

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/20/2012
NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HWY 801 SOUTH ADVANCE, NC 27006	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<p>The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p>	
F 156 SS=C	<p>No deficiencies were cited as a result of the complaint investigation. Event ID #ZK1B11.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered</p>	F 156		



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

John Seyton

TITLE

Administrator

(X6) DATE

1/15/13

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.

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F 156	<p>Continued From page 1 under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and</p>	F 156	<p>F156</p> <p>A. Medicare Non-Coverage (NOMNC) letters were reviewed by the Business Office Manager for provision of reason for services ending and expected costs for residents #18, 7,& 38 and 2 day notice requirement for resident 38. Preventative audits have been implemented and the reason for services ending and the expected costs beyond the Medicare period for long term residents are provided in the Medicare non-coverage letters. All NOMC letters are issued within 48 hours of last covered day.</p> <p>B. All Medicare beneficiary residents have the potential to be affected by this alleged deficient practice. The Business Office Manager (BOM) is compiling supportive documentation for all Medicare skilled residents during weekly Medicare review meetings to determine non coverage status and noting reason for discharge for those residents discharging from skilled services on the NOMNC letter effective 12/20/12. Reason for discharge and costs will be explained verbally and</p>	

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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the reason for services ending and expected costs in the Medicare Non-Coverage letters for 3 of 3 sampled residents (Residents #18, #7 and #38) and the facility failed to provide a two day notice for the Medicare Non-Coverage letter for 1 of 3 sampled residents (Resident #38).</p> <p>The findings are:</p> <p>1. Resident #18's Notice of Medicare Non-Coverage letter stated her skilled nursing services were to end 08/24/12. The written notice failed to include the reason services were ending</p>	F 156	<p>documented on the NOMNC effective 12/20/12.</p> <p>All NOMC letters are issued within 48 hours of last covered day effective 12/20/12.</p> <p>C. Weekly audits are conducted by Administrator to insure discharge reason and costs where indicated are included and issued timely effective January 3, 2013. Weekly audits are conducted weekly x 3 months and Corporate audits will be conducted quarterly x 3 quarters to assure continued compliance. Identified issues will be corrected immediately by the business office staff.</p> <p>D. The Administrator/designee will report weekly to the facility Quality Assurance Meeting the results of the QA monitoring for on-going review and effectiveness with corrective action taken as needed.</p> <p>E. Completion date 1/3/13.</p>	1/3/13

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F 156	<p>Continued From page 3</p> <p>and did not include the expected costs to continue to receive services.</p> <p>Interview with the Business Office Manager (BMO) on 12/20/12 at 12:04 PM revealed she called the family and explained the noncoverage requirements and their right to appeal the decision. She stated that if she understood the clinical reason for the services ending she explained that also to the family but never included the reason in the notice. She further stated the clinical team usually shared the information regarding the reason services were ending with the family. The BMO further stated that she explained the expenses over the phone with the family. Resident #18 paid privately after Medicare services ended.</p> <p>2. Resident #7's Notice of Medicare Non-Coverage letter stated her skilled nursing services were to end on 11/14/12. The written notice failed to include the reason services were ending and did not include the expected costs to continue to receive services.</p> <p>Interview with the Business Office Manager (BMO) on 12/20/12 at 12:04 PM revealed she called the family and explained the noncoverage requirements and their right to appeal the decision. She stated that if she understood the clinical reason for the services ending she explained that also to the family but never included the reason in the notice. She further stated the clinical team usually shared the information regarding the reason services were ending with the family. The BMO further stated that she explained the expenses over the phone with the family.</p>	F 156		

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F 156	Continued From page 4 3. a. Resident #38's Notice of Medicare Non-Coverage letter stated her skilled nursing services were to end 09/28/12. The written notice failed to include the reason services were ending and did not include the expected costs to continue to receive services. Interview with the Business Office Manager (BMO) on 12/20/12 at 12:17 PM revealed she normally called the family and explained the noncoverage requirements and their right to appeal the decision. She stated that if she understood the clinical reason for the services ending she explained that also to the family but never included the reason in the notice. She further stated the clinical team usually shared that information with the family. The notation on the notice stated she left a message for the family to call back and nothing related to the BMO actually discussing the noncoverage with the family. The BMO further stated that she usually explained the expenses over the phone with the family. Resident #38 was a Medicaid recipient after Medicare services ended. b. In addition, the notice indicating services were ending 09/28/12 included a notation that the family was left a message on 09/28/12 at 5:22 PM regarding Medicare non-coverage. The letter was signed by the family on 10/03/12. Interview with the BMO on 12/20/12 at 12:17 PM revealed she did not know why there was not a 2 day notice provided. She reviewed notes in her computer but could not explain the delay in notification.	F 156		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	<p>Continued From page 5</p> <p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and store personal care equipment properly to prevent contamination in 6 resident rooms on 2 of 5 halls.</p> <p>The findings were:</p> <p>1. In Room 500, shared by 2 residents, on 12/18/12 at 10:15 AM, on 12/19/12 at 4:26 PM, and on 12/20/12 at 8:52 AM directly on the floor under the sink were a fracture pan, urine commode catch and wash basin.</p> <p>On 12/20/12 at 9:45 AM, Nurse Aide (NA#4) stated the personal care items should be stored in a trash bag in the bathroom or closet. The items should be labeled with names and room numbers. NA #4 further stated that one of the residents in this room often moved items around in her room.</p> <p>During interview with the unit manager #2 on 12/20/12 at 10:37 AM, it was revealed that personal care equipment should be stored in a bag in the bathroom or in the residents' closets. She was not sure if the equipment should have been labeled with resident names. She referred to the staff development coordinator who stated on 12/20/12 at 10:40 AM that personal care equipment should be labeled with names.</p> <p>2. In Room 506, shared by 2 residents, on</p>	F 253	<p>F253</p> <p>A. Resident rooms 500, 506, 510, 603, and 605 have personal care equipment labeled with permanent makers and stored properly in plastic bags on hooks in the bathrooms effective 1/10/13. The Unit Director/designee will monitor resident rooms daily for proper labeling and storage of personal care equipment.</p> <p>B. All residents have the potential to be affected by this alleged deficient practice. All resident rooms were audited 1/10/13 by Nurse Aides and determined that all resident rooms and personal care equipment has been labeled and stored properly. The Unit Director/designee monitors the resident rooms daily and completes the QA Monitoring Tool 5 x weekly x 4 weeks then monthly for 2 months verifying proper storage and labeling of personal care equipment beginning 1/10/13.</p> <p>C. All nursing staff were in-serviced on 1/8/13 by the Staff Development Director on bagging and labeling of personal care</p>	

