident's representative notified on 5/24/17. Identification of other residents who make involved with this practice: All residents have the potential to be affected by the alleged practice. On Ju | e vy |
| | site. Review of Initial Nurs | ing Assessment dated there was 5 small ulcers | | 2 to June 16 2017 a skin assessment v completed on all residents to ensure th all pressure and non-pressure wounds were identified, physician was notified, | /as |

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| | | 345543 | B. WING | | C 05/25/2047 |
| NAME OF P | ROVIDER OR SUPPLIER | 0.00.0 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 05/25/2017 |
| TVAINE OF T | TOVIDER OR OUT FEEL | | | , , , | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | |
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| (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 APPRO DEFICIENCY) | D BE COMPLETION |
| F 224 | Continued From pag | e 6 | F 22 | 4 | |
| | between left and righ | t buttock. | | and physician orders were followed initiated. All care plans were update | |
| | Review of a physicia | n progress note dated | | pressure and non-pressure wounds | |
| | | , stage 3 decubitus to thigh | | initiated as ordered. Skin assessme | |
| | | . Wound doctor to see on | | were completed by ADON and staff | |
| | Friday (05/19/17) and | d encourage resident to stay | | nurses. The wound review meeting | |
| | on side as much as p | possible. | | held on 6/15/17 by the Nurse | |
| | | | | Management Team (Director of Nur | |
| | | d Care Specialist's Initial | | MDS, NHA, Unit Manager and Supp | |
| | | 19/17 read in part, Stage 3 | | Nurse). All physician orders were fo | llowed |
| | | ne left buttock was pressure | | and initiated as ordered. | |
| | | the recommended treatment ed ointment) once daily. | | Systemic Changes: Director of Nursing and /or Designe | o in |
| | was Santyi (medicate | ed offittherit) office daily. | | serviced all Nurses (RNs, LPNs, full | |
| | Review of physician | order dated 05/19/17 read, | | part time, and PRN) on the fact that | |
| | | cral area every other day | | resident has the right to be free from | |
| | | ound cleaner for wound care. | | abuse, neglect, misappropriation of | |
| | _ | | | resident property, and exploitation. | This |
| | An observation of Nu | | | includes but is not limited to freedor | n from |
| | | performing wound care on | | corporal punishment, involuntary | |
| | | e #2 was observed to apply a | | seclusion and any physical or chem | ical |
| | _ | contained Santyl to Resident | | restraint not required to treat the | |
| | | igh area and then applied a | | resident's symptoms. The facility me | |
| | cover to hold the san | ityi dressing in place. | | develop and implement written police and procedures that: Prohibit and procedures that and procedures that are provided that are provided to the provided that are provided to t | |
| | Review of the Medic | ation Administration Record | | abuse, neglect, and exploitation of | levent |
| | | 7 through 05/31/17 read in | | residents and misappropriation of re | esident |
| | | to buttocks/thigh topically | | property, Establish policies and | Joidont |
| | | ound care. This was initialed | | procedures to investigate any such | |
| | | 7, and 05/23/17 indicating | | allegations including training. All Nu | rses |
| | | d been completed on those | | (RNs, LPNs, full time, part time, and | |
| | days. | | | were also educated on the fact that | it is |
| | | | | the nurse's responsibility to notify | |
| | | prehensive minimum data | | physician, follow and initiate Physic | |
| | set (MDS) dated 05/2 | 23/17 remained in progress. | | orders. Physician should be called 2 | |
| | <u>,</u> | | | hours a day and 7 days a week. Th | |
| | | Assistant Director of Nursing | | process does not change due to tim | e or |
| | , , | cted on 05/24/17 at 10:00 | | day of the week. Physician phone | _ |
| | AIVI. THE ADON CONT | irmed that he was in charge | | numbers are located at each nurse' | S |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | STRUCTION | (X3) DATE COMP | SURVEY |
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| | | 0.455.40 | D. WING | | | 1 | С |
| | | 345543 | B. WING _ | | | 05/ | 25/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREE | T ADDRESS, CITY, STATE, ZIP CODE | | |
| BERMUDA | COMMONS NURSING | AND REHABILITATION CENTER | | 316 NO | C HIGHWAY 801 SOUTH | | |
| DEIMIODA | | AND REMADILITATION SERVER | | ADVA | NCE, NC 27006 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 224 | Continued From pag | e 7 | F 2 | 224 | | | |
| F 224 | of managing wounds when Resident #266 the staff should have treatment orders and the next day to make appropriate. The ADO orders were transcribt they should have been an interview with Nu 05/24/17 at 2:53 PM she had admitted Resided that when the same ulcer she got the wound nurse pressure ulcer with dispersion with the was conducted on 05 DON stated that she some kind of wound wound on admission wound nurse that he b. Review of the Wood Evaluation dated 05/the right posterior and the residuation and the same transfer a | in the facility. He stated that was admitted to the facility implemented some type of the would have followed up a sure the treatment was on stated that no wound oned from the hospital and en. The set of the facility are skin assessment. Nurse #7 sident #266 to the facility are skin assessment. Nurse #7 sident #266 admitted from no wound care orders and "I she added that she did put in the facility of the facility in the faci | F 2 | stato ph dii the ph pr no nu for the all Qu the wow ini we 3 i | ation in the notebook. If you are unal reach the attending physician or the hysician on call, call the facility medic rector within 30 minutes of contacting e primary physician. If the attending hysician or medical director does not ovide an appropriate response or do to call back within 30 minutes then the urse is to contact the DON immediate refurther instructions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, fine, part time, and PRN) who did not ceive in-service training will not be lowed to work until training is completed in estandard orientation training and in quired in-service refresher courses for a employees and will be reviewed by uality Assurance Process to verify the change has been sustained. The change has been sustained. The designee will monitor this issue using the QA survey tool. The facility will monomate by reviewing 5 residents' that swith pressure or non-pressure bounds weekly to ensure that physicial as notified, orders are followed and attiated as ordered. This will be done to be the process of the pr | e cal g g nes e ely e elly eted. nto n the for the at sing ng nitor an | |
| | The recommended to daily. Review of physician 05/01/17 through 05/ | order summary dated 1/23/17 revealed no physician 1/20 Resident #266's right heel | | de the Ac co Ar | apport Nurse, Unit Manager, or esignee. Reports will be presented to e weekly QA Committee by the dministrator or designee to assure prective action initiated as appropriately immediate concerns will be broug e Director of Nursing or Administrator | te. ht to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING [X3] | | | X3) DATE SURVEY COMPLETED | | | | |
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| | | 345543 | B. WING | | | | 25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | 0.00.0 | <u> </u> | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 25/2017 |
| TVAIVIL OF T | TOVIDER OR OUT FIELD | | | | 16 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 224 | o5/22/17 at 4:06 PM observed to apply a vacontained Santyl (me Resident #266's right. An interview was condirector of Nursing (APM. The ADON state have ulcer to the right treatment for it was subseen draining Serosal admission. The ADOI forgot about the wour heel." Review of a physiciar in part, clean wound to cleaner and apply sate and dry dressing event An interview was condo5/24/17 at 2:53 PM. she was the nurse the on 05/16/17 and compassessment. Nurse #266's right foot was and she did not remonot know what kind or under the dressing or stated that when Rest the hospital she had a did not initiate any." Sa referral to the wounder | und care was made on with Nurse #2. Nurse #2 was wound dressing that dicated ointment) to heel. ducted with the Assistant (ADON) on 05/24/17 at 2:22 dt that Resident #266 did at heel on admission and the antyl. He added that it had inguineous fluid since N indicated that he "just had to Resident #266's right or order dated 05/24/17 read to right heel with wound hatyl and cover with maxorb ry other day. ducted with Nurse #7 on Nurse #7 confirmed that hat at admitted Resident #266 pleted her initial skin 7 stated that Resident wrapped with a dressing ve the dressing and does f ulcer 's were present in admission. Nurse #7 ident #266 admitted from the owound care orders and "I she added that she did put in did nurse to assess her in the | F 2 | 224 | for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manages Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _June 16th, 2017 | m ng of | |
| | | ated that if she discovered a would put an order for the sand then cover the | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | ATE SURVEY DMPLETED |
|--------------------------|--|---|---------------------|--|-----------|----------------------------|
| | | | 7 BOILBII | | | С |
| | | 345543 | B. WING _ | | | 05/25/2017 |
| | 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 COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 278 SS=D | conducted on 05/25/1 stated that Nurse #7 stated that Nurse #7 stated that Nurse #7 stated that Nurse #7 stated that was documented it in the state was a wound us Nurse #7 should have wound care treatmen ADON. 483.20(g)-(j) ASSESS ACCURACY/COORD | Director of Nursing was 17 at 10:00 AM. The DON should have removed the Resident #266's right foot under the dressing and medical record. She added if nder the dressing then e initiated some type of t in addition to notifying the SMENT DINATION/CERTIFIED sesments. The assessment | F2 | | | 6/16/17 |
| | (h) Coordination A registered nurse meach assessment with participation of health (i) Certification (1) A registered nurse the assessment is cool (2) Each individual whassessment must significate portion of the assessment for Falsification (1) Under Medicare a who willfully and known (i) Certifies a material | e must sign and certify that mpleted. no completes a portion of the n and certify the accuracy of sessment. ation nd Medicaid, an individual | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|--|-------------------------------|
| | | 345543 | B. WING | | C 05/25/2017 |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | 3 | STREET ADDRESS, CITY, STATE, ZIP CODE 116 NC HIGHWAY 801 SOUTH | 00/20/2017 |
| | | - | <i>,</i> | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 278 | Continued From page penalty of not more the | | F 278 | | |
| | assessment; or | ian \$1,000 for each | | | |
| | and false statement in | dividual to certify a material a resident assessment is ey penalty or not more than ssment. | | | |
| | material and false sta This REQUIREMENT by: Based on observation resident and staff inter accurately code the Mactive diagnoses (Restatus (Resident #272) prosthetic device (Restatus (Resident #272) | n, record review and reviews, the facility failed to Minimum Data Set (MDS) for sident #15 and #176), dental 2 and 273) and the use of a sident #273). Coding errors | | 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 will | I |
| | 06/09/2014. The psy | r MDS accuracy. : admitted to the facility on chiatric consult notes dated | | 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 | |
| | · • | resident had diagnoses and unspecified psychosis. | | F278 ASSESSMENT ACCURACY/COORDINATION/CERTIF D | FIE |
| | received antipsychotic medications on 7 out back period. The MDS depression as an acti include psychosis. | parterly MDS dated oding indicated the resident c and antidepressant of the 7 days during the look S was also coded to reflect ve diagnosis but it did not | | Corrective Action: Resident #15 A Modification Request was created for the OBRA Quarterly Assessment with the Assessment Reference Date of 3/14/2017. This corrected record has all items included, not just the items in error. The Correction Request Section X items were assessed to the correction of t | he e ere |
| | A review of Resident Medication Administra revealed the resident | | | completed on 6/10/2017 and includes to corrected record. Item I5950 has a value of Yes, indicating a modification requestion. | ie |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------|-----|---|-------------------|----------------------------|
| | | 345543 | B. WING _ | | | | 25/2017 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | 007 | 20/2017 |
| | | | | 31 | 6 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | Al | 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | | | | | | | |
| F 278 | Continued From page | e 11 received Seroquel 100mg at | F 2 | 278 | The Medification Request was submitted | v d | |
| | | hotic) during the assessment | | | The Modification Request was submitted to the QIES ASAP system on 6/12/2011 Resident #176 A Modification Request was created for | 7 | |
| | at 9:48 AM. MDS Coo | was interviewed on 05/25/17 ordinator #1 stated that when | | | the OBRA Quarterly Assessment with t Assessment Reference Date of 5/5/201 | he | |
| | the Medical Diagnose | gnoses, she would refer to es section of the electronic | | | This corrected record has all items included, not just the items in error. The | | |
| | maintained in the phy | ric consult notes were | | | Correction Request Section X items we completed on 6/10/2017 and includes t | he | |
| | • | MDS Coordinator said she the physical chart when | | | corrected record. Item I5800 has a value of Yes, indicating a modification request The Modification Request was submitted. | t. | |
| | _ | n 05/25/17 at 3:20 PM, the | | | to the QIES ASAP system on 6/12/201 Resident # 273 | | |
| | Administrator stated sassessments to be co | she would expect the MDS oded accurately. | | | A Modification Request was created for the OBRA Admission Assessment with Assessment Reference Date of 5/19/2017. | | |
| | | s admitted to the facility on atric consult notes dated | | | This corrected record has all items included, not just the items in error. The | a . | |
| | | ne resident had diagnoses | | | Correction Request Section X items we completed on 5/24/2017 and includes t | ere | |
| | Record review reveal | | | | corrected record. Item G0600D has a value of Yes, Item L0200B has a value | | |
| | assessment was a qu | uarterly MDS dated | | | No and Item L0200Z has a value of Yes | | |
| | received an antidepre | coding indicated the resident essant medication on 7 out | | | indicating a modification request. The Modification Request was submitted. | | |
| | | he look back period. The gnoses for the resident but | | | to the QIES ASAP system on 5/26/201 | 7 | |
| | depression. | o uno ulagricolo Ul | | | Resident #272 | | |
| | Administration Recor | | | | A Modification Request was created for the OBRA Admission Assessment with Assessment Reference Date of | | |
| | | antidepressant medication nt period of the MDS dated | | | 5/16/2017. This corrected record has all items included, not just the items in error. The | | |
| | | | | | Correction Request Section X items we | ere | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | (X3) DATE SURVEY COMPLETED | | | |
|---|------------------------|--|---------------|-----|--|----------|--------------------|--|
| | | | A. BOILDII | | | ، ا | С | |
| | | 345543 | B. WING _ | | | | 25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | 20.20 | |
| | | | | 31 | 6 NC HIGHWAY 801 SOUTH | | | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | ΑI | DVANCE, NC 27006 | | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX TAG | (EACH DEFICIENC | 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 278 | Continued From page | e 12 | F 2 | 278 | | | | |
| | MDS Coordinator #1 | was interviewed on | | | completed on 5/24/2017 and includes t | he | | |
| | 05/25/2017 at 9:48 A | M. MDS Coordinator #1 | | | corrected record. Item L0200Z has a | | | |
| | stated that when cod | ing the active diagnoses, | | | value of Yes, and Item L0200B has a | | | |
| | she would refer to the | e Medical Diagnoses section | | | value of No indicating a modification | | | |
| | | rd. The psychiatric consult | | | request. | | | |
| | | ed in the physical chart kept | | | The Modification Request was submitted | | | |
| | _ | . The MDS Coordinator said | | | to the QIES ASAP system on 5/26/201 | | | |
| | - | er to the physical chart when | | | Identification of other residents who ma | ıy | | |
| | coding diagnoses. | | | | be involved with this practice: | | | |
| | During on interview o | on 05/25/2017 at 3:20 PM, | | | All residents have the potential to be | | | |
| | | ted she would expect the | | | affected by the alleged practice. All assessments within the last 6 months | | | |
| | | be coded accurately. | | | were reviewed for accuracy for Item Se | 1 | | |
| | | s admitted to the facility on | | | 15950, 15800, G0600D, L0200B and | ,,, | | |
| | | ses of diabetes mellitus, | | | L0200Z by 6/12/2017 by the RN MDS | | | |
| | _ | ephrosis, acquired absence | | | coordinators. | | | |
| | | absence of left toes, anxiety, | | | Systemic Changes: | | | |
| | hyperlipidemia, and o | _ | | | On 5/24/2017 The RN MDS Coordinate | ors | | |
| | | | | | and any other Interdisciplinary team | | | |
| | Review of the most re | ecent comprehensive | | | member that participates in the MDS | | | |
| | minimum data set (M | | | | assessment process was in serviced | | | |
| | | nt #273 was cognitively | | | /educated by the Cooperate MDS Nurs | e | | |
| | | xtensive assistance with | | | Consultant. | | | |
| | _ | g (ADL). The MDS also | | | The education focused on the Federal | | | |
| | | ent #273 was edentulous | | | regulations at 42 CFR 483.20(b)(1) | | | |
| | | ooth fragments), and the use | | | (xviii),(g), and (h) require that: The | | | |
| | of limb prosthesis wa | is not identified. | | | assessment accurately reflects the | | | |
| | Peview of the Dental | Care Area Assessment | | | residents status. A registered Nurse conducts or coordinates each assessm | ent | | |
