STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345416	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CENTER	142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 03/18/25 through 03/20/25. This facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID 04CM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/18/25 through 03/20/25. Event ID: 04CM11. The following intake was investigated: NC00225700. Three (3) of the three (3) complaint allegations did not result in a deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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 right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		4/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/28/2025

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F 578	Continued From page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure the code status information was accurate throughout the medical record for 1 of 15 residents (Resident #11) reviewed for advanced directives. The findings included: Resident #11 was admitted to the facility on 02/15/25. A review of Resident #11's medical record revealed a physician order dated 02/15/25 for a Full Code. A review of the Code Status notebook kept at the nursing desk revealed Resident #11 had a Do Not Resuscitate (DNR) form dated 02/17/25.	F 578	This plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies. F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? DON corrected the code status on 3/20/25 by ensuring that the code status matched the medical record and the code status notebook.	

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F 578	Continued From page 2 A review of Resident #11's admission History and Physicial dated 02/17/25 revealed the Resident was a DNR. On 03/20/25 at 8:28 AM an interview was conducted with Nurse #1 who explained that if Resident #11 was experiencing a crisis where she had to immediately determine the Resident's code status, she would go to the Code Status notebook first. The Nurse stated the Code Status notebook and the Resident's medical record should match. During an interview with the Director of Nursing (DON) on 03/20/25 at 9:07 AM the DON explained that the Social Worker addresses the residents' code status on admission and the providers will discuss the advanced directives in detail on their initial visit with the residents. The DON continued to explain that she conducted monthly advanced directive audits, but she had not complete the audit for February 2025 yet. An interview was conducted with the Social Worker (SW) on 03/20/25 at 10:02 AM who explained that she addressed code status with the residents or responsible parties when the residents were admitted to the facility then the providers discussed their code status in detail on their initial visit with the residents. The SW stated she assisted the DON with auditing the residents' code status monthly but stated they had not completed the audit for the month of Febuary 2025.	F 578	Address how the facility will identify other residents having the potential to be affected by the same deficient practice? An audit was conducted on 3/21/25 for all residents to ensure that code status matched the order from the physician, and was correct on the medical record and code status notebook. Beginning on 3/21/25 daily and weekly audits will be conducted for 4 weeks and then continue dailyand weekly to ensure compliance by SW and/or designee. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Administrator and DON began education to all staff on 3/27/25 and will conclude April 4, 2025 and then reviewed annually. A daily and weekly audit and review of all orders will be conducted by DON/designee, ensuring that the Physicians order matches the code status in the code status notebook located at the nurses stations on the Short term Rehab hall and Long Term Rehab Hall beginning 3/31/25. This audit will be reviewed daily/weekly by Interdisciplinary Care Plan Team beginning 3/31/25 to ensure that orders, EMAR, and notebook are accurate and match to ensure compliance. All deficiencies will be corrected immediately if needed. How will the facility plan to monitor its performance to make sure that solutions are sustained and what dates will the corrective action will be completed?	

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F 578	Continued From page 3	F 578	Facility will monitor through daily and weekly audits, with immediate corrections if needed and then reviewed in monthly QAPI to ensure compliance. Facility will be in compliance by April 22, 2025.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) 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 under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		4/22/25

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F 582	Continued From page 4 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary notification (Resident #6). The findings included: Resident #6 was admitted to the facility on 10/21/24. Medicare Part A services began on 10/21/24. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #6 on 11/26/24 which indicated	F 582	This plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies. F582 Medicaid/Medicare Coverage Liability Notice How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? Interdisciplinary Care Plan Team was educated on the form CMS-10055 (Centers for Medicare and Medicaid Services and Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN)	

