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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 000	INITIAL COMMENTS An amended Statement of Deficiencies (SOD) was provided to the facility on 06/06/16 and an additional SOD was provided to the facility on 07/05/16 regarding the results of Informal Dispute Resolution (IDR) process. The IDR panel deleted example A from the F-157, kept example B and reduced the scope and severity from G to D. The IDR panel also reduced the scope and severity of F-224 and F-309 to a D and upheld F-514 as written. A review by the Centers for Medicare and Medicaid Services resulted in the following: F-157 with the deletion of example A and the scope and severity reduced to D, the scope and severity for tags F-224 and F-309 were kept at a G, and F-514 remainded upheld as written at a D.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		4/28/16

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

Electronically Signed | 04/28/2016

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review the facility failed to notify the family when the physician ordered the resident to receive a mood stabilizer for 1 of 3 sampled residents (Resident #3). Resident #3 was diagnosed with a fractured hip. The findings included: Resident #3 was admitted to the facility on 02/10/16 diagnosed with heart failure, dementia with behavior disturbances, Alzheimer's disease and hypertension. The most recent Minimum Data Set (MDS) dated 02/17/16 specified she had short and long term memory impairment and moderately impaired cognitive skills for daily decision making, she also had physical and verbal behaviors directed towards others. The MDS also specified the resident required extensive assistance with activities of daily living and the resident had no complaints of pain and had not fallen prior to admission. Review of Resident #3's medical record revealed a new order dated 02/16/16 for Valproic acid (mood stabilizer) twice daily. The order was noted by Nurse #4.	F 157	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS-2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the Statement of Deficiencies F157 A) Physician Notification 1. Corrective actions taken for resident found to have been affected by alleged deficient practice. Resident #3 discharged from the facility on 3/25/2016. 2. Corrective actions taken for other residents having the potential to be	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 157	Continued From page 2 Nurses' notes were reviewed for 02/16/16 and revealed no documentation was made that indicated the family had been notified of the new medication. On 04/05/16 at 9:30 AM the family of Resident #3 was interviewed on the telephone. The family member explained that during a visit to the facility the resident was sound asleep in her chair and difficult to arouse. A nurses reported to the family that the resident was sleeping as result of a new medication ordered by the physician. On 04/06/16 at 10:07 AM Nurse #4 was interviewed and reported that it was routine practice to notify families of new orders including medications. She explained that she tried to notify families via telephone and documented the notification in the nurses' notes of the medical record. Nurses #4 recalled receiving the order for Valproic acid and thought she had notified the family but was unable to explain who she spoke to or why she hadn't documented the conversation in the medical record. On 04/06/16 at 1:55 PM the Director of Nursing (DON) was interviewed and explained that she would expect nurses to notify interested families of medication changes. The DON stated that Resident #3's family was very interested in her care and should have been notified when the Valproic acid was ordered.	F 157	affected by alleged deficient practice: A 100% audit of all residents MARs for scheduled or PRN pain medication was completed on 4/20/2016 by the ADON. Results of the audit revealed that every resident has either a scheduled, PRN, or a standing Physician order for pain medication. On 4/22/16 physician orders were obtained for every resident to have a pain assessment completed by the licensed nurse every shift and document results, including any interventions for residents who had pain. A one-time pain assessment on every resident was completed on 4/28/16 and if pain was noted, the intervention was documented in the clinical record. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice: Licensed nurses were in-serviced beginning on 4/22/16 by DON and MDS Coordinator to notify the Physician of residents change in condition that may warrant an alteration in treatment including accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 157	Continued From page 3	F 157	form of treatment). . As of 4/27/16 all licensed nursing staff had been in-serviced. On 4/28/2016, in-servicing began for all licensed nurses that any resident who has a fall are to be assessed each shift for pain x 72 hours. If a resident complains of pain and is medicated and pain is not relieved, the nurse is to call to notify the physician for further instructions. The nurse is to then notify the resident and legal representative or interested family member. Any new orders and notification is to be documented in the clinical record. In-servicing will continue thru 5/5/16. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: The DON/ADON and MDS Coordinator will review the 24 hour report and chart for 5 residents and any resident who experiences a fall, each week for 4 weeks, then every 2 weeks for 4 weeks to determine if the nurse contacted the Physician for the following if they occurred: Accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 157	Continued From page 4	F 157	form of treatment). Compliance will be monitored by the DON or designee. Audit tools will be collected and reviewed by the DON weekly and reported to the QA committee for one quarter and will assess and modify the action plan as needed to ensure continued compliance. F 157 B) Notifying the interested family member 1. Corrective actions taken for resident found to have been affected by alleged deficient practice Resident #3 was discharged on 3/25/16. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: On 4/28/2016 the DON and MDS Coordinator audited all resident's physician orders and nurses notes for documentation of notification of changes in condition/treatment to resident, legal resident representative or interested family member in the past 90 days (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). 3. Measures taken and systems changed to prevent repeat of alleged deficient	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 157	Continued From page 5	F 157	practice: In-servicing to licensed nurses began on 4/22/2016, by DON instructing nurses that any change in a resident's condition/treatment requires notification to the resident and the resident's legal representative or interested family member. Examples given in the in-service included a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). As of 4/27/16 all licensed nursing staff has been in-serviced. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: DON/ADON or MDS Coordinator will review all physician orders and or medical record daily five times weekly for changes in condition/treatment and documentation of notification to the resident, residents legal representative or interested family member. Review will be on-going. Results of the audits will be reviewed and discussed in the quarterly QA meeting for one quarter and will assess and modify the action plan as needed to ensure continued compliance.	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		4/28/16

