STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING **01 - MAIN BUILDING** B. WING ______	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	**316 NC HIGHWAY 801 SOUTH** **ADVANCE, NC 27006**

(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
K 000	INITIAL COMMENTS A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Stories: 1 Construction Type: V (111) Constructed: 2008 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 117 Census = 86 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations, on Wednesday 5/25/16. at approximately 8:00 AM onward, the following deficiencies were noted: The smoke walls are non-compliant, specific findings include: 1. The smoke walls located on the 200 hall, 600 and 500 hall have holes and/or penetrations that were not sealed in accordance with an approved	K 025	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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	6/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/10/2016

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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K 025	Continued From page 1 fire rated assemble in order to maintain the fire resistance rating of the wall. There are multiple cable, conduit and pipe penetrations in the walls that are not sealed in accordance with an approved and listed fire stop assembly and/or fire stop assembly method. 2000 NFPA 101 Section 5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 NFPA 101, 8.3.6.1. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: 1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.	K 025	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. K025 SMOKE BARRIERS SHALL BE CONSTRUCTED TO PROVIDE AT LEAST ONE HALF HOUR FIRE RESISTANCE RATING Corrective Action: Smoke walls on 200, 600, and 500 halls, holes were caulked and sealed on 6/6/2016 by maintenance director. Identification of other areas that may be involved with this practice: All smoke walls were checked for holes and penetrations on 6/6/2016 by maintenance director and no other holes were found in the smoke walls. Monitoring Maintenance Director/designee will perform weekly smoke wall checks using the smoke wall monitoring tool of all areas of the building weekly X 4 weeks and randomly thereafter for continued compliance. Findings of the inspections will be reported by the Maintenance Director/designee to the monthly Safety Committee with corrective actions taken as needed. Date of Compliance: 6/10/2016	

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K 025	Continued From page 2 b. It shall be protected by an approved device that is designed for the specific purpose. 3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. This deficiency affected four of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 025		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations, on Wednesday 5/25/16. at approximately 8:00 AM onward, the following deficiencies were noted: The magnetically locked doors are non-compliant, specific findings include: 1. When tested the magnetically locked exited door on 300 Hall did not release with the master override switch located at the nurse station. NFPA 101: 7.2.1.6 This deficiency affected one of eight exit doors. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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. K038 EXIT ACCESS IS ARRANGED SO THAT EXITS ARE READILY ACCESSIBLE AT ALL TIMES Corrective Action: On May 26, 2016 Simplex Grinnell came	6/10/16

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K 038	Continued From page 3	K 038	and fixed the magnetic lock on the exit door on 300 hall so that it releases with the master override switch. Identification of other areas that may be involved with this practice: All exit doors were checked by maintenance director on 5/26/2016 and all other doors were compliant and opened using the master override switch. Monitoring Maintenance Director/designee will perform weekly checks on the magnetic exit door using the exit door monitoring tool for all magnetic doors of the building weekly X 4 weeks and randomly thereafter for continued compliance. Findings of the inspections will be reported by the Maintenance Director/designee to the monthly Safety Committee with corrective actions taken as needed. Date of Compliance: 6/10/2016	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations, on Wednesday 5/25/16. at approximately 8:00 AM onward, the following deficiencies were noted: 1. The following Heating, Ventilating, and Air Conditioning system (HVAC) located at the front nurse station was non-compliant; specific findings include	K 067	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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	6/10/16

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K 067	Continued From page 4 A. The HVAC system did not shut down with fire alarm activation. B. The HVAC system did not shut down with the emergency shut down switch. NFPA 90A, 4-2 NFPA 90A 4-4.1 Testing. All automatic shutdown devices shall be tested at least annually. This deficiency affected one of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	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. K067 HEATING, VENTILATING, AND AIR CONDITIONING COMPLY WITH AND ARE INSTALLED IN ACCORDANCE WITH THE MANUFACTURER□S SPECIFICATIONS Corrective Action: On June 8, 2016 Kenco Electric came and fixed the electrical problem and on June 10, 2016 Thermal Technology came and hooked it up to the HVAC unit so it shuts down with alarm activation and with the emergency shutdown switch. Identification of other areas that may be involved with this practice: All HVAC units were checked by maintenance director on 6/10/2016 and no other issues were found. Monitoring Maintenance Director/designee will perform weekly checks on the HVAC unit using HVAC monitoring tool for all HVAC units in the building weekly X 4 weeks and randomly thereafter for continued compliance. Findings of the inspections will be reported by the Maintenance Director/designee to the monthly Safety Committee with corrective actions taken as needed. Date of Compliance: 6/10/2016	