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F 253	<p>Continued From page 6</p> <p>12/17/12 at 3:00 PM, on 12/18/12 at 8:43 AM, on 12/19/12 at 2:57 PM, and on 12/20/12 at 8:51 AM there was an unlabeled, soiled urinal on the back of the commode.</p> <p>Interview on 12/20/12 at 9:48 AM with Nurse Aide (NA) #5 revealed personal care items should be covered but was not sure about the urinals stating neither resident used them. She stated they should have been discarded.</p> <p>During interview with the unit manager #2 on 12/20/12 at 10:37 AM, it was revealed that personal care equipment should be stored in a bag in the bathroom or in the residents' closets. She was not sure if the equipment should have been labeled with resident names. She referred to the staff development coordinator who stated on 12/20/12 at 10:40 AM that personal care equipment should be labeled with names.</p> <p>3. In Room 510, shared by 2 residents, on 12/19/12 at 4:25 PM and 12/20/12 at 8:50 AM there was a soiled fracture pan on the back of the commode.</p> <p>On 12/20/12 at 9:45 AM, Nurse Aide (NA#4) stated the personal care items should be stored in a trash bag in the bathroom or closet. The items should be labeled with names and room numbers. She further stated that neither resident in this room used the bathroom and she wasn't sure who placed those items in the bathroom unless it was another shift.</p> <p>During interview with the unit manager #2 on 12/20/12 at 10:37 AM, it was revealed that personal care equipment should be stored in a</p>	F 253	<p>equipment. This information has been integrated into the standard orientation training and in-service refresher course for all nursing staff.</p> <p>The Unit Director/designee will complete the QA Monitoring Tool 5 x weekly x 4 weeks then monthly x 2 and will monitor for continued compliance.</p> <p>D. Personal care equipment audits and any issues will be reported to the Unit Director or D.O.N and corrective action will be taken immediately. The Unit Director will report weekly to the Quality Assurance Committee for on-going compliance and effectiveness. Any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be immediately.</p> <p>E. Completion date 1/10/13</p>	i/10/13

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F 253	<p>Continued From page 7</p> <p>bag in the bathroom or in the residents' closets. She was not sure if the equipment should have been labeled with resident names. She referred to the staff development coordinator who stated on 12/20/12 at 10:40 AM that personal care equipment should be labeled with names.</p> <p>4. In Room 603, shared by 2 residents, on 12/18/12 at 9:06 AM, on 12/19/12 at 4:51 PM, and on 12/20/12 at 9:05 PM there were 2 unlabeled urinals on the bathroom hand rail.</p> <p>On 12/20/12 at 9:30 AM, Nurse Aide (NA) #1 stated urinals and bedpans were supposed to be labeled with resident names and room numbers and bagged in the bathroom or in the top of closet. She further stated that neither resident in this room used the urinals on first shift, but one of them used a urinal on second shift.</p> <p>During interview with the unit manager #2 on 12/20/12 at 10:37 AM, it was revealed that personal care equipment should be stored in a bag in the bathroom or in the residents' closets. She was not sure if the equipment should have been labeled with resident names. She referred to the staff development coordinator who stated on 12/20/12 at 10:40 AM that personal care equipment should be labeled with names.</p> <p>5. In Room 605, shared by 2 residents, on 12/17/12 at 3:20 PM and on 12/19/12 at 4:21 PM there was an unlabeled, uncovered urinal on the bathroom hand rail. On 12/20/12 at 9:06 AM the unlabeled, uncovered urinal was on a stack of bagged wash basins on the floor.</p> <p>On 12/20/12 at 9:30 AM, Nurse Aide (NA) #1</p>	F 253		

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F 253	Continued From page 8 stated urinals and bedpans were supposed to be labeled with resident names and room numbers and bagged in the bathroom or in the top of closet. She further stated that she felt the urinal in this room was used for measuring urine output. During interview with the unit manager #2 on 12/20/12 at 10:37 AM, it was revealed that personal care equipment should be stored in a bag in the bathroom or in the residents' closets. She was not sure if the equipment should have been labeled with resident names. She referred to the staff development coordinator who stated on 12/20/12 at 10:40 AM that personal care equipment should be labeled with names.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review the facility failed to complete a	F 274	F274 A. An MDS/ significant change was scheduled and completed with Care Plan updated 12/19/12 for resident # 79 . B. All residents who receive Hospice Care have the potential to be affected by this alleged deficient practice. All Hospice residents were audited by the RN MDS Nurse for an MDS significant change 12/19/12 and were found to have completed comprehensive assessments. C. The Unit Director/designee will monitor discharge/admission summaries from the discharging hospital to determine Hospice order status and will provide a copy of the Hospice order to the MDS nurse. The Unit Director has been in-serviced on 12/21/12 on the admission/readmission process to assure that orders are received on Hospice service prior to initiating and submitting a copy of the order to the MDS nurse.	

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F 274	<p>Continued From page 9</p> <p>comprehensive Significant Change Minimum Data Set for 1 of 2 residents reviewed for hospice care, Resident # 79.</p> <p>The findings are:</p> <p>Resident #79 was admitted to the facility with the diagnoses which included Parkinson's disease. Review of Resident #79's most recent Admission Minimum Data Set (MDS) dated 11/02/12 revealed she had mild cognitive impairment.</p> <p>Review of nurses notes dated 12/04/12 revealed Resident #79 was readmitted to the facility from the hospital.</p> <p>Hospice notes written by nursing and social work revealed the resident was admitted to hospice services 12/04/12.</p> <p>Review of Resident #79's care plan revealed no mention of hospice or end of life issues that were being addressed by the facility.</p> <p>An interview was conducted on 12/20/12 at 12:06 PM with the MDS nurse. She stated she did not know Resident #79 was on hospice. She stated she is notified of residents being admitted to hospice services by receiving a copy of the physician's order. She stated she had not received a physician order for Resident #79. She stated had she been notified she would have completed a significant change MDS.</p> <p>During an interview on 12/20/12 at 12:24 PM the Unit Manager #2 stated if the resident returned from the hospital with a consult for hospice then the social worker would be notified by the</p>	F 274	<p>The MDS nurse/designee will audit the Hospice process weekly x 4 weeks and then monthly x 2 months to assure that orders are received and significant changes are completed.</p> <p>D. Hospice audits findings and any issues will be reported to the D.O.N. or Administrator and corrective action will be taken as needed. The MDS nurse/designee will report weekly to the Quality Assurance Committee to assure on-going compliance and any issues requiring action will be corrected immediately.</p> <p>E. Completion date: 1/10/13</p>	1/10/13

