

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Bermuda Commons Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC Highway 801 South Advance, 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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>52236</p> <p>Based on review of Resident Council meeting minutes, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns by residents of noise at night during Resident Council meetings for 3 of 10 months reviewed (January 2024, February 2024 and October 2024).</p> <p>The findings included:</p> <p>The Resident Council meeting minutes were reviewed for January 2024. Under the heading New Business, minutes noted residents' complaints of noise in the hallway at around 4:00 AM and a plan by the Activities Director to notify the Director of Nursing (DON) about the issue.</p> <p>In the February 2024 meeting minutes, under the heading Old Business, there was no documented follow up for the January 2024 noise complaint. The February 2024 minutes, under the heading New Business made note that the noise at night was persisting and a plan was made to speak with the DON about the issue.</p> <p>Meeting minutes for March 2024 revealed no documented follow up on the noise complaints from February 2024 under the heading of Old Business. New Business showed no documentation of new noise complaints.</p> <p>The April 2024 meeting minutes revealed no documented follow up on noise complaints under the heading of Old Business for past noise complaints from February 2024. New Business showed no documentation of new noise complaints.</p> <p>Meeting minutes reviewed for May 2024 revealed no documented follow up on noise complaints under the heading of Old Business for past noise complaints from February 2024. New Business showed no documentation of new noise complaints.</p> <p>The June 2024 meeting minutes showed no documented follow up on noise complaints under the heading of Old Business for past noise complaints from February 2024. New Business showed no documentation of new noise complaints.</p> <p>There was no Resident Council meeting in July 2024 per the Activities Director.</p> <p>(continued on next page)</p>

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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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Meeting minutes reviewed for August 2024 revealed no documented follow up on noise complaints under the heading of Old Business for past noise complaints from February 2024. New Business showed no documentation of new noise complaints.</p> <p>There were no September 2024 meeting minutes provided following two requests.</p> <p>Review of October 2024 Resident Council meeting minutes revealed no documented follow up on noise complaints under the heading of Old Business for past noise complaints from February 2024. New Business showed a resident complaint of having been woken up in the middle of the night from noise and staff talking loudly. There was no plan documented for resolution of the new noise complaint in the October 2024 minutes, however the Administrator and the DON were noted as being in attendance at the meeting.</p> <p>The November 2024 meeting minutes revealed under Old Business that the DON had spoken with staff about the noise at night. There were no new noise complaints under New Business. The DON was noted as in attendance at the meeting.</p> <p>The December 2024 meeting minutes showed under Old Business a repetition of the noise complaint from October 2024. New Business noted the repetition that the DON had spoken to staff about the noise and that the issue was resolved. The DON was noted as in attendance at the meeting.</p> <p>In a Resident Council meeting on 03/05/25 at 11:08 AM, six members of the Resident Council who attended meetings regularly (Resident #93, Resident #50, Resident # 76, Resident #11, Resident #77 and Resident #84), reported that they knew how to complete an individual grievance form and that they knew where the forms were located. All Residents present reported that they were not aware of separate forms to be filled out regarding concerns that were brought forward at their Resident Council meetings with staff. When the surveyor inquired about whether there was any noise at night, all residents present stated that there was sometimes noise at night but that they understood that this happened sometimes and that they knew there were shift changes at night.</p> <p>In an interview with the Activities Director on 03/05/25 at 09:50 AM the Activities Director reported that she documented resident concerns from the meetings in the Resident Council meeting minutes. She stated follow up from Resident Council concerns were then documented in subsequent months' meeting minutes as Old Business and then noted as resolved or not resolved. The Activities Director reported that she did not document resident concerns brought forward at Resident Council meetings separately as a resident grievance or group concern. She reported that she shared all concerns with the Administrator, the DON and whatever person would be responsible for the resolution.