DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				E SURVEY IPLETED
		345543	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	8/06/2025
				3	16 NC HIGHWAY 801 SOUTH		
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		A	ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 001 SS=F		Emergency Program (EP)	E	001			4/3/25
		418.113, §441.184, §460.84, 83.475, §484.102, §485.68, §485.727, §485.920,					
	must comply with all a and local emergency The [facility, except fo	or Transplant Programs] applicable Federal, State preparedness requirements. or Transplant Programs] aintain a [comprehensive]					
	emergency prepared requirements of this s	ness program that meets the section.* The emergency m must include, but not be					
	the terms "facility" or refers to all provider a this appendix. This is lieu of the specific pro the regulations. For	ndicated, the general use of "facilities" in this Appendix and suppliers addressed in a generic moniker used in ovider or supplier noted in varying requirements, the that provider/supplier will be					
	comply with all applic local emergency prep The hospital must de	•					
	section, utilizing an all emergency prepared	gency preparedness ne requirements of this Il-hazards approach. The ness program must include, the following elements:					
	with all applicable Fe	25:] The CAH must comply deral, State, and local ness requirements. The					
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						03/27/2025

**Electronically Signed** 

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

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	PLE CONSTRUCTION G	(X3) DA	IO. 0938-039 TE SURVEY MPLETED	
		345543	B. WING		C 03/06/2025		
NAME OF P	ROVIDER OR SUPPLIER			DE			
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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE	
E 001	Continued From pag	e 1	E 0	01			
	CAH must develop a		20				
	comprehensive emer						
	-	all-hazards approach. The					
		lness program must include,					
		the following elements:					
	This REQUIREMEN	T is not met as evidenced					
	by:						
		view and staff interviews the		To remain in compliance wit			
	facility failed to estab			and state regulations the fac	•		
		rgency Preparedness (EP)		or will take the actions set for			
		id not include the process for		plan of correction. The plan			
		ergency officials contact cluded State licensing and		constitutes the facility⊡s alle compliance such that all alle			
		and office of the State Long		deficiencies cited have been	•		
		nan, alternate means of		corrected by the dates indica			
		rgency Prep Training/testing					
		ployee EP training and two		E001			
		ning and testing exercises.					
		al to affect all residents and		1. Corrective action for resid	ent(s)		
	staff.			affected by the alleged defic	ient practice:		
	The findings included	d:		The facility Administrator cor			
		–		regional state and federal Er			
		y's supplied Emergency		Preparedness officials is on			
	Preparedness (EP) p	viewed the material in		discuss integrated response emergencies. The Emergen			
		e following areas were not		Preparedness plan was upd			
	present, updated, or	-		Administrator on 04/02/2025	•		
		ioniou.		complete contact information			
	a. The facility's EP pl	lan did not include the		numbers and addresses. Th	•		
		poration with local, tribal,		Administrator added alternat	te means of		
	regional, state, and F	Federal EP officials to		communication in the Emerg	jency		
	maintain an integrate	ed response during a disaster		Preparedness on 04/02/202	5. The		
	or emergency.			Administrator added on 04/0			
				emergency preparation train			
		lan did not include any of the		program for the facility which			
		complete contact information		reviewed and updated annu	-		
	with phone numbers	and addresses.		Administrator conducted on annual employee Emergenc			
	1		1		V	1	

Facility ID: 20070039

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		MEDICAID SERVICES					D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	· /	E SURVEY PLETED
			A. BUILDING	·			
		345543	B. WING				C
		343343			REET ADDRESS, CITY, STATE, ZIP CODE	03	/06/2025
NAME OF PI	ROVIDER OR SUPPLIER						
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER			6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006		
							1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
E 001	Continued From pag	e 2	E 00	)1			
	c. Alternate means o	f communication.			Preparedness training for existing staff	:	
					and individuals providing services for		
		lan did not include an			emergency preparedness. The		
	emergency preparati			Administrator added to the plan on			
	for the facility which			03/27/2025 one emergency preparatio	n		
	and updated at least	annually.			training and testing exercises that involved annual full-scale		
	e The facility's FP n	lan did not include annual			community-based exercise or a full-sca	ale	
		g for existing staff and			facility-based exercise clinically- releva		
		services for emergency			to emergency scenarios with analysis		
	preparedness.	5 ;			facility's response to all drills, tabletop		
					exercises, and emergency events. Tal	ble	
	f. The facility's EP pl	an did not include two			top exercise on 03/27/2025 with		
		ion training and testing			Department Leaders of burst water pip		
	exercises that involv				and flooding to hallway/resident rooms		
		ercise or a full-scale facility-			An Active Shooter community exercise		
		cally- relevant to emergency			scheduled for 4/03/2025 with the David		
		sis of facility's response to all sees, and emergency events.			County Sheriff s Office for facility staff table top exercise was conducted	. A	
		ses, and emergency events.			1/31/2025 regarding facility power outa	ane	
	An interview was cor	nducted on 3/6/25 at 1:13 PM			with facility staff.	.90	
		or. The Administrator			······		
		ewed the current EP plan in			2. Corrective action for residents with t	he	
	December of 2024.	The Administrator verified			potential to be affected by the alleged		
		articipated in collaboration or			deficient practice:		
		local, tribal, regional, state,					
		ials prior to his employment			All residents have the potential to be		
	in October of 2024 n	or after his start as Administrator confirmed			affected by the alleged deficient practic	ce.	
		contact information did not			The Regional Director of Operations trained the Administrator on the need f	or	
		r phone numbers. The			an updated EP plan to include: proces		
		he completed one Table-Top			for Emergency Preparedness		
		rt as Administrator in October			collaboration with local, tribal, regional	,	
		istrator verified the facility's			state, and Federal Emergency		
		de annual training for			Preparedness officials to maintain an		
		I-scale exercise that was			integrated response during a disaster of	or	
	-	facility based in 2024. The			emergency; emergency officials'		
	Administrator stated responsible for upda	he would be the person			complete contact information with phor numbers and addresses; Alternate me		

Facility ID: 20070039

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345543	B. WING				C 106/2025
NAME OF P	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	00,2020
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		31	16 NC HIGHWAY 801 SOUTH		
5211105				Α	DVANCE, NC 27006		1
(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) COMPLETION DATE
E 001	Continued From page	≥3	E	001	of communication; emergency prepar training/testing program for the facility which should have been reviewed an updated at least annually; annual employee Emergency Preparedness training for existing staff and individua providing services for emergency preparedness; two emergency preparation training and testing exerce that involved annual full-scale community-based exercise or a full-sc facility based exercise clinically- relev to emergency scenarios with analysis facility's response to all drills, tabletop exercises, and emergency events. Th Administrator trained the Maintenance Director on 03/28/2025 on: process for Emergency Preparedness collaborati with local, tribal, regional, state, and Federal Emergency Preparedness officials to maintain an integrated response during a disaster or emerger emergency officials' complete contact information with phone numbers and addresses; Alternate means of communication; emergency preparati training/testing program for the facility which should have been reviewed an updated at least annually; annual employee Emergency Preparedness training for existing staff and individua providing services for emergency preparedness; two emergency preparedness; two emergency preparation training and testing exerce that involved annual full-scale community-based exercise or a full-sc facility based exercise clinically- relev to emergency scenarios with analysis facility's response to all drills, tabletop	, d als ises cale ant of or e or on e e or on e e or on on , d als ises cale ant of o e e or on o f o le e e on c on c s c ant of o f o le e e on c on c o f o f o f o f o f o f o f o f o f o	

Event ID: IT8N11

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/2025 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 03/06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BERMUD	A COMMONS NURSING A	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH	
		-		ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
E 001	Continued From page	2.4	E 001		
				exercises, and emergency events.	
				3. Measures /Systemic changes to prevent reoccurrence of alleged defi practice:	cient
				The Regional Director of Operations monitor the Emergency Preparedne program monthly for 3 months to en that the plan includes: process for Emergency Preparedness collabora with local, tribal, regional, state, and Federal Emergency Preparedness officials to maintain an integrated response during a disaster or emerge emergency officials' complete conta information with phone numbers and addresses; Alternate means of communication; emergency prepara training/testing program for the facili which should have been reviewed a updated at least annually; annual employee Emergency Preparedness training for existing staff and individu providing services for emergency preparedness; two emergency preparation training and testing exert that involved annual full-scale community-based exercise or a full- response to all drills, tabletop exerci	ss sure tion gency; ct d tion ty nd s Jals
				<ul> <li>response to all drills, tabletop exercises and emergency events. This informative will be brought to monthly Quality Assurance for continued compliance.</li> <li>On 03/27/2025, the Regional Director Operations re-educated the Administion on the need for annual review of the Emergency Management Program at the components of the program. The second s</li></ul>	ation e. or of strator and

Event ID: IT8N11

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/31/2025 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		345543	B. WING			C 03/0	, )6/2025
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0000	
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		-	16 NC HIGHWAY 801 SOUTH		
				A	DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 001	Continued From page	≥ 5	E	001	DEFICIENCY) Administrator began educating the fact Department Leaders; Director of Nursi Assistant Director of Nursing, Staff Development Coordinator, Business Office, Social Services Director, Activit Director, Dietary Director, Maintenanc Director, MDS Coordinator, Health Admissions Director, Rehab Director, Environmental Services Director on 03/28/2025 regarding the Emergency Management Program. Education included overview of the program, purpose and scope, risk assessment, mitigation, communication plan, staffir during an emergency, staffing during evacuation, evacuation locations, coordination with response partners, education and training, activation of the emergency management plan, structu and leadership, and policy and proced An all-facility staff meeting was condu- on 03/28/2025 to review the Emergency Management Program as stated abov This information has been integrated i the standard orientation training for Department Leaders and will be review by the Quality Assurance process to v that the change has been sustained. A 04/03/25, any Department Leader who does not receive scheduled in-service training will not be allowed to work unt training has been completed.	ing, ties e and risk ng e re lure. cted cy e. nto wed erify As of o	
					4. Monitoring Proceedure to ensure that plan of correction is effective and that specific deficiency cited remains corre and/or in compliance with regulatory requirements:		