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 224	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff and nurse practitioner interviews and record review the facility neglected to follow physician orders to obtain a computerized tomography (CT) scan for a resident in pain and waited 7 days before obtaining the CT scan which revealed the resident had a fractured hip for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/10/16 diagnosed with heart failure, dementia with behavior disturbances, Alzheimer's disease and hypertension. The most recent Minimum Data Set (MDS) dated 02/17/16 specified she had short and long term memory impairment and moderately impaired cognitive skills for daily decision making, she also had physical and verbal behaviors directed towards others. The MDS also specified the resident required extensive assistance with activities of daily living and the resident had no complaints of pain and had not fallen prior to admission. While in the facility the resident fell on 02/16/18, 02/18/16 and 03/02/16 with no injuries noted. Resident #3's care plan was dated 02/26/16 that specified the resident was at risk for falls and on psychotropic medications. On 03/02/16 at 8:08 PM a nurse's entry made by Nurse #1 specified the resident was found in floor	F 224	F224 PROHIBIT MISTREATMENT/NEGLECT 1. Corrective actions taken for resident found to have been affected by alleged deficient practice No immediate corrective action could be taken. CT scan was scheduled on 3/15, completed on 3/17. Resident #3 discharged from the facility on 3/25/2016. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: On 4/22/2016 a 100% resident chart audit was completed by the DON and MDS Coordinator for residents with an order for a CT scan. The results of the audit were that no orders were found to have been written. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice: On 4/22/2016 in-servicing began for all licensed nurses. Nurses were in-serviced that when an order for a diagnostic CT scan was given, it is the responsibility of	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 224	Continued From page 7 of the activity room at 7 PM in front of her wheelchair. Nurse #1 documented that no injuries were "observed" and the resident did not complain of pain. On 03/09/16 the physical therapy assistant (PTA) treating Resident #3 documented a progress note that read in part resident "complained of left lower extremity discomfort pointing along her lateral leg from mid-calf to hip and resisted standing." Resident #3 was able to complete a sitting exercise (bicycle) for 4 minutes according to the progress note. The progress note also specified the resident's complaint of pain was also in her toe and the PTA notified "nursing" of the pain. On 03/10/16 at 6:00 AM Nurse #2 documented Resident #3 was awake and yelling out loudly. The nurse administered Ativan gel (anti-anxiety) at 12 AM with little effect. "Resident screaming for 'Joe' very agitated until 4:30 AM. Will continue to monitor." On 03/10/16 a second progress note made by the PTA read in part, "Pt (patient) resists encouragement to participate with any movement including forward lean or movement of lower extremities with facial grimacing following all passive attempts calling out 'no more, no more.' She does complain of lateral thigh pain from sitting, however no facial grimacing or complaints when weight bearing. Also, grimacing with pressure to left knee resisting motion into left hip abduction. Conveyed concerns to nurse practitioner who was present for passive range of motion assessment." On 03/10/16 at 10:00 AM the NP documented a progress note that specified she assessed Resident #3 on site for left hip pain. The NP documented, "Observed PT (physical therapy) working with the patient and patient complained of hip and femur pain then knee pain when the	F 224	the nurse receiving the order to call to schedule the CT at the time the order is given. If the order is given after 5:30pm, the CT cannot be scheduled and the nurse must notify the on-call provider for further instructions and document the instructions in the medical record and on the nursing 24 hour nursing report sheet. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: DON/ADON or MDS Coordinator will review all physician orders and or medical record daily five times weekly for 4 weeks, then once weekly for 2 weeks to assure any ordered diagnostic test(s) were scheduled and completed timely. Results of the audit will be reviewed and discussed in the quarterly QA meeting, will assess and modify the action plan as needed to ensure continued compliance.	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 224	Continued From page 8	F 224		