</p> <p>On 03/06/25 at 2:47 PM, during a follow up interview with Activities Director, she reported resident/group concerns were documented in Resident Council meeting minutes, then she would go to the person responsible for resolution and discuss with that person how to resolve a given complaint/concern. She reported that all concerns were shared with the Administrator or DON every month. The Activities Director confirmed all resolution efforts were conducted verbally. She said once a resolution of a complaint was reached, this was documented in the next months' meeting minutes as resolved. The Activities Director confirmed residents were not given any kind of written notation of resolution of concerns. The Activities Director confirmed any follow-up with residents was conducted verbally.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Director of Nursing (DON) on 03/06/25 at 3:32 PM, the DON confirmed that any concerns brought forward at the Resident Council meeting were followed up on at next month's Resident Council meeting. The DON confirmed that any follow up was done verbally with the person responsible for resolution. She explained that any concerns from Resident Council meetings were brought forward to facility staff at staff meetings. The DON confirmed that she had spoken to staff about the residents' complaints of noise at night. The DON also confirmed there was no written documentation of concerns brought forward apart from the meeting minutes, and no written follow-up documentation was provided to the resident council.</p> <p>On 03/05/25 at 10:03 AM, an interview was conducted with the Administrator, the Social Worker (SW) and the Activities Director. The Administrator stated that the facility's practice was to document any resident concerns brought forward at Resident Council meetings on the meeting minutes and that follow-up was documented on subsequent months' meeting minutes as either resolved or not resolved. The Administrator said that the Activities Director reported concerns to the Administrator, the DON and whatever person was responsible for the resolution. The Activities Director reported that facility leadership conducted these efforts verbally, there was no written documentation. She said leadership spoke with the person who they believed would best be able to resolve the issue. That person then took their own steps to do so. The Administrator confirmed that there was no other documentation of resident group concerns attached or documented with Resident Council minutes. The SW reported that she was instructed by her corporate team to keep all resident grievances separate from Resident Council meeting minutes. The Administrator confirmed he was aware of the noise complaints, and he reported that facility staff were addressed about noise at staff meetings and that noise issue was resolved.</p> <p>In a follow-up interview with the Administrator on 03/06/25 at 3:46 PM, he confirmed that resident concerns mentioned at Resident Council meetings were documented on the meeting minutes including any planned follow-up actions. He said facility leadership was responsible for coordinating resolution of concerns. He verbalized that follow up was then documented on the next month's meeting minutes. The Administrator confirmed any resident or group concerns were then verbally brought to the attention of the person responsible for the resolution and that documentation was in the next months' meeting minutes as resolved or not resolved. The Administrator confirmed resolution efforts were conducted verbally and that there was no written follow-up provided to residents. He voiced that if a concern was not resolved in the next month, that he would then share a new proposed plan to the Resident Council. He reported that he was made aware of issues and/or concerns brought forward at Resident Council meetings. The Administrator confirmed any new resolution plans were also conducted verbally and that there was no written process for staff to follow.</p>		

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<p>F 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>52236</p> <p>Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit for 4 of 4 days of the recertification survey.</p> <p>The findings included:</p> <p>On 3/3/2025 at 11:18 AM, an observation of the facility (inclusive of all hallways) revealed no postings of name or contact information for the following: the local department of social services, the State Long Term Care Ombudsman or the resident advocacy group.</p> <p>On 3/4/2025 at 9:50 AM, an observation of the facility (inclusive of all hallways) revealed no postings of name or contact information for the following: the local department of social services, the State Long Term Care Ombudsman or the resident advocacy group.</p> <p>An observation of the facility (inclusive of all hallways) on 03/05/25 at 2:56 PM, revealed there were no postings of name or contact information for the following: the local department of social services, the State Long Term Care Ombudsman or the advocacy group.