Event ID: IT8N11

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/2029 MAPPROVEI D. 0938-039	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345543	B. WING			C 03/06/2025		
NAME OF PF	ROVIDER OR SUPPLIER	I		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1		
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER			NC HIGHWAY 801 SOUTH VANCE, 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 001	Continued From page	e 6	E OC	01				
					Quality assurance monitoring will be completed by the Regional Director of Operations or designee using the E00 Quality Assurance Tool; Emergency Preparedness. This monitoring consis observing the missing elements of the Emergency Preparedness. Monitoring be completed weekly x 3 weeks and monthly x 2 months. Reports will be presented to the monthly Quality Assurance committee by the Regional Director of Operations or designee to ensure corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MD Coordinator, Therapy Manager, Healt Information Manager, and the Dietary Manager, and Regional Director of Operations (as needed). Deficiencies are identified during the monitoring process will be addressed through the facility Quality Assurance process.	ts of will S h		
F 000	INITIAL COMMENTS		F 00		Date of Compliance: 04/03/2025			
	survey was conducter 03/06/25. Event ID# intakes were investiga NC00215978.	complaint investigation d from 03/03/25 through IT8N11. The following ated NC00214544 and Illegations did not result in						
F 565	deficiency Resident/Family Grou	-	F 56	65			4/1/25	

Event ID: IT8N11

Facility ID: 20070039

If continuation sheet Page 7 of 48

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345543	B. WING				C 06/2025
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER			6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 565 SS=D	CFR(s): 483.10(f)(5)(i §483.10(f)(5) The res and participate in resi (i) The facility must pr group, if one exists, w reasonable steps, wit to make residents and upcoming meetings ir (ii) Staff, visitors, or o resident group or fam the respective group's (iii) The facility must p person who is approv group and the facility providing assistance a requests that result fr (iv) The facility must of resident or family group the grievances and re- groups concerning iss in the facility. (A) The facility must b response and rationa (B) This should not be facility must implement request of the resider §483.10(f)(6) The res family member(s) or o representative(s) meet families or resident re- residents in the facility	i)-(iv)(6)(7) ident has a right to organize ident groups in the facility. rovide a resident or family with private space; and take h the approval of the group, d family members aware of n a timely manner. ther guests may attend ily group meetings only at s invitation. provide a designated staff red by the resident or family and who is responsible for and responding to written om group meetings. consider the views of a up and act promptly upon ecommendations of such sues of resident care and life to able to demonstrate their le for such response. e construed to mean that the nt as recommended every at or family group. ident has a right to roups. ident has a right to have other resident et in the facility with the epresentative(s) of other	F 5	665			
	by:	Resident Council meeting			To remain in compliance with all federa	al	

Facility ID: 20070039

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED	
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDI	NG _		C		
		345543	B. WING			0:	3/06/2025	
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BERMUD	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) COMPLETIOI DATE	
F 565	Continued From page	<b>a</b> 8		565				
		t and staff interviews, the		505	and state regulations the facility has t	akan		
		e and communicate the			and state regulations the facility has t or will take the actions set forth in this			
	-	dress repeated concerns by			plan of correction. The plan of correct			
		night during Resident			constitutes the facility s allegation of			
		3 of 10 months reviewed			compliance such that all alleged			
		ary 2024 and October			deficiencies cited have been or will be	e		
	2024).				corrected by the dates indicated.			
	The findings included	l:			F 565			
		I meeting minutes were			1. Corrective action for resident(s)			
	-	2024. Under the heading			affected by the alleged deficient pract	ice:		
	"New Business", mini				A corrective action was obtained for			
		n the hallway at around 4:00 Activities Director to notify			resident council concern for noise at i	aight		
		ig (DON) about the issue.			and documented in the November	iigin		
					resident Council meeting. Follow-up of	of		
	In the February 2024	meeting minutes, under the			noise at night was competed by Direc			
	heading "Old Busine				of Nursing who spoke with night shift			
		p for the January 2024 noise			A Communication form for facility			
	-	iary 2024 minutes, under the			response to Resident Council concer	ns		
	heading "New Busine	ess" made note that the			was implemented January 2025.			
	noise at night was pe	rsisting and a plan was						
	made to speak with the	he DON about the issue.			2. Corrective action for residents with			
					potential to be affected by the alleged			
		March 2024 revealed no			deficient practice:			
	-	p on the noise complaints						
		under the heading of "Old			All residents have the potential to be			
	Business". "New Bus				affected by the alleged deficient pract			
	documentation of new	w noise complaints.			On 03/27/2025, the Administrator beg	JdH		
	The April 2024 mostin	ng minutes revealed no			identification of follow-up needed for resident council concerns. This audit			
	-	p on noise complaints under			consisted of a 100% look back of resi			
		Business" for past noise			council minutes for January 2025 and			
		uary 2024. "New Business"			February 2025. March Resident Cou			
	showed no document				is scheduled for 3/31/2025. January			
	complaints.				audit had 5 concerns presented at the			
					council meeting; 5 documented			
	Meeting minutes revi	ewed for May 2024 revealed			responses recorded. February⊡s au	dit		

Facility ID: 20070039

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		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		345543	B. WING		C 03/06/20	)25
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF		
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COM O THE APPROPRIATE	(X5) IPLETIC DATE
F 565	Continued From page	e 9	F 56	55		
	under the heading of noise complaints from Business" showed no noise complaints. The June 2024 meeti documented follow up the heading of "Old B complaints from Febr showed no document complaints. There was no Reside 2024 per the Activitie Meeting minutes revis revealed no document complaints under the for past noise compla	ent Council meeting in July s Director. ewed for August 2024 nted follow up on noise heading of "Old Business" aints from February 2024. ved no documentation of		had 6 concerns noted fro Council; 5 of 6 had docur responses. Documented missing February meeting obtained 03/28/2025. Au 2024 had 0 documented concerns, February 2024 documented follow-up of 2024 had 0 documented concerns, April 2024 had follow-up of concerns, Ma documented follow-up of 2024 had 0 documented concerns, no meeting for August 2024 had 0 docur of concerns, no meetin	mented I response for the g concern was udit for January follow-up of had 0 concerns, March follow-up of 0 documented ay 2024 had 0 concerns, June follow-up of July 2024, mented follow-up for September 0 documented ovember 2024 up of noise at r 2024 had esolved.	
	provided following tw	-		3. Measures /Systemic cl prevent reoccurrence of a practice:	alleged deficient	
	up on noise complain Business" for past no February 2024. "New resident complaint of the middle of the nigh talking loudly. There resolution of the new October 2024 minute	ealed no documented follow its under the heading of "Old ise complaints from		On 03/25/2025, the Activ Liberty Corporate Consul the Activities Director on Policy and Procedure, do Resident Council Minutes Communication Form for response to concerns. On Administrator educated th team on responding to th Communication Form and resident Council Policy and and Resident Council Min attendance were Director	Itant educated Resident Council ocumentation of s, and use of the recording n 03/27/2025 he Leadership le d reviewed nd Procedure, nutes. In	

Event ID: IT8N11

Facility ID: 20070039

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	со	MPLETED
						С
		345543	B. WING	·····		3/06/2025
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
		AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
DERIVIODA	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	FIX (EACH CORRECTIVE ACTION SHOULD BE		
F 565	Continued From page	e 10	F 56	5		
	The November 2024	meeting minutes revealed		Assistant Director of Nu	ursing, MDS	
	under "Old Business'	" that the DON had spoken		Coordinator, Therapy N	lanager, Activities	
		oise at night. There were no		Director, Health Informa		
		s under "New Business".		Dietary Manager, Admi		
		as in attendance at the		Human Resources Mar		
	meeting.			Development Coordina	tor, and the	
				Maintenance Director.		
		meeting minutes showed		This information has be		
		a repetition of the noise		the standard orientation		
	-	ber 2024. "New Business"		be reviewed by the Qua	•	
		hat the DON had spoken to and that the issue was		process to verify that the been sustained. As of (		
		I was noted as in attendance		who does not receive s	•	
	at the meeting.	was noted as in attendance		in-service training will n		
	at the meeting.			work until training has t		
	In a Resident Counci	l meeting on 03/05/25 at				
		ers of the Resident Council		4. Monitoring Procedur	e to ensure that the	
		gs regularly (Resident #93,		plan of correction is effe		
		ent # 76, Resident #11,		specific deficiency cited		
		esident #84), reported that		and/or in compliance w		
	they knew how to cor	mplete an individual		requirements:		
	grievance form and t	hat they knew where the				
	forms were located.			Quality assurance mon	-	
		ere not aware of separate		completed by the Direc		
		regarding concerns that		designee using the F56		
		at their Resident Council		Assurance Tool; Reside		
	-	When the surveyor inquired		Communication Form (		
		was any noise at night, all		monitoring consists of a		
	residents present sta			Resident Council Minut		
	sometimes noise at r			Communication Form r	-	
		happened sometimes and were shift changes at night.		Monitoring will be mont Reports will be present	•	
		were shint changes at hight.		Quality Assurance com	-	
	In an interview with t	he Activities Director on		Administrator or design		
		I the Activities Director		corrective action is initia		
		cumented resident concerns		appropriate. The month		
	-	the Resident Council		Assurance Meeting is a		
	-	e stated follow up from		Administrator, Director	-	
	Resident Council cor	-		Coordinator, Therapy N		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 A APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345543	B. WING _				C 106/2025
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2020
				316	6 NC HIGHWAY 801 SOUTH		
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		AD	DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 565	documented in subse minutes as "Old Busi resolved or not resolv reported that she did concerns brought for meetings separately group concern. She r concerns with the Ad whatever person wou resolution. On 03/06/25 at 2:47 I interview with Activitie resident/group concerns Resident Council me would go to the person and discuss with that given complaint/concerns concerns were share DON every month. T confirmed all resoluti verbally. She said on complaint was reached the next months' meet The Activities Director not given any kind of of concerns. The Acti follow-up with resider In an interview with th on 03/06/25 at 3:32 F any concerns brough Council meeting were month's Resident Co confirmed that any for with the person response explained that any concerns were council meetings were	equent months' meeting iness" and then noted as ved. The Activities Director not document resident ward at Resident Council as a resident grievance or reported that she shared all ministrator, the DON and uld be responsible for the PM, during a follow up es Director, she reported erns were documented in teting minutes, then she on responsible for resolution t person how to resolve a exern. She reported that all ed with the Administrator or the Activities Director on efforts were conducted	F	565	Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 04/01/2025	ed	

