PRINTED: 07/01/2020 FORM APPROVED OMB NO. 0938-0391

1	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	IPLE CONSTRUCTIO			E SURVEY IPLETED
		345543	B. WING _			00	6/16/2020
	ROVIDER OR SUPPLIER A COMMONS NURSING	AND REHABILITATION CENTER		STREET ADDRES 316 NC HIGHWA ADVANCE, NC		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	(EAC	PROVIDER'S PLAN OF CORREC' CH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments	OVID-19 Focused Survey	E	000			
F 880	was conducted on 06 information was obta 06/16/20 therefore th facility was found in §483.73 related to E-	6/08/2020. Additional ined 06/09/20 through e exit date was 6/16/20. The compliance with 42 CFR -0024 (b)(6), ents for Long Term Care E00011	F	880			6/29/20
SS=E	S483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environment.	ntrol ablish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable					
	program. The facility must esta	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:					
	reporting, investigating and communicable distaff, volunteers, visit providing services unarrangement based un	upon the facility assessment to §483.70(e) and following					
		n standards, policies, and rogram, which must include,					
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	1	TITLE		(X6) DATE

Electronically Signed 06/29/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345543	B. WING _			06/16/2020	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	ge 1	F 8	80			
	(i) A system of survey possible communications before the persons in the facilitii) When and to wh communicable disease reported; (iii) Standard and trate to be followed to pre (iv) When and how is resident; including the (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive posticity of the circumstances. (v) The circumstances (v) The circumstance must prohibit emploid disease or infected contact with resident contact will transmit (vi) The hand hygier by staff involved in contact with resident corrective actions to \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must har transport linens so a infection.	eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a but not limited to: aration of the isolation, a infectious agent or organism that the isolation should be the sible for the resident under the estable for the resident under the test under which the facility eyees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility. Indie, store, process, and as to prevent the spread of					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB M	<i>J.</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		345543	B. WING _			06	/16/2020
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER			6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006		
040.15	CLIMMA DV CT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	÷ 2	F	880			
	· -	n, staff interview, record			The statements made on this Plan of		
	review, and review of				Correction are not an admission to an	d do	
	· · · · · · · · · · · · · · · · · · ·	rocedures the facility failed			not constitute an agreement with the	u uo	
		nfection control policies for			alleged deficiencies. To remain in		
	hand hygiene when s	•			compliance with all Federal and State		
	residents on isolation			Regulations the facility has taken or w	ill		
	ensure Personal Prot			take the actions set forth in this Plan of			
	were donned and dof			Correction. The Plan of Correction			
	exiting a resident roo			constitutes the facility's allegation of			
	Special Droplet Conta			compliance such that all alleged			
	residents (Resident #			deficiencies cited have been or will be			
	failed to ensure educa			corrected by the date or dates indicate	ed.		
	of staff who provided						
	_	cting with residents for 1 of 1 n proper infection control			F 880 Infection Prevention & Contr	ol	
	practices occurred du	ıring a COVID-19 pandemic			Corrective Action:		
		to affect all residents in the			Resident #1, Resident #2, Resident #3		
	facility through the tra	nsmission of COVID-19.			and Resident #4: Education was provite all Staff on providing care for reside		
	Findings included:				on isolation precautions and ensuring	that	
					they donned and doffed Personal		
		eadmitted to the facility on			Protective Equipment (PPE) when	•••	
	09/26/19 with diagnos	ses that included dementia.			entering and exiting a resident room wasignage indicating Special Droplet Co		