</p> <p>During a walking tour of the facility and interview on 3/6/25 at 3:46 PM with the Administrator, there were no postings of name or contact information for the local department of social services, the State Long Term Care Ombudsman or the advocacy group. The Administrator reported it was the Administrator's responsibility to ensure that postings of name and contact information for the local department of social services, the State Long Term Care Ombudsman and advocacy group were present. The Administrator confirmed that all residents and their representatives should be informed of all available resources and that the postings be in a location easily visible and accessible if any resident or their representative should need them.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51936</p> <p>Based on record review, resident and staff interviews, the facility failed to have a signed Medical Orders for Scope of Treatment (MOST) form for 1 of 7 residents reviewed for advance directives (Resident #55).</p> <p>The findings included:</p> <p>Resident #55 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, congestive heart failure and hypertensive heart disease.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #55 was cognitively intact.</p> <p>A review of the active care plan dated 12/22/2022 revealed that Resident #55 had goals and interventions for Do Not Resuscitate (DNR).</p> <p>A review of the medical record revealed an order from the Nurse Practitioner (NP) dated 07/11/2024 for Do Not Resuscitate (DNR): Intubation if only temporary; hospitalization if needed; IV (intravenous) fluids if needed; Antibiotics if needed; Feeding tube if only temporary.</p> <p>A review of the Nurse Practitioner (NP) note dated 07/11/2024 revealed that the NP had reviewed advance directives with Resident #55 and had confirmed Resident #55's wishes to remain a DNR. The MOST form completed on 07/11/2024 was found in the advance directive's binder at the nurse's station but had not been signed by Resident #55 or her representative.</p> <p>An interview on 03/04/2025 at 9:33 AM with Resident # 55 revealed she had discussed her wishes regarding advanced directives with her representative and thought someone from the facility had discussed this with her as well. She did not recall ever signing a document regarding advanced directives.</p> <p>An interview on 03/04/2025 at 3:54 PM with Social Worker #1 revealed the nurse usually handled the completion of the MOST form and obtained the required signatures. Social Worker #1 indicated she reviewed the resident's wishes as part of the care conference but did not complete the forms if any changes were identified. She did not know why the MOST form was not signed by Resident #55.</p> <p>An interview on 03/04/2025 at 04:01 PM with the Physician revealed the NP had reviewed Resident #55's wishes regarding advance directives on 07/11/2024. The physician did not know why the MOST form was never signed by Resident #55 and thought this was a nursing responsibility to obtain the signature.</p> <p>An interview on 03/06/2025 at 10:21 AM with the Director of Nursing (DON) indicated it was the responsibility of social services to obtain the resident's or representative's signature required on the MOST form.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 03/06/2025 at 4:39 PM with the Administrator revealed he was not sure why the MOST form was not signed by Resident #55.</p> <p>An interview on 03/06/2025 at 4:48 PM with the Medical Records Specialist indicated she assumed the responsibility for the monthly MOST form audit two months ago. The last audit was 02/15/2025. She stated the MOST form should have been signed by Resident #55 and the previous person who audited should have noted the form was missing the signature as Resident #55 had been at the facility for a long time.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51667</p> <p>Based on observations and interviews with a resident and staff, the facility failed to provide an adequate supply of bath linens for 3 of 6 halls (Halls 100, 500, and 600) observed for a homelike environment.</p> <p>The findings included:</p> <p>Observations of linen carts on 3/3/25 between 11:40 AM and 11:50 AM on halls 100, 500 and 600 revealed no washcloths or towels on the linen carts. No linen carts were available for observation on halls 200, 300 or 400.</p> <p>An interview conducted with Resident #90 was completed on 3/3/25 at 11:29 AM. Resident #90 was cognitively intact according to Minimum Data Set (MDS) dated [DATE]. Resident #90 stated she was told she could not get a bath at this time because there were no washcloths available.</p> <p>An interview with Nurse Aide (NA) #1 was completed on 3/3/25 at 11:35 AM. NA #1 stated there were no washcloths available for showers and baths and baths would be on hold until washcloths were available. NA #1 also stated there were no washcloths available on Sunday 3/2/25 when she worked and there had been a shortage of washcloths since she started in January of 2025.