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F 582	Continued From page 5 Resident #6's Medicare Part A coverage for skilled services would end on 11/28/24. Resident #6 remained in the facility. Review of Resident #6's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #6. An interview was conducted with the Social Worker (SW) with the Administrator present on 03/19/25 at 12:07 PM. The SW explained that she was responsible for issuing the NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #6 prior to Medicare Part A skilled services ending on 11/28/24. Resident #6 was unavailable for interview during the survey. A second interview was conducted with the Administrator on 03/20/25 at 1:30 PM who acknowledged that the SW was not issuing the SNF ABN letters prior to the end of the residents' Medicare Part A coverage when residents remained in the facility and indicated the SW would start doing so to abide by the regulation.	F 582	by Administrator on 3/20/25 and that it is to be provided prior to discharge from Medicare Part A skilled services. ABN for this resident was not presented as resident had discharged. Discharges beginning 3/20/25 and thereafter will receive ABN prior to discharge. Address how the facility will identify other residents having the potential to be affected by the same deficient practice? Beginning 3/20/25, all residents who are to be discharged will receive ABN prior to discharge. An audit will be conducted weekly and reviewed by SW and/or designee for 4 weeks and then continue weekly thereafter to ensure compliance. Results of weekly audits will be corrected if found to be deficient; results of audit will be reported in monthly QAPI. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? IDT team created one form that has all elements required for discharge from Medicare Part A services- NOMNC, ABN, and/or DENC. A weekly audit of all discharges will begin on 3/20/25 and continue thereafter to ensure compliance; any deficient results will be corrected immediately. All results will be reviewed in monthly QAPI. How will the facility plan to monitor its performance to make sure that solutions are sustained and what dates will the corrective action will be completed? Facility will monitor through weekly audits and then review in monthly QAPI to ensure compliance. Facility will be in compliance by April 22, 2025.	

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		4/22/25

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F 656	Continued From page 7 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop individualized person-centered comprehensive care plans in the areas of high-risk medication use (anticoagulants, diuretics, opioids, and anti-depressant medications) and oxygen therapy for 5 of 5 residents reviewed for comprehensive care plans (Resident #4, Resident #7, Resident #8, Resident #14 and Resident #24). The finding included: 1. Resident #7 was admitted to the facility on 01/06/2023 with diagnoses including congestive heart failure (CHF), atrial fibrillation (A-fib), and myocardial infarction (heart attack). A review of Resident #7's medical record revealed a physician's order dated 01/02/2024 for Torsemide (a diuretic medication used to treat fluid retention) 40 mg daily for fluid retention, a physician's order dated 02/04/2024 for apixaban (an anticoagulant medication) 2.5 milligrams (mg) twice daily for atrial fibrillation (an irregular, rapid heartbeat which causes poor blood flow), and a physician's order dated 09/24/2024 for Oxycodone (pain medication) 2.5 mg four times a day for pain. A review of the quarterly Minimum Data Set (MDS) assessment dated 02/26/2025 revealed	F 656	This plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies. F656 Develop/Implement ComprehensiveCare Plan How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? MDS Coordinator immediately updated comprehensive care plans on 3/20/25 for identified residents (Residents #4, #7, #8, #14, and #24) to reflect high risk medications with goals and interventions. Address how the facility will identify other residents having the potential to be affected by the same deficient practice? On 3/20/25, MDS Coordinator audited and corrected care plans to ensure compliance for high risk medications with goal and interventions. This audit will be continue daily and weekly for 4 weeks and then continue daily and weekly thereafter to ensure compliance by MDS Coordinator and/or designee. Any deficient care plans will be corrected immediately through this audit. Results of	

