	-	ID HUMAN SERVICES			FOF	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
		345543	B. WING		01	C 3/02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/02/2010
BERMUDA		AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
BEINIOD				ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	D		
5 550	compliant investigation	e cited as a result of the on Event ID #MCDC11.	E EE			0/00/40
F 550 SS=D		•	F 55			8/22/18
	self-determination, ar	ght to a dignified existence, nd communication with and				
	-	d services inside and cluding those specified in				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's				
	promote the rights of					
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source				
	§483.10(b) Exercise of The resident has the	of Rights. right to exercise his or her f the facility and as a citizen				
	resident can exercise	cility must ensure that the his or her rights without h, discrimination, or reprisal				
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE
Electroni	cally Signed					08/17/2018

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/28/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345543	B. WING		08/02/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH	
BERMOB				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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
F 550	Continued From page	e 1	F 55	o	
	\$492 10/b)/2) The re-	aidant has the right to he			
		sident has the right to be coercion, discrimination, and			
		ity in exercising his or her			
		orted by the facility in the			
	exercise of his or her	rights as required under this			
	subpart.				
		Γ is not met as evidenced			
	by: Decod on obconvotio	n record review, recident		The statements made on this	Dian of
		on, record review, resident, he facility failed to provide		Correction are not an admission	
		naintain the resident's dignity		not constitute an agreement w	
		nt in a brief at night instead		alleged deficiencies. To remain	
		ent to use the bed pan for 1		compliance with all Federal an	
	-	ed for bowel and bladder		Regulations the facility has tak	
	continence (Resident	t #42).		take the actions set forth in this	
	The finalization is also deal	1.		Correction. The Plan of Correct	
	The findings included	1:		constitutes the facility's allegat compliance such that all allege	
	Resident #42 was ad	mitted to the facility on		deficiencies cited have been o	
	02/20/18 with diagnos	-		corrected by the date or dates	
	-	mechanical complications			
	of internal hip prosthe	esis, heart failure, anxiety,		F550 RESIDENT RIGHTS/	EXERCISE
	and osteoporosis.			OF RIGHTS	
				The plan of correcting the spec	
	-	rly minimum data set (MDS)		deficiency. The plan should ad	
		aled that Resident #42 was		processes that lead to the defined t	ciency
	u	e MDS further revealed that ve assistance of one staff		The facility failed to provide ca	reina
	member with toileting			manner to maintain the resider	
	incontinent of bladde			by placing the resident in a brid	0,1
				instead of allowing the residen	-
		sident #42 was conducted on		bed pan for 1 of 3 residents sa	
		1. Resident #42 stated that		bowel and bladder continence.	
		as able to go to and from the		The employee involved was no	
	-	and was fully aware of when		knowledgeable and no longer	works for
		e bathroom. She indicated r any accident that she may		the facility. Resident #42. Resident was a	llowed to
			1	\rightarrow NESIGETI π π λ . NESIGETI Was a	

Facility ID: 20070039

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE S	0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLE	
					с	
		345543	B. WING		08/02	2/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	PCODE	
				316 NC HIGHWAY 801 SOUTH		
DERIVIUD	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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 550	Continued From page	e 2	F 55	0		
		e staff would put a brief on		and oriented x3 and was	able to verify and	
		ke that and it made her feel		confirm that her needs w	2	
		ed that she used to ring the		allowed to use the bed pa	an at night.	
		an and the staff would come				
		ed pan. Resident #42 stated		The procedure for impler	-	
		ff told her she was going to mind if she wanted the brief		acceptable plan of correct specific deficiency cited;	ction for the	
	-	he could not have both and		On 8/2/2018, the Director	r of Nursing and	
		in they have placed a brief		Unit Manager began in-s	•	
		he stated that the staff		nursing staff (Registered		
	-	e 2 or 3 times in the diaper"		Practical Nurses and Nur		
	and then ring the call	bell and they would change		time, Part time and PRN) that a resident	
		ed that she had not seen that		has a right to a dignified		
		g time and could not recall		self-determination, and c		
	her name.			with and access to perso		
	An observation of Re	sident #42 was made on		inside and outside the fac must treat each resident		
		Resident #42 was sitting in		manner and in an enviror	-	
		bed elevated and was doing		promotes maintenance o		
		roceeded to raise her gown		of his or her quality of life		
	and stated, "I am still	in this diaper from the		each resident's individua	lity. The facility	
		added that the staff generally		must protect and promote		
		30 Am and at that time they		resident. The facility mus		
	would remove the "di	aper."		access to quality care reg		
	An interview was con	ducted with Nursing		diagnosis, severity of cor payment source. The res		
		08/02/18 at 9:58 AM. NA #3		right to exercise his or he		
		ely cared for Resident #42		resident of the facility and	-	
		ed that during the day		resident of the United Sta		
		ntinent of her bladder and		must ensure that the resi	ident can	
		self to and from the bathroom		exercise his or her rights		
		3 added that Resident #42		interference, coercion, di		
		y accident that she may have		reprisal from the facility.		
		at happen. She stated that		the right to be free of inte		
		her shift in the morning that have a brief on and she		coercion, discrimination, the facility in exercising h	-	
		ef and place a pull up on		and to be supported by the		
	her.			exercise of his or her right	-	
	no.					