	A review of a urine cu				Precautions and implemented hand		
		was positive for a urinary			hygiene before donning and after doff	ng	
		nd the urine culture revealed			PPE. All staff who provided their own		
		eta-lactamase (ESBL) as			protective face covering when interact		
		. ESBL is an enzyme found			with residents, received a new N95 ar		
		ins that cause the strain to			KN-95 mask in lieu of the use of a fit to	ะรเ	
	more difficult to eradic	ntional antibiotic usage and			kit. Identification of other residents who m	21/	
	more unifount to eradic	Cale.			be involved with this practice:	ay	
	A review of a physicia	an's orders dated 05/31/20			All current residents have the potentia	l to	
		was started on Invanz 1			be affected by the alleged practice. O		
		ularly (IM) daily at bedtime			6/23/2020 a chart audit was initiated for		
	for a UTI for 5 days.	and the state of t			current residents on Enhanced Drople		
					Contact Precautions. The audit was	-	
	An observation on 06	/08/20 at 9:07 AM revealed			completed by the Assistant director of		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		E SURVEY MPLETED
		345543	B. WING			6/46/2020
NAME OF P	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP COD	•	6/16/2020
		AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	, <u> </u>	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	#1 which was locate positive unit. There outside of the door to included; an Entericand a Special Drople which had illustratio contact precaution is gown and gloves an with soap and water Special Droplet Conrevealed everyone and staff must clean exiting the room, we protection to include gown and glove at the and use disposable clean multiuse equipicart was placed outsian ample supply of gloves. NA #1 had of Resident #1, baggremoved her gloves plastic bag before it observed to use her marker in the reside white board in the roshe was not observed before exiting the room An interview with NA #1 signage posted to the Enteric Contact Prenot wearing gloves warker and wrote a	was in the room of Resident and on the facility's COVID were two signs posted to the or Resident #1's room which Contact Precautions sign at Contact Precautions sign as for PPE usage. The enteric signage specified the use of diperforming hand hygiene a before leaving the room. The tact Precaution signage including visitors, doctors, a hands when entering and are a facemask, eye a goggles or face shield, must are a facemask, eye a goggles or face shield, must are door, keep door closed, equipment when possible or oment after each usage. A side the room which included and disposed of them in the was sealed. She was a bare hands to pick up a nt's room and wrote on the boom before exiting the room. A #1 on 06/08/20 at 9:08 AM provided personal care to acknowledged there were the door that included both cautions and Enhanced cautions. She stated she was when she picked up the note on the board in Resident	F 88	nursing, Unit Support nurses of Nursing (DON) to ensure the residents who were on Enhard Contact Precautions had a significating that resident was on Droplet Contact Precautions. 6/23/2020, an audit was come DON to determine how many members provided their own face covering when interacting residents, and ensured that estaff members had an acknown of education that documents employee's understanding ar on how to properly apply and N95/KN 95 mask in lieu of the test kit and that they will follow protocols/manufacture guided donning and doffing the N-95 KN-95 masks. All current residents who are Enhanced Droplet Contact Presidents are guided donated by the contact Presidents are assignage indicating that on Special Droplet Contact Presidents, have an acknown of education that documents employee's understanding are on how to properly apply and and/or KN-95 mask in lieu of fit test kit. This audit was come 6/24/2020. Systemic Changes: All Full Time and Part Time a needed (PRN) Staff will be expected.	hat all need Droplet gnage on Special On pleted by the staff protective ag with each of those wledgement the nd agreement use the e use of a fit w routine ines for and/or on recautions at resident is recautions and their own interacting by their own interacting by their own interacting by the use of a appleted on and as	
		not performed hand hygiene		the following by the Director		

