STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	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)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and review of the facilities infection control policies and procedures the facility failed to implement facility infection control policies for hand hygiene when staff provided care for residents on isolation precautions and failed to ensure Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage indicating Special Droplet Contact Precautions for 4 of 4 residents (Resident #1, #2, #3and #4). The facility failed to ensure education was provided on safety of staff who provided their own protective face covering when interacting with residents for 1 of 1 staff. These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents in the facility through the transmission of COVID-19. Findings included: 1. Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 was positive for a urinary tract infection [MEDICAL CONDITION] and the urine culture revealed extended spectrum beta-lactamase (ESBL) as the organism present. ESBL is an enzyme found in some bacteria strains that cause the strain to be resistive to conventional antibiotic usage and more difficult to eradicate. A review of a physician's orders [REDACTED].#1 was started on [MEDICATION NAME] 1 gram (GM) intramuscularly (IM) daily at bedtime for a UTI for 5 days. An observation on 06/08/20 at 9:07 AM revealed nurse aide (NA) #1 was in the room of Resident #1 which was located on the facility's COVID positive unit. There were two signs posted to the outside of the door to Resident #1's room which included; an [MEDICATION NAME] Contact Precautions sign and a Special Droplet Contact Precautions sign which had illustrations for PPE usage. The [MEDICATION NAME] contact precaution signage specified the use of gown and gloves and performing hand hygiene with soap and water before leaving the room. The Special Droplet Contact Precaution signage revealed everyone including visitors, doctors, and staff must clean hands when entering and exiting the room, wear a facemask, eye protection to include goggles or face shield, must gown and glove at the door, keep door closed, and use disposable equipment when possible or clean multiuse equipment after each usage. A cart was placed outside the room which included an ample supply of PPE such as gowns and gloves. NA #1 had completed care at the bedside of Resident #1, bagged up the soiled items, and removed her gloves and disposed of them in the plastic bag before it was sealed. She was observed to use her bare hands to pick up a marker in the resident's room and wrote on the white board in the room before exiting the room. She was not observed to perform hand hygiene before exiting the room. An interview with NA #1 on 06/08/20 at 9:08 AM revealed NA #1 had provided personal care to Resident #1. NA #1 acknowledged there were signage posted to the door that included both [MEDICATION NAME] Contact Precautions and Enhanced Droplet Contact Precautions. She stated she was not wearing gloves when she picked up the marker and wrote a note on the board in Resident #1's room and had not performed hand hygiene before exiting the room. She confirmed there were gloves available for use but didn't reapply gloves after she removed the soiled ones after completing care. She stated she understood this could cause the spread of infection and should have reapplied gloves when touching items in Resident #1's room. An interview with the Unit Manager was conducted on 06/08/20 at 10:15 AM revealed all nursing staff to include NA #1 had received training on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further revealed Resident #1 resided on a closed unit for high risk of suspected COVID-19 residents. She acknowledged Resident #1 had signage for [MEDICATION NAME] Contact Precautions and Special Droplet Contact Precautions on the outside of the door and a cart with PPE was supplied and stocked for usage. She further stated NA #1 should have worn gloves at all times while in Resident #1's room and performed proper hand hygiene before exiting the room. An interview with the Administrator was conducted on 06/08/20 at 10:50 AM revealed Resident #1 was housed on a closed unit for high risk of suspected COVID-19 residents. The Administrator indicated gloves should be worn at all times when in Resident #1's room due to [MEDICATION NAME] Contact Precautions and Special Droplet Contact Precautions and that NA #1 should not have wrote on the board without gloves and hand hygiene should have been performed before exiting the room. An interview with the Director of Nursing (DON) was conducted on 06/08/20 at 11:08 AM and revealed NA #1 had received training on hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further indicated NA#1 should always have worn gloves when in the room of Resident #1, should not have wrote on the dry erase board without gloves, and should have performed hand hygiene before leaving the room of Resident #1 who had signage for [MEDICATION NAME] Contact Precautions and Special Droplet Contact Precautions. An interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 06/08/20 at 11:15 AM revealed Resident #1 resided on a closed unit where all residents should be on Special Droplet Contact Precautions due to high risk of susceptibility to COVID-19. She stated all staff entering these rooms should wear a mask, eye protection, a gown, and gloves always when in the room and perform proper hand hygiene before exiting the room. She stated the facility had an abundant supply of PPE available for usage in the care of Resident #1. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of physician order [REDACTED].#2 is at risk of respiratory infections secondary to [MEDICAL CONDITION]. An observation was made on 06/08/20 at 09:11 AM that revealed a therapist providing treatment to Resident #2 with the resident's room door open to the hall. The resident's room was on the facility's COVID positive unit. There were signs posted on the outside of the door which included Special Droplet Contact Precautions which included the illustrations for personal protective equipment (PPE) usage. The Special Droplet Contact Precaution signage revealed everyone including visitors, doctors, and staff must clean hands when entering and exiting the room, wear a facemask, eye protection to include goggles or face shield, must gown and glove at the door, keep door closed, and use disposable equipment when possible or clean multiuse equipment after each usage. A cart was placed outside the room which included an ample supply of personal protective equipment such as gowns and gloves. The Physical Therapy Assistant was observed wearing a mask, gown, eyewear, and gloves while providing treatment to Resident #2. The observation further revealed the Physical Therapy Assistant exited Resident #2's room wearing her full PPE including a gown, gloves, mask, and eyewear and walk down the hallway to a therapy room. In the therapy room, she approached the weight rack and touched it to retrieve 2 white ankle weights, then returned to Resident #2's room and continued the previously started therapy session. The Physical Therapy Assistant was not observed to change her gloves or perform proper hand hygiene when exiting or before re-entering Resident #2's room. An interview with a Physical Therapy Assistant on 06/08/20 at 09:13 AM revealed she had started the therapy session with Resident #2 and realized she needed weights from the therapy gym which was located at the end of the hall. She acknowledged Resident #2 was on Special Droplet Contact Precautions and she exited the room in full PPE including a gown, mask, eyewear, and gloves to collect the needed supplies. She indicated she was returning to the Resident #2's room and therefore did not remove her gloves and perform hand hygiene before leaving the room to retrieve the weights, but had been educated on hand hygiene, donning and doffing of PPE, and transmission-based precautions. An interview with the Unit Manager was conducted on 06/08/20 at 10:15 AM revealed all nursing staff to include the Physical Therapy Assistant had received training on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further revealed Resident #2 resided on a closed unit for high risk of suspected COVID-19 residents. She acknowledged Resident #2 had signage for Special Droplet Contact Precautions on the outside of the door and a cart with PPE was supplied and stocked for usage. She further stated the Physical Therapy

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Assistant should have removed her gloves and performed proper hand hygiene before exiting the room of Resident #2. She should have not touched supplies in the therapy gym with soiled gloves, and a new pair of gloves should have been donned before re-entering Resident #2's room. An interview with the Administrator was conducted on 06/08/20 at 10:50 AM revealed Resident #2 was housed on a closed unit for high risk of suspected COVID-19 residents. The Administrator indicated gloves should be removed and hand hygiene performed when exiting the room of Resident #2. He further revealed the Physical Therapy Assistant should have not touched items in the therapy room while wearing used gloves and a new pair of gloves should have been applied before entering the room of Resident #2 to continue the therapy session due to Special Droplet Contact Precautions. An interview with the Director of Nursing (DON) was conducted on 06/08/20 at 11:08 AM revealed the Physical Therapy Assistant had received training on hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further indicated Resident #2 was on Special Droplet Contact Precautions and the Physical Therapy Assistant should have removed her gloves and performed hand hygiene before leaving the room. She should not have worn soiled gloves in the therapy gym and a new pair of gloves should have been applied before re-entering the room of Resident #2 due to being on Special Droplet Contact Precautions. An interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 06/08/20 at 11:15 AM revealed Resident #2 resided on a closed unit where all residents should be on Special Droplet Contact Precautions due to high risk of susceptibility to COVID-19. She stated all staff entering these rooms should wear a mask, eye protection, a gown, and gloves always when in the room and perform proper hand hygiene before exiting the room. She stated the Physical Therapy Assistant had been trained on hand hygiene, donning and doffing of PPE and transmission-based precautions and soiled gloves should never be worn in the hallway or therapy gym. The ADON further revealed the facility had an abundant supply of PPE available for usage in the care of Resident #2. 