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/31/2025 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345543	B. WING					C 06/2025
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	 E		
				31	16 NC HIGHWAY 801 SOUTH			
BERMUDA	A COMMONS NURSING A	ND REHABILITATION CENTER		Α	DVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 565	complaints of noise at confirmed there was in concerns brought forw minutes, and no writte was provided to the re- On 03/05/25 at 10:03 conducted with the Ad Worker (SW) and the Administrator stated t to document any resid forward at Resident C meeting minutes and documented on subse minutes as either reso Administrator said that reported concerns to and whatever person resolution. The Activitit facility leadership spoke believed would best b That person then took The Administrator corr other documentation of attached or document minutes. The SW repo- instructed by her corp resident grievances s Council meeting minute and he reported that f about noise at staff m was resolved.	aff about the residents' is night. The DON also no written documentation of vard apart from the meeting en follow-up documentation esident council. AM, an interview was diministrator, the Social Activities Director. The hat the facility's practice was dent concerns brought council meetings on the that follow-up was equent months' meeting olved or not resolved. The the Activities Director the Administrator, the DON was responsible for the ies Director reported that ducted these efforts o written documentation. She e with the person who they e able to resolve the issue. their own steps to do so. firmed that there was no of resident group concerns ted with Resident Council orted that she was orate team to keep all eparate from Resident tes. The Administrator are of the noise complaints, acility staff were addressed eetings and that noise issue	F	565				
		w with the Administrator on he confirmed that resident						

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TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345543	B. WING		C 03/06/2025	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		5/00/2025
			31	6 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING /	AND REHABILITATION CENTER	AI	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 565 F 575 SS=C	minutes including any He said facility leader coordinating resolution verbalized that follow on the next month's in Administrator confirm concerns were then v attention of the person resolution and that do months' meeting minu- resolved". The Admin resolved". The Admin resolved". The Admin resolved". The Admin resolved in the next in share a new propose Council. He reported issues and/or concern Resident Council meet confirmed any new re- conducted verbally an process for staff to fo Required Postings CFR(s): 483.10(g)(5) \$483.10(g)(5) The fac and manner accessib residents, resident re- (i) A list of names, ad and telephone number agencies and advoca Survey Agency, the S protective services wi jurisdiction in long-ter- of the State Long-Ter	at Resident Council nented on the meeting / planned follow-up actions. ship was responsible for on of concerns. He up was then documented neeting minutes. The red any resident or group verbally brought to the n responsible for the ocumentation was in the next utes as "resolved" or "not nistrator confirmed e conducted verbally and then follow-up provided to that if a concern was not nonth, that he would then d plan to the Resident that he was made aware of ns brought forward at etings. The Administrator esolution plans were also nd that there was no written llow. (i)(ii) cility must post, in a form ble and understandable to presentatives: dresses (mailing and email), ers of all pertinent State cy groups, such as the State State licensure office, adult here state law provides for m care facilities, the Office	F 565			4/1/25

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/06/2025	
		345543	B. WING				
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 575	Continued From page	e 14	F	575			
		y based service programs,					
	and the Medicaid Fra						
		he resident may file a					
	complaint with the St	-					
	concerning any susp	ected violation of state or					
	<b>U</b> .	y regulation, including but not					
		use, neglect, exploitation,					
		esident property in the					
		pliance with the advanced					
	-	nts (42 CFR part 489 subpart					
	to the community.	formation regarding returning					
	•	Γ is not met as evidenced					
	by:	i is not met as evidenced					
		ons and staff interviews, the			To remain in compliance with all fee	leral	
		a list of names, addresses			and state regulations the facility has		
		and telephone numbers of all			or will take the actions set forth in th		
		cies and advocacy groups,			plan of correction. The plan of corre	ction	
	such as the State Su	rvey Agency, the State			constitutes the facility□s allegation of	of	
	licensure office, adult	t protective services where			compliance such that all alleged		
		r jurisdiction in long-term			deficiencies cited have been or will	be	
		fice of the State Long-Term			corrected by the dates indicated.		
		ogram, the protection and					
	•	ome and community based			F 575		
		d the Medicaid Fraud			1 Corrective entire for resident/-)		
		ays of the recertification			<ol> <li>Corrective action for resident(s) affected by the alleged deficient pra</li> </ol>	ctice	
	survey.				anected by the aneged dencient pra	clice.	
	The findings included	l:			On 03/26/2025 a corrective action w		
					completed by the facility of posting a		
		AM, an observation of the			names, addresses (mailing and ema		
		ll hallways) revealed no			and telephone numbers of all pertine		
		contact information for the			State agencies and advocacy group		
	•	epartment of social services,			including; State Survey Agency, Sta		
	-	Care Ombudsman or the			licensure office, adult protective services		
	resident advocacy gr	oup.			where state law provides jurisdiction		
	On 2/4/2025 at 0.50	AM, an observation of the			long term care facilities, the Office of State Long Term Care Ombudsman		

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		MEDICAID SERVICES		וסורי	CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · ·	OMPLETED
			-				С
		345543	B. WING				03/06/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTER		310	6 NC HIGHWAY 801 SOUTH		
		AND REHABILITATION CENTER		AD	DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 575	Continued From page	e 15	F 5	575			
		contact information for the			network, home, and community based	ł	
		epartment of social services,			service programs, and the Medicaid F		
		Care Ombudsman or the			Control Unit.		
					2. Corrective action for residents with	the	
		e facility (inclusive of all			potential to be affected by the alleged		
		5 at 2:56 PM, revealed there			deficient practice:		
		name or contact information local department of social			All residents have the potential to be		
	-	ong Term Care Ombudsman			affected by the alleged deficient practi	ice.	
	or the advocacy grou	-			On 03/26/2025, the Administrator beg		
					identification of the missing required		
		During a walking tour of the facility and interview on $2/6/25$ at 2:46 DM with the Administrator, there			posting information. This audit consis	ted	
		with the Administrator, there			of a 100% audit of all locations in the		
		name or contact information			building where this type of information		
		ent of social services, the e Ombudsman or the			displayed; 100 hallway and 400 hallwa Audit was completed on 3/26/2025.	ay.	
	-	Administrator reported it			Results included that facility was miss	ina	
		r's responsibility to ensure			information for the following required		
		e and contact information for			postings: local Department of Social		
	-	of social services, the State			Services, the state Long Term Care		
	-	budsman and advocacy			Ombudsman, and the resident advoca		
		The Administrator confirmed their representatives should			group. Corrective action was taken by obtaining information and posting in the		
	be informed of all ava	ailable resources and that ocation easily visible and			100 hallway and the 400 hallway area		
	· •	dent or their representative			3. Measures /Systemic changes to		
	should need them.	·			prevent reoccurrence of alleged defici	ent	
					practice:		
					On 03/27/2025, the Administrator beg		
					educating the facility Department Lead Director of Nursing, Assistant Director		
					Nursing, Staff Development Coordina		
					Business Office, Social Services Direc		
					Activities Director, Dietary Director,		
					Maintenance Director, MDS Coordina	tor,	
					Health Admissions Director, Rehab		
					Director, and Environmental Services		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 03/06/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2020
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 PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 575	Continued From page	€ 16	F 57	<ul> <li>Director of the importance of ma all required postings.</li> <li>This information has been integr the standard orientation training Department Leaders and will be by the Quality Assurance process that the change has been sustai 04/01/25, any Department Leader does not receive scheduled in-set training will not be allowed to wo training has been completed.</li> <li>4. Monitoring Procedure to ensur plan of correction is effective and specific deficiency cited remains and/or in compliance with regular requirements:</li> <li>Quality assurance monitoring with completed by the Administrator of designee using the F575 Quality Assurance Tool. This monitoring of observing both areas for all re- postings. Monitoring will be com</li> </ul>	rated into for reviewed ss to verify ined. As of er who ervice ork until ure that the d that s corrected atory II be or / consists equired pleted
				weekly x 3 weeks and monthly x months. Reports will be presented monthly Quality Assurance comm the Administrator or designee to corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended I Administrator, Director of Nursin Coordinator, Therapy Manager, Information Manager, and the D Manager. Deficiencies that are in	ed to the mittee by ensure y by the g, MDS Health ietary
				during the monitoring process w addressed through the facility Q Assurance process.	ill be

Event ID: IT8N11

Facility ID: 20070039

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				CONSTRUCTION	OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345543	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	03/06/2025
		AND REHABILITATION CENTER	3	16 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 575	Continued From page	e 17	F 575		
F 578 SS=D		ntnue Trmnt;Formlte Adv Dir (8)(g)(12)(i)-(v)	F 578	Date of Compliance: 04/01/2025	4/1/25
	§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be				
	construed as the righ the provision of medi	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or			
	requirements specifie subpart I (Advance D (i) These requirement inform and provide w residents concerning medical or surgical tro	ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the			
	<ul> <li>(ii) This includes a wr facility's policies to im and applicable State</li> <li>(iii) Facilities are perm</li> </ul>	nitted to contract with other information but are still			
	requirements of this s (iv) If an adult individu time of admission and information or articula has executed an adva	section are met. ual is incapacitated at the			