Facility ID: 20070039

If continuation sheet Page 3 of 16

				OMB NO. 0938-03
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
	345543	B. WING		C 08/02/2018
				00/02/2010
A COMMONS NURSING	AND REHABILITATION CENTER			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
Continued From page	- 3	E 55(
An interview was com 08/02/18 at 11:32 AW worked 3rd shift at th for Resident #42. NA Resident #42 first can use her call bell and bed pan but now she sure why. NA #4 stat Resident #42 to use to to place her on the be when she arrived for already be in the bed that Resident #42 was bladder and if she was would assist her with An interview was com Nursing (DON) on 08 stated that she had 2 residents that they co had to use a brief at those employees still stated that she expect dignified environmento to use the bed pan th	ducted with NA #4 on 1. NA #4 stated that she e facility and routinely cared #4 stated that when me to the facility she would we would place her on the used the brief but was not ed she had never instructed the brief and never refused ed pan. She added that her shift Resident #42 would with a brief on. NA #4 stated anted the bed pan then she using the bed pan. ducted with the Director of 6/02/18 at 3:14 PM. The DON NA that would tell the build not use the bed pan and night and neither one of worked at the facility. She cted that the staff promote a t and if Resident #42 wanted ten they need to assist her		 whenever requested and one can place the resident in a brief at night as of 8/22/2018 no nursing staff (Registered nurses and Nurse Aid time, Part time and PRN) will be at to work until the training has been completed. Effective 8/22/2018, the training is incorporated into the new ployee orientation program. The information has been integrated in standard orientation training and i required in-service refresher course all employees and will be reviewe Quality Assurance Process to verify the change has been sustained. The monitoring procedure to ensure the plan of correction is effective a specific deficiency cited remains of and/or in compliance with the regurequirements; The Director of Nu Unit Manager will interview 5 alert oriented residents weekly to ensure care was provided in a manner to maintain the resident's dignity and resident was assisted with a bed pringht and whenever requested an placed in a brief at night. This will by using a quality assurance (QA) tool for 4 weeks then monthly for months. 	ht. les: Full illowed his ww his nto the n the ses for d by the fy that ire that and that corrected ulatory ursing or and re that d hat ban at d not be done o survey 3 veekly
	Continued From page A COMMONS NURSING SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page An interview was con 08/02/18 at 11:32 AM worked 3rd shift at th for Resident #42. NA Resident #42 first cal use her call bell and bed pan but now she sure why. NA #4 stat Resident #42 to use to place her on the be when she arrived for already be in the bed that Resident #42 was bladder and if she was would assist her with An interview was con Nursing (DON) on 08 stated that she had 2 residents that they co had to use a brief at it those employees still stated that she expect dignified environment to use the bed pan th	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION IDENTIFICATION NUMBER: 345543 345543 ROVIDER OR SUPPLIER A COMMONS NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (IDENTIFYING INFORMATION)	IDENTIFICATION NUMBER: A. BUILDING 345543 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 3 ID An interview was conducted with NA #4 on 08/02/18 at 11:32 AM. NA #4 stated that she worked 3rd shift at the facility and routinely cared for Resident #42. NA #4 stated that when Resident #42 first came to the facility she would use her call bell and we would place her on the bed pan but now she used the brief but was not sure why. NA #4 stated she had never instructed Resident #42 to use the brief and never refused to place her on the bed pan. She added that when she arrived for her shift Resident #42 would already be in the bed with a brief on. NA #4 stated that Resident #42 was continent of her bowel and bladder and if she wanted the bed pan then she would assist her with using the bed pan. An interview was conducted with the Director of Nursing (DON) on 08/02/18 at 3:14 PM. The DON stated that she had 2 NA that would tell the residents that they could not use the bed pan and had to use a brief at night and neither one of those employees still worked at the facility. She stated that she expected that the staff promote a dignified environment and if Resident #42 wanted to use the bed pan then they need to assist her	CPDEFICIENCIES (X1) PROVIDERSUPPLIER (X2) MULTIPLE CONSTRUCTION ACOMMONS NURSING AND REHABILITATION CENTER B. WING ACOMMONS NURSING AND REHABILITATION CENTER STREETADDRESS. CITY.STATE. ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX Continued From page 3 F 550 An interview was conducted with NA #4 on 08/02/18 at 11:32 AM. NA #4 stated that she worked 376 shift at the facility and routinely cared F 550 Whenever requested and one can place the resident in a brief at night on oursing staff Resident #42. NA #4 stated that when Resident #42 to use the brief and never instructed Resident #42 to use the brief and never refused As of 8/22/2018, no nursing staff Idready be in the bed pan. She added that When she arrived for her shift Resident #42 would Matterview was conducted with the brief on NA #4 stated It meant place in refersher coursing and information has been integrated in standard orientation training in is flexible reviewe Quality Assurance Process to veri the change has been sustained. The monitoring procedure to ensust the plan of correction set flexible reviewe Quality Assurance Process to veri the change has been sustained. The monitori