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NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HWY 801 SOUTH ADVANCE, NC 27006		
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F 274	Continued From page 10 admitting nurse. She was unsure how MDS would have been notified of the resident's admission to hospice services if there was not a physician's order. On 12/20/12 at 12:37 PM an interview was conducted with the facility's Social Worker (SW). She state she did not know Resident #79 had been admitted to hospice. The SW stated no one told her and she did not receive an order stating the resident was on hospice. An interview was conducted on 12/20/12 at 12:45 PM with the Director of Nurses (DON). The DON stated she was not sure why a physician's order was not written for hospice for Resident #79. She stated she had not worked with this particular hospice agency before and was unfamiliar with it. She further stated the family could choose which ever agency they wished. An interview was conducted on 12/20/12 at 2:33 PM with the facility's Medical Director (MD). The MD stated there should have been an order written, that is how it should have been generated. She further stated even if the order came from the hospital an order should have been written in the physician's orders by the nurse so everyone would know.	F 274			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281			

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F 281	<p>Continued From page 11</p> <p>Based on observations, record reviews and staff interviews the facility failed to follow physician order accurately in administering the correct dosage form of a bronchodilator (Albuterol inhaler) and administered the medication (Albuterol) as a nebulizer rather than an inhaler as ordered for one of ten sampled residents observed during medication pass. (Resident #233).</p> <p>The findings include:</p> <p>The facility did not have any policies related to medication borrowing and this was discouraged.</p> <p>Resident #233 was admitted to the facility on 12/17/12. Resident #233 had admitting diagnoses including shortness of breath, chronic obstructive pulmonary disease and diabetes mellitus. A review of physician orders dated 12/17/12 included an order for: 'Albuterol Sulfate 90 mcg (microgram) 2 puffs inhaled 4 times a day'.</p> <p>Further review of the Medication Administration Record (MAR) for December 2012 revealed that Albuterol 90 mcg two puffs inhaled four times was scheduled at 9:00 AM, 1:00 PM, 5:00 PM and at 9:00 PM daily. A continued review of the MAR revealed that Resident #233 had received only two doses on 12/18/12 instead of four doses ordered and there was no explanation documented for missing the two doses on 12/18/12.</p> <p>Resident #233 was observed for medication pass and nurse #6 was seen administering medications to Resident #233 on 12/19/12 at 8:10</p>	F 281	<p>F281</p> <p>A. The attending MD was contacted 12/18/12 and resident #233 received the meter dose inhaler as ordered at the next scheduled dosing and MD determined no additional action was required. Resident # 233 was discharged home 1/9/13.</p> <p>B. All residents that have orders for inhalation medications have the potential to be affected by this alleged deficient practice. Those residents on inhalation medications have been reviewed by the Unit Director using the QA Audit Tool and findings indicate that physician orders are followed and medications are administered accurately in the correct dosage form 1/9/13.</p> <p>C. All nurses were in-serviced by SDC nurse on medication administration and verification of medication and dosage forms to be compared to the MAR 1/9/13. This information has been integrated into the standard orientation training and required in-service refresher course for all licensed staff. The Unit Director will</p>	

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F 281	Continued From page 12 AM. The nurse administered all the oral medications appropriately and stated that she did not have the ordered 'Albuterol Nebulizer' solution in the medication cart for Resident #233 and the pharmacy had not yet sent the product and stated that she would borrow from another resident's medication as this was not a narcotic medication. She borrowed a 3 ml nebulizer unit dose of Albuterol 0.083% solution from another current resident 's medications and brought a clean nebulizer machine from the central supplies room and administered the nebulizer solution to Resident #233. The resident received Albuterol 2.5 mg nebulizer solution instead of two sprays of Albuterol metered inhaler 90 mcg each spray as ordered. An interview with nurse #6 on 12/19/12 at 9:06 AM revealed that she had not noticed that Albuterol inhaler was ordered for Resident #233 and she incorrectly administered the Albuterol nebulizer solution than the inhaler. Further review of the medication cart revealed that the inhaler was sent from the pharmacy and was available in the cart. The physician was contacted for further instructions related to the use of a 'wrong dosage' form of Albuterol. Interview with the Director of Nursing on 12/19/12 at 10:15 AM revealed that all nurses were expected and were aware of the protocol to obtain medications from backup pharmacy and stated that nurse #6 had wrongly read the order and administered the medication as a nebulizer than the ordered inhaler with no harm.	F 281	monitor 5 x weekly for 4 weeks then monthly x 2 on two randomly selected nurses to insure that comparing medication to the MAR is followed. Any exceptions will be reported to the D.O.N. or Administrator and corrective action will be taken immediately. D. The Unit Director/Designee will report the results of the monitoring weekly to the Quality Assurance Committee and any reported exceptions will be corrected immediately. E. Completion date 1/9/13	1/9/13	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 13</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to develop and implement interventions and strategies for 1 of 3 sampled residents with a history of falls. (Resident #131).</p> <p>The findings are:</p> <p>Resident #131 was readmitted to the facility on 11/09/11 with diagnoses including rehabilitation after surgery, paralysis, lack of coordination, diabetes, hypertension, Parkinson's Disease and falls.</p> <p>Review of the medical record revealed a physician's telephone order, dated 03/04/12, for an alarm to be on while in the chair and in bed for safety.</p> <p>The significant change assessment dated 03/16/12 coded him with moderately impaired cognitive skills and having one fall with minor injury since the prior assessment.</p> <p>The Care Area Assessment (CAA) relating to falls, dated 03/16/12, stated Resident #131 had recent falls, had impaired balance during</p>	F 323	<p>F323</p> <p>A. The falls interventions for resident # 131 were reviewed and the care plan was updated 12/21/12 and bed and chair alarms were d/c'd 12/21/12. The attending physician discontinued the alarms due to resident noncompliance.</p> <p>B. All residents with a history of falls have the potential to be affected by this alleged deficient practice. The Unit Director conducted an audit 12/20/12 of all residents who have alarms as falls interventions and no additional issues were identified. The MDS nurse reviewed fall risk Care Plans 12/26/12 to assure they were consistent with the interventions in place and will assure going forward that care plans are accurate and updated with each fall by reviewing the daily falls report.</p> <p>C. All nursing staff were in-serviced on alarms and devices placement and functioning 1/9/13 by Staff Development and this information has been integrated into the standard orientation training and required In-service</p>	