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TATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345543	B. WING _			C 03/06/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		0/00/2020
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	ID PROVIDER'S PLAN OF CO EFIX (EACH CORRECTIVE ACTION		SHOULD BE COMPLE	
	1	,			DEFICIENCY)		
F 578	Continued From pag	e 18	F 5	578			
	(v) The facility is not	relieved of its obligation to					
	•	ion to the individual once he					
	or she is able to rece						
		s must be in place to provide					
		e individual directly at the					
	appropriate time.	2					
		T is not met as evidenced					
	by:						
		view, resident and staff			To remain in compliance with all fed	eral	
		y failed to have a signed			and state regulations the facility has		
		cope of Treatment (MOST)			or will take the actions set forth in thi		
	form for 1 of 7 reside	nts reviewed for advance			plan of correction. The plan of correct	ction	
	directives (Resident ;	#55).			constitutes the facility □s allegation o		
					compliance such that all alleged		
	The findings included	d:			deficiencies cited have been or will b corrected by the dates indicated.	e	
	Resident #55 was ad	Imitted to the facility on					
		noses that included diabetes					
	mellitus, congestive l				F 578		
	hypertensive heart di				1. Corrective action for resident(s)		
					affected by the alleged deficient prac	ctice:	
		erly Minimum Data Set			0-02/24/2025		
		2025 revealed Resident #55			On 03/24/2025 a corrective action we	as	
	was cognitively intac	ι.			obtained for Resident #55 when the		
	A rovious of the action	a care plan deted 12/22/2022			advance directives were reviewed,	o plan	
		e care plan dated 12/22/2022 nt #55 had goals and			resident signature obtained, and care	e pian	
		Not Resuscitate (DNR).			updated to reflect code status per physician order.		
	A review of the medio	cal record revealed an order			2. Corrective action for residents with	n the	
	from the Nurse Pract				potential to be affected by the allege		
		ot Resuscitate (DNR):			deficient practice:		
		porary; Hospitalization if			·		
	needed; IV (intraveno				All residents with Advance		
	Antibiotics if needed;	,			Directives/MOST have the potential	to be	
	temporary.				affected by the alleged deficient prac	ctice.	
					On 03/24/2025, the Director of Nurse		
		e Practitioner (NP) note			(DON) began identification of resider		
	dated 07/11/2024 re\	/ealed that the NP had			that were potentially impacted by this	S	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	דעם (גא)	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			. ,	PLETED
						С
		345543	B. WING		0:	3/06/2025
NAME OF PI	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP		0/00/2020
				316 NC HIGHWAY 801 SOUTH		
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG	(	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	) THE APPROPRIATE	COMPLETIO DATE
F 578	Continued From pag	e 19	F 578	8		
		rectives with Resident #55		practice. This audit consis		
		esident #55's wishes to		audit of current residents		
		MOST form completed on		directives/MOST to ensur		
		d in the advance directive's station but had not been		advance directive/MOST		
		55 or her representative.		resident preference, signation orders, and care plans. T		
		of of the representative.		completed on 03/24/2025		
	An interview on 03/04	4/2025 at 9:33 AM with		included: 54 out of 104 re		
	Resident # 55 reveal	ed she had discussed her		advance directives/MOS	Γ forms reflective	
	wishes regarding adv	anced directives with her		of their preference, orders	s, and care	
		nought someone from the		plans. Of the 54 advance		
		this with her as well. She		a consent signature on th		
		gning a document regarding		Corrective action taken by		
	advanced directives.			signature on the remainin MOST forms and this was		
	An interview on 03/0	4/2025 at 3:54 PM with		3/31/2025.	s completed on	
		vealed the nurse usually		0/0 1/2020.		
		on of the MOST form and		3. Measures /Systemic ch	nanges to	
	obtained the required	d signatures. Social Worker		prevent reoccurrence of a	alleged deficient	
	#1 indicated she revi	ewed the resident's wishes		practice:		
	as part of the care co			On 03/23/2025, the DON		
	complete the forms if			Development Coordinato		
	was not signed by Re	ot know why the MOST form		reeducating Licensed Nu Nurses (RN⊡s) and Licer		
		4/2025 at 04:01 PM with the		Nurses (LPN s) including		
		ne NP had reviewed Resident		licensed nurses on advar		
	-	ng advance directives on		(See Education)		
		sician did not know why the		¿ Policy and procedures	for advance	
		er signed by Resident #55		directives		
	-	a nursing responsibility to		This information has been	-	
	obtain the signature.			the standard orientation t	•	
	An interview or 00/0	6/2025 of 10.24 ANA		be reviewed by the Qualit	-	
		6/2025 at 10:21 AM with the DON) indicated it was the		process to verify that the been sustained. As of 3/3	-	
		al services to obtain the		nursing staff who does no	-	
		ntative's signature required		scheduled in-service train		
	on the MOST form.			allowed to work until train	-	
				completed.		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	i	COMPLETED
					С
		345543	B. WING		03/06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HIGHWAY 801 SOUTH	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 578	Continued From pag	e 20	F 57	8	
	MOST form was not An interview on 03/00 Medical Records Spe assumed the respons form audit two month 02/15/2025. She stat have been signed by previous person who the form was missing	ed he was not sure why the signed by Resident #55. 6/2025 at 4:48 PM with the ecialist indicated she sibility for the monthly MOST as ago. The last audit was ted the MOST form should Resident #55 and the audited should have noted the signature as Resident facility for a long time.		<ul> <li>4. Monitoring Procedure to ensure plan of correction is effective and specific deficiency cited remains of and/or in compliance with regulate requirements:</li> <li>Quality assurance monitoring will completed by the Director of Nurs designee using the F587 Quality Assurance Tool. This monitoring of monitoring 5 random residents directives to ensure compliance a the advance directive was reflective resident preference, orders, care and has a consent signature. Mor will be completed weekly x 3 weel monthly x 2 months. Reports will b presented to the monthly Quality Assurance committee by the DON designee to ensure corrective activities appropriate. The mont Quality Assurance Meeting is attee the Administrator, Director of Nurs MDS Coordinator, Therapy Manager, and Dietary Manager. Deficiencies that identified during the monitoring pr will be addressed through the faci Quality Assurance process.</li> </ul>	that corrected ory be es or consists advance nd that ve of plans, nitoring ks and be V or ion is hly nded by sing, ger, the it are ocess
F 584 SS=D		ble/Homelike Environment (7)	F 58	Date of Compliance: 04/01/2025	4/1/25
	§483.10(i) Safe Envir The resident has a ri- comfortable and hom but not limited to rece	ght to a safe, clean, nelike environment, including			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	_	(X3) DATE	
		345543	B. WING				C 06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 S ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall et the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spec §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by:	ng safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for resident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, a temperature range of 71 to maintenance of comfortable - is not met as evidenced	F 58				
	81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio	maintenance of comfortable			npliance with all federa tions the facility has tal		

Facility ID: 20070039

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				5 0010751107:2::		IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · · ·	E SURVEY IPLETED
						С
		345543	B. WING	·····	0;	3/06/2025
NAME OF PI	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP (	CODE	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
				ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From pag	e 22	F 584	1		
	-	ath linens for 3 of 6 halls		or will take the actions set	forth in this	
	(Halls 100, 500, and			plan of correction. The pla		
	homelike environmer			constitutes the facility⊡s a		
				compliance such that all al	-	
	The findings included	d:		deficiencies cited have bee		
				corrected by the dates ind	cated.	
	-	n carts on 3/3/25 between		F 584		
		AM on halls 100, 500 and hcloths or towels on the linen		F 304		
(	carts. No linen carts			1. Corrective action for res	ident(s)	
	observation on halls			affected by the alleged def	. ,	
	An interview conducted with Resident #90 was			On 03/26/2025 and 3/28/2	025 a corrective	
	· ·	at 11:29 AM. Resident #90		action was completed by p		
		t according to Minimum Data		additional washcloths to in	crease par level	
		04/24. Resident #90 stated		for resident care.		
		Ild not get a bath at this time no washcloths available.		2. Corrective action for res	idents with the	
				potential to be affected by		
	An interview with Nu	rse Aide (NA) #1 was		deficient practice:		
		at 11:35 AM. NA #1 stated				
	there were no washc	loths available for showers		All residents have the pote		
		would be on hold until		affected by the alleged def		
		ilable. NA #1 also stated		On 03/26/2025, the Admin		
		loths available on Sunday		identification of the numbe		
		ked and there had been a hs since she started in		washcloths needed to prov care. Audit on morning of		
	January of 2025.			at 10:00 AM par level was		
				washcloths in the laundry		
	On 3/6/25 at 9:33 AM	1 Nurse #1 (worked on the		Washcloths for early morn		
		ated she worked on 3/3/25		already in use on the floor		
		vere out for a "short period of		verbalizations from nursing	g staff regarding	
		y was able to provide more		lack of washcloths.		
		1 reported she found 5		3 Magguros /Quatamia ab	anges to	
		5 that she provided to 3 d a shower while waiting for		3. Measures /Systemic cha prevent reoccurrence alleg		
	laundry to provide m	-		practice:		

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		MEDICAID SERVICES				<u>10. 0938-03</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
		345543	B. WING		C	C 03/06/2025	
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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE	
F 584	Continued From page	23	F 584	a			
	AM with NA #2. NA # 3/3/2025 at 7:15 AM to towels. NA #2 reports washcloths and towel waited for laundry to p An interview was con AM with NA #3 (work halls). NA #3 reporte locate a washcloth fo During the tour of the Administrator on 3/6/20 observed that shelves towels were empty. At 9:49 AM on 3/6/25 Housekeeping Super arrived at 7:00 AM or enough washcloths. T Supervisor reported s washcloths to all the The Housekeeping S continued to supply th 15-minute increments day. The Housekeeping hall linen carts did no the staff would somet and towels away or u Housekeeping Super purchased 54 washcl washcloths on 3/6/25	2 stated on Monday there were no washcloths or ed she had to use is from another hall and provide more. ducted on 3/6/25 at 10:25 ed on the 400, 500, and 600 d it had been difficult to r the past month. laundry room with the 25 at 9:45 AM, it was is labeled washcloths and an interview with the visor was completed. The visor stated when she a 3/3/25 there were not The Housekeeping she provided clean halls at 8:00 AM on 3/3/25. upervisor stated she ne halls with washcloths in a on 3/3/25 for the rest of the ng Supervisor stated if the t have washcloths or towels, imes stash the washcloths se them up. The visor also stated she oths on 3/3/25, 72		<ul> <li>educated the Housekeeping the appropriate par level for Housekeeping Supervisor be educating Laundry departme amount of washcloths that n available for adequate reside 3/28/2025. Regular monthly washcloths will be implemer adequate par level. Through additional purchases are ner monthly order Housekeeping will purchase at a local depa such as Walmart. This inforr been integrated into the star orientation training for the H- Supervisor and laundry emp will be reviewed by the Qual process to verify that the cha been sustained. As of 3/31/2 laundry employee who does scheduled in-service training allowed to work until training completed.</li> <li>Monitoring Procedure to e plan of correction is effective specific deficiency cited rem and/or in compliance with re requirements:</li> <li>Quality assurance monitorin completed by the Administra designee using the F584 Qu</li> </ul>	washcloths. egan ent of the eed to be ent care on purchases of ited to sustain in monitoring if eded prior to g Supervisor intment store mation has indard ousekeeping loyees and ity Assurance ange has 25, any not receive g will not be has been ensure that the ains corrected gulatory g will be itor or		
	Supervisor confirmed washcloths and towe	s observed in the clean laundry room was the only		Assurance Tool; Washcloth A monitoring consists of obser of wash cloths available for Monitoring will be completed weeks and monthly x 2 mon	ving number resident care. I weekly x 3		