Event ID: MCDC11

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/28/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345543	B. WING		08/02/2018
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 550	Continued From page	≥ 4	F 5	50 Manager, Support Nurse, The Information Manager, Dietary and the Administrator The title of the person respon- implementing the acceptable correction; Administrator and /or Director	Manager sible for plan of
F 558 SS=D	CFR(s): 483.10(e)(3) §483.10(e)(3) The rig services in the facility accommodation of re- preferences except w endanger the health of other residents. This REQUIREMENT by: Based on observation resident interviews the resident's call light win residents to request s 2 of 2 residents samp needs (Resident #27	sident needs and then to do so would or safety of the resident or " is not met as evidenced ns, record review, staff, and e facility failed to place a thin reach to allow the staff assistance if needed for oled for accommodations of and #12).	F 5	The statements made on this Correction are not an admissi not constitute an agreement v alleged deficiencies. To remai compliance with all Federal ar Regulations the facility has ta take the actions set forth in th	on to and do vith the in in nd State ken or will is Plan of
	04/30/16 with diagnost palsy, hemiplegia, chi others. Review of the compre- (MDS) dated 06/16/18	s readmitted to the facility on ses that included: cerebral ronic kidney disease, and chensive minimum data set 8 revealed that Resident #27 and required extensive		Correction. The Plan of Corre constitutes the facility's allega compliance such that all alleg deficiencies cited have been of corrected by the date or dates F558 REASONABLE ACCOMMODATIONS NEEDS/PREFERENCES The plan of correcting the spe deficiency. The plan should an processes that lead to the def	ation of ed or will be s indicated. ecific ddress the

Facility ID: 20070039

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/28/20 RM APPROVI O. 0938-03
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345543	B. WING		08	C 3/02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A 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	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 558	Continued From page	e 5	F 55	0		
1 000			F 550			
		esident #27 was made on I. Resident #1 was resting in		cited; The facility failed to place a r	esident's call	
		en. Resident #27's call bell		light within reach to allow the		
		drawer of her night stand		request staff assistance if ne		
		closed. The night stand was		2 residents sampled for acco		
		id the head of the bed and		of needs (Resident #27 and		
	was out of the reach	of Resident #27. Resident		Call bell was not placed at re	each because	
	#27 confirmed that sl	he could not reach her call		staff were not aware that res	idents could	
		needed assistance she		not reach it.		
	-	ait for the staff to come to her		Resident #27: Call bell was i	mmediately	
	room.			placed within reach.	P. ()	
	An abarmation of Da			Resident #12. Call bell was i	-	
		esident #27 was made on . Resident #27 was up in a		placed within reach. Call ligh bifurcated and resident is ab		
		r in her room. Resident #27's		when in bed or when in his re		
		the top drawer of her night				
		r was closed. The night stand		The procedure for implement	tina the	
	was located directly b	-		acceptable plan of correction		
	-	out of the reach of Resident		specific deficiency cited;		
	#27. Resident #27 co	onfirmed that she could not		On 8/2/2018, the Director of	Nursing and	
	reach her call bell.			Unit Manager began in-servi	-	
				nursing staff (Registered nur		
		esident #27 was made on		Licensed Practical Nurses ar		
		. Resident #27 was in bed bed elevated and she was		Aides: Full time, Part time an	'	
		Resident #27's call bell was		a resident has the right to res receive services in the facility		
	-	ver of her night stand and the		reasonable accommodation	•	
		The night stand was located		needs and preferences exce		
		ad of the bed and was out of		so would endanger the healt		
	the reach of Residen			the resident or other resident	•	
	confirmed that she co	ould not reach her call bell.		Resident's call light should b	•	
				within reach at all times to al		
		esident #27 was made on		residents to request staff ass	sistance when	
		Resident #27 was resting in		needed.		
		en. Resident #27's call bell drawer of her night stand		As of 8/22/2018 no pursing a	taff	
		closed. The night stand was		As of 8/22/2018 no nursing s (Registered nurses, Licensed		
		id the head of the bed and		Nurses and Nurse Aides: Fu		
		of Resident #27. Resident		time and PRN) will be allowe		