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F 656	Continued From page 8 Resident #7 had intact cognition. The MDS documented that Resident #7 received anticoagulant, diuretic, and opioid medications during the assessment period. Resident #7's comprehensive care plan last revised on 03/03/2025 revealed there was no care plan in place for anticoagulant, diuretic, and opioid medications. A review of Resident #7's February 2025 and March 2025, for the period of 03/01/2025 through 03/19/2025, Medication Administration Record revealed Resident #7 received apixaban 2.5 mg twice daily, Torsemide 40 mg daily, and Oxycodone 2.5 mg four times a day as prescribed by the physician. On 03/20/2025 at 10:18 AM an interview with the MDS Nurse revealed Resident #7's care plan did not address anticoagulant, diuretic, or opioid medications. The MDS Nurse stated that she had never care planned high-risk medications including anticoagulant, diuretic, or opioid medications. She also stated that she used the Resident Assessment Instrument Manual (RAI Manual) for guidance on how to complete the MDS. She further explained that she had never received any education or information related to care planning high-risk medications. A joint interview was conducted on 03/20/2023 at 11:05 AM with the Director of Nursing and the Administrator. The DON stated that she expects all high-risk medications to be care planned including anticoagulant, diuretic, and opioid medications. She stated the high-risk medications should be addressed in Resident #7's comprehensive care plan so all staff caring	F 656	daily and monthly audits will be reported in QAPI. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? DON educated MDS Coordinator on 3/24/25 on what high risk medications needed to be added to care plans for residents to include but are not limited to anticoagulants, diuretics, opioids, and anti-depressant medications, as well as oxygen therapy. A daily and weekly review of Care Plans will begin on 3/31/25 and continue thereafter to ensure compliance; any deficient results will be corrected immediately. All results will be reviewed in monthly QAPI. How will the facility plan to monitor its performance to make sure that solutions are sustained and what dates will the corrective action will be completed? Facility will monitor through daily and weekly audits and then review in monthly QAPI to ensure compliance. Facility will be in compliance by April 22, 2025.	

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F 656	Continued From page 9	F 656		

for her would be aware she was at risk for medication related side effects. The Administrator stated he expected all resident care plans to be reflective of their clinical condition including the use of high-risk medications.

2. Resident #8 was admitted to the facility on 12/20/2022 with diagnoses including cerebral vascular accident (CVA), vascular dementia, congestive heart failure (CHF), and atrial fibrillation (A-fib).

A review of Resident #8's medical record revealed a physician's order dated 01/02/2024 for Torsemide 20 mg daily for fluid retention, a physician's order dated 01/02/2024 for apixaban 2.5 milligrams (mg) twice daily for atrial fibrillation, and a physician's order dated 01/12/2024 for Tramadol (opioid pain medication) 50 mg three times a day for pain.

A review of the quarterly Minimum Data Set (MDS) assessment dated 02/18/2025 revealed Resident #8 had severely impaired cognition. The MDS documented that Resident #8 received anticoagulant, diuretic, and opioid medications during the assessment period.

Resident #8's comprehensive care plan last revised on 02/21/2025 revealed there was no care plan in place for anticoagulant, diuretic, and opioid medications.

A review of Resident #8's February and March 2025, for the period of 03/01/2025 through 03/19/2025, Medication Administration Record revealed Resident #8 received apixaban 2.5 mg twice daily, Torsemide 20 mg daily, and Tramadol 50 mg three times a day as prescribed by the

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F 656	Continued From page 10	F 656		

physician.

On 03/20/2025 at 10:18 AM an interview with the MDS Nurse revealed Resident #8's care plan did not address anticoagulant, diuretic, or opioid medications. The MDS Nurse stated that she had never care planned high-risk medications including anticoagulant, diuretic, or pain medications. She also stated that she used the Resident Assessment Instrument Manual (RAI Manual) for guidance on how to complete the MDS. She further explained that she had never received any education or information related to care planning high-risk medications.

A joint interview was conducted on 03/20/2023 at 11:05 AM with the Director of Nursing and the Administrator. The DON stated that she expects all high-risk medications to be care planned including anticoagulant, diuretic, and opioid medications. She stated the high-risk medications should be addressed in Resident #8's comprehensive care plan so all staff caring for her would be aware she was at risk for medication related side effects. The Administrator stated that he expected all high-risk medications to be care planned.

3. Resident #24 was admitted to the facility on 02/25/2025. His diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation (A-fib), and cerebral vascular accident (CVA). Resident #24 was discharged on 03/18/2025.

A review of Resident #24's medical record revealed a physician's order dated 02/25/2025 for Mirtazapine (an anti-depressant medication) 30 mg daily at bedtime for depression, and a

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F 656	Continued From page 11	F 656		

physician's order dated 01/26/2025 for Rivaroxaban (an anticoagulant medication) 20 milligrams (mg) daily for prevention of blood clots.

A review of Resident #24's comprehensive care plan dated 02/25/2025 did not reveal any care plan focus areas or interventions related to receiving anti-depressant or anticoagulant medications.