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CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345543	B. WING		C 03/06/202
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/00/202
		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL
F 584	Continued From page	e 24	F 584		
F 695 SS=D	was completed on 3/6 stated housekeeping shortage of washclott DON reported she wa placed an order for 3/ ago because washclo informed the staff. An interview was com Administrator on 3/6/2 Administrator stated I washcloth shortage. all laundry was comp first and second shifts laundry during third s stated there should b available each day to Respiratory/Tracheos CFR(s): 483.25(i)	hs on Monday 3/3/25. The as aware that housekeeping 00 washcloths about a week oths were running low and ducted with the 25 at 09:42 AM. The he was not aware of the The Administrator reported leted in the facility during s and there was no staff in hift. The Administrator e enough washcloths provide resident care. stomy Care and Suctioning ry care, including	F 695	Assurance committee by the Adminis or designee to ensure corrective activinitiated as appropriate. The monthly Quality Assurance Meeting is attended the Administrator, Director of Nursing MDS Coordinator, Therapy Manager Health Information Manager, and the Dietary Manager. Deficiencies that an identified during the monitoring proce- will be addressed through the facility Quality Assurance process. Date of Compliance: 04/01/2025	on is ed by , , re ess
	tracheostomy care ar The facility must ensu- needs respiratory car care and tracheal suc- care, consistent with practice, the compre- care plan, the resider and 483.65 of this su This REQUIREMENT by: Based on observatio resident, staff and Me the facility failed to pr (oxygen that has bee vapor) as ordered by	nd tracheal suctioning. ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences,		To remain in compliance with all fedd and state regulations the facility has or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility s allegation of compliance such that all alleged	taken s tion

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						O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345543	B. WING		0;	C 3/06/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BERMUDA	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 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 695	Continued From page	e 25	F 69	5		
	#20)			deficiencies cited have been or w corrected by the dates indicated.	ill be	
	The findings included	: mitted to facility on 12/20/19		F695		
	with diagnoses that ir pulmonary disease w	ilure and dependence on		1. Corrective action for resident(s affected by the alleged deficient p	,	
	supplemental oxygen	cian orders dated 11/15/24		On 3/4/2025 a corrective action w obtained for Resident #20 when o humidification was not provided a	oxygen	
	revealed oxygen at 4	liters per minute by nasal for chronic obstructive		ordered. On 3/4/2025 nurse #6 immediately replaced oxygen humidification for resident #20.	-	
	focus area for chronic disease and interven continuous oxygen at	blan dated 12/30/24 noted a c obstructive pulmonary tions including the use of nd BIPAP (a bi-level positive hine used to aid breathing)		<ul><li>2. Corrective action for residents potential to be affected by the alle deficient practice:</li><li>All current residents with oxygen</li></ul>	eged	
	every night with oxyg	en bleed-in and water (which on of the inhaled oxygen).		have the potential to be affected I alleged deficient practice. On 3/5, the Director of Nurses (DON)/ sta	by the /2025,	
		m Data Set (MDS) dated lent #20 was cognitively oxygen.		development clinician (SDC)/ Tre nurse began identification of resid that were potentially impacted by practice. Visual inspection comple	atment Jents this	
	revealed BIPAP 15/5 oxygen at 2 liters per	cian orders dated 2/4/25 centimeters of water with minute bleed-in with a large		3/5/2025 of all current residents v oxygen humidification and 0 of 24 found to have humidification not e	vith I resident empty.	
	full-face mask every i apnea.	night for obstructive sleep		No additional corrective action ne that time.	eded at	
	dated 3/2/25 revealed	d humidified oxygen therapy		3. Measures /Systemic changes to prevent reoccurrence of alleged of practice:		
	_	PM, Resident #20 was		On 3/5/2025, the SDC/DON bega reeducating Licensed Nurses, Re		

		MEDICAID SERVICES			OMB NO. 0938-	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	,
			A. DOILDING		с	
		345543	B. WING		03/06/202	5
NAME OF P	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLI	ETIO
F 695	Continued From page	e 26	F 69	5		
	observed to be on 4 l canula via oxygen co canister for humidifie	iters of oxygen by nasal ncentrator with a water d oxygen. The canister was attached to the oxygen		Nurses (RN s) and Licensed Pr Nurses (LPN s)/Medication Aide oxygen administration education Education)	es on	
		25 revealed documentation beived humidified oxygen of 3/3/25.		<ul> <li>policy and procedures relate administration with use of humid</li> <li>Education on changing of humidification when empty for re receiving oxygen therapy</li> </ul>	fication	
		AM, the water canister on en concentrator remained		This information has been integr the standard orientation training		
	On 03/04/25 at 03:01 Resident #20's oxyge empty.	PM, the water canister on en concentrator remained		be reviewed by the Quality Assur process to verify that the change been sustained. As of 3/30/2025 who does not receive scheduled in-service training will not be allo work until training has been com	has , any staff wed to	
	In an interview with Resident #20 on 03/04/25 at 3:03 PM, he stated that his nose was not dry without the use of the humidification. He stated that he had not had any nose bleeds and that his nose was not hurting at that time. During the interview, Resident #20 was wearing his oxygen cannula and the flow regulator on the oxygen concentrator was set to 4 liters per minute.			4. Monitoring Procedure to ensur plan of correction is effective and specific deficiency cited remains and/or in compliance with regula requirements.	re that the I that corrected	
	3/4/25 at 3:11 PM. Th if the nasal cannula w turned the concentrat reported she did not of the concentrator or of During an interview w	vith Medication Aide (MA) #1		Quality assurance monitoring will completed by the Director of Nur designee using the F695 Quality Assurance Tool. This monitoring of monitoring 3 random residents currently receiving oxygen therap ensure that humidification presen oxygen concentrators to ensure	ses or consists s who are by to nt on	
	checked the concent Aide #1 stated she w	, she reported that she rator if it was beeping. Med ould change out the water ty. She also reported the		humidification in use. Monitoring completed weekly x 3 weeks and x 2 months on various days and shifts. Reports will be presented	l monthly various	

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	S FOR MEDICARE &		()(0) <b>1</b> ()			O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	· · · ·	E SURVEY IPLETED	
						С	
		345543	B. WING		0	3/06/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	DRESS, CITY, STATE, ZIP CODE		
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER					
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 695	Continued From page	e 27	F 695	5			
	but she was not allow oxygen level. On 03/04/25 at 04:04 interviewed and repo wear his oxygen com currently on 4 liters b reported the concent an alarm when the w self-muted when wat reported that staff ch canister every time th Upon observation wit PM of Resident #20's water canister was st this and proceeded to and stated that "the o it" and reiterated that monitored and replac Nurse #6 proceeded The Director of Nursi on 3/4/25 at 4:35 PM concentrator settings	Arted Resident #20 liked to nected to his BIPAP and was y nasal cannula. Nurse #6 rator machine would sound ater was getting low and er canister was full. Nurse #6 ecked for water in the ne BIPAP was applied. The Nurse #6 on 3/4/25 at 4:10 is oxygen concentrator, the till empty. Nurse #6 noticed to remove the empty canister canister should have water in		<ul> <li>monthly QA committee by the D designee to ensure corrective ac initiated as appropriate. The mor Meeting is attended by the Admin Director of Nursing, MDS Coordi Therapy Manager, Health Inform Manager, and the Dietary Manage Deficiencies that are identified du monitoring process will be addre through the facility Quality Assurprocess.</li> <li>Date of Compliance: 4/1/2025</li> </ul>	tion is hthly QA nistrator, nator, ation ger. uring the ssed		
	needed. The DON re canisters from the su On 03/05/25 at 03:12 was interviewed by te Director stated, "not g bottle is empty for se Resident #20 needed the day and while us	assessed every shift and as ported nurses refilled water pply cabinet. 2 PM the Medical Director elephone. The Medical good when the humidifying veral days." She also stated d humidified oxygen during ing the BIPAP machine at irector said she thought that					

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		D HUMAN SERVICES MEDICAID SERVICES			FC	NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) D	ATE SURVEY OMPLETED
		345543	B. WING			03/06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
BERMUD	A COMMONS NURSING A	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 695	was sufficient for Res as well. She reported long-term effects from	ident #20's daytime oxygen that there were no n ot having the re were short-term effects M The Administrator itored all oxygen	F 69	95		
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)( §483.45(g) Labeling o Drugs and biologicals	d Biologicals (1)(2) of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary	F 76	61		4/1/25
	§483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acco §483.45(h)(2) The face locked, permanently a storage of controlled the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min be readily detected.	f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. willity must provide separately affixed compartments for drugs listed in Schedule II of brug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can				