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F 323	<p>Continued From page 14</p> <p>transitions, and required limited assistance with transfers and toilet use. The CAA stated he was at risk for further falls and a care plan would be developed.</p> <p>A care plan was developed 03/19/12 for Resident #131 being at risk for falls. The goal was to be free from falls with staff assistance and supervision through 90 days. Interventions included to ensure chair alarm and bed alarm was in place. The care plan was updated on 05/06/12 due to another fall with the added intervention that 'he will at times remove alarm and to remind the resident to call for assistance.' Another fall was documented on the care plan for 05/11/12 with an added intervention to caution resident about getting up by himself.</p> <p>The quarterly MDS dated 05/25/12 coded Resident #131 with moderately impaired cognition, requiring assistance with bed mobility, transfers and walking, balancing and having falls since previous assessment. The care plan interventions remained unchanged. The care plan was updated due to a fall on 06/29/12 with an added intervention dated 06/29/12 to encourage him to use call light for assistance.</p> <p>Review of nursing notes dated 07/26/12 at 9:22 PM revealed Resident #131 was found on the floor by the nurse aide and the bed was sideways. Review of the incident report revealed the supervisor was notified of the fall at 7:00 PM. The report had no mention of alarms and indicated a referral would be made to therapy. Interview with the Unit Manager (UM) #2 and the Director of Nursing (DON) on 12/20/12 at 10:58 AM revealed he was reminded to call for</p>	F 323	<p>refresher course for all staff. The use of devices and alarms have been entered on the patient MAR and is verified by the nurse q shift. The MDS nurse will review weekly x 4 and then monthly x 2 all falls to assure that falls have appropriate interventions and are care planned. Any issues will be reported to the D.O.N. or Administrator and corrective action will be taken immediately.</p> <p>D. The Unit Director/designee is reviewing falls interventions 5 x weekly x 4 weeks and then monthly x2 to assure that alarms and devices are in placed as ordered. The Unit Director and MDS Nurse report weekly to the Quality Assurance Committee for on-going compliance and effectiveness. Any issues identified will be reported and corrective action taken immediately.</p> <p>E. Completion date 1/9/13</p>	1/9/13

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F 323	<p>Continued From page 15</p> <p>assistance and that maintenance checked and repaired the bed brakes. The DON stated that nursing completed incident reports and left them in one of three staff's mailboxes (she could not recall which mailbox it was left in). The incident reports were reviewed at each morning meeting and in the weekly quality of life meetings. These meetings ensured a good intervention was put into place and a therapy referral was filled out. When asked if the bed alarm was in place at the time of this fall the UM stated it was on. She stated her process was that she would go look in the room to see if the alarms were present as soon as she could. She stated it may not happen until the next day after the review of the incident report. The UM stated Resident #131 took the alarms off at times.</p> <p>Resident #131 received therapy from 08/01/12 through 08/27/12.</p> <p>The quarterly MDS dated 08/24/12 coded him with moderately impaired cognition, requiring assistance with bed mobility, transfers and walking. He was coded as having falls since the last assessment. The care plan updated 09/25/12 included the same goals to be free from falls with staff assistance and supervision. Added interventions included will remove alarms, fall mat at beside and encourage to participate in functional maintenance program.</p> <p>The most recent quarterly MDS dated 11/20/12 coded him as being cognitively intact, requiring extensive assistance for bed mobility, transfers and walking. He was coded as needing assistance with balancing and having no falls since the last assessment.</p>	F 323		

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F 323	Continued From page 16 The current care plan last updated 11/21/12 included the same goal and the same interventions including the hand written note that the resident will at times remove his alarm, ensure the alarm was in place when he was in the chair and bed, and remind him to call for assistance as needed for safety. A incident report dated 12/09/12 at 1:19 PM Resident #131 was reaching for an item on his bedside table and he slid to the floor. He was re-educated to call for assistance and referred to therapy. Nonskid socks were placed on the resident. There was no mention of any alarms sounding and there was no nursing note to correlate to this incident report. Review of the nursing notes dated 12/10/12 at 10:16 PM revealed at approximately 8:20 AM the resident was discovered on the floor in his room. He stated he bounced off the bed. The note continued stating at approximately 9:00 AM the resident was found sitting on the floor toward the end of the bed with a skin tear to his elbow. He stated his feet slid. There was no mention of alarms sounding or in use. There were no incident reports to correlate with these falls. On 12/19/12 at 2:48 PM, Nurse Aide (NA) #1 stated she was not present when he last fell. When asked what fall interventions were in place to prevent falls, she stated she tried to be by his side when he transferred. She stated Resident #131 was "pretty independent" and he knew his good days and bad days. She stated she was unaware of any new interventions since this last fall.	F 323		

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F 323	Continued From page 17 On 12/20/12 at 10:58 AM, Resident #131's falls on 12/09/12 and 12/10/12 were reviewed during interview with the DON and UM #2. At first they stated the fall on the incident report was the same as the falls listed in the nursing notes of 12/10/12 due to the computers being down. After some discussion they stated they could not be sure if Resident #131 fell once, twice or three times in this period of time. The DON confirmed Resident #131 was again admitted to therapy on 12/11/12 and he was still participating in therapy. Further interview with UM #2 on 12/20/12 at 11:47 AM revealed she will go see if alarms were in place after she received the incident reports. She stated it may not be that day of the fall. At times she had questioned staff to see if the alarm was in place and at times she stated she has just replaced an alarm when missing without saying anything to staff. Observations made during the survey revealed Resident #131 did not have any alarms attached to him while he was in bed or while he was in the wheelchair at the following times: *on 12/18/12 at 4:27 PM as he was lying across bed and awake; *on 12/19/12 at 9:12 AM as he was lying across bed and awake; *on 12/19/12 at 10:30 AM as he was in a wheelchair in the back of a large activity program; *on 12/19/12 at 4:20 PM as he was propelling in his wheelchair in the hall; *on 12/19/12 at 4:55 PM as he was in his wheelchair outside on the front porch; *on 12/19/12 at 5:16 PM as he was in the hall in his wheelchair; *on 12/19/12 at 6:02 PM as he was lying across	F 323		