Facility ID: 20070039

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ATEMENT (OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMF	PLETED
		345543	B. WING			C
	ROVIDER OR SUPPLIER	010010		STREET ADDRESS, CITY, STATE, ZIP CODE	08/	02/2018
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSIN	G AND REHABILITATION CENTER		ADVANCE, NC 27006		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETIO DATE
TAG	REGULATORY C	R LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	PRIATE	
F 650		•				
F 558		-	F 55			
		she could not reach her call		until the training has been complete	ed.	
	bell.			Effective 8/22/2018, this training is		
	An observation and	d interview was conducted with		incorporated into the new employee orientation program. This information		
		B/02/18 at 9:52 AM with		been integrated into the standard	0111105	
		IA) #1. MA #1 confirmed that		orientation training and in the requir	ed	
	· · ·	able to use her call bell and		in-service refresher courses for all		
	that it should alway	s be within reach. Resident		employees and will be reviewed by	the	
		laying in the top drawer of her		Quality Assurance Process to verify	that	
	-	e drawer was closed. The night		the change has been sustained.		
		slightly behind the head of the		· · · · · · · · · · · · · · · · ·		
		f the reach of Resident #27.		The monitoring procedure to ensure		
		d to MA #1, "I can't reach it apologized to Resident #27		the plan of correction is effective an specific deficiency cited remains co		
		ng out of her reach and		and/or in compliance with the regula		
		d the call bell to her blanket		requirements; The Director of Nurs		
	where she could re			Unit Manager will observe and inter		
				residents weekly to ensure that resi		
	An interview was c	onducted with Nurse #2 on		call light has been placed within rea	ich to	
		AM. Nurse #2 stated that		allow the residents to request staff		
		able to use her call bell and it		assistance when needed. This will b		
		vithin reach. Nurse #2		done by using a quality assurance (
		dent #27 ' s roommate kept a r and would often ring the call		survey tool for 4 weeks then monthl months.	y for 3	
	bell on her behalf.	and would often hing the call		Reports will be presented to the we	eklv	
				QA committee by the Director of Nu	-	
	An interview was c	onducted with the Director of		to ensure corrective action for trend	•	
		08/02/18 at 3:36 PM. The DON		ongoing concerns is initiated as		
	stated that her exp	ectation was that call bells		appropriate. The weekly QA Meetir		
	were within reach a			attended by the Director of Nursing,		
		as readmitted to the facility on		Wound Nurse, MDS Coordinator, U		
	-	noses which included		Manager, Support Nurse, Therapy,		
	disorder, anxiety di	e, dementia, major depressive sorder and others.		Information Manager, Dietary Mana and the Administrator	ger	
	Review of the app	al comprehensive minimum		The title of the person responsible f	or	
		ed 05/25/18 revealed Resident		implementing the acceptable plan o		
		ly cognitively impaired but alert		correction;	•	
		son, place and time. Resident		Administrator and /or Director of Nu	reina	

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PRINTED: 08/28/2018 FORM APPROVED

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/28/2018 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345543	B. WING					C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BERMUD	A COMMONS NURSING A	AND REHABILITATION CENTER			16 NC HIGHWAY 801 SOUTH NDVANCE, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
F 558	activities of daily living wheelchair as his mean An observation of Res 11:03 AM revealed he in his room and was r light was observed to rail at the head of his away from where he Resident #12 confirm wheelchair and roll ov use his call light if he stated he would like to bifurcated so he had a bed and one when he An observation of Res 1:55 PM revealed he in his room with the d call light was wrapped head of his bed appro- not within his reach. An observation of Res 1:29 PM revealed he in his room with his ca side rail at the head of not within his reach. An observation of Res 10:01 AM revealed he his call light wrapped head of his bed. The within his reach. An observation and in	o total assistance with most g (ADL) and used a ans of ambulation. sident #12 on 07/30/18 at e was resting in his recliner eading. Resident #12's call be wrapped around the side bed approximately ten feet was sitting in his recliner. ed he had to get in his ver to the head of the bed to needed assistance. He o have a call light that was a call light when he was in	F	558				
	Resident #12 on 08/0							