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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		06/16	6/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	,,	
				316 NC HIGHWAY 801 SOUTH			
BERMUDA	A COMMONS NURSI	NG AND REHABILITATION CENTER		ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	Continued From բ	page 4	F 88	0			
	-	room. She confirmed there		Education began on 6/24/2020.			
		able for use but didn't reapply		Education began on 0/24/2020.			
		emoved the soiled ones after		Education included:			
	•	She stated she understood this		The facility must establish and ma	aintain		
		pread of infection and should		an infection prevention and control			
		oves when touching items in		program designed to provide a sa			
	Resident #1's roo	<u> </u>		sanitary and comfortable environ			
				to help prevent the development			
	An interview with	the Unit Manager was		transmission of communicable dis	seases		
	conducted on 06/	08/20 at 10:15 AM revealed all		and infections. The facility must e	stablish		
	_	clude NA #1 had received		an infection prevention and control			
		hand hygiene, donning and		program (IPCP) that must include	A		
	_	nd transmission-based		system for preventing, identifying			
	·	further revealed Resident #1		reporting, investigating, and contr	-		
		ed unit for high risk of suspected		infections and communicable dise			
		nts. She acknowledged		all residents, staff, volunteers, vis			
		signage for Enteric Contact Special Droplet Contact		and other individuals providing se under a contractual arrangement			
		e outside of the door and a cart		upon the facility assessment and			
		oplied and stocked for usage.		accepted national standards. The	-		
		NA #1 should have worn		must establish written standards,	-		
		s while in Resident #1's room		and procedures for the program,			
	•	oper hand hygiene before		must include a system of surveilla			
	exiting the room.	, ,,,		designed to identify possible			
	-			communicable diseases or infecti	ons		
	An interview with	the Administrator was		before they can spread to other p	ersons		
		08/20 at 10:50 AM revealed		in the facility; When and to whom	•		
		housed on a closed unit for high		incidents of communicable diseas			
		COVID-19 residents. The		infections should be reported; Sta			
		cated gloves should be worn at		and transmission-based precaution			
		Resident #1's room due to		followed to prevent spread of infe	· ·		
		recautions and Special Droplet		When and how isolation should b			
		ons and that NA #1 should not		for a resident; The type and durat			
		e board without gloves and hand ave been performed before		the isolation, depending upon the infectious agent or organism invo			
	exiting the room.	ave been penonned before		A requirement that the isolation sl			
	CARRING RICE TOURS.			the least restrictive possible for the			
	An interview with	the Director of Nursing (DON)		resident under the circumstances			
		n 06/08/20 at 11:08 AM and		circumstances under which the fa			

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		345543	B. WING		06	14612020	
NAME OF P	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP CO		/16/2020	
IVAIVIL OI I	NOVIDEN ON OUT FIEN			316 NC HIGHWAY 801 SOUTH	OBL		
BERMUD	A COMMONS NURSI	NG AND REHABILITATION CENTER					
	I			ADVANCE, NC 27006		T	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From p	page 5	F 8	80			
	1	ad received training on hand		must prohibit employees wi	th a		
		and doffing of PPE, and		communicable disease or in			
		ed precautions. She further		lesions from direct contact v			
		nould always have worn gloves		or their food, if direct contact			
		of Resident #1, should not have		the disease; and The hand			
		erase board without gloves, and		procedures to be followed by			
		ormed hand hygiene before		involved in direct resident c			
	leaving the room of Resident #1 who had signage			system for recording incide	nts identified		
	for Enteric Contact Precautions and Special			under the facility's IPCP and	d the corrective		
	Droplet Contact P	recautions.		actions taken by the facility			
				must handle, store, process			
		the Assistant Director of Nursing		transport linens so as to pre			
	` ′	Control Nurse on 06/08/20 at		spread of infection. The fac	•		
	_	d Resident #1 resided on a		conduct an annual review o			
		all residents should be on		update their program, as ne	-		
		ontact Precautions due to high ity to COVID-19. She stated all		Staff members providing the protective face covering wh			
		se rooms should wear a mask,		with residents, must have a			
		gown, and gloves always when		acknowledgment of educati			
		erform proper hand hygiene		documents the employee's			
		room. She stated the facility		and agreement on how to p			
	_	supply of PPE available for		and use the N95 and/or KN			
	usage in the care			lieu of the use of a fit test ki	it, must ensure		
				to follow routine protocols/n			
	2. Resident #2 wa	as admitted to the facility on		guidelines for donning and	doffing the		
		gnoses that included Chronic		Masks. This masks must no	ot leave the		
		onary Disease (COPD),		facility. The Masks must be			
	· ·	ntact or suspected exposure to		the facility and may be store			
	viral communicab	le disease.		paper bag when not in use.			
				the mask , an employee ma			
		cian order dated 05/26/20		to fold it, so just slip it in the			
		for Enhanced Droplet		masks can be used for up to	` '		
		ed to contact with and suspected		but must be replaced after t	` '		
	requiring isolation	viral communicable disease		anytime they are damaged difficult to breathe through.	or pecome		
		plan dated 05/27/20 revealed		All staff members must perf			
		risk of respiratory infections		hand hygiene techniques : l			
	secondary to COF	PD.		after contact with the reside	ent, after		