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F 323	<p>Continued From page 18</p> <p>bed; *on 12/20/12 at 8:14 AM as he was lying across bed; and *on 12/20/12 at 9:08 AM as he was asleep across his bed.</p> <p>On 12/19/12 at 4:55 PM an interview with Resident #131 was conducted. When asked about his most recent fall from bed, he stated he got tangled on the bed and missed the bed. When asked if the facility had applied alarms to remind him not to fall, Resident #131 stated he used to have one on his ankle that alarmed whenever he went out the front door (wandergard alarm). He further stated he could not recall having an alarm on the back of his wheelchair and he stated he did not have an alarm when he went to bed.</p> <p>On 12/19/12 at 5:00 PM, NA #2 was asked how staff knew the individual needs of the residents. NA #2 stated most nurse aides work with the same residents and know them. She further stated that new information was passed verbally during shift reports.</p> <p>On 12/19/12 at 5:01 PM, Nurse #2 stated nurse aides had lists near the nursing station with information until they were oriented. Nurse aides also could ask other aides or nurses for information. She further stated that any changes are related by the nurse. Related to the list at the nursing station, a vital sign report was observed. This had some information specific to each resident. For Resident #131 the report stated "fall risk, assist with adls and toileting, shave daily."</p> <p>On 12/19/12 at 5:10 PM, NA #3 (assigned to</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>Resident #131) stated she did not know much about Resident #131. She stated that there was charting on the computer and she could look at a book at the nursing station for information. She showed the surveyor the book but could not locate a paper regarding Resident #131. She stated if a resident falls they should have an alarm. She was not sure of Resident #131's need for an alarm.</p> <p>On 12/20/12 at 9:28 AM, NA #1 stated Resident #131's fall prevention was for him to call her for assistance. She further stated Resident #131 transferred himself to bed and would call her for further assistance. She stated when he got dressed all he had to do was stand at bedside to pull his pants up. When specifically asked about the use of chair or bed alarms, NA #1 stated he did not use alarms recently and had none currently ordered. She stated the alarms were discontinued "way back" and not listed in the care tracker computer for nurse aide information.</p> <p>On 12/20/12 at 10:43 AM, Nurse #3 stated Resident #131 had a chair alarm in the past but was no longer listed as a current order in the computer. She stated it was not in the treatment record either. As for fall interventions, she stated the nurse aides on the hall were familiar with him and increased rounds on Resident #131 and encouraged him to call for assistance before transferring himself. NA #3 referred the surveyor to UM #2.</p> <p>On 12/20/12 at 10:46 AM, UM #2 stated a mat should be used at night and folded during the day when he was in his wheelchair. She stated that alarms are placed in his chair but he removed</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>them and hid them. She further stated he has had alarms in bed and the wheelchair for a long time. UM #2 stated the nurse aides should know about the alarms and should ask the nurse or other nurse aides if they have any questions.</p> <p>On 12/20/12 at 10:58 AM, fall interventions were discussed during interview with the DON and UM #2. UM #2 stated she checked to see if alarms were in place after review of incident reports. If there was a change in the care plans, the DON stated there was a care plan book for staff to refer to which was located at the nursing station. For changes, nurses were expected to verbally pass information on such as the addition or discontinuation of alarms during report. Nurse aides were expected to ask the nurse or other nurse aides if they had any questions regarding a resident's individual needs. UM #2 was asked if a change occurred while a nurse aide was off for a few days if she would hear about changes in report upon her return. UM #2 stated that nurses could not give the same report over and over again as it would be too time consuming. Nurse aides were expected to look at the care plan book or in the computer in the care tracker for specific information.</p> <p>Review of the care tracker record revealed nurse aides had been signing off that the chair alarm was in place. There was nothing about a bed alarm. The DON and UM #2 stated on 12/20/12 at 11:32 AM that the chair alarm was interchangeable with the bed alarm and the chair alarm listed in the care tracker meant the alarm went from the bed to the wheelchair.</p> <p>On 12/20/12 at 11:38 AM, interview with the MDS</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/20/2012
NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HWY 801 SOUTH ADVANCE, NC 27006	
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F 323	Continued From page 21 nurse #2 revealed she added the note to the care plan that Resident #131 removed his alarm after hearing about it from the nursing staff. She further stated the problem was first noted in March 2012. When asked why it was still an intervention, the DON (also present in the room) stated "to help prevent another fall." MDS stated the nurse aides should have known the alarm was necessary because it was on the caretracker computer for them to address.	F 323	F363 A. All residents on pureed meals have been identified by the Dietary Manager and all meals are prepared and served following the menus and include pureed bread where indicated effective 12/21/12. Those residents on pureed diets receive their meals according to the planned, approved menu cycle, meeting the recommended dietary allowances and prepared to the proper consistency. B. All residents with diet orders have the potential to be affected by this alleged deficient practice. Diet cards are written for each resident based on physician orders and menu items served are in accordance with the menu cycle spreadsheet. Dietary staff place tray identification cards on the meal trays. Resident meals have been audited by the Dietary Manager beginning 12/21/12 at tray line service to assure proper consistency and diet cards are being followed. C. All dietary staff were in-serviced on 1/9/13 by the Registered Dietician/Dietary Manager on adherence to menus and diet	
F 363 SS=E	483.35(c) MENU MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, record and menu reviews, and staff interviews, the facility failed to follow the menu and provide bread to 10 residents on a pureed diet for 2 of 2 meals observed on 12/19/12. The findings are: 1. According to the menu, the pureed breakfast for 12/19/12 was to include juice, pureed banana, pureed hot cereal, pureed egg, pureed sausage patty, and 2 ounces of pureed bread. On 12/19/12 at 7:51 AM, the breakfast meal was observed being set up and served from the steam table.	F 363		