| | | 7 read in part, Resident #273 | | | with the appropriate participation of hea | | | |
| | | and would proceed to the | | | professionals. The assessment proces | | | |
| | care plan. | | | | includes direct observation, as well as | - | | |
| | 1 - | | | | communication with the resident and | | | |
| | An observation and in | nterview was conducted with | | | direct care staff on all shifts. An accura | te | | |
| | Nursing Assistant (Na | A) #2 on 05/24/17 at 9:35 | | | assessment requires collecting | | | |
| | | was up in her wheel chair in | | | information from multiple sources, som | е | | |
| | | was assisting her with ADL | | | of which are mandated by regulations. | | | |
| | care. Resident #273 | was noted to have natural | | | Those sources must include the reside | nt | | |
| | teeth and she told NA | A #2 she wanted to brush her | | | and direct care staff on all shifts, and | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|-----------------------|--|---------------|---|--------------|-------------------------------|--|
| | | | | | | C | |
| | | 345543 | B. WING _ | | 0.5 | 5/25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | 00 | |
| | | | | 316 NC HIGHWAY 801 SOUTH | | | |
| BERMUDA | A COMMONS NURSIN | IG AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COR | RECTION | (X5) | |
| PREFIX TAG | , | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFI) TAG | ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | | COMPLETION DATE | |
| F 278 | Continued From pa | age 13 | F 2 | 278 | | | |
| | teeth. Resident #2 | 73 was noted to have her right | | should also include the resider | nt's medical | | |
| | | ace and was propelling herself | | record, physician, and family, g | guardian, or | | |
| | | ne room with the use of the | | significant other as appropriate | - | | |
| | | #2 stated that Resident #273 | | acceptable. The information of | | | |
| | | ner own teeth on the bottom | | should cover the same observa | | | |
| | | partial. She added that | | as specified by the MDS items | • | | |
| | | re her prosthetic leg every day | | assessment, and should be va | | | |
| | | n working with her and | | accuracy (what the resident's a | actual | | |
| | | while working with the therapy | | status was during the observat | tion period) | | |
| | department. | | | the interdisciplinary team comp | oleting the | | |
| | | | | assessment. | | | |
| | An interview with the | he MDS Coordinator #2 on | | The Observation (Look Back) I | Period is | | |
| | 05/24/17 at 11:41 / | AM revealed that she was | | the time period over which the | resident's | | |
| | unclear on what ed | dentulous actually meant. She | | condition or status is captured | by the MDS | | |
| | stated she did see | Resident #273 prosthetic leg | | assessment. The observation | period for a | | |
| | lying in the chair d | uring the assessment period | | particular assessment for a pa | rticular | | |
| | when she visited th | ne resident but was not sure if | | resident will be chosen based | upon the | | |
| | she used it or not, | and she had not talked with the | | regulatory requirements conce | rning timing | | |
| | staff to see if Resid | dent #273 was using the | | and the ARDs of previous asse | essment. | | |
| | prosthetic leg or no | ot. | | Most MDS items themselves re | equire an | | |
| | | | | observation period, such as 7 | or 14 days, | | |
| | An interview was o | conducted with the Director of | | depending on the item. Since a | a day | | |
| | | 05/24/17 at 12:10 PM. The | | begins at 12:00 a.m. and ends | | | |
| | | spected all MDS's to be | | p.m., the observation period m | | | |
| | | rately as possible to reflect the | | cover this time period. When c | | | |
| | current status of th | e resident. | | the MDS, only those occurrence | | | |
| | | | | the look back period will be ca | • | | |
| | | vas admitted to the facility on | | did not occur during the look b | ack period, | | |
| | | noses that included atrial | | it is not coded on the MDS. | | | |
| | | ardia, hypertension, | | The Director of Nursing or RN | - | | |
| | hyperlipidemia, an | d others. | | will review OBRA assessments | | | |
| | | | | accurate coding for item set I5 | | | |
| | | t recent comprehensive | | G0600D, L0200B and L0200Z | | | |
| | | (MDS) dated 05/16/17 | | Any issues will be reported to t | | | |
| | | dent #272 was cognitively | | of Nursing or Administrator for | appropriate | | |
| | | decision making and extensive | | action. | | | |
| | | tivities of daily living (ADL). | | During the daily Clinical Meetir | | | |
| | | d that Resident #272 was | | through Friday), the RN MDS (| | | |
| | edentulous (having | g no teeth or tooth fragments). | | or Designee will review assess | ment | | |

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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 _ | | | | 25/2017 |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | 31 | REET ADDRESS, CITY, STATE, ZIP CODE 6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 278 | (CAA) dated 05/17/17 had an upper partial a plan. An observation of Res 05/22/17 at 3:05 PM in had some natural tee. An interview with the 05/24/17 at 11:41 AM unclear on what eden that was why she mis indicated she would conversing (DON) on 05 DON stated she expe | Care Area Assessment If read in part, Resident #272 and would proceed to care sident #272 was made on revealed that Resident #272 th left. MDS Coordinator #2 on revealed that she was tulous actually meant and coded the MDS. She orrect the error immediately. ducted with the Director of If 24/17 at 12:10 PM. The cted all MDS assessments becurately as possible to | F2 | 278 | reference dates for OBRA assessment. The Daily Clinical Meeting is attended the Director of Nursing, Unit Managers MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others a needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a reviusing the QA Assessment Accuracy To Five residents OBRA assessments will reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Assessment Accur Tool will include: Section I-Active Diagnosis: Accuracy of Section I-Active Diagnosis: Accuracy of Section Section Go600D; Section L-Oral/Dental Status: Accuracy of Sect L0200B and L0200Z. Identified issues be reported immediately to the Director Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manage Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: June 16TH 2017 | iew ol. be acy ion will r of end the | |
| F 281 SS=D | PROFESSIONAL STA | | F 2 | 281 | | | 6/16/17 |
| | (b)(3) Comprehensive | e Care Plans | | | | | |
| | The services provided | d or arranged by the facility, | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543 | | | \ \ ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|--|-------------------------------|--|
| | | 345543 B. WING _ | | | C 05/25/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 03/23/2017 | |
| | | | | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOTICIENCY) | BE COMPLETION | |
| F 281 | Continued From page | e 15 | F 28 | | | |
| | as outlined by the co must- | mprehensive care plan, | | | | |
| | (i) Meet professional This REQUIREMENT by: | standards of quality. Γ is not met as evidenced | | | | |
| | Based on observation interviews the facility wound care orders for ulcer to the resident's 1 sampled resident (If the findings included Resident #266 was a 05/16/17 with diagnoresistant staphylocod septicemia, decubitus 2 present on admissingreat toe, pressure u on admission, and di | dmitted to the facility on ses that included: methicillin cus aureus (MRSA) sulcer of sacral region stage on, diabetic ulcer of right lcer of thigh stage 3 present | | 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 F281 SERVICES PROVIDED MEE PROFESSIONAL STANDARDS Corrective Action: Resident #266. Physician was notified on 5/24/2017. | ill of ed. ET | |
| | Evaluation dated 05/ the left posterior anklexcisional debridement performed." The reconstruction of the performed of the performance of th | 19/17 read in part, "wound of e was healing and surgical ent of the site was ommended treatment was ntment) once daily. | | physician orders placed and initiated a ordered. Resident and Resident's representative notified on 5/24/2017. Care plan was updated on 5/24/2017. Identification of other residents who m be involved with this practice: All residents have the potential to be affected by the alleged practice. On Ju 2 to June 16 2017 a skin assessment completed on all residents to ensure the all pressure and non-pressure wounds were identified, physician was notified and physician orders were followed ar initiated. All care plans were updated. | as ay une was nat s | |
| | Santyl to Resident #2 | 266's right and left back of urse #2 was observed to | | pressure and non-pressure wounds w initiated as ordered. Skin assessments | ere | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|---|-------------------------------|--|
| | | 345543 | B. WING _ | | <u> </u> | C 05/25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | <u> </u> | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| | | | | 316 NC HIGHWAY 801 SOL | UTH | | |
| BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | ADVANCE, NC 27006 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTION CROSS-REFERE | S PLAN OF CORRECTION CCTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | 5.475 | |
| F 281 | Continued From pag | e 16 | F 2 | 81 | | | |
| F 281 | also apply a wound of Santyl to Resident ##. Review of a physicial in part, "clean wound cleaner and apply Sa and dry dressing ever An interview was con Nursing (DON) on 08. Assistant Director of present for the interview confirmed that the Al management of wou DON further explained seen by the wound co 05/19/17 and they do off-site. The ADON to system and see if the completed. The DON just received the republication of the pool of t | dressing that contained 266's right heel. In order dated 05/24/17 read a to right heel with wound antyl and cover with maxorb ery other day." Inducted with the Director of 5/25/17 at 10:46 AM. The Nursing (ADON) was iew. The DON and ADON DON was responsible for the end care in the facility. The end that Resident #266 was are specialist on Friday ocumented their notes then had to go into their er wound care notes were a stated that the ADON had nort from 05/19/17 on the that time to review them. In the wound care specialist antyl be used once daily, der should have immediately inscribed into Resident #266's or should not have waited until | F2 | were completed by nurses. The wound held on 6/15/17 by Management Team MDS, NHA, Unit M Nurse). All physicia and initiated as orc Systemic Changes Director of Nursing serviced all Nurses part time, and PRN interdisplinary care fact that the service by the facility, as o comprehensive car professional standa Nurses (RNs, LPN and PRN) were also that it is the nurse's physician, follow an orders. Physician shours a day and 7 process does not of day of the week. Fumbers are located station in the notet to reach the attended. | d review meeting way the Nurse in (Director of Nursing Manager and Support an orders were follow dered. S: g and /or Designee in s (RNs, LPNs, full time) and the explanning team on the fact of quality. All lists, full time, part time is one educated on the fact of a responsibility to no and initiate Physician should be called 24 days a week. This change due to time of the educate and the educate of the educate | g, ved ne, ne ged gact tify | |
| | treatment because s days for the facility to The ADON confirmed the wound specialist the Santyl was order | initiate the prescribed ometimes it took several o obtain a copy of the report. It that he had not reviewed note and was not aware that ed every day and not every uld correct that immediately. | | director within 30 n the primary physici physician or medic provide an appropriate and call back within nurse is to contact for further instruction This in service was 14th, 2017. Any N time, part time, and | call the facility medic minutes of contacting ian. If the attending cal director does not riate response or doe a 30 minutes then the the DON immediate ons. s completed by June Jurse (RNs, LPNs, fu d PRN) and member y team who did not | es e ly | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---------------------------|---|--|--|-------------------------------|--|
| | 345543 B. WING | | | C 05/25/2017 | | | |
| NAME OF PE | ROVIDER OR SUPPLIER | <u> </u> | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | | 03/23/2011 | |
| | | | | 316 NC HIGHWAY 801 SOUTH | | | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | 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 | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 281 | Continued From page | PROVIDE CARE/SERVICES | F 2 | receive in-service training will no allowed to work until training is control to the standard orientation training required in-service refresher courall employees and will be reviewed Quality Assurance Process to verthe change has been sustained. Monitoring: To ensure compliance, Director of designee will monitor this issue the QA survey tool. The facility were compliance by reviewing 5 residencharts with pressure or non-pressive wounds weekly to ensure that phase weekly basis for 4 weeks then made as ordered. This will be weekly basis for 4 weeks then made as ordered. This will be weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. The weekly basis for 4 weeks then made as ordered. This will be weekly basis for 4 weeks then made as ordered. This will be weekly basis for 4 weeks then made as ordered. This will be weekly basis for 4 weeks then made as ordered. This will be reserved as the weekly QA Committee by the Administrator or designee to ass corrective action initiated as apply Any immediate concerns will be the Director of Nursing or Administrator or designee to ass corrective action initiated as apply Any immediate concerns will be the Director of Nursing or Administrator or designee to ass corrective action initiated as apply Any immediate concerns will be the Director of Nursing or Administrator or designee to ass corrective action initiated as apply Any immediate. | ompleted. ated into and in the rses for ed by the rify that of Nursing e using vill monitor ents' sure hysician and done on onthly for ing, the tropriate. brought to istrator istrato | | |
| SS=D | FOR HIGHEST WELL | | | | | 5. 15/11 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---------------------|--|-------------------------------|--|--|
| | | 345543 | B. WING | | C 05/25/2017 | | |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | 03/23/2011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION | | |
| F 309 | applies to all care ar residents. Each res facility must provide services to attain or practicable physical well-being, consiste comprehensive asset 483.25 Quality of care is a fapplies to all treatmet facility residents. Bat assessment of a residents received accordance with propractice, the compression of the service of the compression of the service of the serv | ndamental principle that and services provided to facility ident must receive and the the necessary care and maintain the highest mental, and psychosocial and with the resident's essment and plan of care. The undamental principle that ent and care provided to sed on the comprehensive sident, the facility must ensure the treatment and care in fessional standards of thensive person-centered the sidents' choices, including | F 30 | | | | |
| | provided to resident consistent with profethe comprehensive and the residents' go. (I) Dialysis. The factoresidents who requires services, consistent of practice, the compare plan, and the repreferences. This REQUIREMENT by: Based on observations. | sure that pain management is s who require such services, essional standards of practice, person-centered care plan, pals and preferences. Ility must ensure that the dialysis receive such with professional standards prehensive person-centered | | The statements made on this Plan of Correction are not an admission to an | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|---|----------------------------|
| | | 345543 | B. WING _ | | | C 05/25/2017 |
| NAME OF PR | ROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, ZIP COI | I DE | 03/23/2017 |
| | | | | 316 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | COMMONS NURSING | S AND REHABILITATION CENTER | | 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 309 | Continued From page | ge 19 | F 3 | 09 | | |
| F 309 | resident's skin to ide to the right heel on a treatment for 8 days (Resident #266). The findings included Resident #266 was 05/16/17 with diagnoresistant staphylocous septicemia, decubit 2 present on admissingerat toe, pressure on admission, and control of the thigh states where the thinks where the thigh states where the thigh states where the thigh states where the thinks | entify a non-pressure wound admission and failed to initiate a for 1 of 1 sampled resident add: admitted to the facility on oses that included: methicillin occus aureus (MRSA) us ulcer of sacral region stage sion, diabetic ulcer of right ulcer of thigh stage 3 present diabetes mellitus. #266's discharge summary ted 05/16/17 read in part, he sacrum stage 2/pressure age 3 present on admission. o manage." The discharge dicate a right heel wound. Tring Assessment dated rt, there was 5 small ulcers he initial nursing assessment. The progress note dated rt, "Stage 3 decubitus to thigh so wound doctor to see on and encourage resident to stay possible." The report did not | F3 | not constitute an agreement alleged deficiencies. To rema compliance with all Federal a Regulations the facility has to take the actions set forth in the Correction. The Plan of Correction. The Plan of Corrections that all alleged efficiencies cited have been corrected by the date or date F309 PROVIDE CARE/SI FOR HIGHEST WELL BEING Corrective Action: Resident #266. Physician was notified on 5/2 physician orders placed and ordered. Resident and Resid representative notified on 5/2 Care plan was updated by the potent affected by the alleged pract 2 to June 16 2017 a skin ass completed on all residents to all pressure and non-pressure was and physician orders were for initiated. All care plans were pressure and non-pressure winitiated as ordered. Skin ass were completed by ADON ar nurses. The wound review manuface of the formation of the pressure and non-pressure was were completed by ADON ar nurses. The wound review manuface of the face | ain in and State aken or will his Plan of rection ation of ged or will be as indicated. ERVICES G 24/2017. New initiated as lent's 24/2017. Its who may a in the sessment was a ensure that re wounds as notified, ollowed and updated. All wounds were sessments and staff | |