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		345543	B. WING _			06/	16/2020
	ROVIDER OR SUPPLIER	G AND REHABILITATION CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 16 NC HIGHWAY 801 SOUTH DVANCE, NC 27006	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	AM that revealed a to Resident #2 with to the hall. The resifacility's COVID posposted on the outside Special Droplet Corincluded the illustratequipment (PPE) use Contact Precaution including visitors, do hands when entering a facemask, eye proface shield, must go keep door closed, a when possible or cleach usage. A cart which included an aprotective equipment The Physical Therate wearing a mask, go while providing treated baservation further Assistant exited Refull PPE including a eyewear and walk or oom. In the therapy weight rack and towankle weights, then room and continued therapy session. The was not observed to perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the perform proper han before re-entering Fan interview with a 06/08/20 at 09:13 American and continued the performance and co	s made on 06/08/20 at 09:11 therapist providing treatment the resident's room door open dent's room was on the sitive unit. There were signs de of the door which included ntact Precautions which tions for personal protective sage. The Special Droplet signage revealed everyone octors, and staff must clean ag and exiting the room, wear obtection to include goggles or own and glove at the door, and use disposable equipment ean multiuse equipment after was placed outside the room ample supply of personal ant such as gowns and gloves. py Assistant was observed own, eyewear, and gloves tment to Resident #2. The revealed the Physical Therapy sident #2's room wearing her gown, gloves, mask, and down the hallway to a therapy y room, she approached the ached it to retrieve 2 white returned to Resident #2's d the previously started the Physical Therapy Assistant to change her gloves or d hygiene when exiting or Resident #2's room. Physical Therapy Assistant on the revealed she had started	F	380	contact with blood, body fluids, or visible contaminated surfaces, after contact wobjects and surfaces in the resident's environment, before donning and after doffing PPE, before performing a procedure. This in service was completed by 6/27/2020. Any staff (full time, part time and PRN) who did not receive in-service training will not be allowed to work untiteraining is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: The Director of Nursing and/or Assistan Director of Nursing, Unit Manager will review weekly starting on 7/3/2020, and during quality of life meeting. The monitoring will be done by the Director Nursing or Assistant Director of Nursing Unit Support Nurses and will include infection control monitoring focused toon hand hygiene and infection control monitoring on PPE. The Director of Nursing Unit Support nurse will observe 10 statements to ensure that proper hand hygiene was performed when required (instances; before and after contact with the resident, after contact with blood, by fluids, or visibly contaminated surfaces after contact with objects and surfaces after contact with objects and surfaces	e, see I at of gor bls gor ff chody	
		with Resident #2 and realized			the resident's environment before		