PTA would move her left leg. When questioned PTA how long patient with this acute pain reported 2 days. She has history of falls since coming to the facility. Patient when asked cannot say exactly where the pain is but she complained the most when her left leg was abducted. Patient cannot give good history as she has severe dementia."

On 03/10/16 the nurse practitioner (NP) wrote an order for portable x-ray of left knee/femur/hip due to left leg pain and hip pain. The NP also ordered Tylenol (pain medication) three times a day for five days and as needed pain medication if the resident's pain was not relieved with the Tylenol. The NP ordered Ultram 50mg (pain medication) to be given as needed if the resident was in pain but review of the Medication Administration Record (MAR) revealed she did not receive the as needed pain medication.

On 03/10/16 the mobile x-ray results were received by the facility and the impression was "an occult femoral neck fracture cannot be excluded. CT (computerized tomography) imaging with sedation is strongly recommended." The documented was initialed by Nurse #3 and the NP was notified of the findings on 03/10/16 at 4:50 PM.

On 03/10/16 at 5:05 PM the NP ordered a CT scan of Resident #3's left hip with orders to administer antianxiety medication 45 minutes prior to scan.

On 03/10/16 at 6:40 PM Nurse #3 documented she informed Resident #3's family of x-ray results and new orders for further evaluation. Nurse #3 documented that the resident was verbalizing no pain or discomfort.

Review of Resident #3's medical record revealed a CT scan was not performed on 03/10/16 as ordered. Further review revealed the CT scan

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 224	Continued From page 9	F 224		

was performed on 03/17/16 and indicated the resident had a fractured hip.
On 03/17/16 at 9:30 AM the NP assessed Resident #3 at the request of staff for "yelling out all night every night." The NP also documented that she "asked about the CT scan that was ordered last Thursday (03/10/16) and the patient was having the scan today (03/17/16). The patient was still complaining of left hip and leg pain."
On 03/17/16 at 3:10 PM the NP ordered Resident #3 to be sent to the Emergency Department for evaluation and treatment of a fractured hip.
On 03/17/16 Resident #3 was evaluated in the Emergency Department and the family declined surgical intervention or an orthopedic referral. Resident #3 returned to the facility on 03/17/16 with orders for Roxanol (pain medication).
On 04/06/16 at 11:03 AM the Director of Nursing (DON) was interviewed and explained that on 03/09/16 through 03/11/16 she was out of the building for training. She added that when she returned to the facility on 03/14/16 she became aware the order for Resident #3's CT had yet to be performed. She stated she instructed staff to get the CT scheduled.
On 04/06/16 at 11:10 AM the Assistant Director of Nursing (ADON) was interviewed and explained at the time the order was written for the CT scan for Resident #3 the family had considered moving her to another facility. The ADON stated that the nurses waited a day or two to see if the family was going to move the resident and the order for the CT scan would be sent with the resident for the new facility to perform. The ADON added that after a few days the family did not move Resident #3 and that was when the facility realized they needed to proceed with scheduling the CT scan. The ADON stated that the scan should not have