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F 363	<p>Continued From page 22</p> <p>Observations of the steam table revealed there was no pureed bread on the steam table or at the line of service.</p> <p>The cook was asked about the location of the pureed bread on 12/19/12 at 8:24 AM after observing several pureed meals being plated without any pureed bread. The cook stated that she had been instructed by the facility's dietician that applesauce could be used as a substitute for pureed bread.</p> <p>Interview with the Dietary Manager (DM) on 12/19/12 at 2:17 PM verified the dietician stated applesauce was a suitable substitution.</p> <p>On 12/20/12 at 8:40 AM a phone interview with the facility's dietician (RD) was conducted. She stated recipes were used for pureeing bread or could add a piece of bread per serving when preparing the pureed meat. She stated she never instructed the facility to use applesauce as a substitute for pureed bread.</p> <p>Review of the list of residents and their diets revealed 10 residents were ordered pureed meals.</p> <p>2. The menu for the pureed noon meal on 12/19/12 included pureed chicken, pureed au gratin potato, pureed greens, pureed fruit and 2 ounces of pureed dinner roll.</p> <p>Observations of the steam table revealed there was no pureed bread on the steam table or at the line of service.</p>	F 363	<p>spreadsheets, mechanically altered consistency diets, and ensuring proper food handling and safety. This information has been integrated into the standard orientation training and required in-service refresher course for all dietary staff. Dietary QA Audits are performed by the Dietary Manager/designee daily x 4 weeks and then weekly x 2 months. The Dietary Manager will review audits and identify any additional concerns to be addressed and corrected immediately.</p> <p>D. Audit results and any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be taken as needed. Ongoing compliance will be reviewed at the weekly Quality Assurance meetings.</p> <p>E. Completion date 1/9/13</p>	1/9/13	

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F 363	Continued From page 23 After several pureed trays were plated without any pureed bread, the cook was asked about the location of the pureed bread on 12/19/12 at 12:07 PM. The cook and the Dietary Manager (DM), also present, both stated the cook usually mixed the bread into the pureed chicken per the recipe. When asked if she had added bread to the pureed chicken this date, she stated no. The DM went to look for bread crumbs in the reach in refrigerator and found none. On 12/19/12 at 2:22 PM, the cook stated she had not followed any recipe in preparing the chicken with bread. Review of the recipe for the pureed roasted chicken revealed nothing in terms of bread. On 12/20/12 at 8:40 AM a phone interview with the facility's dietician (RD) was conducted. She stated recipes were used for pureeing bread or could add a piece of bread per serving when preparing the pureed meat. Review of the list of residents and their diets revealed 10 residents were ordered pureed meals.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364		

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F 364	<p>Continued From page 24</p> <p>by:</p> <p>Based on observations, resident interviews and staff interviews, the facility failed to serve food hot enough for 7 out of 16 interviewed residents. (Residents #64, #113, #136, #99, #137, #131 and #79).</p> <p>The findings are:</p> <p>Resident interviews revealed 7 residents complained that the food was served too cool as follows:</p> <p>*Resident #64 stated on 12/17/12 at 2:29 PM the food was served mostly cold.</p> <p>*Resident #113 stated on 12/17/12 at 3:15 PM the coffee and eggs were cold.</p> <p>*Resident #136 stated on 12/17/12 at 3:53 PM the food was cold sometimes.</p> <p>*Resident #99 stated on 12/18/12 at 8:25 AM the food and coffee was not hot.</p> <p>*Resident #137 stated on 12/18/12 at 8:32 AM the food was lukewarm 50 percent of the time.</p> <p>*Resident #131 stated on 12/18/12 at 9:13 AM the food was cold 50 percent of the time.</p> <p>*Resident #79 stated on 12/18/12 at 11:31 AM the food was not hot.</p> <p>On 12/19/12 at 7:51 AM the temperatures using a calibrated thermometer of the food on the steam table were taken and revealed temperatures of pureed sausage at 171 degrees Fahrenheit (F), mechanical soft sausage at 183 F, applesauce at 135 F, pureed eggs at 175 F, cardiac eggs at 183 F, regular scrambled eggs at 170.6 F, regular sausage at 198 F, grits at 196 F, and oatmeal at 198 F.</p> <p>At 8:40 AM the last cart including 400, 500 and</p>	F 364	<p>F364</p> <p>A. All residents including #'s, 64, 113, 136,99,137,131 and 79 are receiving food prepared by proper methods to conserve nutritive value, flavor appearance and is served at the proper temperatures which are verified by the Dietary manager/designee at the food service line daily and on test trays taken on alternative resident halls weekly effective 1/9/13.</p> <p>B. All residents have the potential to be affected by this alleged deficient practice. Trays are delivered to conserve nutritive value, flavor and temperature and meal delivery schedules are followed effective 12/21/12. Food temperatures are measured and verified by the Dietary manager/designee at the food line daily and on test trays taken on alternative halls weekly effective 12/21/12.</p> <p>C. All dietary staff were in-serviced on 1/9/13 by the Registered Dietician/Dietary Manager on conserving nutritive value, flavor and temperature. This information</p>	

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F 364	Continued From page 25 600 hall trays began being plated using heated plates and thermal top and bottom plate covers. The test tray, plated with regular consistency foods, was approximately the third plate on the cart of 11 other trays. The last tray was placed on the metal non-insulated cart at 8:49 AM and immediately was delivered to the nursing station at the junction of the 400, 500, and 600 halls. At 8:51 AM, staff separated the trays so that some stayed in the metal cart and others went into a metal shelving unit covered in plastic. At 9:03 AM the last of the trays which left the kitchen with the test tray were served. At 9:03 AM the Dietary Manager (DM) and surveyor took the temperatures of the foods and tasted the foods for palatability. The scramble eggs' temperature at 99 F tasted by both staff and surveyor to be "at room temperature." The grits were 129 F and "warm." The coffee was 127 F and both agreed "should be warmer." The milk was 43.3 F and "good." The sausage patty was 97.6 F. The DM said it was okay for a patty and the surveyor thought it was room temperature.	F 364	has been integrated into the standard orientation training and required in-service refresher course for all dietary staff. Dietary QA Audits are performed by the Dietary Manager/designee daily x 4 weeks and then weekly x 2 months. The Dietary Manager will review audits and identify any additional concerns to be addressed and corrected immediately. D. Audit results and any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be taken as needed. Ongoing compliance will be reviewed at the weekly Quality Assurance meetings. E. Completion date: 1/9/13	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide ground chicken for 2 of 2 sampled residents with	F 365		1/9/13