</p> <p>On 3/6/25 at 9:33 AM Nurse #1 (worked on the 100 and 200 halls) stated she worked on 3/3/25 and the washcloths were out for a short period of time until the laundry was able to provide more washcloths. Nurse #1 reported she found 5 washcloths on 3/3/25 that she provided to 3 residents that wanted a shower while waiting for laundry to provide more washcloths.</p> <p>An interview was conducted on 3/6/2025 at 10:20 AM with NA #2. NA #2 stated on Monday 3/3/2025 at 7:15 AM there were no washcloths or towels. NA #2 reported she had to use washcloths and towels from another hall and waited for laundry to provide more.</p> <p>An interview was conducted on 3/6/25 at 10:25 AM with NA #3 (worked on the 400, 500, and 600 halls). NA #3 reported it had been difficult to locate a washcloth for the past month.</p> <p>During the tour of the laundry room with the Administrator on 3/6/25 at 9:45 AM, it was observed that shelves labeled washcloths and towels were empty.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 9:49 AM on 3/6/25 an interview with the Housekeeping Supervisor was completed. The Housekeeping Supervisor stated when she arrived at 7:00 AM on 3/3/25 there were not enough washcloths. The Housekeeping Supervisor reported she provided clean washcloths to all the halls at 8:00 AM on 3/3/25. The Housekeeping Supervisor stated she continued to supply the halls with washcloths in 15-minute increments on 3/3/25 for the rest of the day. The Housekeeping Supervisor stated if the hall linen carts did not have washcloths or towels, the staff would sometimes stash the washcloths and towels away or use them up. The Housekeeping Supervisor also stated she purchased 54 washcloths on 3/3/25, 72 washcloths on 3/6/25 and was expecting a shipment on 3/10/2025 of 300 washcloths that she ordered 2 weeks ago. The Housekeeping Supervisor confirmed the shelves labeled washcloths and towels observed in the clean linen entrance of the laundry room was the only storage area for clean washcloths and towels.</p> <p>An interview with the Director of Nursing (DON) was completed on 3/6/25 at 11:00 AM. The DON stated housekeeping nor staff reported a shortage of washcloths on Monday 3/3/25. The DON reported she was aware that housekeeping placed an order for 300 washcloths about a week ago because washcloths were running low and informed the staff.</p> <p>An interview was conducted with the Administrator on 3/6/25 at 09:42 AM. The Administrator stated he was not aware of the washcloth shortage. The Administrator reported all laundry was completed in the facility during first and second shifts and there was no staff in laundry during third shift. The Administrator stated there should be enough washcloths available each day to provide resident care.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52236</p> <p>Based on observation, record review, and resident, staff and Medical Director interviews, the facility failed to provide humidified oxygen (oxygen that has been moistened with water vapor) as ordered by the physician for 1 of 1 resident reviewed for respiratory care (Resident #20)</p> <p>The findings included:</p> <p>Resident #20 was admitted to facility on 12/20/19 with diagnoses that included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure and dependence on supplemental oxygen.</p> <p>Resident #20's physician orders dated 11/15/24 revealed oxygen at 4 liters per minute by nasal cannula continuously for chronic obstructive pulmonary disease</p> <p>Resident #20's care plan dated 12/30/24 noted a focus area for chronic obstructive pulmonary disease and interventions including the use of continuous oxygen and BIPAP (a bi-level positive airway pressure machine used to aid breathing) every night with oxygen bleed-in and water (which produces humidification of the inhaled oxygen).</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] noted Resident #20 was cognitively intact and coded for oxygen.</p> <p>Resident #20's physician orders dated 2/4/25 revealed BIPAP 15/5 centimeters of water with oxygen at 2 liters per minute bleed-in with a large full-face mask every night for obstructive sleep apnea.</p> <p>The Medication Administration Record (MAR) dated 3/2/25 revealed documentation that Resident #20 received humidified oxygen therapy for the night of 3/2/25.</p> <p>On 03/03/25 at 12:01 PM, Resident #20 was observed to be on 4 liters of oxygen by nasal canula via oxygen concentrator with a water canister for humidified oxygen. The canister was observed empty and attached to the oxygen concentrator.</p> <p>The MAR dated 3/3/25 revealed documentation that Resident #20 received humidified oxygen therapy for the night of 3/3/25.</p> <p>On 03/04/25 at 08:08 AM, the water canister on Resident #20's oxygen concentrator remained empty.</p> <p>On 03/04/25 at 03:01 PM, the water canister on Resident #20's oxygen concentrator remained empty.