Facility ID: 20070039

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 08/02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				316 NC HIGHWAY 801 SOUTH	
BERMUDA COMMONS NURSING AND REHABILITATION CENTER		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 558	Continued From page	e 8	F 55	8	
		and Nurse #1 both confirmed	1 00	č	
		is able to use his call light			
		be within reach. Resident			
		gain wrapped around the			
		of his bed approximately ten			
	feet from the resident	. Resident #12 stated to NA			
	#1 and Nurse #1 that	he would like to have a call			
		on the recliner at all times.			
		would have the maintenance			
		cated call light so he could and one at his recliner within			
		Nurse #1 stated his call			
		his reach at all times.			
		ducted with the Director of			
		/02/18 at 3:36 PM. The			
	within reach at all tim	ctation was call lights were			
F 641	Accuracy of Assessm		F 64	1	8/22/18
SS=D	CFR(s): 483.20(g)		1 04		0/22/10
33-D	01 H(0). 100.20(g)				
	§483.20(g) Accuracy	of Assessments.			
	The assessment mus	st accurately reflect the			
	resident's status.				
		is not met as evidenced			
	by:	iou and staff interview the		The statements made as this Direct	
		iew and staff interview the ately code a resident ' s		The statements made on this Plan of Correction are not an admission to and	Ido
		juarterly minimum data set		not constitute an agreement with the	
		ampled for nutritional status		alleged deficiencies. To remain in	
	(Resident #42).			compliance with all Federal and State	
	. ,			Regulations the facility has taken or wi	11
	The finding included:			take the actions set forth in this Plan of	
				Correction. The Plan of Correction	
		mitted to the facility on		constitutes the facility's allegation of	
	02/20/18 with diagno			compliance such that all alleged	
		mechanical complications esis, heart failure, anxiety,		deficiencies cited have been or will be corrected by the date or dates indicate	a

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/28/2018 MAPPROVED D: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345543	B. WING _				C 102/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				31	16 NC HIGHWAY 801 SOUTH		
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		Α	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 641	Continued From page	9	F 6	641			
	and osteoporosis.						
					F641 ACCURACY OF ASSESSME	INTS	
		ly minimum data set (MDS)			The plan of correcting the specific		
	dated 07/04/18 revea cognitively intact and	led that Resident #42 was			deficiency. The plan should address the processes that lead to the deficiency	ıe	
		ff member with eating.			cited;		
		in member with cating.			The facility failed to accurately code a		
	An observation of Re	sident #42 was made on			resident's eating ability on the quarter	y	
		I. Resident #42 was sitting in			minimum data set for 1 of 3 residents	-	
		Iside and was feeding			sampled for nutritional status (Resider	nt	
		as observed to eat 100% of			#42)	10	
	the lunch meal with h	o assistance from staff.			Employee who coded Section G0110H (Eating Support) was not knowledgeal		
	An observation of Re	sident #42 was made on			on coding support provided for late los		
		Resident #42 was sitting up			ADL Eating. Employee was educated		
		ng herself breakfast that			8/2/2018 on accurately coding late los		
		, and a biscuit. The tray also			ADL Eating in point of care (POC).		
		ce, and coffee. Resident #42			Resident #42. Resident Minimum Data		
	was observed to eat assistance from staff.	100% of the meal with no			Set (MDS) assessment (Quarterly) with	h	
	assistance from starr.				Assessment Reference Date (ARD) 7/4/2018) was modified with a Correct	ivo	
	An observation of Re	sident #42 was made on			Attestation Date of 8/2/2018. The		
		Resident #42 was sitting up			assessment was submitted to the stat	е	
	in bed and was feeding	ng herself breakfast that			QIES system on 8/3/2018 and was		
		ge, and toast. Resident #42			accepted on 8/3/2018. Submission ID	:	
		ad jelly over her toast			15203265		
		ast. She was observed to eat			The procedure for implementing the		
	100% of the meal with	h no assistance from staff.			The procedure for implementing the acceptable plan of correction for the		
	An interview was con	ducted with the MDS			specific deficiency cited;		
		/18 at 11:56 AM. She			On 8/2/2018 the Quality Assurance N	urse	
		ad completed the quarterly			Consultant and Minimum Date Set (M		
		She indicated that she ran			Coordinator reviewed the most recent		
		pint of care documentation			Minimum Data Set (MDS) for current		
	÷	stants (NAs) enter and that			residents in the last 6 months to ensur	re	
		hat to code for activities of			that Section G0110H2 was coded		
		eating on the MDS. The MDS ne was not very familiar with			accurately.		
		en she ran the report and			On 8/2/2018, Quality Assurance and		