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F 365	<p>Continued From page 26</p> <p>physician diet orders for ground meat diets. (Residents #63 and #93).</p> <p>The findings were:</p> <p>On 12/19/12 the noon meal menus were reviewed and included ground rotisserie chicken to be served for a ground mechanical soft diet. At 11:55 AM observations of the steam table revealed pureed chicken, diced chicken and chicken breasts. There was no ground chicken observed in the steam table.</p> <p>On 12/19/12 at 12:12 PM, the cook was asked about the location of ground chicken. The cook stated she did not think there were any residents who received ground meat.</p> <p>At 12:15 PM, Resident #93's tray was plated. The tray card clearly indicated the need for ground meat. The cook was observed to push down onto the diced chicken and scoop up the diced chicken onto the plate. Once covered for service, the surveyor asked the cook about Resident #93's need for ground chicken. The cook stated that the chicken was soft so she just smashed it and broke it up a little more. She continued to send the tray to be served to Resident #93.</p> <p>On 12/19/12 at 12:18 PM, the Dietary Manager (DM) stated that ground chicken was finer than mechanical soft chicken. He further stated that if the chicken was tender, it was acceptable for the cook to just mash it up to make it more ground. He further stated there was no policy related to ground meat, just the recipe.</p>	F 365	<p>F365</p> <p>A. Residents # 63 and 93 are receiving meals prepared in a form designed to meet their individual needs including ground meats as indicated. The Dietary manger/designee verifies daily through Dietary QA audits that appropriate diet consistencies are followed for these residents from the menus effective 12/21/12.</p> <p>B. All residents with ground meat diet orders have the potential to be affected by this alleged deficient practice. Proper food preparation procedures and diet consistencies are followed from the menus and diet cards. Diet cards are written for each meal from physician's orders reflecting changes and/or additions and dietary staff places the cards on the meal trays. Resident meals have been audited 3 meals daily by the Dietary Manager/designee beginning 12/21/12 at tray line.</p> <p>C. All dietary staff were In-serviced on 1/9/13 on</p>	

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F 365	<p>Continued From page 27</p> <p>Review of the recipe for ground chicken revealed cooked chicken should be ground to the appropriate consistency using a food processor.</p> <p>On 12/20/12 at 8:40 AM the facility dietician (RD) was interviewed via phone. The RD stated there was a difference between mechanical soft chicken and ground chicken. She further stated the chicken should have been ground using the robo machine and ground chicken needed more grinding than mechanical soft.</p> <p>Review of the list of residents and their diets provided by the facility revealed 2 residents were ordered ground meat diets as follows:</p> <p>a. Resident #93's diet was changed on 06/28/10 to a mechanical soft diet with ground meats. On 12/19/12 at 12:30 PM, Resident #63 was observed in the dining room with her tray in front of her. Per her tray card, Resident #63 was supposed to receive pureed chicken. The chicken on her tray was observed to in bite size pieces. The nurse aide assisting her stated Resident #63 would have no difficulties eating the chicken. Resident #63 was agitated during this meal and did not eat any chicken. On 12/20/12 at 5:00 PM, the Dietary Manger stated Resident #93's diet had changed to ground meats per a speech therapy evaluation.</p> <p>b. Resident #63's diagnoses included dysphagia, history of stroke and chronic airway obstruction. On 11/27/12, the physician ordered her diet changed from a mechanical soft diet to a soft diet with ground meat. On 12/20/12 at 4:00 PM, Nurse #3 stated Resident #63 had been receiving a mechanical soft diet based on what she has</p>	F 365	<p>mechanically altered diets/ ground meets by the registered Dietician/Dietary manger. This information has been integrated into the standard orientation training and required in-service refresher course for all dietary staff. Dietary QA Audits are performed by the Dietary Manager/designee daily x 4 weeks and then weekly x 2 months. The Dietary Manger will review the audits and identify any additional concerns to be addressed and corrected immediately. D. Audit results and any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be taken as needed. Ongoing compliance will be reviewed at the weekly Quality Assurance meetings.</p> <p>E. Completion date: 1/9/13</p>	1/9/13

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F 365	Continued From page 28 seen the resident receive at meal times.	F 365		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 2 of 2 clean and sanitary ice chests (cambros), 1 of 2 nourishment rooms with: labeled and dated frozen foods; labeled, dated and sealed cabinet foods; maintain 2 drawers free of crumbs and dried spills; and failed to maintain potentially hazard sandwiches within proper temperatures at the line of service. The findings were: 1. On 12/17/12 at 12:41 PM observation of the 600 hall pantry revealed the following: *3 opened, unlabeled, undated quarts of ice cream with ice crystals inside on the lid and ice cream in the freezer. *1 undated, unlabeled frozen lean cuisine dinner in the freezer. *1 carton of fresh watermelon in the refrigerator drawer that was unlabeled and undated. *1 opened, undated, unlabeled jar of bread	F 371	F371 A. Food storage areas including nourishment rooms, cabinets, refrigerators and ice chests, scoops and holders have been cleaned by housekeeping 12/21/12 and are maintained in clean and sanitary conditions. Nourishment rooms are monitored by a designated Nurse Aide/staff member daily for cleanliness and outdated food items beginning 1/9/13. B. All residents have the potential to be affected by this alleged deficient practice. A designated Nurse Aide/staff member monitors nourishment rooms daily to ensure nourishment rooms and ice chests are in clean and sanitary condition and records findings on the daily assignment sheet and initials for compliance when completed. Housekeeping designee removes the ice scoop and scoop holder weekly and assures they are cleaned by kitchen. The Nurse Unit Director/designee verifies and initials the daily assignment sheet. Dietary designee monitors nourishment room for stocked food items daily for expired food items.	

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F 371	<p>Continued From page 29 spread that had separation. *1 open to air, unlabeled, undated box of cereal in the lower cabinet. *2 of 3 cabinet drawers with plastic ware had dried sticky residue and crumbs inside.</p> <p>These items remained in place during observations on 12/18/12 at 8:15 AM and on 12/19/12 at 10:48 AM.</p> <p>On 12/19/12 at 2:31 PM, Nurse #4 stated she thought that the pantry was the responsibility of the dietary, housekeeping and nursing staff, depending on the food item. All resident food should be dated by nursing and the kitchen supplied food should be dated by dietary staff. she stated housekeeping was responsible for checking the refrigerators for outdated items.</p> <p>On 12/19/12 at 2:34 PM, housekeeper #1 stated she had never been instructed to clean the cabinets in the pantry nor the ice cambros. She stated she did not discard food from the refrigerator. She further stated housekeepers work first shift only.</p> <p>On 12/20/12 at 9:34 AM, Nurse Aide (NA) #1 stated the nourishment room was assigned to a nurse aide each day. The NA assigned should check food items for dates. All items in the refrigerator should have dates and names on them if for residents. She further stated resident food items are discarded based on the type of food it is and whether it appeared good or not, and by use by dates.</p> <p>On 12/20/12 at 9:43 AM, Nurse #3 stated she thought housekeeping cleaned the cabinets and</p>	F 371	<p>C. All dietary staff were in-serviced on 1/9/13 by the Dietary Manager on proper food handling, storage, and expiration dates and housekeeping staff were in-serviced on 1/4/13 on proper cleaning procedures and infection control by Staff Development. Nursing staff were in-serviced on 1/9/13 by Staff Development on proper cleaning and storage procedures and the inspection and reporting process. This information has been integrated into the standard orientation training and required in-service refresher course for all dietary, housekeeping and nursing staff. Nourishment room/food storage areas are monitored daily x 4 weeks and then monthly x 2 by the designated Nurse Aide/ nursing staff member who reports findings to the Unit Director/designee. Unit Director will monitor for on-going compliance.</p> <p>D. Audit results and any issues will be reported to the Unit Director or D.O.N. and corrective action will be taken immediately. On-going compliance will be reviewed for effectiveness at the weekly Quality Assurance meetings.</p> <p>E. Completion date: 1/9/13</p>	1/9/13