</p> <p>In an interview with Resident #20 on 03/04/25 at 3:03 PM, he stated that his nose was not dry without the use of the humidification. He stated that he had not had any nose bleeds and that his nose was not hurting at that time. During the interview, Resident #20 was wearing his oxygen cannula and the flow regulator on the oxygen concentrator was set to 4 liters per minute.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing Assistant (NA) #5 was interviewed on 3/4/25 at 3:11 PM. The NA reported she assisted if the nasal cannula was off or not in place and turned the concentrator on if it was off. NA #5 reported she did not do anything else related to the concentrator or oxygen.</p> <p>During an interview with Medication Aide (MA) #1 on 3/4/25 at 3:20 PM, she reported that she checked the concentrator if it was beeping. Med Aide #1 stated she would change out the water canister if it was empty. She also reported the machine would beep when water was getting low, but she was not allowed to assess Resident #20's oxygen level.</p> <p>On 03/04/25 at 04:04 PM Nurse #6 was interviewed and reported Resident #20 liked to wear his oxygen connected to his BIPAP and was currently on 4 liters by nasal cannula. Nurse #6 reported the concentrator machine would sound an alarm when the water was getting low and self-muted when water canister was full. Nurse #6 reported that staff checked for water in the canister every time the BIPAP was applied.</p> <p>Upon observation with Nurse #6 on 3/4/25 at 4:10 PM of Resident #20's oxygen concentrator, the water canister was still empty. Nurse #6 noticed this and proceeded to remove the empty canister and stated that the canister should have water in it and reiterated that canisters were to be monitored and replaced as needed when empty. Nurse #6 proceeded to obtain new/full canister.</p> <p>The Director of Nursing (DON) was interviewed on 3/4/25 at 4:35 PM and reported oxygen concentrator settings should be correct, water canisters should be full for humidification and canisters should be assessed every shift and as needed. The DON reported nurses refilled water canisters from the supply cabinet.</p> <p>On 03/05/25 at 03:12 PM the Medical Director was interviewed by telephone. The Medical Director stated, not good when the humidifying bottle is empty for several days. She also stated Resident #20 needed humidified oxygen during the day and while using the BIPAP machine at night. The Medical Director said she thought that the humidification mentioned in the BIPAP order was sufficient for Resident #20's daytime oxygen as well. She reported that there were no long-term effects from not having the humidification but there were short-term effects such as discomfort.</p> <p>On 03/06/25 at 5:00PM The Administrator reported nursing monitored all oxygen administration and concentrators.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51464</p> <p>Based on observations and staff interviews the facility failed to (1a.) date an open bottle of eyedrops and an open bottle of nasal spray with an open/discard by date for 1 of 4 medication carts (500 hall cart), (1b.) failed to dispose of a loose pill in 1 of 4 medication carts (100 hall cart) and (2.) and failed to secure medication left at 1 of 1 resident (Resident #19) bedside reviewed for medication storage.</p> <p>The findings included:</p> <p>1a. An observation of the 500 hall medication cart was conducted with Nurse #3 on 03/05/25 at 4:40 PM. An open bottle of moxifloxacin (a medication used to treat eye infections) solution 0.5% was observed in a small plastic container with no open date. An open bottle of fluticasone (a medication used to treat allergies) nasal spray 50 microgram was observed in a small plastic container with no open date. Both bottles of medication were verified as open by Nurse #3.</p> <p>An interview with Nurse #3 on 03/05/25 at 4:42 PM revealed she didn't work often at the facility and did her best to keep up with what was on the medication cart. She indicated the open dates should have been documented when the medications were opened.</p> <p>b. An observation of the 100 hall medication cart was conducted with Nurse #4 on 03/05/25 at 3:50 PM. An unidentified white round pill was observed loose in the top right drawer of the medication cart. Nurse #4 revealed she didn't know how the pill got there as she checked the cart regularly and the pill shouldn't have been loose and unsecured in the medication cart.</p> <p>On 03/06/25 at 2:16 PM an interview with the Director of Nursing (DON) revealed the third shift (11:00 PM to 7:00 AM) nurse conducted a weekly audit of all the medication carts. She indicated nurses should date medications when they were opened and discard according to expiration dates, and that pills should not be loose and unsecured in the medication carts.</p> <p>An interview with the Administrator on 03/06/25 at 2:25 PM revealed he expected nurses who opened medications to label them upon opening and that pills should not be loose and unsecured in the medication carts.</p> <p>52236</p> <p>2. Resident #19 was admitted to the facility on [DATE] with diagnoses including late onset Alzheimer's disease and dementia.