3. A review of the CDC Guidance for Extended Use and Limited Reuse of N95 filtering facepiece respirators in healthcare settings dated March 27, 2020 read in part: When manufacturer guidance is unavailable, preliminary data suggest limiting the number of reuses to no more than five uses per device to ensure an adequate safety margin and use an alternative. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#3 to be febrile on 05/23/20. A Situation Background Assessment Recommendation (SBAR) was completed on 05/23/20 and Resident #3 was moved to a COVID positive unit due to symptomatic and potential exposure in the facility to COVID-19. An observation was made on 06/08/20 at 10:05 AM of Resident #2. Signage on the door indicated Resident #3 was on Special Droplet Contact Precautions which included the illustrations for personal protective equipment (PPE) usage. The Special Droplet Contact Precaution signage revealed everyone including visitors, doctors, and staff must clean hands when entering and exiting the room, wear a facemask, eye protection to include goggles or face shield, must gown and glove at the door, keep door closed, and use disposable equipment when possible or clean multiuse equipment after each usage. He had opened his door and was sitting in his wheelchair in the doorway of his room. He had a cloth face mask attached to both ears and tucked under his chin. He hollered out for this surveyor and Nurse #1 and asked if the facility was going to gas them since staff were now wearing face shields which he stated he had not seen before. The observation further revealed Nurse #1 who walked up to Resident #3 and told him to put his mask back on correctly. He lightly pulled it to cover his chin. A nurse then lifted the mask up to cover Resident #3's nose and mouth. She touched his cheek and mouth to perform this task while not wearing gloves. The observation also revealed Nurse #1 wearing a gray KN95 mask with an exhalation valve filter that appeared to be fuzzy on the exterior and slightly faded when she was in contact with Resident #3. An interview with Nurse #1 on 06/08/20 at 10:06 AM revealed Resident #3 had signage that indicated Special Droplet Contact Precautions on the door of the room. She acknowledged she did not apply gloves when she assisted Resident #3 to reapply his mask. She indicated she should always wear gloves when reapplying a resident mask because she touched Resident #3's face with her bare hands. The interview further revealed the KN95 facemask Nurse #1 wore had been supplied by herself to help her feel like she could breathe better. Nurse #1 indicated she could wear her own and had been wearing the same mask since March 2020. She further stated to have a clean mask, she had been taking the mask home with her after her shift and washing it in the washing machine. She acknowledged the facility had enough surgical masks available for use on the date of the survey and she was not sure what the manufacturer instructions list as acceptable length of use and was unaware KN95 masks were unable to be laundered in the washing machine. An interview with the Unit Manager was conducted on 06/08/20 at 10:15 AM revealed all nursing staff to include Nurse #1 had received training on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further revealed Resident #3 resided on a closed unit for high risk of suspected COVID-19 residents. She acknowledged Resident #3 had signage for Special Droplet Contact Precautions on the outside of the door and PPE was supplied and stocked for usage. She further stated Nurse #1 should have applied her gloves before assisting Resident #3 to apply his face mask. He further indicated she did not believe the KN95 mask should be used more than 5 shifts and then it should be discarded and that it was ineffective once it was laundered. An interview with the Administrator was conducted on 06/08/20 at 10:50 AM revealed Resident #3 was housed on a closed unit for high risk of suspected COVID-19 residents. The Administrator indicated gloves should be used when applying a facemask to Resident #3. He also indicated he was not aware at the time Nurse #1 had continued using the same face mask past manufacturers recommendations or laundering the mask in the washing machine. He acknowledged face mask should be used according to manufacturer's recommendations. An interview with the Director of Nursing (DON) was conducted on 06/08/20 at 11:08 AM revealed Nurse #1 had received training on hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further indicated Resident #3 was on Special Droplet Contact Precautions and Nurse #1 should have applied gloves before applying Resident #3's facemask. She further indicated the facility had allowed staff to provide their own mask if they signed a paper and followed manufacturers guidelines for usage. She stated Nurse #1 should not have been using the facemask since March 2020 and should not have laundered the mask. An interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 06/08/20 at 11:15 AM revealed Resident #3 resided on a closed unit where all residents should be on Special Droplet Contact Precautions due to high risk of susceptibility to COVID-19. She stated all staff should wear a mask, eye protection, a gown, and gloves always when caring for Resident #3. She stated Nurse #1 had been trained on donning and doffing of PPE and transmission-based precautions. The ADON further revealed the facility had an abundant supply of PPE available for usage in the care of Resident #3 and that the personal KN95 mask should not have been worn for an extended amount of time or put in the washing machine for cleaning. 