A review of the admission MDS assessment dated 03/04/2025 for Resident #24 revealed he had intact cognition. The MDS also documented that he had received anti-depressant and anticoagulant medications during the assessment period.

A review of Resident #24's March 2025, for the period of 03/01/2025 through 03/19/2025, Medication Administration Record (MAR) revealed he received Mirtazapine 30 mg daily at bedtime and Rivaroxaban 20 mg daily as ordered by the physician.

On 03/20/2025 at 10:18 AM an interview with the MDS Nurse revealed Resident #24's care plan did not address anti-depressant or anticoagulant medications. The MDS Nurse stated that she had never care planned high-risk medications including anti-depressants and anticoagulant medications. She also stated that she used the Resident Assessment Instrument Manual (RAI Manual) for guidance on how to complete the MDS. She further explained that she had never received any education or information related to care planning high-risk medications.

A joint interview was conducted on 03/20/2023 at 11:05 AM with the Director of Nursing and the

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Administrator. The DON stated that she expects all high-risk medications to be care planned including anti-depressant and anticoagulant medications. She stated the high-risk medications should be addressed in Resident #24's comprehensive care plan so all staff caring for him would be aware he was at risk for medication related side effects. The Administrator stated he expected all resident care plans to be reflective of their clinical condition including the use of high-risk medications.

4. Resident #14 was readmitted to the facility on 03/05/25 with diagnoses that included chronic pulmonary edema and cirrhosis.

A review of Resident #14's physician orders revealed orders dated:
-03/05/25 spironolactone 25 mg by mouth one time a day for hypertension.
-03/05/25 for furosemide 40 mg one tablet by mouth one time a day for cirrhosis.

The significant change Minimum Data Set (MDS) assessment dated 03/12/25 revealed Resident #14's cognition was intact, and he received a diuretic.

Review of Resident #14's care plan last reviewed on 03/12/25 revealed high-risk medications such as diuretics were not care planned.

A review of Resident #14's Medication Administration Records for 03/2025 indicated he received the diuretic medications as ordered.

An interview was conducted with the MDS Nurse on 03/20/25 at 9:32 AM. The MDS Nurse explained that she had been responsible for the

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MDS and care planning process for over 5 years and had never care planned high risk medications such as diuretics. The MDS Nurse stated she used the Resident Assessment Instrument as her guide but had never received education on care planning high risk medications.

Interviews were conducted with the Administrator and Director of Nursing (DON) simultaneously on 03/20/25 at 1:45 PM. The DON stated that she expected all high-risk medications, which included diuretics, to be care planned so that all staff caring for the residents would be aware of the potential side effects to look for. The Administrator stated he expected all resident care plans to be reflective of their clinical condition including the use of high-risk medications.

5. Resident #4 was admitted to the facility on 02/21/25 with diagnoses that included pneumonia.

The admission Minimum Data Set (MDS) dated 02/28/25 revealed Resident #4s cognition was moderately impaired and he did not receive supplemental oxygen therapy.

A review of Resident #4's physician orders revealed an order dated 03/04/25 for oxygen at 2 liters via nasal cannula.

Review of Resident #4's care plan reviewed 03/04/25 revealed there was no care plan for oxygen therapy.

On 03/18/25 at 11:46 AM an observation was made of Resident #4 who was in bed sleeping. The Resident wore oxygen via nasal cannula delivered at 2 liters per minute by an oxygen

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F 656	Continued From page 14 concentrator. On 03/19/25 at 9:00 AM an observation of Resident #4 was made while he was sleeping. The Resident was wearing oxygen via nasal cannula at 2 liters per minute. An interview was conducted with the MDS Nurse on 03/20/25 at 9:32 AM. The MDS Nurse explained that Resident #4 was not on oxygen therapy when he was admitted and that was why it was not on the admission MDS dated 02/28/25. When the MDS Nurse was asked how she captured issues that should be care planned in between MDS assessments the MDS Nurse reported that she sometimes looked at 24-hour reports and orders and when issues were discussed in the morning clinical meetings, she would update the care plans at that time. The MDS Nurse indicated she had observed Resident #4 wearing oxygen but did not think about if the oxygen had been care planned but it should be care planned. Interviews were conducted with the Administrator and Director of Nursing simultaneously on 03/20/25 at 1:45 PM. Both indicated their expectations were for the oxygen to be care planned.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/22/25