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] noted Resident #19 had moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bermuda Commons Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 316 NC Highway 801 South Advance, NC 27006	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/03/25 at 12:14 PM Resident #19 was observed to have a tube of antibiotic/pain reliever ointment on her bedside table. Resident #19 stated I put it on my forehead, but reported she did not remember why she was using it. When asked, she said she did not remember where she got the ointment.</p> <p>During an observation of Resident #19's room on 03/04/25 at 8:10 AM the tube of antibiotic/pain reliever ointment remained on her bedside table.</p> <p>During an interview with Nurse #1 on 3/4/25 at 2:06 PM, she reported that she was not aware of any medication on Resident #19's bedside table.</p> <p>On 03/04/25 at 3:08 PM the tube of antibiotic/pain reliever ointment was observed still on Resident #19's bedside table. Resident #19 again reported she put the ointment on her forehead about three times a day, it itches sometimes.</p> <p>Upon observation of Resident #19's bedside table with Nurse #2 on 3/4/25 at 4:27 PM, Nurse #2 observed the antibiotic/pain relieving ointment on the bedside table and removed the tube and took it to the nurse's station. Nurse #2 reported that it should not have been on the resident's bedside table.</p> <p>On 03/05/25 at 2:19 PM the Director of Nursing (DON) reported that a physician's order was required to have any medication at a resident's bedside.</p> <p>In a telephone interview with the Medical Director on 3/5/25 at 3:12 PM, she reported that Resident #19's family member probably brought the medicated ointment. The Medical Director stated she was surprised the staff had not seen the medicated ointment before it was brought to their attention. She also stated she would have expected the staff to see the medicated ointment and remove it from Resident #19's room.</p> <p>In an interview with the Administrator on 3/5/25 at 5:15 PM. The Administrator confirmed that residents and family were educated to not bring in medications from home and leave them at resident's bedside.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51936</p> <p>Based on record review, observations and staff interviews, the facility failed to discard expired nutritional supplement drinks that were past the use by date in 2 of 2 nourishment rooms (300 Hall and 500 Hall Nourishment rooms).</p> <p>The findings included:</p> <p>An observation was made on [DATE] at 2:33 PM of the nourishment room on the 300 Hall. The observation revealed that there were 17 individual nutritional supplement drink cartons with a use by date of [DATE] available for use located on a lower shelf in the nourishment room.</p> <p>An observation was made on [DATE] at 2:44 PM of the nourishment room on the 500 Hall. The observation revealed that there were 121 individual nutritional supplement drinks with a use by date of [DATE] available for use located on a lower shelf in the nourishment room.</p> <p>An interview and tour of the nourishment room on the 300 Hall on [DATE] at 3:00 PM with the Dietary Manager revealed she was responsible for stocking snacks and the fortified nutritional shakes. She stated Central Supply was responsible for stocking the nutritional supplement drinks and should have pulled the out of date items.</p> <p>An interview and tour of the nourishment rooms on 300 Hall and 500 Hall on [DATE] at 3:05 PM with Central Supply revealed that she checked the nourishment rooms once a week for expired items. She checked both rooms last week and did not know why the out of date nutritional supplement drinks had not been removed.</p> <p>An interview on [DATE] at 4:32 PM with the Administrator and the Dietary Manager revealed they were unsure why the expired nutritional supplement drinks had not been removed from stock. The Dietary Manager stated that Central Supply should have pulled the out of date nutritional supplement drinks. The Administrator indicated all food/drink items should have been removed from stock as soon as they expired.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51838</p> <p>Based on record review and staff interviews, the facility failed to document education was provided in the medical record regarding the benefits and potential side effects of the influenza and pneumonia vaccines prior to the administration of vaccines. This occurred for 4 of 5 residents (Resident #98, Resident #77, Resident #262, and Resident #27) reviewed for vaccines.</p> <p>The findings included:</p> <p>a. Resident #98 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed that staff answered no under the education provided tab for influenza vaccine administered by Nurse #7 on 10/03/24 and for pneumonia vaccine administered by Nurse #7 on 10/18/24. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for these doses.