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If continuation sheet Page 10 of 16

TATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING	i	C
		345543	B. WING		08/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 641	with eating on 3 sepa 07/03/18, and 07/04/ period that was what she had no reason to that NA #5 had enter An interview was cor 08/02/18 at 1:45 PM. 06/28/18, 07/03/18, a only required set up a He confirmed that sh assistance with eatin the facility and was le he provided but state incorrectly at the time An interview was cor Consultant on 08/02/ consultant stated tha correct the MDS to re and not the extensive inaccurately. An interview was cor Nursing (DON) on 08 stated that she expect	coded extensive assistance arate occasions (06/28/18, 18) during the lookback she coded. She indicated o question the information ed. nducted with NA #5 on . NA #5 stated that on and 07/04/18 Resident #42 assistance with her meals. e did not require extensive g and that he was still new at earning how to code the care ed he coded her eating	F 64	1 Minimum Data Set Consultant in set the Minimum Data Set Coordinator the Minimum Data Set assessment accurately reflect the resident's stat On 8/2/2018 the Minimum Data Set Coordinator and or Director of nursi or Unit Manager in serviced Nurse and Nurses (full time, part time or F on accurately documenting late loss Eating (How resident eats and drink regardless of skill. Do not include eating/drinking during medication po- Includes intake of nourishment by or means for example tube feeding, to parenteral nutrition, IV fluids, admin for nutrition or hydration). When coor Section G0110H2 (support provided the most support provided by staff. ADL support Setup help with late lo Eating this includes cutting meat an opening containers at meals; giving food item at a time. For ADL suppor Supervision with late loss ADL Eatin includes for residents seated togeth in close proximity of one another du meal who receive individual supervi with eating. General supervision of dining room is not the same as indir supervision of a resident and is not captured in the coding for Eating. F	that much us. ing and Aides PRN) s ADL s, ass. ther tal istered ding d) code For ss ADL d one t ng this her or uring a ision a vidual

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/28/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 08/02/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
BERMUD	A COMMONS NURSING A	AND REHABILITATION CENTER		16 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 641	Continued From page	2 11	F 641	As of 8/22/2018 no nursing staff (Registered nurses Licensed Practica and Nurse Aides: Full time, Part time PRN) will be allowed to work until the training has been completed. Effective 8/22/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientatio training and in the required in-service refresher courses for all employees at will be reviewed by the Quality Assura Process to verify that the change has been sustained. The monitoring procedure to ensure the the plan of correction is effective and specific deficiency cited remains correct and/or in compliance with the regulato requirements; The Director of Nursin and/or Minimum Data Set (MDS) Coordinators will review 5 resident electronic medical records Minimum D Set (MDS) assessment this could be either one of the following assessment that is Comprehensive/ Quarterly / PF Mini Data Set (Assessments) per wee ensure that Section G0110H2 (Suppo provided for Late loss ADL Eating) we coded appropriately. This will be done weekly basis to include the weekend for weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 3 months. Reports will be presented to the weekend weeks then monthly for 4 months. Reports will be presented to the weekend weeks then monthly for 5 months. Reports will be presented to the weekend weeks then monthly for 5 months. Reports will be presented to the weekend weeks then monthly for 5 months. Reports will be	and e d n n hd ince hat that ected bry ig Data ts PS ik to brt as e on for 4 ly ing or is

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY			
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDI	. BUILDING			COMPLETED	
		B. WING			C 08/02/2018			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER			16 NC HIGHWAY 801 SOUTH DVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 641	Continued From page	a 12	E E	641				
				0-1	Manager, Support Nurse, Therapy, He Information Manager, Dietary Manage and the Administrator			
					The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nurs			
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2)	or Dependent Residents	F	677		-	8/22/18	
	out activities of daily services to maintain of personal and oral hys	lent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced						
	interviews the facility	ns, record review, and staff failed to trim a dependent r 1 of 5 residents sampled iving (Resident #35).			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	nd do		
	The findings included	:			Regulations the facility has taken or w take the actions set forth in this Plan	vill		
	01/10/17 with diagnos	mitted to the facility on ses that included dementia, order, anxiety, and history 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 indicat	e		
	Review of Resident #	35's medical record						
	revealed that she had on 02/07/18 and agai	d been seen by the podiatrist in on 04/13/18.			F677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS The plan of correcting the specific	२		
	data set (MDS) dated	ecent quarterly minimum I 07/01/18 revealed that			deficiency. The plan should address t processes that lead to the deficiency	he		
		verely cognitively impaired king and no behaviors or			cited; The facility failed to trim a dependent			