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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	·		
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F 880	was located at the enacknowledged Resid Droplet Contact Precroom in full PPE inclueyewear, and gloves supplies. She indicate Resident #2's room a her gloves and perfoleaving the room to rebeen educated on had offing of PPE, and to precautions. An interview with the conducted on 06/08/2 nursing staff to inclue Assistant had receive hygiene, donning and transmission-based prevealed Resident #2 high risk of suspected acknowledged Resid Special Droplet Contact outside of the door as supplied and stocked stated the Physical Thave removed her gle hand hygiene before #2. She should have therapy gym with soil gloves should have the re-entering Resident #2 was hould Resident #2 was hould Resident #2 was hould have beginned to the removed on 06/08/2 Resident #2 was hould have beginned to the removed have the removed hav	from the therapy gym which ad of the hall. She ent #2 was on Special autions and she exited the ading a gown, mask, to collect the needed ed she was returning to the and therefore did not remove rm hand hygiene before etrieve the weights, but had and hygiene, donning and ransmission-based Unit Manager was 20 at 10:15 AM revealed all let the Physical Therapy ed training on proper hand doffing of PPE, and precautions. She further the resided on a closed unit for act COVID-19 residents. She ent #2 had signage for act Precautions on the end a cart with PPE was for usage. She further therapy Assistant should be and performed proper exiting the room of Resident not touched supplies in the end gloves, and a new pair of the pending the room. Administrator was 20 at 10:50 AM revealed sed on a closed unit for high VID-19 residents. The	F 8	donning and after doffing PPE, before performing a procedure) Director of Nursing or Assistant Nursing or Unit Support nurse of 10 staff members to ensure that provided their own protective factovering when interacting with have used the masks for up to days but must have replaced at days or anytime they are dama become difficult to breathe throensuring that they follow routing protocols/manufacture guideling donning and doffing the Masks be done on weekly basis for 4 monthly for 3 months. Reports presented to the weekly QA Cothe Director of Nursing and/or Mest (MDS) Coordinators to enscorrective action initiated as ap Any immediate concerns will be the Director of Nursing or Admit for appropriate action. Complia monitored and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly QA Committed is attended by Administrator, Dinursing, MDS Coordinator, Uni Support Nurse, Therapy, HIM(Hinformation Management), Diet Manager, Wound Nurse.). The c Director of will observe at staff who ace residents, five (5) fter five (5) ged or ugh, also e es for . This will weeks then will be mmittee by Mini Data ure propriate. e brought to nistrator nce will be g program of Life e meeting irector of it Manager, Health cary		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		TE SURVEY
		345543	B. WING		,	06/16/2020
	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 R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	exiting the room of Frevealed the Physich have not touched its wearing used gloves should have been a room of Resident #2 session due to Special Precautions. An interview with the was conducted on the Physical Therap training on hand hyg PPE, and transmiss further indicated Reproplet Contact Preserving the room. Since soiled gloves in the of gloves should have re-entering the room on Special Droplet Contact Preserving the room and performent proposed in the room	rygiene performed when Resident #2. He further all Therapy Assistant should tems in the therapy room while is and a new pair of gloves opplied before entering the it to continue the therapy stial Droplet Contact Be Director of Nursing (DON) 6/08/20 at 11:08 AM revealed by Assistant had received giene, donning and doffing of iton-based precautions. She is ident #2 was on Special cautions and the Physical cautions are cautions.	F 88			

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			6/16/2020
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	facility had an abundary for usage in the care. 3. A review of the C Use and Limited Review of the C Use and Limited Review of the Council of the care of the car	DON further revealed the dant supply of PPE available e of Resident #2. DC Guidance for Extended use of N95 filtering facepiece care settings dated March 27, //hen manufacturer guidance minary data suggest limiting es to no more than five uses e an adequate safety margin ve. mitted to the facility on coses that included diabetes. In orders dated 5/26/20 or Enhanced Droplet Contact to contact with and suspected ral communicable disease rature log for May to June dent #3 to be febrile on	F 88			
	AM of Resident #2. Resident #3 was on Precautions which in personal protective Special Droplet Cor	made on 06/08/20 at 10:05 Signage on the door indicated Special Droplet Contact ncluded the illustrations for equipment (PPE) usage. The itact Precaution signage including visitors, doctors,				

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		345543	B. WING		06/	16/2020
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 816 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880	exiting the room, wear protection to include gown and glove at the and use disposable exclean multiuse equipment of the door wheelchair in the door cloth face mask attact under his chin. He had and Nurse #1 and as to gas them since state the observation furth walked up to Resider mask back on correct cover his chin. A nurse cover Resident #3's in touched his cheek are while not wearing glo revealed Nurse #1 we with an exhalation varefuzzy on the exterior was in contact with R. An interview with Nur AM revealed Resider indicated Special Drothe door of the room. Not apply gloves where to reapply his mask. It always wear gloves where to reapply his mask. It always wear gloves where the bear hands. The revealed the KN95 father bear hands. The revealed by here could breathe better. Could wear her own as the could wear her own and the could wear her own as the could wear her own.	hands when entering and ar a facemask, eye goggles or face shield, must e door, keep door closed, equipment when possible or ment after each usage. He and was sitting in his arway of his room. He had a ched to both ears and tucked ollered out for this surveyor ked if the facility was going off were now wearing face end he had not seen before. Her revealed Nurse #1 who hat #3 and told him to put his tilly. He lightly pulled it to be then lifted the mask up to hose and mouth. She had mouth to perform this task earing a gray KN95 mask live filter that appeared to be and slightly faded when she esident #3. The observation also had signage that had signage that had signage that had signage that had sassisted Resident #3. The acknowledged she did in she assisted Resident #3. The plet Contact Precautions on the assisted Resident #3. The plet Contact Precautions on the assisted Resident #3. The plet Contact Precautions on the assisted Resident #3. The plet Contact Precautions on the assisted Resident #3. The plet Contact Precautions on the assisted Resident #3.	F 880			