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F 371	<p>Continued From page 30 drawers.</p> <p>On 12/20/12 at 11:54 AM, housekeeper #2 stated she was responsible for nothing related to the food in the nourishment rooms and doesn't look inside the drawers very often.</p> <p>2. The 2 portable ice chests (ice cambros) were observed with dirty ice scoop holders as follows: a. On 12/17/12 at 12:05 PM there was scrap straw papers inside the ice scoop holder on the side of the ice cambros located in the 600 hall activity room. It remained in the ice scoop holder on 12/18/12 at 9:34 AM, at 4:25 PM.</p> <p>On 12/18/12 at 4:52 PM the ice cambros in the activity room full of ice and ice scoop container has straw wrappers in catch bowl. At 4:53 PM interview with Nurse Aide (NA) #7 revealed nurse aides fill the ice cambros up but she was not sure who cleaned them out.</p> <p>On 12/18/12 at 4:55 PM the unit manager #2 stated she too was unsure who cleaned the ice cambros.</p> <p>On 12/18/12 at 5:06 PM NA #8 stated she had filled the ice cambros in the activity room. Upon seeing the straw paper in the scoop holder, she stated she had no idea as to who was to clean the scoop holders and that the nurse aides just kept the ice cambros filled. At this time a paper towel was used and black residue was scraped from the bottom of the ice scoop holder.</p> <p>b. On 12/18/12 at 4:34 PM the ice cambros in the 100 hall nourishment room had dark residue that came off with a paper towel in the bottom of the</p>	F 371		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/20/2012
NAME OF PROVIDER OR SUPPLIER BERMUDA COMMONS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC HWY 801 SOUTH ADVANCE, NC 27006	
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F 371	Continued From page 31 holder. At 4:40 PM this ice cambros was being used on the resident halls. On 12/18/12 at 4:46 the Nurse Aide (NA) #6 stated if the ice cambros needed ice before the ice pass, whoever passes ice would fill it up. She stated that as far as she knew, nurse aides drained the water from the ice cambros but were not responsible for cleaning them out or cleaning the scoop. She further stated she had used the ice scoop for this round of ice pass. On 12/18/12 at 4:50 PM, Nurse #5 stated the ice cambros were cleaned by the 11-7 nurse aides. On 12/18/12 at 4:57 PM, the Dietary Manager (DM) stated the kitchen was to clean the ice cambros once a week. The ice scoops were also cleaned once a week in the kitchen. The DM stated when the scoop holders are soiled in between the nurse aides should wipe them out. On 12/18/12 at 5:03 PM, the Director of Nursing (DON) observed the soiled ice scoops holders and stated the nurse aides should be wiping them out when observed dirty.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		

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F 425	<p>Continued From page 32 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to obtain required stock of the accurate strength of an over the counter medication containing Calcium and Vitamin D.</p> <p>The findings include:</p> <p>A review of the medication storage areas included medication carts, all medication rooms and central supply storage areas as a part of the recertification protocol. During the review of medication rooms the following medication was not in stock in both the medication rooms: 'Calcium 500 mg (milligram) + Vitamin D 400 IU (International Units)'</p> <p>A review of the stock in the medication carts revealed only one bottle of Calcium 500 mg + Vitamin D 400 IU in the 100-hall medication cart and the physician orders reflected to use Calcium with Vitamin D 400 IU. No stock was available in any other area medication carts.</p>	F 425	<p>F425 A. Over the counter medications are ordered and obtained to the accurate strength as prescribed by the physician. Calcium 600 (correction) Vitamin D 400 IU was obtained from the supplier 12/22/12 and continues to be stocked in the med room stock cabinet.</p> <p>B. All residents have the potential to be affected by this alleged deficient practice. An audit by the D.O.N./designee of residents with orders for calcium vitamin D was conducted on 12/21/12 and no other issues were identified.</p> <p>C. The Unit Director/designee is monitoring OTC supplies and med carts weekly x 4 and then monthly x 2 to assure all needed OTC medications are available including Calcium 600 (correction)Vitamin D 400 in the accurate strength and the central supply department is notified of any medication requirements. The Unit Director will notify the D.O.N. or Administrator of any issues and corrective action will be taken as immediately.</p>	

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F 425	Continued From page 33 Interview on 12/19/12 at 9:32 AM, with the central supply staff person who ordered and maintained the stock of over-the-counter medications revealed that she had wrongly ordered Calcium 500 mg + Vitamin D 200 IU instead of Calcium 500 mg + Vitamin D 400 IU. The interview revealed that all nurses were aware of the mistake in the order. Further review of the medication carts revealed bottles of Calcium 500 mg + Vitamin 200 IU and nurses had been using Vitamin D 200 IU in place of 400 IU. The interview revealed that the correct strength of Calcium with Vitamin D was on the order would be arriving soon. There was no documentation available to show when the right strength of Calcium + Vitamin D 400 IU was previously ordered. Observations during the medication pass revealed that Calcium 500 mg + Vitamin D 200 IU was used in two observations which resulted in counting them as two non-significant medication errors. Interview on 12/18/12 at 4:40 PM with Nurse #3 who was the unit supervisor for 100-hall, revealed the Calcium 500 mg with Vitamin D 400 IU and the 200 IU bottles looked alike and was not aware that Vitamin D 200 IU bottles were ordered in place of 400 IU.	F 425	D. The Unit Director/designee will report results from weekly monitoring to the Quality Assurance Committee weekly to assure ongoing compliance and corrective action will be taken immediately. E. Completion date 1/9/13	1/9/13	