4. Resident #4 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An additional care plan dated 04/20/20 revealed Resident #4 was a probable or confirmed case of a highly contagious respiratory infection with interventions that included education to resident/family/staff regarding in preventive measures to contain the infection, emphasize good hand washing techniques to all staff, enhanced droplet precautions that included to be placed in a private room (when available) with the door kept closed, staff should don eye protection (goggles), surgical mask, gown and gloves prior to entry. Hand hygiene should be performed prior to entering the room and after PPE is removed and use as much disposable equipment as possible or use dedicated equipment such as thermometer and blood pressure cuff. A review of the nurse progress noted dated for May 2020 revealed Resident #4 had experienced decrease blood pressure's, increase sleepiness, decrease appetite with weight loss, decrease blood sugars, a urinary tract infection, and nausea before COVID-19 protocol was initiated when Resident #4 was found to be febrile on 05/26/20. A review of a physician order [REDACTED].#2 exit the room of Resident #4 holding a meal tray without gloves. Signage on the outside of the door indicated Resident #4 was on Special Droplet Contact Precautions which included the illustrations for personal protective equipment (PPE) usage. The Special Droplet Contact Precaution signage revealed everyone including visitors, doctors, and staff must clean hands when entering and exiting the room, wear a facemask, eye protection to include goggles or face shield, must gown and glove at the door, keep door closed, and use disposable equipment when possible or clean multiuse equipment after each usage. NA #2 placed the tray on the meal service cart in the hallway along with other meal trays and closed the external door. She removed her gown then returned to the meal service cart and began pushing it through the double doors closing off the COVID-19 unit and returned it to the dining room for dietary to empty before returning to the unit. An interview with NA #2 was made on 06/08/20 at 9:38 AM revealed NA #2 acknowledged she had not worn gloves when picking up meal trays in rooms labeled Special Droplet Contact Precautions including Resident #4. She stated she touched the tray, cart, cart door without gloves and after removing her isolations gown, she did not reapply gloves to return the contaminated meal cart to the dining room. She stated she had received education on hand washing, donning and doffing of PPE, and transmission-based precautions but did not think about wearing gloves when touching items removed from a room on Special Droplet Contact Precautions. She acknowledged this practice increased the risk of spread of infections. An interview with Nurse #1 on 06/08/20 at 9:42 AM revealed she was the nurse for Resident #4 who was on Special Droplet Contact Precautions. She stated NA #2 should have worn gloves when removing items from a room on Special Droplet Contact Precautions. An interview with the Unit Manager was conducted on 06/08/20 at

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) 10:15 AM revealed all nursing staff to include NA #2 had received training on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further revealed Resident #4 resided on a closed unit for high risk of suspected COVID-19 residents. She acknowledged Resident #4 had signage for Special Droplet Contact Precautions on the outside of the door and PPE was supplied and stocked for usage. She further stated NA #2 should always have worn gloves while in Resident #4's room and when removing a meal tray from Resident #4's room. An interview with the Administrator was conducted on 06/08/20 at 10:50 AM revealed Resident # 4 was housed on a closed unit for high risk of suspected COVID-19 residents. The Administrator indicated gloves should always be worn when in Resident #4's room due to Special Droplet Contact Precautions and that NA #2 should not have picked up a meal tray from Resident #4's room without gloves. An interview with the Director of Nursing (DON) was conducted on 06/08/20 at 11:08 AM revealed NA #2 had received training on hand hygiene, donning and doffing of PPE, and transmission-based precautions. She further indicated NA #2 should always have worn gloves when in the room of Resident #4, should not have picked up contaminated items from the room without gloves. An interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 06/08/20 at 11:15 AM revealed Resident #4 resided on a closed unit where all residents should be on Special Droplet Contact Precautions due to high risk of susceptibility to COVID-19. She stated all staff entering these rooms should wear a mask, eye protection, a gown, and gloves always when in the room and perform proper hand hygiene before exiting the room. She stated the facility had an abundant supply of PPE available for usage in the care of Resident #4.