Facility ID: 20070039

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	1 Y /	E SURVEY IPLETED
		345543	B. WING			C 03/06/2025	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETIO DATE
F 761	Continued From pag	e 29	F7	761			
	by:						
		ons and staff interviews the			To remain in compliance with all feder		
		date an open bottle of			and state regulations the facility has ta		
	eyedrops and an ope			or will take the actions set forth in this			
		late for 1 of 4 medication			plan of correction. The plan of correction	ion	
		(1b.) failed to dispose of a			constitutes the facility□s allegation of		
	-	edication carts (100 hall cart)			compliance such that all alleged		
		secure medication left at 1			deficiencies cited have been or will be	;	
		ent #19) bedside reviewed for			corrected by the dates indicated.		
	medication storage.				F 704		
	The findings includes	4.			F 761		
	The findings included	1:					
	10 An observation	of the 500 hall medication			1. How corrective action will be accomplished for those residents four	nd to	
		with Nurse #3 on 03/05/25 at			have been affected by the deficient		
		ottle of moxifloxacin (a			practice:		
		reat eye infections) solution					
		in a small plastic container			On 3/5/2025 Nurse # 3 removed the o	nen	
		An open bottle of fluticasone			bottle of moxifloxacin for Resident # 4		
		o treat allergies) nasal spray			from the medication cart and discarde		
		bserved in a small plastic			The order for moxifloxacin for resident		
	-	en date. Both bottles of			#43 was completed on 3/4/2025.	•	
		fied as open by Nurse #3.					
					On 3/5/25 Nurse #3 removed the oper	n	
	An interview with Nu	rse #3 on 03/05/25 at 4:42			bottle of (fluticasone) nasal spray 50 r		
	PM revealed she did	n't work often at the facility			from the 500 hall medication cart and	-	
	and did her best to k	eep up with what was on the			notified pharmacy for refill.		
	medication cart. She	e indicated the open dates					
	should have been do				On 3/5/2025 Nurse #4 discarded 1 loc		
	medications were op	ened.			unidentified white round pill observed	in	
					the top right drawer of 100 Hall		
		the 100 hall medication cart			medication cart. On 3/5/2025 Nurse #	4	
		Nurse #4 on 03/05/25 at 3:50			immediately discarded the 1 loose		
	PM. An unidentified	-			unidentified white round pull found on	100	
		e top right drawer of the			hall medication cart.		
		se #4 revealed she didn't					
		t there as she checked the			On 3/4/2025 Nurse #2 observed the		
		e pill shouldn't have been			antibiotic/pain relieving ointment on th	e	
	loose and unsecured	I in the medication cart.			bedside table of resident #19 and		

Facility ID: 20070039

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDING			
		345543	B. WING			С
		345543				3/06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	e 30	F 76			
				immediately removed the tub	e from	
	On 03/06/25 at 2:16 I	PM an interview with the		resident #19 s bedside table		
	Director of Nursing (E	DON) revealed the third shift		3/5/2025 Resident⊡s family n	nember	
	•	<ol> <li>nurse conducted a weekly</li> </ol>		contacted by Director of Nurs		
		ation carts. She indicated		about the antibiotic/pain reliev	•	
		nedications when they were		and educated any medication		
		according to expiration		must have a physician order a		
	unsecured in the med	should not be loose and		administration evaluation con	ipleted by	
		dication carts.		nursing.		
	An interview with the	Administrator on 03/06/25 at		2. How the facility will identify	/ other	
		expected nurses who		residents having the potential		
	opened medications	to label them upon opening not be loose and unsecured		affected by the same deficien		
	in the medication car			On 3/5/2025, the Director of N	Nurses	
				(DON)/designee completed a		
	2. Resident #19 was	admitted to the facility on		check of all current resident r	ooms to	
		es including late onset		ensure no other resident subj	•	
	Alzheimer's disease a	and dementia.		deficient practice of medication		
				bedside. Findings included no		
	2/13/25 noted Reside	Im Data Set (MDS) dated ent #19 had moderate		residents found to have medi bedside.	cations left at	
	cognitive impairment.			On 3/26/2025 an initial audit of	completed	
	On 03/03/25 at 12.14	PM Resident #19 was		for medication cart inspection	•	
		ube of antibiotic/pain reliever		medications were not expired		
		ide table. Resident #19		were stored per pharmacy	2	
		forehead", but reported she		recommendations. This comp		
		iy she was using it. When		3/26/2025. The audit revealed		
	· ·	did not remember where she		drops and 2 nose sprays rem		
	got the ointment.			the 4 medication carts that ha		
	During on choon atte	n of Posidont #10's room on		These medications were rem DON and immediately discard	•	
		n of Resident #19's room on the tube of antibiotic/pain		replaced from OTC backup a		
		ained on her bedside table.		notified to replenish.	па рнаннасу	
	-	vith Nurse #1 on 3/4/25 at		3. Address what measures w		
		d that she was not aware of		place or systematic changes		
	any medication on Re	esident #19's bedside table.		ensure that the deficient prac	tice will not	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					с
		345543	B. WING		03/06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				316 NC HIGHWAY 801 SOUTH	
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
iAo	REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)	
F 761	Continued From page	e 31	F 761		
				reoccur:	
	On 03/04/25 at 3:08 F	PM the tube of antibiotic/pain			
	reliever ointment was	observed still on Resident		Education:	
		Resident #19 again reported			
		on her forehead "about		On 3/5/25 the Staff Development	
	three times a day, it if	ches sometimes".		Clinician/DON/ began educating all licensed nurses (RN s and Licensed	
	Linon observation of I	Resident #19's bedside table		Practical Nurses, full time, part time, F	
	•	25 at 4:27 PM, Nurse #2		staff, and medication aides on Drug	
		ic/pain relieving ointment on		Storage and Biologicals. This education	on
		I removed the tube and took		includes:	
	it to the nurse's statio	n. Nurse #2 reported that it			
		on the resident's bedside		Medications are stored safely and	
	table.			securely. All unidentified medications	
	On 03/05/25 at 2:10 [	PM the Director of Nursing		to be discarded immediately when fou	ina.
		a physician's order was		Pay attention to medication expiration	
	, , ,	medication at a resident's		dates (ex. Fluticasone date when ope	
	bedside.			and discard when applicable to compl	
				with manufactures instructions).	
		ew with the Medical Director			
		, she reported that Resident		Medications cannot be left at bedside.	-
	#19's family member	The Medical Director stated		medications found at resident□s beds will be removed immediately.	alde
		e staff had not seen the		will be removed infinediately.	
		before it was brought to their		The DON or designee will be respons	ible
	attention. She also st	0		for ensuring this information has been	
		see the medicated ointment		integrated into the standard orientatio	
	and remove it from R	esident #19's room.		training and agency orientation for all	
		Administration 0/E/OE		identified above and will be reviewed	-
		ne Administrator on 3/5/25 at strator confirmed that		the Quality Assurance process to verify that the change has been sustained.	
		were educated to not bring in		of the above staff who does not receiv	-
	medications from hor	-		scheduled in-service training will not b	
	resident's bedside.			allowed to work until training has been	
				completed by 3/31/2025.	
				4. Monitoring Procedure to ensure that	
				the plan of correction is effective and	Inat

Event ID: IT8N11

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STATEMENT (	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345543	B. WING		C 03/06/2025	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	05/00/2025	
			3	16 NC HIGHWAY 801 SOUTH		
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 761	Continued From page 32		F 761	specific deficiency cited remains corre and/or in compliance with regulatory requirements:	ected	
				The Director of Nursing or designee w begin monitoring compliance on utilizi the QA tool: Medication/ Treatment Ca Inspection beginning 3/27/2025 week 3 weeks then monthly x 2 months to ensure that medications are labeled w opened and no loose pills.	ng art y x	
				The DON/designee will monitor 5 rand resident rooms beginning 3/27/2025 weekly x3 weeks then monthly for 2 months to ensure there are no medications left at bedside. The DON designee will monitor for compliance to proper way to store medications and remove expired medications.	or	
				Reports will be presented to the month Quality Assurance committee by the D to ensure corrective action is initiated appropriate. Compliance will be monit and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administra Director of Nursing, Minimum Data Se Nurse, Therapy Manager, Unit Suppo Nurses, Health Information Manager, the Dietary Manager.	oON as ored tor, et rt	
F 812 SS=E	Food Procurement,S CFR(s): 483.60(i)(1)(	tore/Prepare/Serve-Sanitary 2)	F 812	Compliance Date: 4/1/2025	4/1/25	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/20 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345543	B. WING		C 03/06/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BEDMUD				316 NC HIGHWAY 801 SOUTH		
DERINUUF		AND REHABILITATION CENTER		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
F 812	Continued From page 33 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources		F 81	12		
	approved or consider state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foo (iii) This provision doe	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility pompliance with applicable				
	serve food in accorda standards for food se	prepare, distribute and nce with professional rvice safety. is not met as evidenced				
	interviews, the facility nutritional supplement			To remain in compliance with and state regulations the facili or will take the actions set forth plan of correction. The plan of constitutes the facility allega compliance such that all allega deficiencies cited have been of corrected by the dates indicate	ty has taken h in this correction ation of ed or will be	
	PM of the nourishmen observation revealed	nade on 03/05/2025 at 2:33 nt room on the 300 Hall. The that there were 17 individual		F812		
		t drink cartons with a use by /ailable for use located on a rishment room.		<ol> <li>For dietary services, a corre was obtained on 3/05/2025.</li> <li>Based on nourishment room o on 3/05/2025, it was noted the</li> </ol>	bservations	
		nade on 03/05/2025 at 2:44 nt room on the 500 Hall. The that there were 121		failed to discard expired suppl from 2 of 2 nourishment rooms 3/05/2025 expired supplement	ements s. On	

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ATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DA	TE SURVEY	
d plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED		
						С		
		345543	B. WING			0	3/06/2025	
IAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BERMUD	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 812	Continued From page	e 34	F	812				
	individual nutritional s	upplement drinks with a use available for use located on			out.			
A th D fc sl re su	a lower shelf in the no An interview and tour			<ol> <li>Corrective action for residents with potential to be affected by the allege deficient practice:</li> </ol>				
	the 300 Hall on 03/05/2025 at 3:00 PM with the Dietary Manager revealed she was responsible for stocking snacks and the fortified nutritional shakes. She stated Central Supply was responsible for stocking the nutritional supplement drinks and should have pulled the out of date items.				All residents have the potential to be affected by the alleged deficient prac On 3/05/2025 Central Supply comple walk-through of the nourishment roo ensure nourishments rooms met	tice. eted a ms to		
		of the nourishment rooms			standards to store, prepare, and servise sanitary supplements.	/e		
	on 300 Hall and 500 l PM with Central Supp checked the nourishn expired items. She ch	Hall on 03/05/2025 at 3:05			3. Measures /Systemic changes to prevent reoccurrence of alleged define practice: Education:	cient		
		d not been removed. 5/2025 at 4:32 PM with the Dietary Manager revealed			In-service education was provided to Central Supply and Housekeeping Supervisor on 3/24/2025.	•		
	they were unsure why supplement drinks ha	/ the expired nutritional d not been removed from			Topics included:	4.		
	Supply should have p nutritional supplemen indicated all food/drin	anager stated that Central oulled the out of date t drinks. The Administrator k items should have been as soon as they expired.			<ul> <li>First In First Out with supplement</li> <li>Inventory to be completed and</li> <li>reviewed prior to ordering.</li> <li>Supplement orders to be update</li> <li>reviewed prior to ordering.</li> </ul>			
					This information has been integrated the standard orientation training and required in-service refresher courses all staff and will be reviewed by the C Assurance process to verify that the change has been sustained.	in the for		