| | Review of the Wour Evaluation dated 05 the left posterior and excisional debridem | nd Care Specialist Initial 6/19/17 read in part, "wound of kle was healing and surgical | | held on 6/15/17 by the Nurse Management Team (Director MDS, NHA, Unit Manager ar Nurse). All physician orders and initiated as ordered. Systemic Changes: | e of Nursing, nd Support | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C 05/25/2017 | |
|---|---------------------------|---|---------------------|--|-------------|--|--|
| | | 345543 | B. WING | B. WING | | | |
| NAME OF PE | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 03 | 5/25/2017 | |
| | 10 115211 011 001 1 21211 | | | 316 NC HIGHWAY 801 SOUTH | | | |
| BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE | |
| F 309 | Continued From pag | ge 20 | F 30 | 9 | | | |
| | santyl once daily. | | | Director of Nursing and /or Design | gnee in | | |
| | | | | serviced all Nurses (RNs, LPNs, | | | |
| | Review of physician | order summary dated | | part time, and PRN) on the fact t | hat | | |
| | | 5/23/17 revealed no physician | | Quality of life is a fundamental p | rinciple | | |
| | order for a treatmen | t to Resident #266's right heel | | that applies to all care and service | | | |
| | wound. | | | provided to facility residents. Each | | | |
| | | | | resident must receive and the fa | • | | |
| | | ound care was made on I with Nurse #2. Nurse #2 was | | provide the necessary care and | services | | |
| | | wound dressing that | | to attain or maintain the highest practicable physical, mental, and | 1 | | |
| | | nedicated ointment) to | | psychosocial well-being, consist | | | |
| | Resident #266's right | • | | the resident's comprehensive as | | | |
| | _ | Nurse #2 was observed to | | and plan of care. Quality of care | | | |
| | | dressing that contained | | fundamental principle that applie | | | |
| | Santyl to Resident # | _ | | treatment and care provided to fa | | | |
| | | | | residents. Based on the comprel | nensive | | |
| | Review of the medic | cal record on 05/22/17 at 4:50 | | assessment of a resident, the fa | cility must | | |
| | | 5/23/17 at 3:00 PM revealed | | ensure that residents receive tre | | | |
| | _ | Review (non pressure)" | | and care in accordance with pro- | | | |
| | | "Weekly Pressure Ulcer | | standards of practice, the compr | | | |
| | Review" assessmer | nt was present. | | person-centered care plan, and | | | |
| | Daviou of the daily | nurse's notes in the medical | | resident choices, including but n to the following: Pain Manageme | | | |
| | | at 4:50 PM and again on | | Dialysis. The facility must ensure | | | |
| | | I revealed no documentation | | management is provided to resid | | | |
| | of a right heel ulcer. | | | require such services, consisten | | | |
| | J | | | professional standards of practic | | | |
| | An interview with Nu | urse #8 was conducted on | | comprehensive person-centered | | | |
| | 05/23/17 at 10:27 A | M. Nurse #8 confirmed that | | plan, and the residents' goals an | ıd | | |
| | _ | for Resident #266 on first shift | | preferences. The facility must er | sure that | | |
| | | s that Resident #266 had | | residents who require dialysis re | ceive | | |
| | | n the back of thighs and in | | such services, consistent with | | | |
| | | ks." During the interview | | professional standards of practic | | | |
| | | confirmed with the Assistant | | comprehensive person-centered | | | |
| | _ | (ADON) that those were the | | plan, and the residents' goals an | iu | | |
| | only ulcers that Res | ouch #200 Hau. | | preferences. All Nurses (RNs, LPNs, full time, | nart | | |
| | An interview with the | e ADON was conducted on | | time, and PRN) were also educa | • | | |
| | | M. The ADON confirmed that | | the fact that it is the nurse's resp | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | MULTIPLE CONSTRUCTION UILDING | | (X3) DATE SURVEY COMPLETED | |
|---|----------------------|---|---------------|--|-----------------|-------------------------------|--|
| | | | | | | С | |
| | | 345543 | B. WING _ | | 0: | 5/25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | | |
| | | | | 316 NC HIGHWAY 801 SOUTH | | | |
| BERMUDA | A COMMONS NURSI | NG AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | | |
| (X4) ID | SUMMAR | Y STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | ORRECTION | (X5) | |
| PRÉFIX TAG | , | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | E APPROPRIATE | COMPLETION DATE | |
| F 309 | Continued From p | page 21 | F 3 | 09 | | | |
| | he was responsib | le for the wound care | | to notify physician, follow and | d initiate | | |
| | | ne facility. The ADON stated that | | Physician orders. Physician | | | |
| | Resident #266 cu | rrently had a diabetic ulcer to | | called 24 hours a day and 7 | days a week. | | |
| | her right great toe | that was being treated with | | This process does not chang | ge due to time | | |
| | hydrogel every da | y. He added that Resident #266 | | or day of the week. Physicia | an phone | | |
| | currently had ulce | ers to the back of her | | numbers are located at each | n nurse's | | |
| | thigh/buttock that | were being treated with Santyl | | station in the notebook. If yo | u are unable | | |
| | | Γhe ADON confirmed that | | to reach the attending physic | | | |
| | | d no other wounds or ulcers. He | | physician on call, call the fac | • | | |
| | | ecently placed Resident #266 on | | director within 30 minutes of | _ | | |
| | | he ADON stated that on Friday | | the primary physician. If the | • | | |
| | | he medical doctor observed the | | physician or medical director | | | |
| | | d he initiated Santyl. He stated | | provide an appropriate response | | | |
| | | lent #266 on 05/17/17 but did | | not call back within 30 minut | | | |
| | not document tha | t in the medical record. | | nurse is to contact the DON | immediately | | |
| | A. - I | | | for further instructions. | ad last desires | | |
| | | wound care was made on | | This in service was complete | | | |
| | | PM. The ADON removed old | | 14th, 2017. Any Nurse (RNs | | | |
| | _ | esident #266 right great toe and | | time, part time, and PRN) an | | | |
| | | a new dressing to both areas | | the interdisciplinary team wh | | | |
| | | ntyl and a cover was then eas. The old dressing that was | | receive in-service training wi allowed to work until training | | | |
| | •• | right heel contained a | | This information has been in | • | | |
| | | of serosanguinous drainage. | | the standard orientation train | • | | |
| | moderate amount | or scrosurigumous dramage. | | required in-service refresher | - | | |
| | A follow up intervi | ew was conducted with the | | all employees and will be rev | | | |
| | | 7 at 2:22 PM. The ADON stated | | Quality Assurance Process t | - | | |
| | | 6 did a have ulcer to the right | | the change has been sustair | | | |
| | | and the treatment for it was | | Monitoring: | | | |
| | | that it had been draining | | To ensure compliance, Direc | ctor of Nursing | | |
| | | fluid since admission. The | | or designee will monitor this | | | |
| | _ | hat he "just forgot about the | | the QA survey tool. The facil | | | |
| | | nt #266's right heel." | | compliance by reviewing 5 n | | | |
| | | - | | admissions charts to ensure | | | |
| | Review of a physi | cian order dated 05/24/17 read | | check was completed and ar | ny pressure or | | |
| | | nd to right heel with wound | | non-pressure areas were ide | • • | | |
| | | santyl and cover with maxorb | | that the physician was notified | | | |
| | and dry dressing | every other day. | | followed and initiated as orde | ered. This will | | |
| | | - | | be done on weekly basis for | 4 weeks then | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|--------------------------------------|----------------------------|--|
| | | 345543 | B. WING | | 1 | C 05/25/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 23/2017 | |
| BEDMIID | COMMONS NUIDSING | AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH | | | |
| DEKINIODA | A COMMONS NORSING | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 309 | o5/24/17 at 2:53 PM. she was the nurse that on 05/16/17 and com assessment. Nurse # had scattered bruises areas on left buttock and surse #7 stated that was wrapped with a cremove the dressing kind of ulcer's were pon admission. Nurse fine and had no ulcer of any ulcers on the root removed the dressunder it. An interview with the conducted on 05/25/1 stated that Nurse #7 routine dressing from to visualize what was documented it in the other was a wound un Nurse #7 should have wound care treatmen ADON. 483.25(b)(1) TREATM PREVENT/HEAL PRIMEVENT/HEAL PRIMETMAN AND ADMINISTRATION AND ADMINISTRAT | ducted with Nurse #7 on Nurse #7 confirmed that at admitted Resident #266 pleted her initial skin r7 stated that Resident #266 at to both arms and 3 open and 2 on the right buttock. Resident #266's right foot dressing and she did not and does not know what resent under the dressing #7 stated the other foot was s. Nurse #7 was not aware ight heel because she had using to visualize what was Director of Nursing was r7 at 10:00 AM. The DON should have removed the Resident #266's right foot under the dressing and medical record. She added if nder the dressing then e initiated some type of t in addition to notifying the MENT/SVCS TO ESSURE SORES Based on the sement of a resident, the nat- se care, consistent with | F 30 | monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriat Any immediate concerns will be broughthe Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing prograreviewed at the 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, Social Services. Date of Compliance: _June 16th, 2017 | te. tht to r be am ng of ger, | 6/16/17 | |
| | (1) Pressure ulcers. comprehensive asses facility must ensure the (i) A resident receives | ssment of a resident, the nat- | | | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--|---|---|--|
| | | 345543 | B. WING | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER | G AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | | 1 00/20/2017 | |
| (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 314 | ulcers unless the ir demonstrates that (ii) A resident with processary treatment professional standard healing, prevent inform developing. This REQUIREMED by: Based on observation interviews the facility orders on admission and once treatment facility failed to follow admitted to the facility and went 3 days and went 3 days are successive. | d does not develop pressure adividual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent with ards of practice, to promote fection and prevent new ulcers and staff ty failed to initiate treatment and for a stage 3 pressure ulcer to orders were obtained, the pow them. The resident was lity with a stage 3 pressure ays before receiving treatment resident (Resident #266). | F 31 | · · · · · · · · · · · · · · · · · · · | e will | |
| | from the hospital didecubitus ulcer of the thigh st Wound care nurse Resident #266 was 05/16/17 with diagrulcer stage 3, diabethyperlipidemia, and staphylococcus austite. Review of a physic 05/17/17 read in parand sacral decubitus | t #266's discharge summary ated 05/16/17 read in part, he sacrum stage 2/pressure age 3 present on admission. | | 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 a TREATMENT /SVCS TO PREVENT /HEAL PRESSURE SOR Corrective Action: Resident #266. Physician was notified on 5/24/2017 physician orders placed and initiated ordered. Resident and Resident's representative notified on 5/24/2017 Care plan was updated on 5/24/2017 Care plan was updated on 5/24/2011 Identification of other residents who be involved with this practice: All residents have the potential to be affected by the alleged practice. On 2 to June 16 2017 a skin assessmer completed on all residents to ensure all pressure and non-pressure wound | ted. ES New as 7. may June at was that | |

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|--------------------------|-----------------------|---|---------------------|--|---------------|----------------------------|
| | | 345543 | B. WING | | | C |
| NAME OF D | ROVIDER OR SUPPLIER | 343343 | B: Willo | STREET ADDRESS, CITY, STATE, ZIP CODE | | 05/25/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | | |
| BERMUDA | COMMONS NURSING | AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH | | |
| | | , | | ADVANCE, NC 27006 | | |
| (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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 314 | Continued From pag | e 24 | F 31 | 4 | | |
| | on side as much as | nossible | | were identified, physician was i | notified | |
| | on olde de maen de p | occolore. | | and physician orders were follo | | |
| | Review of the Wound | d Care Specialist's Initial | | initiated. All care plans were up | | |
| | | 19/17 read in part, Stage 3 | | pressure and non-pressure wor | | |
| | | ne left buttock was pressure | | initiated as ordered. Skin asses | | |
| | · · | the recommended treatment | | were completed by ADON and | | |
| | | ed ointment) once daily. | | nurses. The wound review mee | | |
| | , , | , | | held on 6/15/17 by the Nurse | J | |
| | Review of physician | order dated 05/19/17 read, | | Management Team (Director of | Nursing, | |
| | | cral area every other day | | MDS, NHA, Unit Manager and | | |
| | after cleaning with w | ound cleaner for wound care. | | Nurse). All physician orders we | re followed | |
| | _ | | | and initiated as ordered. | | |
| | Review of the Medic | ation Administration Record | | Systemic Changes: | | |
| | (MAR) dated 05/01/1 | 7 through 05/31/17 read in | | Director of Nursing and /or Des | ignee in | |
| | part, santyl ointment | to buttocks/thigh topically | | serviced all Nurses (RNs, LPNs | s, full time, | |
| | every other day for w | ound care. This was initialed | | part time, and PRN) on the fact | that when | |
| | on 05/19/17, 05/21/1 | 7, and 05/23/17 indicating | | it comes to Skin integrity, speci | fically | |
| | that the treatment ha | d been completed on those | | Pressure ulcers. Based on the | | |
| | days. | | | comprehensive assessment of | | |
| | | | | , the facility must ensure that a | | |
| | | nprehensive minimum data | | receives care, consistent with p | | |
| | set (MDS) dated 05/2 | 23/17 remained in progress. | | standards of practice, to preven | | |
| | | | | ulcers and does not develop pr | | |
| | | rse #2 was made on | | ulcers unless the individuals cli | | |
| | | performing wound care on | | condition demonstrates that the | - | |
| | | e #2 was observed to apply a | | unavoidable; and a resident wit | - | |
| | | contained Santyl to Resident | | ulcers receives necessary treat | | |
| | | igh area and then applied a | | services, consistent with profes | | |
| | | ityl dressing in place. Nurse | | standards of practice, to promo | | |
| | | wound with wound cleaner | | prevent infection and prevent n | | |
| | per the physician ord | ICI. | | from developing . All Nurses (R | | |
| | An intension with No. | roo #2 was conducted as | | full time, part time, and PRN) w | | |
| | | rse #2 was conducted on . Nurse #2 stated she was | | educated on the fact that it is the | | |
| | | urse out but generally she | | responsibility to notify physiciar and initiate Physician orders. P | | |
| | | s on a medication cart. She | | should be called 24 hours a da | | |
| | | s on a medication cart. She | | days a week. This process do | • | |
| | | ed if "I would have brought a | | change due to time or day of th | | |
| | | ner into Resident #266's | | Physician phone numbers are I | | |
| | Sound of Wound oldal | 101 1110 1 100100111 TE00 0 | 1 | i riyororan prione numbers are i | Juliou ul | I |

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| . , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|---|--|
| | | 345543 | B. WING | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | _ L | ' | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/23/2017 |
| | | | | 316 NC HIGHWAY 801 SOUTH | |
| BERMUD | A COMMONS NURSING | AND REHABILITATION CENTER | | ADVANCE, NC 27006 | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| F 314 | Continued From pag | ge 25 | F 31 | 4 | |
| F 314 | room it would have it she was on isolation stated that she shou on and asked some cleaner and she sho wound before apply? An interview with the (ADON) was conducted. The ADON confirmed managing wounds it when Resident #266 the staff should have treatment orders and the next day to make appropriate. The ADO orders were transcrit they should have be expected all nurses follow the physician with wound cleaner. Would clarify with the wanted the Santyl of then take care of transmer were originally given. An interview with Nu 05/24/17 at 2:53 PM she had admitted Reand did complete the stated that when Reand did not initiate any." a referral to the would morning. Nurse #7 spressure ulcer she gets. | nad to stay in here because precautions." Nurse #2 ald have turned the call light one to bring her some wound ould have properly cleaned the ing the dressing. Assistant Director of Nursing oted on 05/24/17 at 10:00 AM. In the facility. He stated that is was admitted to the facility of the would have followed up the sure the treatment was incharge of the would have followed up the sure the treatment was incharge of the would have followed up the sure the treatment was incharge of the would have followed up the sure the treatment was incharged the wound bed from the hospital and the ended that he that performed wound care to order and clean the wound incharged that he wound specialist that he have a day per his note and inscribing those orders that in on 05/19/17. Aurse #7 was conducted on the wound inscribing those orders that the ended that the facility is skin assessment. Nurse #7 sident #266 to the facility is skin assessment. Nurse #7 sident #266 admitted from in wound care orders and "I She added that she did put in the stated that if she discovered a generally would put an order to assess and then cover the | F 31- | each nurse's station in the notebool you are unable to reach the attendir physician or the physician on call, of facility medical director within 30 min of contacting the primary physician. attending physician or medical direct does not provide an appropriate rest or does not call back within 30 minuthen the nurse is to contact the DOI immediately for further instructions. This in service was completed by Ju 14th, 2017. Any Nurse (RNs, LPNs time, part time, and PRN) and mem the interdisciplinary team who did not receive in-service training will not be allowed to work until training is come This information has been integrate the standard orientation training and required in-service refresher course all employees and will be reviewed Quality Assurance Process to verify the change has been sustained. Monitoring: To ensure compliance, Director of Nor designee will monitor this issue us the QA survey tool. The facility will recompliance by observing 5 resident wound care treatments to ensure the physician orders are followed and treatments are applied appropriately will be done on weekly basis for 4 we then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Mai or designee. Reports will be preser the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropant in the Director of Nursing or Administrator or Director of Nursing | all the nutes If the ctor sponse stes If the ctor sponse stee If the ctor spon |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | pe |