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 224	Continued From page 10	F 224		

been delayed for 7 days.
On 04/06/16 at 2:30 PM the NP was interviewed on the telephone and reported that she was in the facility and witnessed Resident #3 in pain while working with therapy. The NP stated she first became aware of the Resident's pain on 03/10/16 but was told this was day 2 of pain for the resident. The NP explained she reviewed the resident's history and noted that the resident fell on 03/02/16 and ordered x-rays. The NP added that the x-rays were inconclusive and a CT scan was ordered to rule out a fracture. On 03/17/16 the NP was in the facility for her weekly visit and asked about the results of Resident #3's CT scan and was told it had not been done. The NP stated that it was "not appropriate" to wait to get the CT and added she was "shocked" on 3/17/16 the facility had not gotten the CT scan. The NP also reported that she would have expected to be notified of pain at the time of onset especially for Resident #3 because she did not have "as needed" pain medication ordered for her pain she developed on 03/09/16. The NP stated she reviewed the internal phone-log and no calls were received from the facility regarding Resident #3 on 03/09 through 03/10/16. The NP reviewed Resident #3's CT results and reported that the fracture was considered non-pathological (did not spontaneously happen).
On 04/06/16 at 3:50 PM Nurse #3 was interviewed and explained that she had received the order for Resident #3 to have a CT scan but did not call the hospital to schedule the procedure because it was late and she didn't think anyone that was capable of scheduling a CT scan would be working at 5:05 PM. The nurse added that she passed the order off in report. The nurse couldn't recall if the resident was in pain and thought the resident's anxiety and yelling at night

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 224	Continued From page 11 was behavior related.	F 224		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and nurse practitioner interviews and record review the facility failed to identify a change in condition for a resident with a history of falls by administering psychoactive medications when the resident was yelling out rather than assessing her for pain. When the facility identified the resident was in pain they waited 7 days before obtaining a physician ordered computerized tomography (CT) scan that revealed the resident had a fractured hip for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/10/16 diagnosed with heart failure, dementia with behavior disturbances, Alzheimer's disease and hypertension. The most recent Minimum Data Set (MDS) dated 02/17/16 specified she had short and long term memory impairment and moderately impaired cognitive skills for daily decision making, she also had physical and verbal behaviors directed towards others. The MDS also specified the resident required extensive assistance with activities of daily living	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING - A) Administered psychoactive medication rather than assessing resident for pain 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident # 3 was discharged from the facility on 3/25/2016. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: A 100% audit of all residents MARs for scheduled or PRN pain medication was completed on 4/20/2016 by the ADON. Results of the audit revealed that every resident had either a scheduled, PRN, or a standing Physician order for pain medication. On 4/22/16 physician orders were	4/28/16