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/202 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED	
		345543	B. WING _				C / <b>06/2025</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 F 883 SS=E	CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influen policies and procedur (i) Before offering the each resident or the r	ecococcal Immunizations (2) and pneumococcal za. The facility must develop res to ensure that- influenza immunization, resident's representative egarding the benefits and of the immunization; ffered an influenza	F 8		plan of correction is effective and that specific deficiency cited remains correct and/or in compliance with regulatory requirements: Central Supply or Housekeeping Supervisor will monitor procedures for proper supplement storage weekly x 3 weeks then monthly x 2 months using th Nourishment Room Inspection Tool whi will observe that all supplements are labeled, dated, within proper dates, and stored properly. Reports will be present to the weekly Quality Assurance committee by the Administrator to ensu corrective action initiated as appropriate Compliance will be monitored and ongoing auditing program reviewed at t weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Informatio Manager, and the Dietary Manager Date of Compliance:4/1/2025	he ich ted re e. he	4/1/25

Facility ID: 20070039

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/31/2025 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345543	B. WING		_	03/0	C 06/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BERMUD	A COMMONS NURSING A	AND REHABILITATION CENTER		16 NC HIGHWAY 801 SOL NDVANCE, NC 27006	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of was provided education and potential side effe- immunization; and (B) That the resident of immunization or did n immunization due to r refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each re representative received benefits and potential immunization; (ii) Each resident is of immunization, unless medically contraindica already been immuniz (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of	mmunization is medically e resident has already been a time period; e resident's representative o refuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza nedical contraindications or ococccal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; e resident's representative o refuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits	F 883				

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345543	B. WING			3/06/2025
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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 883	Continued From page	e 37	F8	383		
	the pneumococcal im contraindication or re This REQUIREMENT by: Based on record rev facility failed to docur in the medical record potential side effects pneumonia vaccines vaccines. This occurr (Resident #98, Resid Resident #27) review The findings included a. Resident #98 was 04/04/24. The reside reviewed and reveale under the education	nization or did not receive munization due to medical fusal. T is not met as evidenced iew and staff interviews, the ment education was provided regarding the benefits and of the influenza and prior to the administration of red for 4 of 5 residents lent #77, Resident #262, and ved for vaccines. d: admitted to the facility on nt's immunization record was ed that staff answered "no" provided tab for influenza		To remain in compliance of and state regulations the f or will take the actions set plan of correction. The pla constitutes the facility s a compliance such that all a deficiencies cited have be corrected by the dates ind F883 The plan of correcting the deficiency. The plan shoul processes that lead to the cited:	facility has taken t forth in this an of correction allegation of alleged een or will be licated. specific Id address the	
	and for pneumonia va Nurse #7 on 10/18/24 review also revealed documented under th on the immunization b. Resident #77 was 03/22/22. The reside reviewed and reveale the education tab for administered by Nurs pneumonia vaccine a 10/21/24. Review of revealed nothing was	admitted to the facility on nt's immunization record was ed staff answered "no" under influenza vaccine se #7 on 10/07/24, and administered by Nurse #7 on the immunization record also s documented under the ion on the immunization		The Facility did not follow outlined in the policies and ensure that documentation was provided in the medic regarding the benefits and effects of the influenza an- vaccines prior to administr vaccine. Residents # 98. Resident #262, Resident #27 were eligibility of and offered the and influenza vaccines an immunization record revea answered no under the ec- provided tab for influenza pneumonia vaccine admin	d procedures to n of education cal record d potential side d pneumonia ration of #77, Resident assessed for the e pneumococcal ind resident⊡s aled that staff ducation vaccine and	

Facility ID: 20070039

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		& MEDICAID SERVICES	0.00			10.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345543	B. WING			C 3/06/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	5/00/2025
		G AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
				ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 883	Continued From pa	ge 38	F 8	83		
	-	as admitted to the facility on				
		lent's immunization record was		1. Corrective action for residen	t(s)	
	reviewed and revea	aled staff answered "no" under or influenza vaccine		affected by the alleged deficient	( )	
	administered by Nu	irse #7 on 02/12/25, and		Resident #98 was assessed an	d offered	
		administered by Nurse #7 on		the influenza vaccine and admir	nistration	
		f the immunization record also		documented on 10/03/2024 and		
	-	as documented under the		pneumonia vaccine on 10/18/20		
		ction on the immunization		was informed. Resident represe		
	record for these do	Ses.		educated on 3/27/2025 for influe	enza and	
	d Resident #27 wa	is admitted to the facility on		pneumonia vaccine.		
		lent's immunization record was		Resident #262 was assessed a	nd offered	
		aled the education area was		the influenza vaccine and admir		
		er the education tab for		for influenza vaccine on 2/12/20		
	influenza vaccine a	dministered by Nurse #7 on		pneumonia vaccine on 2/15/202	25.	
		f the immunization record also				
	revealed nothing w	as documented under the		No corrective action due to resid	dent	
	education notes se	ction on the immunization		discharged from facility 3/17/20	25.	
	record for these do	ses.				
				Resident #77 was assessed an		
		e Infection Preventionist (IP)		the pneumococcal and influenza		
		) PM revealed that the floor		Influenza was administered 01/		
		ister the vaccines per the		and pneumonia on 10/21/2024.		
		stration Record (MAR). She be education provided prior to		informed. Resident educated or and pneumonia vaccine on 3/27		
		accines by the nurse			12020.	
		accine. The IP stated she and		Resident #27 assessed and offe	ered the	
		sing track which staff and		influenza vaccine on 10/3/2024		
	residents received	-		informed. Resident educated or vaccine on 3/27/2025.		
	An interview with D	irector of Nursing on 03/06/25				
		d she kept a record of the		2. Corrective action for residen	ts with the	
		red on the Vaccine Information		potential to be affected by the a	lleged	
	Flowsheet. She sta	ted the education should be		deficient practice:		
	provided to the resi					
		to the vaccine being		All current residents have the po		
		Director of Nursing stated the		be affected by the alleged defic	ient	
	expectation was for	r the nurse that provided the		practice.		

Facility ID: 20070039

PRINTED: 03/31/2025 FORM APPROVED

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 03/06/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				316 NC HIGHWAY 801 SOUTH	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER		ADVANCE, NC 27006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 883	education to docume education had been p immunization record. An interview with the 5:05 PM revealed he and/or the resident's provided with educati and potential side eff vaccines. He stated t	nt in the medical record that provided on the Administrator on 03/06/25 at expected the resident legal representative to be ion regarding the benefits ects prior to offering he expectation of procedures for providing	F 88	<ul> <li>On 3/27/2025 corrective action was initiated. The Director of Nurses/UM Managers/Minimum data nurse corra 100% Initial audit of all current refrom 3/1/2025-3/27/2025 who were offered pneumonia/influenza vaccir upon admission and provided educ revealed 3 out of the 9 residents direceive education prior to refusal or influenza/pneumococcal Education provided to the identified residents responsible party on 3/27/2025 and medical record has been updated t documentation of the influenza and pneumococcal education. Despite education the residents continued t refuse the pneumonia/influenza vaccinations.</li> <li>3. Measures /Systemic changes to prevent reoccurrence of alleged de practice:</li> <li>Education:</li> <li>The Director of Nurses educated al and LPN s on the influenza and pneumococcal policy and procedur including:</li> <li>Explain risk and benefits of receivir vaccine to the resident and /or responsible party and document education in resident s medical re</li> </ul>	nit mpleted sidents ene cation d not f n was or d o show d to o fficient II RN⊡s res ng the cord.
EORM CMS 256	7(02-99) Previous Versions Ob	solete Event ID: IT8N1	11	Nurses/Nurse Management team b           Facility ID: 20070039         If cc	began bontinuation sheet Page 40 of 48

Event ID: IT8N11

Facility ID: 20070039

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/31/2025 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	LETED
		345543	B. WING _			03/	; 06/2025
NAME OF P	ROVIDER OR SUPPLIER	l			REET ADDRESS, CITY, STATE, ZIP CODE	1	
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER			6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page	≥ 40	F 8	383	education of all RN s and LPN s full time, part time and as needed nurses of the Pneumococcal and Influenza administration. The in-service will be completed by 3/31/2025 at which time nurses must be in-serviced prior to working. The Director of Nurses will ensure that that any of the above identified staff who does not complete in-service training by 3/31/2025 will no allowed to work until the training is completed. The in-service will be incorporated into the new employee facility orientation. Monitoring Procedure to ensure that th plan of correction is effective and that specific deficiency cited remains corre- and/or in compliance with regulatory requirements: The Director of Nurses/Unit Managers monitor the immunization process for pneumococcal and influenza vaccines observing 5 residents utilizing the Immunization Audit Tool during the Dai Clinical Meeting Monday through Frida for compliance of the facility policy. Th audit will be completed weekly for a peri of 3 weeks and then monthly for a peri of 2 months. Reports will be presented the monthly Quality Assurance commit by the Director of Nurses to ensure corrective action is initiated as appropriate. The Clinical Team will rev in the Quality Assurance Meeting week until resolved. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality	all the t be cted will by ily ay nis eriod od d to ttee iew kly	

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/31/202 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			COMF	E SURVEY PLETED
		345543	B. WING _				/06/2025
NAME OF PI	ROVIDER OR SUPPLIER	I		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	
BERMUDA	A COMMONS NURSING	AND REHABILITATION CENTER			NC HIGHWAY 801 SOUTH /ANCE, 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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 883	Continued From page	9 41	F 8		Assurance Meeting. The weekly Quali Assurance Meeting is attended by the Administrator, Director of Nurses, MD Coordinator, Unit Manager, Therapy Manager, Health Information Manager and the Dietary Manager. Date of Compliance: 4/1/2025	S	
F 887 SS=E	CFR(s): 483.80(d)(3) §483.80(d) (3) COVII LTC facility must deve and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID- immunization is medi resident or staff mem immunized; (ii) Before offering CO members are provide regarding the benefits effects associated wit (iii) Before offering CO resident or the reside receives education re- risks and potential sid the COVID-19 vaccin (iv) In situations wher- requires multiple dose resident representativ provided with current	(i)-(vii) D-19 immunizations. The elop and implement policies sure all the following: vaccine is available to the and staff member -19 vaccine unless the cally contraindicated or the ber has already been DVID-19 vaccine, all staff d with education s and risks and potential side th the vaccine; DVID-19 vaccine, each nt representative egarding the benefits and de effects associated with e; re COVID-19 vaccination es, the resident, ve, or staff member is information regarding those uding any changes in the	F 8	87			4/1/25