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		345543	B. WING			06/16/2020	
	ROVIDER OR SUPPLIER A COMMONS NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	•	0.10,2020	
(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 THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From page 11 to have a clean mask, she had been taking the mask home with her after her shift and washing it		F 88	0			
	facility had enough s use on the date of th sure what the manuf acceptable length of	ine. She acknowledged the urgical masks available for e survey and she was not acturer instructions list as use and was unaware KN95 o be laundered in the					
	nursing staff to include training on proper hat doffing of PPE, and the precautions. She further than the precautions are the training of the training training to the training training training the training tra	20 at 10:15 AM revealed all de Nurse #1 had received nd hygiene, donning and ransmission-based her revealed Resident #3					
	COVID-19 residents. Resident #3 had sign Contact Precautions and PPE was supplie She further stated No	unit for high risk of suspected She acknowledged hage for Special Droplet on the outside of the door ed and stocked for usage. urse #1 should have applied sisting Resident #3 to apply					
	his face mask. He fu believe the KN95 ma than 5 shifts and the that it was ineffective	rther indicated she did not ask should be used more it should be discarded and conce it was laundered.					
	Resident #3 was hourisk of suspected CC Administrator indicat when applying a face also indicated he wa Nurse #1 had continumask past manufacti	20 at 10:50 AM revealed used on a closed unit for high VID-19 residents. The ed gloves should be used emask to Resident #3. He is not aware at the time used using the same face urers recommendations or in the washing machine. He					

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NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		· • • • • • • • • • • • • • • • • • • •			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	An interview with was conducted or Nurse #1 had rec donning and doffi transmission-base indicated Resider Contact Precautic applied gloves be facemask. She fu allowed staff to pr signed a paper ar guidelines for usa not have been us 2020 and should An interview with (ADON)/Infection 11:15 AM reveale closed unit where Special Droplet Crisk of susceptibili staff should wear and gloves alway She stated Nurse donning and doffi transmission-base further revealed the supply of PPE avenue. Resident #3 and the should not have be amount of time or cleaning.	the Director of Nursing (DON) n 06/08/20 at 11:08 AM revealed eived training on hand hygiene, ng of PPE, and ed precautions. She further at #3 was on Special Droplet ons and Nurse #1 should have fore applying Resident #3's rther indicated the facility had rovide their own mask if they and followed manufacturers age. She stated Nurse #1 should aing the facemask since March not have laundered the mask. the Assistant Director of Nursing Control Nurse on 06/08/20 at d Resident #3 resided on a a all residents should be on ontact Precautions due to high ity to COVID-19. She stated all a mask, eye protection, a gown, s when caring for Resident #3. #1 had been trained on ng of PPE and ed precautions. The ADON the facility had an abundant ailable for usage in the care of that the personal KN95 mask the put in the washing machine for	F 8	80			
	04/18/20 with diag	as readmitted to the facility on gnoses that included an open ominal wall, contact with and re to other viral communicable					