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 309	Continued From page 12 and the resident had no complaints of pain and had not fallen prior to admission. While in the facility the resident fell on 02/16/18, 02/18/16 and 03/02/16 with no injuries noted. Resident #3's care plan was dated 02/26/16 that specified the resident was at risk for falls and on psychotropic medications. On 03/02/16 at 8:08 PM a nurse's entry made by Nurse #1 specified the resident was found in floor of the activity room at 7 PM in front of her wheelchair. Nurse #1 documented that no injuries were "observed" and the resident did not complain of pain. On 03/08/16 nurse #2 documented that the Resident #3 slept well. On 03/09/16 at 6:30 AM nurse #2 documented that Resident #3 was awake at 11:48 PM and given a hypnotic medication with "some effect" but the resident would call out loudly with agitation and "as needed" antianxiety medication was given at 3:05 AM that was effective and the that the resident "remained awake but quiet." On 03/09/16 the physical therapy assistant (PTA) treating Resident #3 documented a progress note that read in part resident "complained of left lower extremity discomfort pointing along her lateral leg from mid-calf to hip and resisted standing." Resident #3 was able to complete a sitting exercise (bicycle) for 4 minutes according to the progress note. The progress note also specified the resident's complaint of pain was also in her toe and the PTA notified "nursing" of the pain. Review of the medical record revealed there were no nurse's notes on 03/09/16 that addressed pain for Resident #3. Review of the Medication Administration Record (MAR) for 03/09/16 revealed the resident did not have orders for as needed pain medication or scheduled pain medication.	F 309	obtained for every resident to have a pain assessment completed every shift. On 4/22/2016 in-servicing began with full-time, part-time, and PRN nurses that included the location of the blue binder that would have pain assessment sheets for every resident would be located at the nurses station, each resident is to have the assessment completed each shift, and directions if residents were noted to have pain when the assessment was complete. A sample MAR was attached to the in-service sheet A pain assessment was completed on all residents on 4/28/16 by DON and MDS Coordinator and the results of the audit found no residents with a compliant of pain. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice: Licensed nursing staff was in-serviced on "Recognizing signs/symptoms of pain" and "assessing for pain when residents exhibit behaviors such as yelling out". In-services were completed by the DON on 4/27/16. DON/ADON or MDS Coordinator will audit all resident pain assessments for completion 5 times a week for 3 weeks, three times a week for 2 weeks, twice weekly for 2 weeks, weekly for 2 weeks, and monthly for one month. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented:	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 309	Continued From page 13 On 03/10/16 at 6:00 AM Nurse #2 documented Resident #3 was awake and yelling out loudly. The nurse administered Ativan gel (anti-anxiety) at 12 AM with little effect. "Resident screaming for 'Joe' very agitated until 4:30 AM. Will continue to monitor." On 03/10/16 a second progress note made by the PTA read in part, "Pt (patient) resists encouragement to participate with any movement including forward lean or movement of lower extremities with facial grimacing following all passive attempts calling out 'no more, no more.' She does complain of lateral thigh pain from sitting, however no facial grimacing or complaints when weight bearing. Also, grimacing with pressure to left knee resisting motion into left hip abduction. Conveyed concerns to nurse practitioner who was present for passive range of motion assessment." On 03/10/16 the NP documented a progress note that specified she assessed Resident #3 on site for left hip pain. The NP documented, "Observed PT (physical therapy) working with the patient and patient complained of hip and femur pain then knee pain when the PTA would move her left leg. When questioned PTA how long patient with this acute pain reported 2 days. She has history of falls since coming to the facility. Patient when asked cannot say exactly where the pain is but she complained the most when her left leg was abducted. Patient cannot give good history as she has severe dementia." On 03/10/16 the nurse practitioner (NP) wrote an order for portable x-ray of left knee/femur/hip due to left leg pain and hip pain. The NP also ordered Tylenol (pain medication) three times a day for five days and as needed pain medication if the resident's pain was not relieved with the Tylenol. On 03/10/16 the mobile x-ray results were	F 309	The DON and ADON and/or MDS Coordinator will audit to assure nursing staff have completed pain assessments for residents who have displayed behaviors such as yelling out, through observation during routine daily rounds and review of 24 hour report. The auditing will be done daily for 2 weeks, then weekly for 4 weeks. Compliance will be monitored by the DON or designee. Audit tools will be collected and reviewed by the DON and reported to the QA committee for one quarter. QA committee will assess and modify the action plan as needed to ensure continued compliance. F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING - B) Waited 7 days to order CT scan. 