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F 657	Continued From page 15 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to develop a comprehensive care plan in the area of high-risk medications (insulin) for 1 of 1 resident reviewed for comprehensive care plans (Resident #11). The findings included: Resident #11 was admitted to the facility on 02/15/25 with diagnoses that included diabetes mellitus. A review of Resident #11's physician orders revealed orders dated: -02/16/25 for glargine insulin 14 units subcutaneously one time a day for diabetes	F 657	This plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies. F657 Care Plan Timing and Revision How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? MDS Coordinator updated comprehensive care plan on 3/20/25 for identified resident (Resident #11) to reflect high risk medications with goals and interventions related to insulin.	

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F 657	Continued From page 16 mellitus. The admission Minimum Data Set (MDS) assessment dated 02/22/25 revealed Resident #11 received insulin. Review of Resident #11's care plan reviewed on 02/22/25 revealed high risk medication such as insulin was not care planned. A review of Resident #11's Medication Administration Records for 02/2025 and 03/2025 revealed the Resident received insulin as ordered. An interview was conducted with the MDS Nurse on 03/20/25 at 9:32 AM. The MDS Nurse confirmed Resident #11's care plan did not address high risk medications such as insulin medications. The MDS Nurse stated that she had never care planned high-risk medications, but she could see where it would be beneficial to care plan the insulin so that the staff taking care of her would be aware of monitoring signs and symptoms of hypoglycemia. She also stated that she used the Resident Assessment Instrument Manual (RAI Manual) for guidance on how to complete the MDS. She further explained that she had never received any education or information related to care planning high-risk medications. Interviews were conducted simultaneously with the Administrator and Director of Nursing (DON) on 03/20/25 at 1:45 PM. The DON stated that she expected all high-risk medications which included insulin to be care planned so that all staff caring for the residents would be aware of the potential side effects to look for. The Administrator stated	F 657	Address how the facility will identify other residents having the potential to be affected by the same deficient practice? On 3/20/25, MDS Coordinator audited and corrected care plan for Resident #11 to ensure compliance for high risk medications with goal and interventions related to insulin, then audited and corrected care plans for residents in the area of high risk medications related to insulin. This audit will be continue daily and continue weekly for 4 weeks and then continue daily and weekly thereafter to ensure compliance by MDS Coordinator and/or designee. Any deficient care plans will be corrected immediately through this audit. Results of daily and weekly audits will be reported in QAPI. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? DON educated MDS Coordinator on 3/24/25 on what high risk medications needed to be added to care plans for residents to include but are not limited to insulin, anticoagulants, diuretics, opioids, and anti-depressant medications, as well as oxygen therapy. A daily and weekly review of Care Plans will begin on 3/31/25 and continue thereafter to ensure compliance; any deficient results will be corrected immediately. All results will be reviewed in monthly QAPI. How will the facility plan to monitor its performance to make sure that solutions are sustained and what dates will the corrective action will be completed? Facility will monitor through daily and weekly audits and then review in monthly	

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F 657	Continued From page 17 he expected all resident care plans to be reflective of their clinical condition including the use of high-risk medications.	F 657	QAPI to ensure compliance. Facility will be in compliance by April 22, 2025.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to date an open vial of Tuberculin Purified Protein Derivative (PPD) solution stored in 1 of 1 medication refrigerator and failed to secure medications that were stored	F 761	This plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies.	4/22/25