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Facility ID: 20070039

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RRECTION IDER OR SUPPLIER DMMONS NURSING A SUMMARY STA (EACH DEFICIENCY REGULATORY OR L DONTINUED FROM page vealed that Residen sistance of one staf aily living.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543 AND REHABILITATION CENTER ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 113 12 13 14 #35 required extensive if member with activities of		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
SUMMONS NURSING A SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Dontinued From page vealed that Residen ssistance of one staf aily living.	AND REHABILITATION CENTER ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 13 at #35 required extensive	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION (X5) HOULD BE COMPLETIO
SUMMONS NURSING A SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Dontinued From page vealed that Residen ssistance of one staf aily living.	AND REHABILITATION CENTER ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 13 at #35 required extensive	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION (X5) HOULD BE COMPLETIO
SUMMONS NURSING A SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Dontinued From page vealed that Residen ssistance of one staf aily living.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 13 13 14 #35 required extensive	PREFIX TAG	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
(EACH DEFICIENCY REGULATORY OR L pontinued From page vealed that Residen ssistance of one staf aily living.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 13 13 14 #35 required extensive	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
vealed that Residen ssistance of one staf ally living. n observation of Res	t #35 required extensive	F 67		
vealed that Residen ssistance of one staf ally living. n observation of Res	t #35 required extensive		7	
			 sampled for activities of daily liv (Resident #35). The resident did not have her to trimmed by the podiatrist in July 	be nails
An observation of Resident #35 was made on 07/30/18 at 3:08 PM. Resident #35 was up in a geri chair in the hallway and had pulled her socks off. Resident #35's toe nails were noted to be approximately a half inch long and jagged on both feet.			because she was accidently left podiatrist list. Resident #35: Outpatient Appoin was scheduled with podiatrist of 8/2/2018. On 8/9/2018 resident the appointment and was asses	ntment n went for
7/31/18 at 8:31 AM. eri chair and her toe	sident #35 was made on Resident #35 was up in a nails were observed to be nch long and jagged on both		podiatrist. The procedure for implementing acceptable plan of correction for specific deficiency cited; On 8/6/2018 all current resident were assessed by Director of No	r the ts toe nails
8/01/18 at 8:57 AM. eri chair in front of th 85's toe nails were o	Resident #35 was up in a e nurse's station. Resident bserved to be		other residents were noted to ha accidentally left off the podiatris July 2018. Podiatrist was sched these residents immediately. On 8/2/2018 the Director of nurs	ave been t list for luled for sing and or
8/01/18 at 3:55 PM. eri chair in the hallwa ails were observed to	Resident #35 was up in a ay with no socks on. Her toe o be approximately a half		and Nurses (full time, part time that a resident who is unable to Activities of daily living receives necessary services to maintain nutrition, grooming, and persona	or PRN) carry out the good al and oral
8/02/18 at 11:06 AM utinely took care of miliar with her needs ad never trimmed Re he was routinely see	. Nurse #2 stated that she Resident #35 and was s. Nurse #2 stated that she esident #35's toe nails and n by the podiatrist. She		should be assessed. Toe nails r trimmed by nursing staff, if unat trimmed, resident needs to be s podiatrist in facility or as an outr of facility. All residents schedule podiatrist have to be seen at fac	need to be ble to be seen by a patient out ed for the cility or out
אר איז איז איז איז איז איז איז איז איז איז	proximately a half in t. observation of Res 01/18 at 8:57 AM. i chair in front of th 5's toe nails were of proximately a half in t. observation of Res 01/18 at 3:55 PM. i chair in the hallwa is were observed to h long and jagged interview was cond 02/18 at 11:06 AM tinely took care of niliar with her need d never trimmed Res was routinely see ted that the last tim ility Resident #35 v	oroximately a half inch long and jagged on both t. observation of Resident #35 was made on 01/18 at 8:57 AM. Resident #35 was up in a i chair in front of the nurse's station. Resident 5's toe nails were observed to be oroximately a half inch long and jagged on both	broximately a half inch long and jagged on both t. observation of Resident #35 was made on 01/18 at 8:57 AM. Resident #35 was up in a i chair in front of the nurse's station. Resident 5's toe nails were observed to be broximately a half inch long and jagged on both t. observation of Resident #35 was made on 01/18 at 3:55 PM. Resident #35 was up in a i chair in the hallway with no socks on. Her toe Is were observed to be approximately a half h long and jagged on both feet. interview was conducted with Nurse #2 on 02/18 at 11:06 AM. Nurse #2 stated that she tinely took care of Resident #35 and was niliar with her needs. Nurse #2 stated that she d never trimmed Resident #35's toe nails and e was routinely seen by the podiatrist. She ted that the last time the podiatrist was at the ility Resident #35 was accidentally left off the	broximately a half inch long and jagged on both t. observation of Resident #35 was made on 01/18 at 8:57 AM. Resident #35 was up in a i chair in front of the nurse's station. Resident 5's toe nails were observed to be oroximately a half inch long and jagged on both t. observation of Resident #35 was made on 01/18 at 3:55 PM. Resident #35 was up in a i chair in the hallway with no socks on. Her toe Is were observed to be approximately a half h long and jagged on both feet. interview was conducted with Nurse #2 on 02/18 at 11:06 AM. Nurse #2 stated that she tinely took care of Resident #35's toe nails and a news routinely seen by the podiatrist. She ted that the last time the podiatrist was at the ility Resident #35 was accidentally left off the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the podiatrist was at the ility Resident #35 was accidentally left off the by the the podiatrist was at the ility Resident #35 was accidentally left off the by the the podiatrist was at the ility Resident #35 was accidentally left off the by the the podiatrist was at the ility Resident #35 was accidentally left off the