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345543	B. WING		C 03/06/2025
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BERMUD	A COMMONS NURSING	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 887	member has the oppor COVID-19 vaccine, a (vi) The resident's me documentation that in the following: (A) That the resident was provided educati benefits and potential COVID-19 vaccine; a (B) Each dose of CO to the resident; or (C) If the resident did vaccine due to medic contraindications or n (vii) The facility maint to staff COVID-19 vac includes at a minimur (A) That staff were pr the benefits and pote associated with COV (B) Staff were offered information on obtain (C) The COVID-19 var related information as Disease Control and Healthcare Safety Ne This REQUIREMENT by: Based on record rev facility failed to docur in the medical record potential side effects prior to administration occurred for 5 of 5 re- immunizations (Resid	dent representative, or staff ortunity to accept or refuse a ind change their decision; edical record includes indicates, at a minimum, or resident representative on regarding the l risks associated with ind VID-19 vaccine administered not receive the COVID-19 ral efusal; and tains documentation related ccination that m, the following: ovided education regarding ntial risks ID-19 vaccine; I the COVID-19 vaccine or ing COVID-19 vaccine; and accine status of staff and is indicated by the Centers for Prevention's National etwork (NHSN). T is not met as evidenced iew and staff interviews, the ment education was provided regarding the benefits and of the COVID-19 vaccines in of the vaccines. This sidents reviewed for dent #43, Resident #98, ent #262, and Resident #27).	F 887	To remain in compliance with all fe and state regulations the facility ha or will take the actions set forth in plan of correction. The plan of corre constitutes the facility⊡s allegatior compliance such that all alleged deficiencies cited have been or wil corrected by the dates indicated. F887	as taken this rection n of

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STATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345543	B. WING			С
		343343				3/06/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 887	Continued From page	e 43	F 88	7		
	07/10/19. The Reside was reviewed and rev "no" under the educa	admitted to the facility on ent's immunization record vealed that staff answered tion provided tab for dministered by Nurse #7 on		The plan of correcting the spec deficiency. The plan should ad processes that lead to the defic cited:	dress the	
	11/06/24. The immun revealed that nothing	ization record review also was documented under the on on the immunization		The Facility did not follow proce outlined in the policies and pro- ensure that documentation of e was provided in the medical re- regarding the benefits and pote	cedures to education cord	
	04/04/24. The resider reviewed and revealed	admitted to the facility on nt's immunization record was ed that staff answered "no"		effects of the COVID-19 vaccin administration of vaccine.	ne prior to	
	05/25/24. The immun revealed that nothing	dministered by Nurse #7 on ization record review also was documented under the on on the immunization		Residents # 43, Resident #98, #262, Resident #77, and Resid were assessed for the eligibility offered COVID-19 vaccine and that staff answered no under the documentation for education put for the COVID-19 vaccines.	lent #27 y of and l revealed ne	
	03/22/22. The resider reviewed and revealed	admitted to the facility on nt's immunization record was ed staff answered "no" under the COVID-19 vaccine		<ol> <li>Corrective action for resider affected by the alleged deficier</li> </ol>		
	the immunization reco was documented und	e #7 on 10/21/24. Review of ord also revealed nothing ler the education notes nization record for this dose.		Resident #98 was assessed ar the COVID-19 vaccine by nurs 5/25/2024. MD was informed. F provided education on 3/27/202 the vaccine information statem	e #7 on Resident 25 using	
	02/11/25. The resider reviewed and revealed	s admitted to the facility on nt's immunization record was ed staff answered "no" under the COVID-19 vaccine		updated version 1/31/2025. Ed was documented in point click the immunization tab.	lucation	
	administered by Nurs the immunization reco was documented und	e #7 on 02/12/25. Review of ord also revealed nothing ler the education notes lization record for this dose.		Resident #43 was assessed ar the COVID-19 vaccine by nurs 11/6/2024. MD was informed. F provided education on 3/27/202	e #7 on Resident	

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	· · · ·	OATE SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		
			5.44440			С
		345543	B. WING			03/06/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E	
BERMUDA	COMMONS NURSING	AND REHABILITATION CENTER		316 NC HIGHWAY 801 SOUTH		
				ADVANCE, NC 27006		
(X4) ID			ID	PROVIDER'S PLAN OF CO		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		DATE
F 887	Continued From page	e 44	F 88	7		
	e. Resident #27 was	admitted to the facility on		updated version 1/31/2025. E	ducation	
		nt's immunization record was		was documented in point click		
		ed the education area was		the immunization tab.		
		the education tab for the				
		dministered by Nurse #7 on		Resident #77 was assessed a		
		the immunization record also		the COVID-19 vaccine by nurs		
		documented under the ion on the immunization		10/21/2024. MD was informe		
	record for this dose.	ion on the immunization		provided education on 3/27/20 the vaccine information staten	-	
				updated version 1/31/2025. E		
	An interview with the	Infection Preventionist (IP)		was documented in point click		
		<sup>P</sup> M revealed that the floor		the immunization tab.		
	nurse would administ	ter the vaccines per the				
	Medication Administr	ation Record (MAR). She		Resident #262 assessed and	offered the	
	stated there should b	e education provided prior to		COVID-19 vaccine on 2/12/20	25	
	administration of the					
	administering the vac	ccine.		No corrective action due to re		
	A m intermierus suith the	Discoton of Number of		discharged from facility 3/17/2	2025.	
		Director of Nursing on revealed she kept a record		Resident #27 assessed and o	ffor the	
		istered on the Vaccine		COVID-19 vaccine by nurse of		
		et. She stated the education		10/25/2024.		
	should be provided to					
		tive prior to the vaccine		MD was informed. Resident p	rovided	
		The Director of Nursing		education on 3/27/2025 using	the vaccine	
		n was for the nurse that		information statement updated		
	provided the education			1/31/2025. Education was doo		
		ducation had been provided		point click care under the imm	unization	
	on the immunization	record.		tab.		
	An interview with the	Administrator on 03/06/25 at		2. Corrective action for reside	ents with the	
		expected the resident		potential to be affected by the	alleged	
		legal representative to be		deficient practice:		
	-	ion regarding the benefits				
	and potential side eff			All residents who have not be		
	vaccines. He stated t			and offered the COVID-19 vac		
	vaccine education wa	procedures for providing		2024/2025 season have the p be affected by the alleged def		
	vaccine equivation wa	as not carried out.		practice. All residents who ha		

Event ID: IT8N11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X2)         345543       B. WING       (X2)	(X3) DATE SURVEY COMPLETED C 03/06/2025
345543 B. WING	
	0.5/06/2025
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BERMUDA COMMONS NURSING AND REHABILITATION CENTER       316 NC HIGHWAY 801 SOUTH         ADVANCE, NC 27006       ADVANCE, NC 27006	00,00,2020
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 887       Continued From page 45       F 887         assessed and offered education including the vaccine information sheet prior to administration have the potential to be affected by the alleged deficient practice. On 3/27/2025 a corrective action was initiated. The Director of Nurses/Unit Managers/Minimum data nurse complete a 100% initial audit of all current resident from 3/1/2025/2025 who were offered COVID-19 vaccine upon admission and provided education revealed 2 out of the 9 residents did not have education documentation of to refusal of COVID-19. Education was provided to the identified residents on 3/2/7/2025 and medical record has been updated to show documentation of education. Despite education of accenter.         3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:         Education:         The Director of Nurses and the Nurse Management team were re-educated on the immunization policy to include COVID-19 documentation of education.         Documentation process for education.         Continued to the vaccination education in the resident_s immunization process for education.	e. ed hts or n nt

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Facility ID: 20070039

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/31/2025 A APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		LETED
		345543	B. WING _				C 06/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2020
BERMUD	A COMMONS NURSING	AND REHABILITATION CENTER			6 NC HIGHWAY 801 SOUTH DVANCE, NC 27006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 887	Continued From page	e 46	F	387	Nurses/Nurse Management team bega education of all RN and LPN s full time, part time and as needed nurses the COVID-19 administration to include documentation of education in the med record in point click care under the immunization tab. The in-service will b completed by 3/31/2025 at which time nurses must be in-serviced prior to working. The Director of Nurses will ensure that that any of the above-mentioned staff who do not complete the in-service training by 3/31/2025 will not be allowed to work of the training is completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and t specific deficiency cited remains corre and/or in compliance with regulatory requirements: The Director of Nurses/Unit Managers monitor the immunization process for COVID-19 vaccines by observing 5 residents utilizing the Immunization Au Tool during the Daily Clinical Meeting Monday through Friday for compliance the facility policy. This audit will be completed weekly for a period of 3 we and then monthly for a period of 3 we and then monthly for a period of 2 months. Reports will be presented to 5 monthly Quality Assurance committee the Director of Nurses to ensure corrective action is initiated as appropriate. The Clinical Team will rev in the Quality Assurance Meeting weel	on e dical e all until ce that cted will dit e of eks the by iew	

Event ID: IT8N11

Facility ID: 20070039

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	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
NAME OF PROVIDER OR SLIPPI IFR	345543			COMPLETED
NAME OF PROVIDER OR SUPPLIER		B. WING		C 03/06/2025
		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
		:	316 NC HIGHWAY 801 SOUTH	
BERMUDA COMMONS NURSING AND F	REHABILITATION CENTER		ADVANCE, NC 27006	
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 887 Continued From page 47		F 887	<ul> <li>until resolved. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Qual Assurance Meeting. The weekly Qual Assurance Meeting is attended by the Administrator, Director of Nurses, MD Coordinator, Unit Manager, Therapy Manager, Health Information Manage and the Dietary Manager.</li> <li>Date of Compliance: 4/1/2025</li> </ul>	s

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