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F 761	Continued From page 18 at bedside for 1 of 1 resident (Resident #14) reviewed for medication storage. The findings included: 1. During an observation of the refrigerator in the medication room on 03/19/25 at 2:03 PM the observation yielded an open and undated vial of PPD solution. An interview was conducted with Nurse #3 on 03/19/25 at 2:03 PM who explained that the vial should be dated when it was opened to determine how long it can be used which was 30 days. The Nurse stated there was no way to determine how long it had been opened since it was not dated. A review of the manufacturer's instructions for PPD solution indicated to discard open vials after 30 days. On 03/20/25 at 9:01 PM during an interview with the Director of Nursing she explained that it was every nurse's responsibility to check the refrigerator for undated and expired medications and that the PPD vial should have been dated by the nurse who opened it. 2. Resident #14 was admitted on 01/06/25 with diagnoses that included chronic obstructive pulmonary disease (COPD) and respiratory failure. The admission Minimum Data Set (MDS) assessment dated 01/13/25 revealed Resident #14 was cognitively intact. A review of Resident #14's physician orders dated 03/04/25 revealed there were no orders for the	F 761	F761Label/Store Drugs and Biologicals How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1. Nurse #3 immediately removed the open vial of PPD solution that was not labeled from refrigerator when identified by surveyor. 2. 2. Nurse #1 communicated to family that bedside medications will need to have an order for residents use. Bedside medications were placed in a drawer outside of residents reach as resident requested that the medications not be removed, as he would have his family to come and get them. Family removed medications from drawer and took them home. Nurse #1 obtained order for facility to administer cream and the nasal spray on 3/20/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice? 1. On 3/27/25, DON educated all staff on ensuring that PPD solution is labeled and dated when opened. This education will conclude April 4, 2025. DON and/or designee will audit medication refrigerator twice weekly for 4 weeks, and then continue twice weekly to ensure compliance. Any negative results from audit will be corrected immediately. Results of audit will be reviewed in monthly QAPI. 2. On 3/27/25, DON educated all staff on ensuring that bedside medications are care planned, identified, and/or removed if	

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F 761	Continued From page 19 fluticasone nasal spray or the mupirocin ointment. A review of Resident #14's medical record revealed there was no assessment to self-administer medications. On 03/18/25 at 12:28 PM an observation was made as well as attempts to interview Resident #14, but the Resident was sleeping. On the Resident's bedside table was a bottle of fluticasone nasal spray and a tube of mupirocin ointment. On 03/19/25 at 9:08 AM an observation was made of Resident #14 in his bed sleeping. On the Resident's bedside table were the fluticasone nasal spray and the mupirocin ointment. An attempt was made to interview Resident #14 on 03/19/25 at 1:55 PM but the Resident was sleeping. The two medications remained on his bedside table. An interview was conducted with Nurse #1 on 03/20/25 at 8:43 AM. The Nurse explained that Resident #14's health was declining and therefore, he was sleeping more. The Nurse continued to explain that on Resident #14's "good days" it was possible that he would be able to administer his own medications but that was not consistent. She indicated Resident #14 did not have an order to self-administer any medications and there should not be any medications at his bedside. Nurse #1 observed the fluticasone nasal spray and mupirocin ointment on his bedside table. Nurse #1 remarked that in the past the Resident's family had brought medications to him and the facility had educated the family about the policy and it looked like the same thing has	F 761	not ordered. This education also included self administration assessment, and ensuring order is in place for those identified residents who are capable of self administering. This education will conclude April 4, 2025 and be reviewed annually. All staff will audit and monitor residents rooms upon admission and thereafter to ensure compliance. Any deficient practice will be corrected immediately. Results of audit and monitoring will be reviewed daily weekly and monthly- results of audits will be reported in QAPI. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? 1.On 3/27/25, DON educated all staff on ensuring that PPD solution is labeled and dated when opened. This education will conclude April 4, 2025 and reviewed annually. DON and/or designee will audit medication refrigerator twice weekly for 4 weeks, and then continue twice weekly to ensure compliance. Any negative results from audit will be corrected immediately. Results of audit will be reviewed in monthly QAPI. 2.On 3/27/25, DON educated all staff on ensuring that bedside medications are care planned, identified, and/or removed if not ordered. This education also included self administration assessment, and ensuring order is in place for those identified residents who are capable of self administering. This education will conclude April 4, 2025 and be reviewed annually. All staff will audit and monitor residents rooms upon admission and	