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CENTERS FOR MEDICARE & MEDICAID SERVICES			(X2) MULTIPLE CONSTRUCTION				
ND PLAN OF CORRECTION		. ,	A. BUILDING				
						С	
		345543	B. WING		0	8/02/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
BERMUDA COMMONS NURSING AND REHABILITATION CENTER				316 NC HIGHWAY 801 SOUTH			
				ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)		I SHOULD BE	(X5) COMPLETIC DATE	
F 677	Continued From page	e 14	F 67	7			
	could not be seen until the next visit. Nurse #2			(Registered nurses , Licensed	Practical		
		oticed Resident #35's toe		Nurses and Nurse Aides: Full	time, Part		
	-	d not really think anything		time and PRN) will be allowed			
		was aware that she would		until the training has been cor	•		
	be seen by the podia	unst.		Effective 8/22/2018, this traini incorporated into the new em	-		
	An observation of Re	sident #35 was made on		orientation program. This info	•		
		with Nurse #3. Resident		been integrated into the stand			
		chair and her toe nails were		orientation training and in the			
		ximately a half inch long and		in-service refresher courses for			
	jagged on both feet. I			employees and will be review			
		ails were long and she		Quality Assurance Process to	-		
	needed to be seen by	y the podiatrist.		the change has been sustaine	ed.		
	An interview was con	•		The monitoring procedure to e			
		08/02/18 at 11:27 AM. NA utinely cared for and was		the plan of correction is effect specific deficiency cited rema			
		t #35. NA #2 stated that she		and/or in compliance with the			
		toe nails but assumed that		requirements; The Director of	• •		
	she was being seen b			and/or Unit Manager will obse			
				dependent residents weekly to	o ensure that		
		ducted with the Social		toe nails have been trimmed a			
		2/18 at 2:08 PM. The SW		have been seen by a podiatris			
		on the unit where Resident		ordered. This will be done on			
		n by the podiatrist. She rist came to the facility every		basis to include the weekend then monthly for 3 months.			
		aw a certain number of		Reports will be presented to t	he weeklv		
		. The SW indicated that the		QA committee by the Director	•		
		facility in February 2018 and		to ensure corrective action for	trends or		
		at the facility in May of 2018,		ongoing concerns is initiated			
		he added the podiatrist was		appropriate. The weekly QA	-		
		July 2018, but Resident #35		attended by the Director of Nu Wound Nurse, MDS Coordina	-		
		visit, she would be seen on August 2018. The SW		Manager, Support Nurse, The			
		lent #35's toe nails were		Information Manager, Dietary			
		en as an outpatient and		and the Administrator	5		
	-	to let her know that and					
	she would schedule t	he appointment.		The title of the person respon			
				implementing the acceptable	plan of		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/28/2018 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345543	B. WING			C 08/02/2018		
NAME OF PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP CODE				
BERMUDA COMMONS NURSING AND REHABILITATION CENTER					16 NC HIGHWAY 801 SOUTH DVANCE, NC 27006			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)			(X5) COMPLETION DATE	
F 677	Nursing (DON) on 08 stated that each resid days and nail care wa process. The DON st Resident #35's toe na were unable to be trir	e 15 ducted with the Director of /02/18 at 3:14 PM. The DON lent had scheduled bath as a part of the bathing ated she expected that alls be trimmed or if they nmed then an appointment be seen as an outpatient	F	677	correction; Administrator and /or Director of Nursir	ng.		
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: MCD	IC11	Fac	liity ID: 20070039 If continu	uation sheet	Page 16 of 16	