</p> <p>b. Resident #77 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed staff answered no under the education tab for influenza vaccine administered by Nurse #7 on 10/07/24, and pneumonia vaccine administered by Nurse #7 on 10/21/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for these doses.</p> <p>c. Resident #262 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed staff answered no under the education tab for influenza vaccine administered by Nurse #7 on 02/12/25, and pneumonia vaccine administered by Nurse #7 on 02/15/25. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for these doses.</p> <p>d. Resident #27 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed the education area was answered no under the education tab for influenza vaccine administered by Nurse #7 on 10/03/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for these doses.</p> <p>An interview with the Infection Preventionist (IP) on 03/06/25 at 1:40 PM revealed that the floor nurse would administer the vaccines per the Medication Administration Record (MAR). She stated there should be education provided prior to administration of vaccines by the nurse administering the vaccine. The IP stated she and the Director of Nursing track which staff and residents received vaccines.</p> <p>An interview with Director of Nursing on 03/06/25 at 2:40 PM revealed she kept a record of the vaccines administered on the Vaccine Information Flowsheet. She stated the education should be provided to the resident or resident's representative prior to the vaccine being administered. The Director of Nursing stated the expectation was for the nurse that provided the education to document in the medical record that education had been provided on the immunization record.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Administrator on 03/06/25 at 5:05 PM revealed he expected the resident and/or the resident's legal representative to be provided with education regarding the benefits and potential side effects prior to offering vaccines. He stated the expectation of consistency and the procedures for providing vaccine education was not carried out.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51838</p> <p>Based on record review and staff interviews, the facility failed to document education was provided in the medical record regarding the benefits and potential side effects of the COVID-19 vaccines prior to administration of the vaccines. This occurred for 5 of 5 residents reviewed for immunizations (Resident #43, Resident #98, Resident #77, Resident #262, and Resident #27).</p> <p>The findings included:</p> <p>a. Resident #43 was admitted to the facility on [DATE]. The Resident's immunization record was reviewed and revealed that staff answered no under the education provided tab for COVID-19 vaccine administered by Nurse #7 on 11/06/24. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for this dose.</p> <p>b. Resident #98 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed that staff answered no under the education provided tab for the COVID-19 vaccine administered by Nurse #7 on 05/25/24. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for this dose.</p> <p>c. Resident #77 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed staff answered no under the education tab for the COVID-19 vaccine administered by Nurse #7 on 10/21/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this dose.</p> <p>d. Resident #262 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed staff answered no under the education tab for the COVID-19 vaccine administered by Nurse #7 on 02/12/25. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this dose.</p> <p>e. Resident #27 was admitted to the facility on [DATE]. The resident's immunization record was reviewed and revealed the education area was answered no under the education tab for the COVID-19 vaccine administered by Nurse #7 on 10/25/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this dose.</p> <p>An interview with the Infection Preventionist (IP) on 03/06/25 at 1:40 PM revealed that the floor nurse would administer the vaccines per the Medication Administration Record (MAR). She stated there should be education provided prior to administration of the vaccine by the nurse administering the vaccine.</p> <p>An interview with the Director of Nursing on 03/06/25 at 2:40 PM revealed she kept a record of the vaccine administered on the Vaccine Information Flowsheet. She stated the education should be provided to the residents or the resident's representative prior to the vaccine being administered. The Director of Nursing stated the expectation was for the nurse that provided the education to document in the medical record that education had been provided on the immunization record.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Administrator on 03/06/25 at 5:05 PM revealed he expected the resident and/or the resident's legal representative to be provided with education regarding the benefits and potential side effects prior to offering vaccines. He stated the expectation of consistency and the procedures for providing vaccine education was not carried out.</p>		