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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bermuda Village Retirement Center	142 Bermuda Village Drive Bermuda Run, NC 27006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on record reviews and interviews, the facility failed to develop individualized person-centered comprehensive care plans for the use of psychotropic medications (medications that alter brain functions, affecting mood, perception, thoughts or behavior) for 1 of 5 residents reviewed for comprehensive care plans (Resident #2). The findings include:Resident #2 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and dementia with severe behavioral disturbances. Review of Resident #2's medical record revealed physician orders for quetiapine fumarate (antipsychotic) 100 milligrams (mg) at bedtime for behavioral disturbance related to dementia dated 03/09/26 and sertraline (antidepressant) 200 mg at bedtime for dementia related behaviors dated 03/09/26. The admission Minimum Data Set assessment dated [DATE] revealed Resident #2 received antipsychotic and antidepressant medications.The Care Area Assessment for Psychotropic Drug Use dated 03/16/26 revealed Resident #2 triggered for psychotropic drug use related to receiving daily antipsychotics and antidepressant medications and would proceed to care plans.Review of Resident #2's Medication Administration Records for 03/2026, revealed the Resident received the antipsychotic and antidepressant medications daily as ordered by the physician.Review of Resident #2's comprehensive care plan dated 03/29/26 revealed the high-risk medications of antipsychotic and antidepressant were not care planned.An interview was conducted with the Minimum Data Set Coordinator on 06/11/26 at 11:00 AM. The MDS Coordinator explained that she was responsible for completing the high-risk medication care plans which included antipsychotic and antidepressant medications. The MDS Coordinator looked for Resident #2's care plan for the high-risk medications and when she discovered the high-risk medication care plan was not included in the comprehensive care plan, she stated it was not done because she overlooked it.An interview was conducted with the Administrator on 06/11/26 at 12:00 PM. The Administrator explained that if a resident was on high-risk medications, then he expected the medications to be addressed on the care plan.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews and staff interviews, the facility failed to implement their Infection Control policies and procedures for Enhanced Barrier Precautions (EBP) when Nurse #1 failed to wear a gown while providing urinary catheter care (flushing the catheter) for Resident #8. In addition, Nurse #1 failed to change gloves and sanitize her hands during wound care for Resident #8. This deficient practice occurred for 1 of 6 staff members observed for infection control practices (Nurse #1). The findings included:Review of the facility's posted Enhanced Barrier Precautions (EBP) policy updated 07/26/22 revealed the following in part: All healthcare personnel must wear gloves and gowns for the following high contact resident care activities including device care (urinary catheter) and wound care (any skin opening that requires dressing).Review of the facility's policy on Handwashing/Hand Hygiene revised 08/2019 revealed in part: The facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel and residents.Procedures:7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations:Before donning gloves and after removing glovesBefore and after handling clean or soiled dressings, gauze pads, contaminated equipment, etc.9. The use of gloves does not replace handwashing/hand hygiene.An observation was conducted on 06/10/26 at 11:50 AM of a urinary catheter flush and wound care for Resident #8 provided by Nurse #1. Nurse #1 applied clean gloves retrieved from the Personal Protective Equipment (PPE) tower on the back of the Resident's door and proceeded to disconnect the urinary catheter and instilled approximately 60 milliliters (ml) of sterile water using a 60 ml syringe. After completion of the task, Nurse Aide (NA) #1 entered the Resident's room and asked Nurse #1 if she needed a gown and the Nurse then removed her dirty gloves and without washing her hands the Nurse put on a gown and clean gloves. The Nurse then touched the trash bag (with trash) to position it closer for the procedure then removed her dirty gloves and donned clean gloves without sanitizing her hands. Nurse #1 proceeded to remove a soiled gauze dressing from Resident #8's left chest area and threw it in the trash bag and without removing her dirty gloves and sanitizing her hands the Nurse washed the wound with soap and water, and a washcloth then applied the antiseptic solution around the wound bed using a cotton swab. Then without removing her dirty gloves, the Nurse picked up a gauze soaked with a saline solution containing hypochlorous acid (non-toxic antimicrobial used for wound care) and packed the wound bed using her fingers then placed a border dressing to cover the wound. Nurse #1 then turned Resident #8 to his right side to expose his stage IV sacral wound. The Nurse removed her dirty gloves and washed her hands before donning clean gloves. Nurse #1 removed the old sacral dressing saturated with bloody drainage and proceeded to clean the wound using soap and water and a washcloth. Then without removing her dirty gloves and sanitizing her hands the Nurse picked up the gauze soaked with the saline solution and packed the stage IV wound using her fingers and applied the border dressing. Nurse #1 then repositioned Resident #8 and removed her gloves and gown and washed her hands.During an interview with Nurse #1 on 06/10/26 at 1:30 PM, the Nurse was asked if Resident #8 was on precautions and she stated that the Resident was on EBP because of his urinary catheter and wounds. She explained that she should have put on the gown before she flushed his urinary catheter, but she forgot. The Nurse also stated that she should have removed her gloves and washed her hands after she removed the old dressings and after cleansing the wounds, but she was nervous and forgot that too. She explained that the facility periodically educated on infection control specifically EBP and she should have remembered to utilize the correct precautions because the EBP signage and PPE were posted on the Resident's door and she should have paid closer attention to it.An interview was conducted with the Director of Nursing (DON), who was also the Infection Preventionist, on 06/10/26 at 3:52 PM. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON explained that the facility educated on infection control through a computerized educational program as well as educational programs held in person which was what the facility was doing when the survey began on 06/09/26. He stated Nurse #1 should have followed the EBP signage posted on Resident #8's door and should have changed her gloves and sanitized her hands when she removed the dirty dressings, after cleansing the wounds and before she applied the treatment ordered for the wounds to prevent developing infections.On 06/11/26 at 12:00 PM an interview was conducted with the Administrator who explained that he expected Nurse #1 to follow the EBP signage and change her gloves and sanitize her hands according to the infection control policy.