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: CT scan was scheduled on 3/15, completed on 3/17. Resident #3 discharged from the facility on 3/25/2016. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: On 4/22/2016 a 100% resident chart audit was completed by the DON and MDS Coordinator for residents with an order for a CT scan. The results of the audit were	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 309	Continued From page 14 received by the facility and the impression was "an occult femoral neck fracture cannot be excluded. CT (computerized tomography) imaging with sedation is strongly recommended." The documented was initialed by Nurse #3 and the NP was notified of the findings on 03/10/16 at 4:50 PM. On 03/10/16 at 5:05 PM the NP ordered a CT scan of Resident #3's left hip with orders to administer antianxiety medication 45 minutes prior to scan. On 03/10/16 at 6:40 PM Nurse #3 documented she informed Resident #3's family of x-ray results and new orders for further evaluation. Nurse #3 documented that the resident was verbalizing no pain or discomfort. Review of Resident #3's medical record revealed a CT scan was not performed on 03/10/16 as ordered. Further review revealed the CT scan was performed on 03/17/16 and indicated the resident had a fractured hip. On 03/17/16 at 9:30 AM the NP assessed Resident #3 at the request of staff for "yelling out all night every night." The NP also documented that she "asked about the CT scan that was ordered last Thursday (03/10/16) and the patient was having the scan today (03/17/16). The patient was still complaining of left hip and leg pain." On 03/17/16 at 3:10 PM the NP ordered Resident #3 to be sent to the Emergency Department for evaluation and treatment of a fractured hip. On 03/17/16 Resident #3 was evaluated in the Emergency Department and the family declined surgical intervention or an orthopedic referral. Resident #3 returned to the facility on 03/17/16 with orders for Roxanol (pain medication). Nurse #2 was unable to be interviewed. On 04/06/16 at 11:03 AM the Director of Nursing	F 309	that no orders were found to have been written. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice: On 4/22/2016 in-servicing began for all licensed nurses. Nurses were in-serviced that when an order for a diagnostic CT scan was given, it is the responsibility of the nurse receiving the order to call to schedule the CT at the time the order is given. If the order is given after 5:30pm per the scheduling department at WFUBMC, the CT cannot be scheduled and the nurse must notify the on-call provider for further instructions and document the instructions on a physician telephone order, in the medical record and on the nursing 24 hour nursing report sheet. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: DON/ADON or MDS Coordinator will review the nursing 24 hour report sheet, all physician orders and or medical record daily five times weekly for 4 weeks, then once weekly for 2 weeks to assure any ordered diagnostic CT scan(s) were scheduled and completed timely. Compliance will be monitored by the DON or designee. Audit tools will be collected and reviewed by the DON and reported to the QA committee for one quarter. QA committee will assess and modify the	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 309	Continued From page 15 (DON) was interviewed and explained that on 03/09/16 through 03/11/16 she was out of the building for training. She added that when she returned to the facility on 03/14/16 she became aware the order for Resident #3's CT had yet to be performed. She stated she instructed staff to get the CT scheduled. On 04/06/16 at 11:10 AM the Assistant Director of Nursing (ADON) was interviewed and explained at the time the order was written for the CT scan for Resident #3 the family had considered moving her to another facility. The ADON stated that the nurses waited a day or two to see if the family was going to move the resident and the order for the CT scan would be sent with the resident for the new facility to perform. The ADON added that after a few days the family did not move Resident #3 and that was when the facility realized they needed to proceed with scheduling the CT scan. The ADON stated that the scan should not have been delayed for 7 days. On 04/06/16 at 12:00 PM the PTA was interviewed and reported that Resident #3 had varying abilities to participate with therapy due to her impaired cognition. The PTA reviewed her progress notes on 03/09 and 03/10/16 and explained that the resident did complain of pain but her resistance to participating with exercises was not unusual. The PTA added that on 03/09/16 she reported to the "nurse" the resident was complaining of pain in her leg but the PTA did not remember who the nurse was. The PTA added that she was treating Resident #3 near the nurses' station on 03/10/16 when attempting to move the leg the resident yelled out in pain and the NP was at the station and heard the resident's yell. The PTA stated she told the NP that the resident had been complaining of pain for 2 days. The nurse working on 03/09/16 on the 7 AM to 3	F 309	action plan as needed to ensure continued compliance.	