|---|--|--|---------------------|-----|---|---------------|------------|
| | | 345543 | B. WING _ | | | l | |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | 31 | REET ADDRESS, CITY, STATE, ZIP CODE 6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION |
| F 314 | An interview with the was conducted on 05 DON stated that she some kind of wound of wound on admission wound nurse that he pon stated that when Resident #266 and result once daily that transcribed and compadded that they will his clear of what the worder while in the faci obtain the report. She all nurses that were of follow the physician of with wound cleaner. 483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVI (d) Accidents. The facility must ensure the facility must ensure correct in appropriate alternative bed rail. If a bed or smust ensure correct is maintenance of bed in to the following elements. | Director of Nursing (DON) /25/17 at 10:46 AM. The expected Nurse #7 to initiate care for Resident #266's in addition to notifying the needed to follow up. The n the wound specialist saw commended treatment of corder should have been bleted daily as ordered. She ave to make sure everyone ound specialist wanted and e for the doctor to write the lity instead of waiting to e also stated she expected ompleting wound care to order and clean the wound (3) FREE OF ACCIDENT SION/DEVICES The that - Tonment remains as free as as is possible; and ever adequate supervision the sto prevent accidents. Facility must attempt to use the sprior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited | | 314 | for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meetin is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manage Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _June 16th, 2017 | m ng of | 6/16/17 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|----------------------------|--|---|
| | | 345543 | B. WING | | 05/25/2017 |
| | ROVIDER OR SUPPLIER | G AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | 1 00/20/2011 |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| F 323 | Continued From pa | - | F 32 | 23 | |
| | the resident or resinformed consent properties of the appropriate for the This REQUIREME by: Based on staff interfacility failed to impute to protect a resident times in 11 days. (Emergency Depart laceration for 1 of 1775). The findings include Resident #75 was 04/21/17 with diagrof the scalp, historia urinary tract inference admission Minimum 04/28/17 specified intact, he required with activities of daspecified the resident properties. | bed's dimensions are resident's size and weight. NT is not met as evidenced erviews and record review the element effective interventions at from injury, the resident fell 7 One fall resulted in an ment visit to repair a facial I sampled residents (Resident | | The statements made on this Plan Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation or compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICE Corrective Action: Resident #75 Discharged on 5/10/2017 to a Memcare unit. Identification of other residents who be involved with this practice: | and do e Inte The will The of The becated. The states of |
| | needed stabilization resident had a hist admission. The M was occasionally infrequently incontinuate the state of the stat | n with staff assistance; the bry of falls but no falls since DS also specified the resident acontinent of bladder and | | All residents have the potential to be affected by the alleged practice. On 6/15/2017 a falls review meeting was in the Weekly Quality of Life meeting assessments were completed on all current residents by 6/14/2017. In the meeting all residents were reviewed high falls risk and current intervention place to prevent falls and the need to be affected by the province of the provinc | as held g. Risk I nis d for ons in |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION 3 | (X3) DATE SURVEY COMPLETED |
|--|---|--|---------------------|---|-------------------------------|
| | | 345543 | B. WING | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | <u>'</u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/20/2011 |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| F 323 | Continued From page | e 28 | F 32 | 23 | |
| | completed. | | | additional interventions for residents poor safety awareness. This was completed on 6/15/2017. In addition | |
| | | /08/17 for the resident's risk erventions that included: | | this, any new interventions put in pla were added to the individual resident care plan by the MDS Coordinator ar | s |
| | transfers - Staff to ensure n | t to use call light with | | were reflected on the Kardex and Caplan respectively. Systemic Changes: | |
| | | s as much as possible mize potential for falls while nd distraction | | Director of Nursing and /or Designee serviced all staff (full time, part time, PRN) to inform that the facility must ensure that the resident environment | and |
| | - Staff to make mo | ore frequent care rounds to t to use call light with | | remains as free of accident hazards possible; and each resident receives adequate supervision and assistance | |
| | leaving the room | l items were in reach before | | devices to prevent accidents. The factorist attempt to use appropriate alternatives prior to installing a side of | or bed |
| | - Continue curren | | | rail. If a bed or side rail is used, the famust ensure correct installation, use, maintenance of bed rails, including b | and ut not |
| | | incident reports for Resident he had fallen 7 times in 11 | | limited to the following elements. Ass the resident for risk of entrapment fro bed rails prior to installation, Review | m |
| | interviewed and desc very confused, restle | AM the Unit Manager was cribed Resident #75 to be ss, agitated, impulsive and | | risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to | - |
| | stated the resident di | ninding to sit down; and and and and what he was and | | installation, Ensure that the bed's dimensions are appropriate for the residents size and weight. | |
| | Administrator review | ne Administrative nurses and ed falls each day Monday ermine root cause analysis | | When a resident has a fall, the perso discovering the resident reassures the resident and immediately alerts the | |
| | prevent injuries from | falls and fall reoccurrences. viewed Resident #75's 7 falls | | primary nurse. The nurse assesses t resident for injuries. With suspected fractures of limbs, the limbs in questi | |
| | while in the facility ar | | | are immobilized and an order to send the ER is obtained. When other fract | d to |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | E SURVEY MPLETED |
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| | | 345543 | B. WING | | 0 | 5/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DE | |
| | | | | 316 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | A COMMONS NURSI | NG AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| | | | | | • | |
| F 323 | Continued From p | age 29 | F 3 | 23 | | |
| | Manager used the to review the follow | incident reports and care plan wing falls: | | are suspected of limbs, the li questions are immobilized ar send to the ER is obtained. V fractures are suspected the r | nd an order to When other | |
| | from his wheelcha | 12:15 PM the resident stood up iir and fell in the floor without entions implemented was to | | kept immobilized on the floor to send to the ER is obtained are obtained. The attending | and on order d. Vital signs | |
| | remind the resider | nt to call for assistance. The ed that due to the resident | | notified immediately of the fa apparent. If no injury is appa | ıll if injury is | |
| | cognition this inter | vention was not effective but to try it because the facility | | physician is notified. Notify the resident representative. Initia | ne family or | |
| | preferred to use le | east restrictive measures. | | documentation in the nurse's to be completed and through resident is to be thoroughly a | ı. The | |
| | entry made by Nu | dical record revealed a nurse's rse #2 that stated the resident | | every shift after the incident vital signs for 72 hours. A ne | with complete uro | |
| | fell in his room try wheelchair withou | ing to get up out of his t assistance. | | assessment is done every she hours or according to MD ord Quality assurance incident recompleted in detail and all sp | ders. A eport is to be | |
| | Nurse #2 was una | ble to be interviewed. | | completed. The Director of n designee should make sure to | ursing or that the | |
| | the floor in the bat Manager stated th | 53 AM the resident was found in throom without injury. The Unit the facility implemented non-skid bed after this fall. | | resident has been thoroughly the physician and the family notified, and the incident reputily completed. Then the incident should be investigated and a analysis identified. All residentiallen should be referred to the | have been ort has been cident report root cause nts who have | |
| | specified the resid | ted 05/01/17 made by Nurse #1 lent was found in the bathroom mpted to ambulate unassisted. | | Assurance Committee. Interview should be documented on the care plan. This in service was complete | ventions e residents ed by June | |
| | interviewed and e confused and did he tried to do thing | 28 AM Nurse #1 was xplained Resident #75 was not ask for assistance because gs for himself such as walking She explained that the resident | | 14th, 2017. Any Nurse (RNs time, part time, and PRN) an the interdisciplinary team wh receive in-service training will allowed to work until training This information has been in | d member of o did not Il not be is completed. | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | LE CONSTRUCTION | | E SURVEY IPLETED | |
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| | | 345543 | B. WING | | | C 05/25/2017 | |
| NAME OF D | DOVIDED OD CLIDDLIED | 343343 | B. WING | OTDEET ADDRESS CITY OTATE ZID CODE | | 5/25/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| BERMUDA | COMMONS NURSING | AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH | | | |
| | | | | ADVANCE, NC 27006 | | | |
| (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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 323 | Continued From pag | e 30 | F 32 | 23 | | | |
| | family would take hin that Resident #75's of | uld be independent then his in home. The nurse added cognition was such that you for assistance but 5 minutes in. | | the standard orientation training required in-service refresher coall employees and will be revied Quality Assurance Process to the change has been sustained Monitoring: To ensure compliance, Administration | ourses for wed by the verify that d. | | |
| | sitting in the floor besinjury. The Unit Man reminded the resider | 23 PM the resident was found side the bathroom without larger stated the facility on to use call light to ask for throom and that this was the son 04/29/17. | | Director of Nursing or designed monitor this issue using the QA tool. Facility will monitor complicompleting a daily falls review clinical Quality of life meeting to complete investigation of the facause, and interventions are in Weekend falls will be reviewed | e will A survey iance by during daily o ensure a all, root itiated. | | |
| | related to this fall on assigned to the resid Nurse #3. | s made in the medical record 05/02/17. The nurse lent was | | Monday by the clinical team. The will ensure that the physician was of the fall promptly, physician of initiated, resident representative notified and plan of care was unfalls review meeting will be held | he review vas notified orders were e was pdated. A | | |
| | d. On 05/05/17 at 7:5 in the floor lying on h from a water pitcher resident. The reside elbow. The Unit Mar | 50 PM the resident was found his back and the floor was wet that was knocked over by the nt had a skin tear to his right hager reported that the ented was to remind staff to | | weekly Quality of Life meeting weekly falls to ensure that inter are sustained. This will be done basis for 4 weeks then monthly months by the Support Nurse, Manager, or designee. Report presented to the weekly QA Cotthe Administrator or designee to corrective action initiated as ap Any immediate concerns will be | to review rventions e on weekly for 3 Unit s will be ommittee by o assure opropriate. | | |
| | read in part, the residence hack and had appare pitcher. The residen slipped on the water. | | | the Director of Nursing or Admi for appropriate action. Complia monitored and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly QA Committe is attended by Administrator, D Nursing, MDS Coordinator, Un | inistrator ince will be g program r of Life e meeting irector of it Manager, | | |
| | Nurse #4 was unable | e to be interviewed. | | Support Nurse, Therapy, HIM, | Dietary | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345543 | B. WING | | | C 5/25/2017 | |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | | 5/25/2017 | |
| (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 AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 323 | found under the sink from his head. Orderesident was sent to and returned to the fhead. The Emergen 05/08/17 specified the facial laceration that Manager reported the provide more freque. She stated that this is orally to nurse aides. A nurse's entry made at 1:10 AM read in puthe resident was four | :00 PM the resident was in his bathroom bleeding rs were obtained and the the Emergency Department acility with sutures to his cy Department report dated be resident presented with a required sutures. The Unit at staff were educated to not rounds on the resident. Information was provided assigned to the resident. | F 323 | Manager, Wound Nurse. Date of Compliance: June 16th | 2017 | | |
| | confused and did no he tried to do things to the bathroom. Nur assigned to the Resi PM to 11 PM shift withe bathroom floor be was received to send Emergency Department had suggested using resident but was told personal alarms on resident #75's could tell him to call | ained Resident #75 was t ask for assistance because for himself such as walking rse #1 reported that she was dent on 05/08/17 on the 3 nen the resident was found in leeding. She stated an order | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 345543 | B. WING _ | | | C 5/25/2017 | |
| | ROVIDER OR SUPPLIER A COMMONS NURSING | AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | | | 00/20/2011 | |
| (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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 323 | resident but he almost nurse was unaware of keep the resident from reminding not to get reported that interver not changed because ambulatory and confiredirection and monitoredirection of 5/08/17 the resident needed assist had fallen but was not more frequent monitoredirection of 5/08/17 the resident fellowers. | staffing to monitor the st required a sitter. The of interventions in place to m falling other than constant up unassisted. The nurse ntions for the resident had the resident was used and needed constant | F3 | 23 | | | |
| | in his room without in | sident was found in the floor njury. The Unit Manager entions were developed to m falling. | | | | | |
| | related to this fall on | s made in the medical record 05/02/17. The nurse ent was Nurse #3. Attempts it Nurse #3. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION (X | | (X3) DATE SURVEY COMPLETED | |
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| | | 345543 | B. WING _ | | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER A COMMONS NURSING | AND REHABILITATION CENTER | • | STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG | PROVIDER'S PLAN OF CORE X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 323 | beside his bed without stated no new interviewed and did not appear in Nurse #5 was unable Resident #75 was did In the same interviewed #75's falls, the Unit Nurse was interviewed and admitted to the facilitincluded: anticipate keep personal items | esident was in the floor ut injury. The Unit Manager entions were developed to im falling. e by Nurse #5 on 05/09/17 lent was found in the floor njured. e to be interviewed. scharged on 05/10/17. v, after reviewing Resident Manager reported the t been effective. 2 AM the MDS Coordinator explained that all residents ty at risk for falls received an h basic interventions that needs, wear non-skid socks, in each and remind to call added that once a resident | F | 323 | | | |
| | Administrative nursir down and individuali On 05/25/17 at 2:08 (DON) was interview had made changes t | pg team would "start to drill ze the care plan." PM the Director of Nursing red and stated that facility o Resident #75's care plan to pon explained the facility | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | IPLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | |
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| | | 345543 | B. WING _ | | C 05/25/2017 | |
| | 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 | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | HOULD BE COMPLETION | |
| F 323 | Continued From pag | e 34 | F 3 | 923 | | |
| F 371 SS=E | measures. 483.60(i)(1)-(3) FOO STORE/PREPARE/S | | F3 | 371 | 6/16/17 | |
| | 1 * * * * | from sources approved or ory by federal, state or local | | | | |
| | | ood items obtained directly subject to applicable State ulations. | | | | |
| | facilities from using p | es not prohibit or prevent produce grown in facility ompliance with applicable d-handling practices. | | | | |
| | | es not preclude residents Is not procured by the facility. | | | | |
| | | e, distribute and serve food in essional standards for food | | | | |
| | foods brought to resivisitors to ensure safthandling, and consure This REQUIREMENT by: | egarding use and storage of dents by family and other e and sanitary storage, mption. T is not met as evidenced ons and staff interviews the | | The statements made on this PI | lan of | |
| | facility failed to keep room microwaves cle The findings included | | | Correction are not an admission not constitute an agreement with alleged deficiencies. To remain it compliance with all Federal and Regulations the facility has taker take the actions set forth in this F Correction. The Plan of Correcti | n the n State n or will Plan of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (3) DATE SURVEY COMPLETED | |
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| | | 345543 | B. WING _ | | | C 05/25/2017 |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | E, ZIP CODE | 03/23/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY) | (X5) COMPLETION DATE |
| F 371 | kitchen was made wi (DM). During the obsonourishment rooms with the microwave was inspendictor wave contained along the interior wal microwave. The DM the microwave needs was not aware how compared to the microwave was not explattered inside. The stated the microwave was not wave to the microwave was not was | AM an initial tour of the th the Dietary Manager servations, the two were also observed. B AM nourishment room 2's ected. The inside of the burnt food debris splattered is and ceiling of the was interviewed and stated ed to be cleaned and she | F | constitutes the facility compliance such that deficiencies cited have corrected by the date F371 FOOD PROO STORE/PREPARE/SE Corrective Action for F No specific resident is Corrective Action for F Affected: All residents residing potential to be affecte ensure that dietary stanourishment room mid preparation and service and properly stored. Systemic Changes: The Environmental Se serviced all Housekee 5/26/17 regarding promicrowaves in the not ensure that microwavinspected during the crequired. An audit too monitor the inspection ovens. Any housekeed did not receive in-service allowed to work uncompleted. This infor integrated into the stata training and in the required refresher courses for employees. A compre was put into place to ref/1/17. Monitoring: To ensure compliance Services Director or dithis issue using the Q | all alleged e been or will be or dates indicated. CURE, ERVE – SANITARY Resident Affected: is identified. Resident Potentially in the facility have d. The facility is to aff maintain crowaves, all food be equipment clean ervices Director in eping staff on per cleaning of urishment units to e ovens are day and cleaned as I was developed to n of the microwave eping employee whice training will not till training is mation has been indard orientation quired in-service all Housekeeping thensive audit tool monitor compliance et, the Environmenta esignee will monitor | o cal |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | (X | (X3) DATE SURVEY COMPLETED | |
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| | | 345543 | B. WING _ | | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER A COMMONS NURSING | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | · · | | |
| (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 CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 371 | The facility must providrugs and biologicals them under an agree §483.70(g) of this particles particles and personne law permits, but only supervision of a licental (a) Procedures. A far pharmaceutical servithat assure the accurdispensing, and admibiologicals) to meet the | DRUG RECORDS, IGS & BIOLOGICALS vide routine and emergency is to its residents, or obtain ement described in rt. The facility may permit lt to administer drugs if State under the general ised nurse. | | will be done 5 days per week, in weekend days, for 4 weeks ther for 2 additional months or until re QOL/QA committee. Reports will presented to the weekly QOL/Q Committee by the Director of Environmental Services or desig Corrective Action initiated as ap Any immediate concerns will be the Administrator for appropriate Compliance will be monitored an ongoing auditing program review Weekly Quality of Life Meeting. QA Committee meeting is attend Administrator, Director of Nursin Coordinator, Unit Manager, Sup Nurse, Therapy, HIM, Dietary M Social Services. Date of Compliance:June 16:2017 | n weekly esolved b II be A gnee and propriate brought te action. nd weekly ded by ng, MDS port lanager, | to | |

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| | | | | 3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---------------------|---|------------|----------------------------|
| | | 345543 | B. WING _ | | | C 05/25/2017 |
| | ROVIDER OR SUPPLIER A COMMONS NURSING | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | 33/23/2017 | |
| (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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 431 | pharmacist who (2) Establishes a syst disposition of all condetail to enable an auxiliary and controls, and permit that an account of all maintained and permit (g) Labeling of Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. (h) Storage of Drugs (1) In accordance with facility must storlocked compartment controls, and permit have access to the left (2) The facility must permanently affixed controlled drugs listed Comprehensive Drugs (1) Control Act of 1976 and controls and permit controls and permit have access to the left (2) The facility must permanently affixed controlled drugs listed Comprehensive Drugs (1) Control Act of 1976 and control access to the left (2) The facility must permanently affixed controlled drugs listed controlled drugs listed Comprehensive Drugs (1) Control Act of 1976 and controlled drugs listed controlled | stem of records of receipt and trolled drugs in sufficient ccurate reconciliation; and drug records are in order and I controlled drugs is odically reconciled. Is and Biologicals. Is used in the facility must be be with currently accepted es, and include the gry and cautionary expiration date when Is and Biologicals. It State and Federal laws, eall drugs and biologicals in sunder proper temperature only authorized personnel to | F 4 | 31 | | |
| | package drug distrib quantity stored is mi be readily detected. This REQUIREMEN by: | ution systems in which the nimal and a missing dose can T is not met as evidenced ons, record reviews, and staff | | The statements made on this Pla Correction are not an admission | | |

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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 05/25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | ZIP CODE | 00/20/2017 | |
| | | | | 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 | (EACH CORRECTIVE CROSS-REFERENCED | | | |
| F 431 | Continued From page | e 38 | F 4 | 31 | | | |
| | medication carts, (10 400 hall medication cunattended. | 0 hall medication cart and cart) which were left | | not constitute an agreer alleged deficiencies. To compliance with all Fed Regulations the facility I | remain in eral and State | | |
| | The findings included | ! : | | take the actions set forti Correction. The Plan of | | | |
| | The nurses' station was residents were seate nurses' station. The unlocked and unatter On 05/23/17 at 3:30 Nursing (ADON) enters smoking area, walked observed that it was resident to the served that the served that it was resident to the served that the served the served that the served that the served that the served that | parked at the nurses' station. yas vacant of staff but 5 d in wheelchairs at the 400 Hall medication cart was ended. PM the Assistant Director of ered the building from the d by the medication cart and unlocked. The ADON was | | constitutes the facility's compliance such that al deficiencies cited have corrected by the date or F431 DRUG RECOFLABEL/STORE DRUGS BIOLOGICALS Corrective Action: 100 and 400 hall Medic locked and secured whi not in attendance. Medi immediately secured processors and secured processors. | Il alleged been or will be r dates indicated RDS, S AND ation carts wher ile the nurse was cations were operly. | e s | |
| | when unattended and nurse assigned to the | ed the cart should be locked d attempted to locate the e medication cart. The cate the medication aide she was on break. | | Identification of other re be involved with this pra All residents have the p affected by the alleged were done by DON on 6 medication and treatme locked and secured who | actice: otential to be practice. Audits 6/14/17 and all ent carts were | | |
| | | | | not in attendance. All m stored and secured. All treatment carts are lock when not in immediate Medication and treatme any area that medicatio stored were checked to | medication and ted at all times use by Nurse. A ent carts and also in was securely | II O | |
| | was made on 05/23/2 medication aide was cart and could not fin The medication aide from the medication of | the 400 hall medication cart I7 at 4:16 PM. The standing at the medication d a medication she needed. was observed to walk away cart down an adjacent rse. The medication aide left | | was, no expired, undate open insulin by the nurs Systemic Changes: Director of Nursing and serviced all nursing staf time, part time, and PRI must store all drugs and | ed or not initialed se. /or Designee in ff (RNs, LPNs, fo N) that the facilit | d, | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|-----------------------|---|---------------|--|-------------------------------|
| | | 345543 | B. WING | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/20/2011 |
| | | | | 316 NC HIGHWAY 801 SOUTH | |
| BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | , | ADVANCE, NC 27006 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTIO | |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | |
| F 431 | Continued From pa | ge 39 | F 431 | ı | |
| | the medication cart | unlocked and there was 3 | | locked compartments under proper | |
| | residents in wheelc | hairs parked directly in front of | | temperature controls, and permit only | / |
| | | medication cart. The | | authorized personnel to have access | |
| | | s away from her medication | | the key's. The facility must also sepa | rately |
| | cart for approximate | ely 2 minutes. | | lock, and have permanently affixed | |
| | A iti | and a standard with Marking Atom Atom | | compartments for storage of controlle | |
| | | onducted with Medication Aide | | drugs. Drugs and biologicals used in facility must be labeled in accordance | |
| | | 3 PM. Medication Aide #1 her second day working at | | currently accepted professional princ | |
| | | was nervous. Medication Aide | | and include the appropriate accessor | - |
| | | art was supposed to always | | and cautionary instructions, and the | y |
| | be locked when she | | | expiration date when applicable. This | sin |
| | | | | service was completed by 6/14/2017 | |
| | An interview with th | e Director of Nursing (DON) | | nursing staff member (RNs, LPNs, fu | |
| | was conducted on (| 05/25/17 at 11:41 AM. The | | time, part time, and PRN) who did no | t |
| | DON stated that me | edication carts are to be | | receive in-service training will not be | |
| | locked at all times v | vhen not in use. She added | | allowed to work until training is comp | |
| | that the use of Med | | | This information has been integrated | |
| | | as new to the facility and | | the standard orientation training and | |
| | | tion Aide #1 would no longer | | required in-service refresher courses | |
| | _ | nedication cart in the facility." | | all employees and will be reviewed b | |
| | | e staff needed to understand | | Quality Assurance Process to verify t | nat |
| | carts are locked wh | naking sure the medication | | the change has been sustained. Monitoring: | |
| | carts are locked will | en leit anattended. | | To ensure compliance, Administrator | or |
| | | | | Maintenance Director or designee wi | |
| | 3. An observation o | f the 100 hall medication cart | | monitor this issue using the QA surve | |
| | | 3/217 at 3:29 PM. The | | tool. Facility will monitor compliance | • |
| | | s parked outside of a resident | | auditing each medication cart, and | |
| | | d to be unlocked and the keys | | treatment cart and any other areas th | at |
| | to the medication ca | art were noted to be lying on | | medication is stored to ensure that the | ey |
| | | on cart. The door to the | | are secured properly at all times. This | |
| | | closed and no staff was | | be done on weekly basis for 4 weeks | |
| | _ | cation cart. The medication | | monthly for 3 months by the Support | |
| | | nded for 5 minutes before the | | Nurse, Unit Manager, or designee. | |
| | | om and grabbed the keys to | | Reports will be presented to the week | - |
| | tne medication cart | and locked the cart. | | QA Committee by the Administrator of | or |
| | An intensional All | urae #6 was sandusted as | | designee to assure corrective action | |
| | All linerview with in | urse #6 was conducted on | 1 | initiated as appropriate. Any immedia | ll C |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | I DENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|--|---|-------------------------------|--|
| | | 345543 | B. WING _ | | | | C / 25/2017 | |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | | 1 00/ | 20/2017 | |
| (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 APPROPRI DEFICIENCY) | ON SHOULD BE COMPLET E APPROPRIATE DATE | | |
| F 441 SS=D | Continued From page 05/23/17 at 3:36 PM. that the medication cashould always have he "I just went in and knoout." An interview with the was conducted on 05 DON stated that med locked at all times who to the medication can of the medication can should be with the nut the cart. 483.80(a)(1)(2)(4)(e)(PREVENT SPREAD, (a) Infection prevention The facility must estal and control program of a minimum, the follow (1) A system for preventions a minimum, the follow of the conducted disease volunteers, visitors, a providing services un arrangement based of conducted according accepted national stal implementation is Philipping services. | Nurse #6 stated she knew art was to be locked and she her keys with her and stated, ew that I would be right back Director of Nursing (DON) 6/25/17 at 11:41 AM. The lication carts were to be hen not in use and the keys at should never be left on top to the shear was responsible for (f) INFECTION CONTROL, LINENS In and control program. blish an infection prevention (IPCP) that must include, at wing elements: lenting, identifying, reporting, introlling infections and less for all residents, staff, and other individuals der a contractual upon the facility assessment to §483.70(e) and following undards (facility assessment) | F | 431 | | r of e ınd the y | 6/16/17 | |
| | for the program, whic limited to: | th must include, but are not | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|---|-----------|-------------------------------|--|--|
| | | 345543 | B. WING | | | C)5/25/2017 | | |
| | 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 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 441 | before they can spre facility; (ii) When and to who communicable disease reported; (iii) Standard and trast to be followed to president; including by the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected secontact with resident contact will transmit (vi) The hand hygier by staff involved in contact with facility's IF actions taken by the | able diseases or infections and to other persons in the om possible incidents of use or infections should be unsmission-based precautions event spread of infections; solation should be used for a ut not limited to: Tration of the isolation, infectious agent or organism at the isolation should be the sible for the resident under the under which the facility eves with a communicable skin lesions from direct the disease; and the procedures to be followed direct resident contact. | F 4 | , | | | | |
| | process, and transpospread of infection. | ort linens so as to prevent 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 | | | l ' | C | |
| | | 343343 | D. WING_ | | | 05/ | 25/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| BERMUDA | COMMONS NURSING | AND REHABILITATION CENTER | | 31 | 16 NC HIGHWAY 801 SOUTH | | | |
| | | THE REINGERIA CONTROL OF THE PROPERTY OF THE P | | Α | DVANCE, NC 27006 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 441 | Continued From page | . 42 | F.4 | | | • | | |
| Г 44 І | Continued From page | | F 4 | 141 | | | | |
| | annual review of its IF | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | | ry. is not met as evidenced | | | | | | |
| | by: | no record reviews and staff | | | The statements made on this Dien of | | | |
| | | ns, record reviews, and staff staff failed to wash hands | | | The statements made on this Plan of Correction are not an admission to and | do | | |
| | _ | r stick glucose test and after | | | not constitute an agreement with the | uo | | |
| | | nt care for 2 of 3 residents | | | alleged deficiencies. To remain in | | | |
| | (#255 and #266). | it care for 2 or o residents | | | compliance with all Federal and State | | | |
| | ("200 and "200). | | | | Regulations the facility has taken or wil | . | | |
| | The findings included | : | | | take the actions set forth in this Plan of | | | |
| | J | | | | Correction. The Plan of Correction | | | |
