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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 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 [DATE]. 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. 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.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 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 [DATE]. 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 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 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 [DATE] 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 [DATE] revealed 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 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #8 was admitted to the facility on [DATE] 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 [DATE] 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 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 [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation (A-fib), and cerebral vascular accident (CVA). Resident #24 was discharged on [DATE]. 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 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 [DATE] 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 37280 4. Resident #14 was readmitted to the facility on [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #4 was admitted to the facility on [DATE] with diagnoses that included pneumonia. The admission Minimum Data Set (MDS) dated [DATE] 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 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 [DATE]. 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 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 [DATE] 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 mellitus. The admission Minimum Data Set (MDS) assessment dated [DATE] 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 he expected all resident care plans to be reflective of their clinical condition including the use of high-risk medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 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 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 [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and respiratory failure. The admission Minimum Data Set (MDS) assessment dated [DATE] 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 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48006 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. 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.