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 309	Continued From page 16	F 309		

PM shift was not working during the investigation and was unable to be reached for an interview.
On 04/06/16 at 1:15 PM Nurse #1 was interviewed on the telephone and stated she could not recall anything about Resident #3 or if she was in pain or not.
On 04/06/16 at 2:30 PM the NP was interviewed on the telephone and reported that she was in the facility and witnessed Resident #3 in pain while working with therapy. The NP stated she first became aware of the Resident's pain on 03/10/16 but was told this was day 2 of pain for the resident. The NP explained she reviewed the resident's history and noted that the resident fell on 03/02/16 and ordered x-rays. The NP added that the x-rays were inconclusive and a CT scan was ordered to rule out a fracture. On 03/17/16 the NP was in the facility for her weekly visit and asked about the results of Resident #3's CT scan and was told it had not been done. The NP stated that it was "not appropriate" to wait to get the CT and added she was "shocked" on 3/17/16 the facility had not gotten the CT scan. The NP also reported that she would have expected to be notified of pain at the time of onset especially for Resident #3 because she did not have "as needed" pain medication ordered for her pain she developed on 03/09/16. The NP stated she reviewed the internal phone-log and no calls were received from the facility regarding Resident #3 on 03/09 through 03/10/16. The NP reviewed Resident #3's CT results and reported that the fracture was considered non-pathological (did not spontaneously happen).
On 04/06/16 at 3:50 PM Nurse #3 was interviewed and explained that she had received the order for Resident #3 to have a CT scan but did not call the hospital to schedule the procedure because it was late and she didn ' t think anyone

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 309	Continued From page 17 that was capable of scheduling a CT scan would be working at 5:05 PM. The nurse added that she passed the order off in report. The nurse couldn't recall if the resident was in pain and thought the resident's anxiety and yelling at night was behavior related.	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to have physician progress notes in the closed medical record for 1 of 1 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/10/16 and was discharged from the facility on 03/25/16. The facility provided Resident #3's closed medical record. Review of Resident #3's medical record revealed the resident had no physician documented visits.	F 514	F514 Maintenance of clinical records. 1. Corrective actions taken for resident found to have been affected by alleged deficient practice No immediate action could be taken for Resident # 3 since he was discharged from the facility on 3/25/2016. 2. Corrective actions taken for other residents having the potential to be	4/28/16

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 04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	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 514	Continued From page 18 On 04/06/16 at 11:18 AM the physician faxed progress notes for Resident #3. One faxed copy was for an initial consult dated 02/16/16 and a second visit dated 03/22/16. On 04/06/16 at 4:05 PM the Director of Nursing (DON) was interviewed and explained that the facility utilized a nurse aide who was cross-trained in medical records to "breakdown" closed medical records for storage. The DON reported that the NP and physician utilized an electronic documentation system and had to fax their progress notes in order to be included in the medical record. The DON was not aware that the physician had not faxed progress notes to the facility for inclusion in Resident #3's medical record. The DON added that the medical record staff member would not know to request physician visits.	F 514	affected by alleged deficient practice: The DON audited all current medical records on 4/28/2016 to determine if the Physician progress notes had been filed onto the medical record. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice: 0N 4/19/2016 DON consulted the Medical Director related to the process of progress notes after they have been seen by the providers. All provider progress notes will be completed, processed, and faxed to the facility no more than 7 days after being seen by the provider. Prior to the provider leaving the facility on the days resident are seen, the medical records employee will obtain a roster of residents seen on that day to ensure progress notes are received for those residents seen. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: DON/ADON/MDS Coordinator will audit records once a week for 4 weeks to assure compliance utilizing the roster of residents seen by Physician's each week. Results of the audit will be reviewed and discussed in the quarterly QA Committee meeting and will assess and modify the action plan as needed to ensure continued compliance.	