| | Review of a facility po | olicy titled "Clostridium | | | constitutes the facility's allegation of | | | |
| | Difficille (C-Diff)" date | d July 2002 and revised | | | compliance such that all alleged | | | |
| | | art, gloves must be worn | | | deficiencies cited have been or will be | | | |
| | with resident care and | d environment contact. Hand | | | corrected by the date or dates indicated | d. | | |
| | | nd water has demonstrated | | | F441 INFECTION CONTROL, PREVE | NT | | |
| | · · | o prevent the spread of | | | SPREAD, LINENS | | | |
| | | f healthcare workers. Hand | | | Corrective Action: | | | |
| | | and water as alcohol gel is | | | Resident # 255 Medication was | | | |
| | not effective against (| J-DIπ. | | | administered as ordered maintaining | _ | | |
| | Davious of facility policy | cy titled "Infection Control | | | standard precautions during medication administration. | ı | | |
| | | y 2002 and revised January | | | Resident #266 Hand washing was | | | |
| | | health care workers shall | | | performed after Incontinence care was | | | |
| | • | iate barrier precautions to | | | provided, maintaining standard | | | |
| | | and/or spread of infection. | | | precautions. Wound care treatment wa | s | l | |
| | | anged after contact with a | | | provided as ordered maintaining standa | | | |
| | patient and hands wa | • | | | precautions. | | | |
| | | | | | Facility immediately in serviced all Nurs | sing | | |
| | 1. Resident #255 was | admitted to the facility on | | | staff (RN, LPN, CNAs and Med Techs: | - | | |
| | 05/05/17 with diagnos | ses that included diabetes | | | Full time, Part Time and PRN) about | | | |
| | mellitus. | | | | infection control, preventing spread of | | l | |
| | | | | | infection during medication administrati | | | |
| | | ecent minimum data set | | | and wound care treatment. To ALWAYS | 6 | | |
| | , | 7 revealed that Resident | | | maintain standard precautions during | | | |
| | #255 was cognitively | | | | medication administration, wound care | | | |
| | extensive assistance | with activities of daily living | | | treatment, and to always wash their ha | nds | | |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|---------------|-------------------------------|---|---------------|--|-------------------------------|----------|
| | | 345543 | B. WING | | C 05/25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 03/23/2017 | \dashv |
| | | | | 316 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | COMMONS NURSING | AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | |
| (X4) ID | SUMMARY S | FATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) | \dashv |
| PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | | BE COMPLETION | N |
| F 441 | Continued From pag | e 43 | F 44 | 41 | | |
| | (ADL). | | | when resident contact is made after | | |
| | (182). | | | performing incontinence care. | | |
| | Review of a physicia | n order for Resident #255 | | Identification of other residents who | may | |
| | | contact isolation for C-Diff. | | be involved with this practice: | | |
| | | | | All residents have the potential to be | | |
| | An observation of Nu | ırse #6 was made on | | affected by the alleged practice. Dire | ctor | |
| | 05/23/17 at 3:40 PM | . Nurse #6 was observed to | | of Nursing observed Medication | | |
| | | s room that had a sign on | | Administration Passes on Nurses (R | N, | |
| | the door that stated ' | | | LPN and Med Techs). All residents | | |
| | | #6 was observed to don | | medications administered as ordere | | |
| | | or to entering room. Once in | | maintaining standard precautions ar | d/ | |
| | - | roceeded to perform a finger | | contact isolation during medication | | |
| | _ | on Resident #255. After | | administration. Director of Nursing | mont | |
| | | stick glucose test Nurse #6 nd gloves and exit Resident | | observed hand washing during treat and medication administration, and | | |
| | _ | urned to the medication cart | | incontinence care. All nursing staff | itei | |
| | | izer gel on her hands and | | observed washed hands after performing | | |
| | then entered another | _ | | incontinence care during medication | - | |
| | administer medicatio | ns. | | treatment administration. | | |
| | | | | Systemic Changes: | | |
| | An interview was cor | nducted with Nurse #6 on | | Director of Nursing and/or Designee | in | |
| | 05/23/17 at 3:55 PM | . Nurse #6 stated she was | | serviced all Nursing staff (RN, LPN, | CNAs | |
| | | ity and she did not recall any | | and Med Techs: full time, part time, | | |
| | _ | provided to her on hand | | PRN) about infection control, prever | _ | |
| | washing. She recalled | | | spread of infection during medication | I | |
| | • | out could not recall any | | administration and during and after | | |
| | | on hand washing or the use | | performing incontinence care. | | |
| | | Nurse #6 stated she always | | The facility must establish and main | | |
| | | gel between patient's even solations precautions for | | an infection Control Program design | | |
| | C-Diff. | solations precautions to | | provide a safe, sanitary and comfort environment and to help prevent the | IDIE | |
| | O Dilli. | | | development and transmission of dis | ease | |
| | An interview with the | Assistant Director of Nursing | | and infection.(a) Infection Control | | |
| | | ted on 05/24/17 at 10:15 AM. | | Program The facility must establish | ın | |
| | The ADON confirmed | | | Infection Control Program under whi | | |
| | | fection control program in | | (1) Investigates, controls, and preve | | |
| | | ON confirmed that Nurse #6 | | infections in the facility;(2) Decides v | | |
| | had recently gone th | rough orientation and the | | procedures, such as isolation, shoul | | |
| | training on infection | control. He stated that the | | applied to an individual resident; and | (3) | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|----------------------------|--|---------------|---|--------------|-------------------------------|--|
| | | | 7 t. BOILDII | | | С | |
| | | 345543 | B. WING _ | | 0. | 5/25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | 5/20/20 11 | |
| | | | | 316 NC HIGHWAY 801 SOUTH | | | |
| BERMUD | A COMMONS NURSI | NG AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | | |
| (V4) ID | SLIMMAR | Y STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | | (VE) | |
| (X4) ID PREFIX TAG | (EACH DEFIC | IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | | SHOULD BE | (X5) COMPLETION DATE | |
| F 441 | Continued From p | page 44 | F 4 | 41 | | | |
| | employees were | required to watch a power point | | Maintains a record of incidents | s and | | |
| | 1 | nfection control that included | | corrective actions related to in | fections.(b) | | |
| | blood borne patho | ogens, use of personal | | Preventing Spread of Infection | ı(1) When | | |
| | protective equipm | nent (PPE), and hand washing. | | the Infection Control Program | determines | | |
| | | I that the facility policy did not | | that a resident needs isolation | • | | |
| | | hand sanitizer gel versus hand | | the spread of infection, the fac | • | | |
| | _ | s "ok to use hand sanitizer even | | isolate the resident.(2) The fac | • | | |
| | | re to residents on contact | | prohibit employees with a com | | | |
| | | f", he added "they can use hand | | disease or infected skin lesion | | | |
| | sanitizer anytime soiled." | unless their hands are visibly | | direct contact with residents o | , | | |
| | solled. | | | if direct contact will transmit the (3) The facility must require st | | | |
| | An interview was | conducted with the Director of | | their hands after each direct re | | | |
| | | n 05/25/17 at 9:50 AM. The DON | | contact for which hand washir | | | |
| | | the staff about infection control | | indicated by accepted profess | - | | |
| | | you cannot use hand sanitizer is | | practice.(c) Linens Personnel | | | |
| | | DON stated that Nurse #6 was | | handle, store, process and tra | | | |
| | fairly new to the fa | acility and had been through an | | linens so as to prevent the spr | • | | |
| | extended orientat | ion program and she expected | | infection. | | | |
| | Nurse #6 to wash | her hands with soap and water | | Medications are administered | at the time | | |
| | | he finger stick glucose test on | | they are prepared. Medication | | | |
| | | nd before providing care to | | pre-poured. The person who p | - | | |
| | another resident. | | | dose for administration is the | | | |
| | 0 Decide 4000 | Suran admittad to the Security of | | administers the dose. Hand hy | | | |
| | | was admitted to the facility on | | should be performed before a | | | |
| | | gnoses that included methicillin occcus aureus (MRSA) of | | administration of topical, ophtle parenteral, enteral, rectal, and | | | |
| | unspecified site a | , , | | medications. | vagiriai | | |
| | unspecified site a | na otners. | | All staff was in-serviced about | contact | | |
| | The comprehensi | ve minimum data set (MDS) | | precautions and use of PPD. | contact | | |
| | • | emained in progress. | | Always observe Standard Pre | caution | | |
| | | F 13 1151 | | and/or contact isolation during | | | |
| | Review of a phys | ician order dated 05/16/17 read, | | medication administration. Wa | , , | | |
| | | precautions due to MRSA of | | resident contact is made. Was | sh hands | | |
| | foot. | | | before and after resident conta | act. Wash | | |
| | | | | hands when soiled. Standard | Precautions | | |
| | | Nurse #2 was made on | | should be used with all proced | | | |
| | | PM. Nurse #2 was observed to | | involving blood or other potent | tially | | |
| | don gown and glo | oves and enter Resident #266's | | infectious body fluids. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | |
|---|--|---|---------------------|---|---|
| | | 345543 | B. WING | | C 05/25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | <u> </u> | | STREET ADDRESS, CITY, STATE, ZIP CODE | 03/23/2017 |
| | | | | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| F 441 | requested to use the #2 assisted Resident bedside commode. We finished Nurse #2 was incontinent care and a putting on clean pull up and pants. Nuperform wound care to wound. Nurse #2 remand placed a new dresher gloves after the insubsequent wound care to wound care to wound and it was the weekend supout the wound nurse had changed her glovincontinent care but so the sadded that Residisolation and it was find between wound and it changed my gloves a | the room Resident #266 bedside commode. Nurse #266 from the bed to the When Resident #266 was sobserved to provide assisted Resident #266 with up and then pulling up her arse #2 then proceed to to Resident #266's right foot avoid the soiled dressing assing and did not change accontinent care and are. ducted with Nurse #2 on Nurse #2 explained that she bervisor and she was helping today. Nurse #2 stated she are after providing the did not wash her hands. then #266 was on contact | F 44 | Ointments and drops should be kept in separate containers labeled with the resident's name. Liquid and PO medications should be stored separate in the medication carts. No medication used for treatments such as creams should be kept in the medication cart. These items should be kept in the treatment cart. Any medication used for the treatment of a resident who is on isolation precautions should be stored separately from other resident's treatm supplies and should be locked to preve unauthorized access. Medication carts shall be cleaned when visibly soiled. F and utensils shall be handled in a sani manner. Unused medication cups shall kept covered or inverted. Sharps containers on medication carts shall be affixed or secured to prevent spillage. When administering oral medications, never touch pills or tablets with bare hands. If blister pack medications are prepared by pharmacy, punch the | ely s or eent eood tarry I be |
| | Nursing (DON) on 05 assistant Director of Nursent during this into that she expected any changed their gloves with soap and water. expected Nurse #2 to wash her hand with s | terview. The DON stated ytime a staff member that they wash their hands The DON stated that she o change her gloves and oap and water after care and before performing | | medication directly into a medication of for dispensing. If tablets are in a bottle then pour the medication into the lid are then transfer ordered dose into the medication cup. Clean any spilled liquid medication immediately. When administering eye drops, Always wear gloves. Wash hands after administration. Ensure that eye medication dispensers/containers do not touch the resident's eyes. If eye secretions are present, cleanse the lid with saline. Always wipe from the inner canthus outward. Always use separate tissue wipes or cotton balls for each eye. | nd d d s |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
|--------------------------|-------------------------------|---|---------------------|---|------------------------------------|--|
| | | 345543 | B. WING _ | | C 05/25/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/20/2017 | |
| | | | | 316 NC HIGHWAY 801 SOUTH | | |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | CROSS-REFERENCED TO THE APPROPRI | DATE | |
| | | | | DEFICIENCY) | | |
| F 441 | Continued From page | e 46 | F | to prevent cross contamination. When administering injections, Always wear gloves. Wash hands after administration. Use sterile technique when preparing the medication for injection. Cleanse the site with an antiseptic prior to administration of the injection. Dispose of the sharp in an appropriate container immediately following administration. Monitor the injection site for sign and symptoms of infection. When administering medications via syringe, the syringe should be used for one resident only. Syringe shall be changed at least every 24 hours. Syring shall be rinsed thoroughly, separated a dried thoroughly after each use and placed in cover by bedside or in a plass bag, which is attached to feeding pole ready for next use. Wash hands before and after resident contact. Wash hands when soiled. Wash hands after performing incontinence can this in services were completed on Just 14th 2017. Any nursing staff member (RNs, LPNs, full time, part time, and P who did not receive in-service training 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 an will be reviewed by the Quality Assural Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of nursor designee will monitor this issue usin | r age and stic sh are. ne RN) will | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | |
|--|--|---|-------------------------------|---|--|---------------------------------------|----------------------------|
| | | 345543 | B. WING | | | | C 25/2047 |
| NAME OF P | ROVIDER OR SUPPLIER | 040040 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 05/ | 25/2017 |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | 3′ | 16 NC HIGHWAY 801 SOUTH 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 441 | Continued From page | . 47 | | 1441 | the QA survey tool. Facility will monitor compliance by observing 5 different medication or treatment administration passes done by an RN or LPN or Med aides during any shift. This will be done ensure that standard precautions and/ocontact isolation are maintained during medication administration and that han are washed if resident contact is made The facility will also monitor compliance by observing handwashing for 5 nursin staff after performing incontinence care. This will be done on a weekly basis for weeks then monthly for 3 months by th 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 appropriat Any immediate concerns will be brough 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 of Nursing, MDS Coordinator, Unit Manage Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017 | e to or ds . e g e. 4 e o tto be m ng | |
| F 490 SS=D | 483.70 Administration | | F 2 | 190 | | | 6/16/17 |
| | enables it to use its re efficiently to attain or | ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial | | | | | |

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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 05/25/2017 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODI | | 13/23/2017 | |
| | 10115211 011 001 1 21211 | | | 316 NC HIGHWAY 801 SOUTH | _ | | |
| BERMUDA | COMMONS NURSING | AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | | |
| | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY 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) | I SHOULD BE | (X5) COMPLETION DATE | |
| F 490 | Continued From pag | ge 48 | F 4 | 90 | | | |
| | well-being of each re This REQUIREMEN by: | esident. T is not met as evidenced | | | | | |
| | | ons, record review and staff cy's administration failed to | | The statements made on this Correction are not an admission | | | |
| | | effectively to implement and | | not constitute an agreement w | | | |
| | | rection to ensure the facility | | alleged deficiencies. To remai | | | |
| | - | ed non-compliance with | | compliance with all Federal ar | | | |
| | F-431, drug storage. | | | Regulations the facility has tal | | | |
| | , a. a.g o.o. a.g o. | • | | take the actions set forth in thi | | | |
| | | | | Correction. The Plan of Corre | | | |
| The findings included: | | d: | | constitutes the facility's allega | | | |
| | Ŭ | | | compliance such that all allege | | | |
| | | | | deficiencies cited have been of | | | |
| | Cross refer to F-431 | : Based on observations and | | corrected by the date or dates | indicated. | | |
| | staff interviews the fa | acility failed to lock 2 of 4 | | F490 EFFECTIVE ADMINIST | TRATION | | |
| | medication carts (10 | 00 and 400 halls) when left | | /RESIDENT WELL-BEING | | | |
| | unattended. | | | Corrective Action: | | | |
| | | | | Cross reference Tag F490 to | Tag F431 | | |
| | | | | No residents identified. | | | |
| | The facility was cited | d for F-431 in May 2016 for | | 100 and 400 hall Medication of | arts where | | |
| | failing to label open | insulin and failing to lock a | | locked and secured while the | nurse was | | |
| | medication cart whe | n left unattended. | | not in attendance. Medication | s were | | |
| | | | | immediately secured properly | | | |
| | | | | Identification of other resident | • | | |
| | _ | ted for F-431 in June 2016 for | | be involved with this practice: | | | |