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F 761	Continued From page 20 happened again. The Nurse informed Resident #14 that she needed to take the medications and give them to his family, but the Resident told Nurse #1 to leave the medications, and he would have his family take the medications home. During an interview with the Director of Nursing (DON) on 03/20/25 at 9:16 AM the DON explained that medications could not be stored at the residents' bedside unless they had an order to self-administer their medications and Resident #14 did not have an order to self-medicate.	F 761	thereafter to ensure compliance. Any deficient practice will be corrected immediately. Results of audit and monitoring will be reviewed daily , weekly and monthly- results of audits will be reported in QAPI. How will the facility plan to monitor its performance to make sure that solutions are sustained and what dates will the corrective action will be completed? Facility will monitor through daily and weekly audits and then review in monthly QAPI to ensure compliance. Facility will be in compliance by April 22, 2025.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		4/22/25

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F 880	Continued From page 21 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 22 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to develop and implement Enhanced Barrier Precautions policy and procedures that included the use of Personal Protective Equipment (PPE) during high-contact care activities for residents with indwelling medical devices and wounds. In addition, nursing staff did not don a gown while providing wound care to a chronic wound for 1 of 1 nursing staff observed for infection control practices (Nurse #2). This deficient practice had the potential to affect all residents. The finding included: Review of the facility's infection control policy and procedures revealed no policy and procedure for Enhanced Barrier Precautions (EBP). An observation on 03/20/2025 at 10:00 AM revealed Nurse #1 sanitized her hands and put on clean gloves but did not put on a gown. Nurse #2 proceeded to provide wound care for Resident #26's chronic right hip wound. An interview was conducted with Nurse #2 on 03/20/2025 at 10:19 AM. Nurse #2 stated that she only wore gloves when she provided wound care. She further stated that she knew about EBP, but the facility had not implemented EBP, and she had never received any education on EBP.	F 880	This plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies. F880 Infection Prevention and Control How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? DON educated Nurse #1 and Nurse #2 on 3/20/25 on Enhanced Barrier Precautions-wearing gown and gloves when providing wound care. PPE will be placed in room for these residents identified for use during care with identifying signage. DON developed a written policy on 3/24/25 on EBP when providing care for residents. This policy was reviewed with all staff on 3/27/25 about EBP and PPE for residents with wounds and indwelling medical devices. This education will conclude on 4/4/25 and be reviewed annually with all staff. Facility will be in compliance by 4/22/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice? DON and/or designee will audit all residents to identify need for EBP; PPE will be placed in room for use during care with identifying signage for identified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345416	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CENTER	142 BERMUDA VILLAGE DRIVE BERMUDA RUN, 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 880	Continued From page 23 An interview was conducted with the Director of Nursing (DON) who also served as the facility's Infection Preventionist on 03/20/2025 at 10:00 AM. The DON stated that she knew about the regulation and the Center for Disease Control's (CDC) recommendations for EBP, but she had not implemented EBP or provided the staff with any education regarding EBP. An interview was conducted with the Administrator on 03/20/2025 at 10:40 AM. The Administrator stated that he knew about the regulation but thought the facility was in compliance with the regulation because the facility only had private rooms. The Administrator further explained that he does expect the facility to be in compliance with all infection control regulations including the implementation of EBP.	F 880	residents. Beginning 3/28/25 all new admissions will be assessed for EBP and required PPE will be placed in room for care and use with identifying signage. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? DON and/or designee will audit all residents with wounds and indwelling medical devices for EBP; PPE will be placed in room for use during care with identifying signage. Beginning 3/28/25 all new admissions will be assessed for need of EBP related to wounds and indwelling medical devices and required PPE will be placed in room for care and use with identifying signage. All residents identified for need of EBP due to wounds and/or indwelling medical devices will have focus, goals, and interventions added to comprehensive care plans. Beginning 3/31/25 Comprehensive Care Plans will be audited, implemented, and reviewed upon admission, significant changes, quarterly, and annually to ensure compliance for EBP. How will the facility plan to monitor its performance to make sure that solutions are sustained and what dates will the corrective action will be completed? Facility will monitor through weekly audits, and review care plans upon admission, significant change, quarterly and annually and then review in monthly QAPI to ensure compliance. Facility will be in compliance by April 22, 2025.	