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		345543	B. WING _			06/16/2020	
	NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER		•	STREET ADDRESS, CITY, STATE, ZIP COI 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Resident #4 was a practice and a highly contagious of interventions that incresident/family/staff or measures to contain good hand washing the enhanced droplet presplaced in a private rost door kept closed, state (goggles), surgical modern to entry. Hand hygier to entering the room and use as much dispossible or use dedict thermometer and bloch and the entry. A review of the nurse decrease blood presside decrease appetite with blood sugars, a urina nausea before COVI when Resident #4 was 05/26/20. A review of a physicia revealed an order for exposure. A review of a physicia revealed an order for Precautions related to	an dated 04/20/20 revealed robable or confirmed case of espiratory infection with luded education to regarding in preventive the infection, emphasize techniques to all staff, ecautions that included to be foom (when available) with the lift should don eye protection task, gown and gloves prior and after PPE is removed posable equipment as eated equipment such as food pressure cuff. The progress noted dated for Resident #4 had experienced sure's, increase sleepiness, the weight loss, decrease ary tract infection, and D-19 protocol was initiated as found to be febrile on an order dated 05/26/20 an order dated 05/27/20 and order d	F	880			

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NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		
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F 880	nurse aide (NA) #2 exholding a meal tray with outside of the docon Special Droplet Coincluded the illustratic equipment (PPE) usa Contact Precaution sincluding visitors, dochands when entering a facemask, eye protface shield, must gow keep door closed, and when possible or cleaeach usage. NA #2 p service cart in the halt trays and closed the her gown then return and began pushing it closing off the COVID the dining room for direturning to the unit. An interview with NA 9:38 AM revealed NA not worn gloves wher rooms labeled Special Precautions including she touched the tray, gloves and after remoshe did not reapply grontaminated meal castated she had receiv washing, donning and transmission-based pabout wearing gloves removed from a room	M to 9:35 AM revealed kit the room of Resident #4 ithout gloves. Signage on or indicated Resident #4 was contact Precautions which ons for personal protective ignage revealed everyone etors, and staff must clean and exiting the room, wear ection to include goggles or an and glove at the door, duse disposable equipment an multiuse equipment after laced the tray on the meal leavernal door. She removed ed to the meal service cart through the double doors of an unit and returned it to etary to empty before #2 was made on 06/08/20 at a #2 acknowledged she had a picking up meal trays in all Droplet Contact and Resident #4. She stated cart, cart door without oving her isolations gown, loves to return the last to the dining room. She red education on hand didoffing of PPE, and a recautions but did not think when touching items on Special Droplet Contact knowledged this practice	F 880			

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		345543	B. WING		0	6/16/2020	
	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 DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	AM revealed she way who was on Special She stated NA #2 she removing items from Contact Precautions. An interview with the conducted on 06/08, nursing staff to inclustraining on proper has doffing of PPE, and precautions. She fur resided on a closed COVID-19 residents Resident #4 had sig Contact Precautions and PPE was supplied She further stated New worn gloves while in when removing a meroom. An interview with the conducted on 06/08, Resident #4 was he high risk of suspected Administrator indicated worn when in Reside Droplet Contact President #4's room. An interview with the conducted on the properties of suspected Administrator indicated worn when in Reside Droplet Contact President #4's room. An interview with the was conducted on 0	arse #1 on 06/08/20 at 9:42 as the nurse for Resident #4 Droplet Contact Precautions. a room on Special Droplet b. E Unit Manager was 20 at 10:15 AM revealed all de NA #2 had received and hygiene, donning and transmission-based ther revealed Resident #4 unit for high risk of suspected b. She acknowledged ange for Special Droplet be on the outside of the door and stocked for usage. A #2 should always have Resident #4's room and beal tray from Resident #4's E Administrator was 20 at 10:50 AM revealed bused on a closed unit for and COVID-19 residents. The and COVID-19 residents and	F 88				
	donning and doffing	training on hand hygiene, of PPE, and precautions. She further					

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NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006	DE		
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F 880	when in the room of F picked up contaminat without gloves. An interview with the (ADON)/Infection Con 11:15 AM revealed R closed unit where all Special Droplet Contarisk of susceptibility to staff entering these reeye protection, a gow in the room and performance.	Assistant Director of Nursing arteriol Nurse on 06/08/20 at esident #4 resided on a residents should be on act Precautions due to high to COVID-19. She stated all poms should wear a mask, yn, and gloves always when orm proper hand hygiene	F 8	80			
		m. She stated the facility ply of PPE available for Resident #4.					