| | _ | unattended at the nurses' | | All residents have the potentia | | | |
| | | secure a medication cart | | affected by the alleged practic | | | |
| | when left unattended | d. | | Cross Reference Tag F490 to | • | | |
| | | | | All residents have the potentia | | | |
| | | | | affected by the alleged practic | | | |
| | | PM the Administrator was | | were done by DON on 6/14/17 | | | |
| | | lained the facility had | | medication and treatment cart | | | |
| | - | es and monitoring specific to | | locked and secured when the | | | |
| | | past citations. She added | | not in attendance. All medicat | | | |
| | | monitoring she believed the | | stored and secured. All medic | | | |
| | | iance with the regulation and | | treatment carts are locked at a | | | |
| | | hly monitoring and reporting | | when not in immediate use by | | | |
| | of drug storage to th | e Quality Assurance | | Medication and treatment cart | .s and also | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|---|---|---------------------|---|--|--|
| | 345543 | B. WING | | С | |
| NAME OF PROVIDED OR OURDUIED | 349343 | B. WING _ | OTDEET ADDRESS OUTV STATE 710 OODE | 05/25/2017 | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BERMUDA COMMONS NURSING | AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH | | |
| | | | ADVANCE, NC 27006 | | |
| PREFIX (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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION | |
| F 490 Continued From page Committee. | e 49 | F 49 | any area that medication was securely stored were checked to ensure that th was, no expired, undated or not initials open insulin by the nurse. Systemic Changes: Director of Nursing and /or Designee i serviced all nursing staff (RNs, LPNs, Medication Aides, full time, part time, a PRN) that: Cross reference Tag F490 to Tag F43 residents identified. The Cooperate Nurse Consultant in-serviced the Nursing Home Administrator on 6/12/2017 that A faci must be administered in a manner that enables it to use its resources effective and efficiently to attain or maintain the highest practicable physical, mental, a psychosocial well-being of each reside This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, fi time, part time, and PRN) and membe the interdisciplinary team who did not receive in-service training will not be allowed to work until training is comple This information has been integrated i the standard orientation training and ir required in-service refresher courses fall employees and will be reviewed by Quality Assurance Process to verify the change has been sustained. Monitoring: To ensure compliance, Administrator of Director of Nursing will monitor this issusing the QA survey tool. Facility will monitor compliance of QA for F 431. Twill be done on weekly basis for 4 weethen monthly for 3 months by the Supl Nurse, Unit Manager, or designee. | ere ed, n and 1 No lity t ely and ent. e ull r of eted. nto n the for the at crue Chis eks | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|--|--|-------------------------------|----------------------------|
| | | 345543 | B. WING _ | B. WING | | | C 25/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | | <u> </u> | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | | 25/2011 |
| BERMUDA | A COMMONS NURSING | AND REHABILITATION CENTER | | | 6 NC HIGHWAY 801 SOUTH | | |
| DER. MODA | | AND REMADIENTATION GENTER | | 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 | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 490 | (i) Medical records. (1) In accordance with standards and practic maintain medical recordare- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org. (5) The medical recording Sufficient information (i) Sufficient information (ii) Sufficient information (iii) Provided (iii) Sufficient information (iii) Sufficient information (iiii) Provided (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | ETE/ACCURATE/ACCESSIB th accepted professional ces, the facility must ords on each resident that ented; ented; e; and ganized | | 514 | 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 Director Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at tweekly 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: June 16th 2017 | er of ee nd the / | 6/16/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | L LIDENTIEICATION NITIMBED: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---------------------|--|-------------------------------|
| | 345543 | | | | C 05/25/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | <u> </u> | | STREET ADDRESS, CITY, STATE, ZIP CODE | 00/20/2017 |
| BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | | 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY) | D BE COMPLETION |
| F 514 | Continued From pag | e 51 | F 51 | 4 | |
| | (iii) The comprehens provided; | ive plan of care and services | | | |
| | (iv) The results of any and resident review of determinations condu | | | | |
| | (v) Physician's, nurse professional's progre | e's, and other licensed ss notes; and | | | |
| | services reports as re | logy and other diagnostic equired under §483.50. Γ is not met as evidenced | | | |
| | Based on staff intervious facility failed to docur record for 1 of 1 sam (Resident #75) and fa | views and record review the ment two falls in the medical pled resident that had fallen ailed to document a wound th a wound (Resident #266). | | 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 Federal and State Regulations the facility has taken or | te |
| | The findings included | 1: | | take the actions set forth in this Plar Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged | |
| | 04/21/17 with diagno of the scalp, history of a urinary tract infection admission Minimum specified the residen | Data Set dated 04/28/17 t's cognition was intact, he person assistance with | | deficiencies cited have been or will I corrected by the date or dates indica F514 RES RECORDS-COMPLETE/ACCURAT /ACCESSIBLE Corrective Action: Resident #75 Discharged on 5/10/2017 to a Memocare unit. | eted. E |
| | | incident reports for Resident he had fallen 7 times in 11 rred on: | | Resident #266. Physician was notific 5/24/17. New physician orders place initiated as ordered. Care plan upda Resident and Resident's representa notified on 5/24/17. | ed and ted. |

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| 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 | | |
|--|---|---|-------------|--|--|--|
| | 345543 | | B. WING | | 05/25/2017 | |
| | ROVIDER OR SUPPLIER | NG AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 | 00/20/2017 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | RY STATEMENT OF DEFICIENCIES ID CIENCY MUST BE PRECEDED BY FULL PREF Y OR LSC IDENTIFYING INFORMATION) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION | |
| F 514 | documentation wa the falls on 05/02/ the nurse for Resi | dical record revealed that no as made by the nurse related to 17 or 05/09/17. Nurse #3 was dent #75 on the two dates. de to contact Nurse #3 for an | F 51 | Identification of other residents who be involved with this practice: All residents have the potential to be affected by the alleged practice. On 6/15/2017 a falls review meeting war in the Weekly Quality of Life meeting assessments were completed on all current residents by 6/14/2017. In the meeting all residents were reviewed high falls risk, incident documentation current interventions in place to previously falls and the need for additional interventions for residents with poor awareness. This was completed on 6/15/2017. In addition to this, any ne interventions put in place were added the individual residents care plan by MDS Coordinator and were reflected the Kardex and Care plan respective. | s held g. Risk is for an and rent safety w d to the | |
| | reviewed the med was no document 05/02/17 and 05/0 explained that it a completed the incifailed to link the dimedical record. Tincident reports we record and nurses in the medical record. Resident #266 05/16/17 with diagresistant staphylos septicemia, decub 2 present on admigreat toe, pressur on admission, and | :33 AM the Administrator ical record and reported there ation that the resident fell on 19/17. The Administrator opeared when Nurse #3 ident reports for the falls she occumentation to the electronic in the Administrator stated the ere not part of the medical is should document any incident ord. Was admitted to the facility on proses that included: methicillin occcus aureus (MRSA) itus ulcer of sacral region stage ission, diabetic ulcer of right in the ulcer of thigh stage 3 present in diabetes mellitus. | | All residents have the potential to be affected by the alleged practice. On 2 to June 16 2017 a skin assessmer completed on all residents to ensure all pressure and non-pressure woun were identified, physician was notified and physician orders were followed initiated. All care plans were updated pressure and non-pressure wounds initiated as ordered. Skin assessment were completed by ADON and staff nurses. The wound review meeting wheld on 6/15/17 by the Nurse Management Team (Director of Nurse MDS, NHA, Unit Manager and Supp Nurse). All physician orders were fol and initiated as ordered. Systemic Changes: Director of Nursing and /or Designed serviced all Nurses (RNs, LPNs, full | June June It was It that Ids | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|----------------------|---|---------------|--|----------------|-------------------------------|--|
| | | | D WING | | | С | |
| | | 345543 | B. WING _ | | | 05/25/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CC | DE | | |
| REDMIID | A COMMONS NITESIA | IG AND REHABILITATION CENTER | | 316 NC HIGHWAY 801 SOUTH | | | |
| BEKINIODA | A COMMONS NORSIN | NG AND REHABILITATION CENTER | | ADVANCE, NC 27006 | | | |
| (X4) ID | SUMMARY | / STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | ORRECTION | (X5) | |
| PREFIX TAG | , | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | IE APPROPRIATE | COMPLETION DATE | |
| F 514 | Continued From p | age 53 | F 5 | 14 | | | |
| | from the hospital of | lated 05/16/17 read in part, | | part time, and PRN) on the f | act that the | | |
| | | f the sacrum stage 2/pressure | | resident has the right to be f | | | |
| | | stage 3 present on admission. | | abuse, neglect, misappropri | | | |
| | | to manage." The discharge | | resident property, and explo | | | |
| | summary did not in | ndicate a right heel wound. | | includes but is not limited to | freedom from | | |
| | | | | corporal punishment, involu | ntary | | |
| | | ursing Assessment dated | | seclusion and any physical of | or chemical | | |
| | | art, there were 5 small ulcers | | restraint not required to trea | | | |
| | | ight buttock. No other ulcers | | resident's symptoms. The fa | - | | |
| | were identified on | the initial nursing assessment. | | develop and implement writt | - | | |
| | | | | and procedures that: Prohib | • | | |
| | | cian progress note dated | | abuse, neglect, and exploita | | | |
| | · · | art, "Stage 3 decubitus to thigh tus. Wound doctor to see on | | residents and misappropriat | | | |
| | | and encourage resident to stay | | property, Establish policies a procedures to investigate ar | | | |
| | | is possible." The report did not | | allegations including training | | | |
| | reference a right h | | | (RNs, LPNs, full time, part ti | | | |
| | | | | were also educated on the f | - | | |
| | Review of physicia | an order summary dated | | the nurse's responsibility to | notify | | |
| | | 05/23/17 revealed no physician | | physician, follow and initiate | - | | |
| | order for a treatme | ent to Resident #266's right heel | | orders. Physician should be | called 24 | | |
| | wound. | | | hours a day and 7 days a we | eek. This | | |
| | | | | process does not change du | ue to time or | | |
| | | wound care was made on | | day of the week. Physician | - | | |
| | | M with Nurse #2. Nurse #2 was | | numbers are located at each | | | |
| | | a wound dressing that | | station in the notebook. If yo | | | |
| | | medicated ointment) to | | to reach the attending physic | | | |
| | | ght and left back of | | physician on call, call the fac | • | | |
| | | . Nurse #2 was observed to | | director within 30 minutes of | • | | |
| | Santyl to Resident | d dressing that contained | | the primary physician. If the | | | |
| | Jantyi to Resident | . #200 S HYTIL HEEL. | | physician or medical directo provide an appropriate response | | | |
| | Review of the med | dical record on 05/22/17 at 4:50 | | not call back within 30 minut | | | |
| | | 05/23/17 at 3:00 PM revealed | | nurse is to contact the DON | | | |
| | | d Review (non pressure)" | | for further instructions. | | | |
| | | o "Weekly Pressure Ulcer | | Director of Nursing and /or D | Designee in | | |
| | Review" assessme | | | serviced all staff (full time, p | • | | |
| | | | | PRN) to inform that the faci | | | |
| | Review of the daily | v nurse's notes in the medical | | ensure that the resident env | • | | |

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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 05/25/2017 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 20/2011 | |
| | | | | 3 | 16 NC HIGHWAY 801 SOUTH | | | |
| BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | AND REHABILITATION CENTER | | | 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 | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 514 | Continued From page | e 54 | F 5 | 514 | | | | |
| | 05/23/17 at 3:00 PM of a right heel ulcer. | t 4:50 PM and again on revealed no documentation | | | remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facil | | | |
| | 05/24/17 at 10:00 AW he was responsible for | ADON was conducted on 1. The ADON confirmed that or the wound care acility. He added that they | | | must attempt to use appropriate alternatives prior to installing a side or rail. If a bed or side rail is used, the fac must ensure correct installation, use, a | ility | | |
| | recently placed Resident #266 on an air mattress. The ADON stated that on Friday 05/17/17 he and the medical doctor observed the Resident #266's wounds and he initiated Santyl. The ADON stated that he saw Resident #266 on 05/17/17 but did not document that in the medical record. A follow up interview was conducted with the ADON on 05/24/17 at 2:22 PM. The ADON stated | | | | maintenance of bed rails, including but limited to the following elements. Asset the resident for risk of entrapment from bed rails prior to installation, Review the | not ss | | |
| | | | | | risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation, Ensure that the bed's | | | |
| | heel on admission an santyl. He added that | id a have ulcer to the right ad the treatment for it was t it had been draining d since admission. The | | | dimensions are appropriate for the residents size and weight. When a resident has a fall, the person discovering the resident reassures the | | | |
| | ADON indicated that wound to Resident #2 | he "just forgot about the 266's right heel." | | | resident and immediately alerts the primary nurse. The nurse assesses the resident for injuries. With suspected | | | |
| | Nursing (DON) on 05 DON stated that she | ducted with the Director of /25/17 at 10:46 AM. The expected the medical record ccurate at all times to reflect | | | fractures of limbs, the limbs in question are immobilized and an order to send the ER is obtained. When other fracturare suspected of limbs, the limbs in | 0 | | |
| | the resident's skin sta | | | | questions are immobilized and an orde send to the ER is obtained. When othe fractures are suspected the resident is kept immobilized on the floor and on or | er | | |
| | | | | | to send to the ER is obtained. Vital signare obtained. The attending physician notified immediately of the fall if injury apparent. If no injury is apparent the | ns is | | |
| | | | | | physician is notified. Notify the family or resident representative. Initial documentation in the nurse's notes need to be completed and through. The | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| TVAINE OF T | NOVIDEN ON OUT FEEL | | | | SHWAY 801 SOUTH | | |
| BERMUD | BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | | E, NC 27006 | | |
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| F 514 | Continued From page | e 55 | F | reside every vital si assess hours Quality comple design reside the ph notifier fully conshould analysi fallen Assura should care por This in 14th, 2 time, preceiver allower This in the starequire all emplement Quality the chemical complement or design or | n service was completed by June 2017. Any Nurse (RNs, LPNs, fix part time, and PRN) who did not be in-service training will not be ed to work until training is comple information has been integrated in andard orientation training and in ed in-service refresher courses fix ployees and will be reviewed by a Assurance Process to verify the lange has been sustained. | be d, n een ort se ave ts euill eted. nto or the at | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 514 | | o(i)(ii)(h)(i) QAA BERS/MEET S | F 52 | completing a daily falls review (includir weekends) during daily clinical Quality life meeting to ensure a complete investigation of the fall, root cause, and interventions are initiated. The review ensure that the physician was notified the fall promptly, physician orders were initiated, resident representative was notified and plan of care was updated. falls review meeting will be held during weekly Quality of Life meeting to review weekly falls to ensure that interventions are sustained. This will be done on we 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 appropriat Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing programe reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manages, Wound Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017 | of d will of e A the w s ekly e te. nt to r be am | 6/16/17 |
| | (1) A facility must ma and assurance comm | nintain a quality assessment nittee consisting at a | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | E CONSTRUCTION | COMPLETED | | |
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| F 520 | (iii) At least three of staff, at least one of administrator, owner individual in a leader (g)(2) The quality at committee must: (i) Meet at least quality at coordinate and evaluate identifying issues which assessment and assessment and assessment and assessment and impaction to correct idea. (ii) Develop and impaction to correct idea. (h) Disclosure of introduced in the secretary may not records of such correct idea. | ursing services; ector or his/her designee; ther members of the facility's f who must be the er, a board member or other | F 520 | | | |
| | committee to identi deficiencies will not sanctions. This REQUIREMEI by: The facility's Quali Committee failed to | faith attempts by the fy and correct quality be used as a basis for NT is not met as evidenced by Assessment and Assurance maintain implemented onitor these interventions the | | The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the | d do | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF F | NOVIDER OR SUFFLIER | | | | | | |
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| F 520 | 2016. This was for 4 originally cited in May recertification survey follow-up survey. The areas of provide serv maintain kitchen sani infection control. The facility during two fed a pattern of the facilitieffective Quality Asse Committee. The findings included This tag is cross reference and staff interviews the treatment orders on a pressure ulcer and or obtained, the facility for resident was admitted pressure ulcer and we treatment for 1 of 1 st. #266). The facility was cited failing to implement he pressure ulcer for a resource ulcer for a re | ace in May 2016 and June recited deficiencies / 2016 on an annual and in June 2016 on a e deficiencies were in the ices to treat pressure ulcers, tation, drug storage and e continued failure of the eral surveys of record show y's inability to sustain an essment and Assurance :: Tred to: Observation, record reviews, the facility failed to initiate admission for a stage 3 ance treatment orders were failed to follow them. The did to the facility with a stage 3 ent 3 days before receiving ampled resident (Resident for F-314 in June 2016 for the facility to prevent a desident with a contracture. | F | 520 | 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 F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Corrective Action: Cross reference Tag F520 to Tag F314 Resident #266 Resident #266. Physician was notified on 5/24/2017. No physician orders placed and initiated as ordered. Resident and Resident's representative notified on 5/24/2017. Care plan was updated on 5/24/2017. Care plan was updated on 5/24/2017. Cross Reference Tag F520 to Tag F371 No residents identified No specific resident is identified. Cross Reference Tag F520 to Tag F431 No residents identified 100 and 400 hall Medication carts when locked and secured while the nurse wa not in attendance. Medications were immediately secured properly. Cross Reference Tag F520 to Tag F441 Resident #255 and Resident #266 Resident #255 Medication was administered as ordered maintaining standard precautions during medication administration. Resident #266 Hand washing was | d. lew s | |
| | _ | failed to keep two of two crowaves clean for use. | | | performed after Incontinence care was provided, maintaining standard | | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 520 | | l for F-371 in May 2016 for | F 5: | precautions Facility immediately in service staff (RN, LPN, CNAs and Me Full time, Part Time and PRN | ed Techs: | ng | | |
| | failing to store perishable food at safe temperatures, failing to keep ingredient bins clean and failing to store food items past the use by date. | | | infection control, preventing s infection during medication ac To ALWAYS maintain standar precautions during medication administration and to always | spread of dministration of d | on. | | |
| | and record review th | bservations, staff interviews e facility failed to lock 2 of 4 0 and 400 Halls) when left | | hands when resident contact after performing incontinence Identification of other residen be involved with this practice. All residents have the potentiaffected by the alleged practic | e care. ts who may : al to be | ′ | | |
| | The facility was cited for F-431 in May 2016 for failing to label open insulin and failing to lock a medication cart when left unattended. | | | Cross reference Tag F520 to Resident #266 All residents have the potenti affected by the alleged practi 2 to June 16 2017 a skin asso | Tag F314 al to be ce. On Jun | | | |
| | leaving medications | ed for F-431 in June 2016 for unattended at the nurses' secure a medication cart | | completed on all residents to all pressure and non-pressure were identified, physician was and physician orders were for initiated. All care plans were pressure and non-pressure w | e wounds s notified, llowed and updated. A | п | | |
| | and staff interviews thands after performi | bservations, record reviews, the facility staff failed to wash ng finger stick glucose test incontinent care for 2 of 3 #266). | | initiated as ordered. Skin ass were completed by ADON an nurses. The wound review me held on 6/15/17 by the Nurse Management Team (Director MDS, NHA, Unit Manager an Nurse). All physician orders w | essments ad staff eeting was of Nursing d Support | | | |
| | | I for F-441 in May 2016 for infection control program pread of scabies. | | and initiated as ordered. Cross Reference Tag F520 to No residents identified All residents residing in the fa potential to be affected. The fa | o Tag F371 | | | |
| | On 05/25/17 at 3:42 | PM the Administrator was | | ensure that dietary staff main | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STA 316 NC HIGHWAY 801 SOUT ADVANCE, NC 27006 | • | 03/23/2017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | ((EACH CORREC' CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | | |
| F 520 | (QA)Program. The A QA Committee met m areas identified for co areas that needed im Administrator stated thannual recertification had been incorporate agenda but had since | e facility's Quality Assurance dministrator explained the nonthly to review ongoing oncern and identify new | F | nourishment room in preparation and sen and properly stored. Cross Reference Ta No residents identifi All residents have the affected by the alleg were done by DON medication and treat locked and secured not in attendance. A stored and secured treatment carts are lighter when not in immediate Medication and treatment carts are lighter when not in immediate Medication and treatment carts are lighter when not in immediate Medication and treatment carts are lighter when not in immediate Medication and treatment carts are lighter when not in immediate Medication and treatment carts are lighter when not in immediate Medication and treatment carts are lighter when not in immediate was, no expired, undopen insulin by the resident #255 and lighter All residents have the affected by the alleg of Nursing observed Administration Pass LPN and Med Techstand medications administration. Director of Served hand was Nursing Assistant Pocare. All certified nuther observed washed have incontinence care. Systemic Changes: Director of Nursing a serviced all nursing Medication Aides, Company of the property | vice equipment clear ing F520 to Tag F437 ied ine potential to be ged practice. Audits on 6/14/17 and all attment carts were when the nurse way all medications were All medications were All medication and locked at all times atte use by Nurse. A attment carts and als attion was securely d to ensure that the dated or not initialed nurse. Ing F520 to Tag F447 Resident #266 The potential to be ged practice. Directed Medication The potential to be ged practice. Directed Medication The potential to be ged practice on Nurses (RN, Tag). All residents the potential to be ged practice on Nurses and free certified the potential to be ged practice on Nurses and stered as ordered and precautions and/ ring medication fector of Nursing thing after Certified the performed incontiner and safter performing and for Designee in staff (RNs, LPNs, | an 1 as as as as as as as as as | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| F 520 | Continued From page | e 61 | F | time, and PRN) that: Cross reference Tag F520 to Tag F314 Resident #266 Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full tim part time, and PRN) on the fact that wh it comes to Skin integrity, specifically Pressure ulcers. Based on the comprehensive assessment of a resided, the facility must ensure that a resident receives care, consistent with profession standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with professional standards of practice, to promote healing prevent infection and prevent new ulcer from developing. All Nurses (RNs, LPN full time, part time, and PRN) were also educated on the fact that it is the nurse responsibility to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director with 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse i to contact the DON immediately for furt | ne, en ent t t conal cure and ang, ers als, ers als e hin | |

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| F 520 | Continued From page | e 62 | F 5 | instructions. Cross Reference Tag F520 to Ta No residents identified The Registered Dietitian & Dieta Services Director in serviced all staff on insert dates regarding p cleaning of microwaves and ser equipment to ensure that all equipment to ensure that all equipment to ensure that all equipment and stored. An initial audit tool winto place insert date. A follow-uservice on Preparing, Storing ar Food Under Sanitary Conditions conducted for all Dietary staff or date by the Registered Dietitian dietary employee who did not rein-service training will not be allowork until training is completed. information has been integrated standard orientation training and required in-service refresher could all Dietary employees. A compressional tool was put into place to recompliance insert date. Cross Reference Tag F520 to Ta No residents identified Director of Nursing and /or Desiserviced all nursing staff (RNs, Itime, part time, and PRN) that the must store all drugs and biologic locked compartments under protemperature controls, and perminauthorized personnel to have act the keys. The facility must also slock, and have permanently affice compartments for storage of cordrugs. Drugs and biologicals us facility must be labeled in accord currently accepted professional | ary Dietary roper vice uipment is y air dried was put up in nd Serving s was n insert . Any eceive owed to This I into the d in the urses for ehensive monitor ag F431 ignee in LPNs, full he facility cals in oper it only exes to separately xed ntrolled sed in the dance with | | |

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| F 520 | Continued From page | e 63 | F | and include the appropriate accessor and cautionary instructions, and the expiration date when applicable. This service was completed by 6/14/2017 Cross Reference Tag F520 to Tag F4 Resident #255 and Resident #266 Director of Nursing and /or Designee serviced all Nursing staff (RN, LPN, (and Med Techs: full time, part time, a PRN) about infection control, prevent spread of infection during medication administration and during and after performing incontinence care. The facility must establish and mainta an infection Control Program designe provide a safe, sanitary and comforta environment and to help prevent the development and transmission of dis and infection.(a) Infection Control Program The facility must establish a Infection Control Program under whic (1) Investigates, controls, and prever infections in the facility;(2) Decides we procedures, such as isolation, should applied to an individual resident; and Maintains a record of incidents and corrective actions related to infection Preventing Spread of Infection(1) Whithe Infection Control Program determ that a resident needs isolation to preventing Spread of infection (1) Whithe Infection Control Program determ that a resident needs isolation to preventing the spread of infection, the facility must be spread of infection, the facility must be spread of infection to preventing the resident.(2) The facility must be spread of infected skin lesions from direct contact with residents or their fif direct contact with residents or their fif direct contact will transmit the disease (3) The facility must require staff to we their hands after each direct resident contact for which hand washing is | in 41 in CNAs nd ing ain d to ble ease n h it - ts hat be (3) en ines rent st st st able cod, se. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 520 | Continued From page | e 64 | F 5 | indicated by accepted profession practice.(c) Linens Personnel muthandle, store, process and transplinens so as to prevent the spread infection. Medications are administered at they are prepared. Medications a pre-poured. The person who predose for administration is the peradministers the dose. Hand hygic should be performed before and administration of topical, ophthalic parenteral, enteral, rectal, and varied medications. All staff were educated on contact isolation and the use of PPE. Always observe Standard Precautand/or contact isolation during armedication administration. Wash resident contact is made. Wash I before and after resident contact hands when soiled. Standard Preshould be used with all procedure involving blood or other potential infectious body fluids. Ointments and drops should be separate containers labeled with resident's name. Liquid and PO medications should be stored sein the medication carts. No medicused for treatments such as created should be kept in the medication unthe treatment cart. Any medication unthe treatment of a resident who is isolation precautions should be separately from other resident's supplies and should be locked to unauthorized access. Medication | ust port ad of the time are not pares the rson who ene after mic, otic, aginal ct ution ny hands if hands t. Wash ecautions es lly kept in the parately cations ams cart. ie ised for s on stored treatment o prevent | | |

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| | | | | 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 CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 520 | Continued From pag | e 65 | F 5 | shall be cleaned when visibly and utensils shall be handled manner. Unused medication kept covered or inverted. Sha containers on medication car affixed or secured to prevent When administering oral medication directly into a medication cup. Clean any spendication immedication immedication immedication immedication wear gloves. Wash hands aft administration. Ensure that emedication dispensers/contatouch the resident's eyes. If esecretions are present, clean with saline. Always wipe from canthus outward. Always use tissue wipes or cotton balls for to prevent cross contamination when administering injection wear gloves. Wash hands aft administration. Use sterile terministerion. Cleanse the site with antiseptic prior to administratinjection. Dispose of the shar appropriate container immed following administration. Moninjection site for sign and syninfection. When administering medications yringe, the syringe should be | I in a sanitary cups shall be arps ts shall be spillage. dications, it hare tions are h the dication cup n a bottle, to the lid and to the billed liquid by the lid and to the context of the lid and the inner when the separate by the lid and the inner when the lid and the liquid by th | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | _ | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------|---|--|---|--------|
| | | 345543 | B. WING | | | C | 5/2017 |
| | ROVIDER OR SUPPLIER | AND REHABILITATION CENTER | | STREET ADDRESS, CITY, 316 NC HIGHWAY 801 SC ADVANCE, NC 27006 | оитн | 1 03/2 | 5/2017 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY) | | | (X5) COMPLETION DATE | | | |
| F 520 | Continued From page | e 66 | F | changed at least shall be rinsed the dried thoroughly applaced in cover be bag, which is attaready for next us. Wash hands before contact. Wash hands after performs assessment and consisting of their services; a physic facility; and at least the facility's staff, and assurance of quarterly to identify which quality assurance and implements a action to correct if deficiencies. A Stanot require disclosuch committee of disclosure is related to the section. Good committee to identify the section. Good committee to identify the section. This in service will respect to the section of the section of the section of the section. This in service will respect to identify the section of the section | ore and after resident ands when soiled. Was arming incontinence caraintain a quality assurance committee m director of nursing cian designated by the ast 3 other members of a the quality assessment meets at leasify issues with respect dessment and assurance essary; and develops appropriate plans of | ind tic sh tre. f f ent st to ce nay of of e y for e III | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|---|-------------------------------|--|
| | | 345543 | B. WING | | | C | |
| NAME OF D | ROVIDER OR SUPPLIER | 040040 | 1 2: | STREET ADDRESS, CITY, STATE, ZIP CODE | | 05/25/2017 | |
| NAIVIE OF F | ROVIDER OR SUFFLIER | | | 316 NC HIGHWAY 801 SOUTH | | | |
| BERMUD | BERMUDA COMMONS NURSING AND REHABILITATION CENTER | | | ADVANCE, NC 27006 | | | |
| | I | | | | | | |
| (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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 520 | Continued From page | ge 67 | F 5 | the standard orientation training required in-service refresher could employees and will be review Quality Assurance Process to verthe change has been sustained. Monitoring: To ensure compliance, Administ Director of Nursing will monitor to using the QA survey tool. Facility monitor compliance of QA for F3 F431 and F441. This will be don weekly basis for 4 weeks then m3 months by the Support Nurse, Manager, or designee. Reports presented to the weekly QA Conthe Administrator or designee to corrective action initiated as app Any immediate concerns will be the Director of Nursing or Admin for appropriate action. Complian monitored and ongoing auditing reviewed at the Weekly Quality of Meeting. Weekly QA Committee is attended by Administrator, Dir Nursing, MDS Coordinator, Unit Support Nurse, Therapy, HIM, D Manager, Wound Nurse. Date of Compliance: June 16th 2 | rator or his issue y will 314, F371, e on nonthly for Unit will be nmittee by assure brought to istrator ce will be program of Life meeting ector of Manager, bietary | | |