STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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E 000	Initial Comments A recertification survey was conducted from 08/12/19 to 08/15/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID LZ3S11.	E 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews, the facility failed to accurately code Minimum Data Set (MDS) Assessments for history of falls, hospice services and use of an anticoagulant (blood thinner) for 3 of 6 residents sampled for medication reviews (Resident #44, Resident #69, & Resident #68). 1. Resident #44 was admitted to the facility on 07/02/19 with diagnoses that included leg fracture and unspecified falls. A review of Resident #44's admission MDS Assessment revealed her to be cognitively intact. Resident #44 was coded as "unable to determine" if she had a fall any time in the last month prior to admission or reentry, "unable to determine" if she had a fall anytime in the last 2-6 months prior to admission or reentry, and "unable to determine" if she had any fracture related to a fall in the 6 months prior to admission or reentry. A review of Resident #44's discharge summary from her hospital stay revealed the reason for her admission to the hospital was due to a fracture	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 Accuracy of Assessments Corrective Action: Resident # 69: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment) with Assessment /Reference Date (ARD) [7/24/2019] was modified with a Corrective Attestation Date of 8/16/2019. The assessment was submitted to the state QIES system on 8/16/2019 and was accepted on 8/16/2019 Submission ID: 17292091	8/29/19

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

Electronically Signed | 09/05/2019

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F 641	Continued From page 1 sustained from a fall at her home. Resident was treated at the hospital and subsequently discharged to the facility for rehabilitation. A review of Resident #44's care plan revealed care plans that included "I am [at] increased risk for falls related to ... history of fall prior to admission ...", an "I am on pain medication with risk for adverse side effects related to left femur (leg) fracture ...". During an interview with Resident #44 on 08/14/19 at 10:05 AM, she revealed she was in the facility for short term rehab following a fall at home where she suffered a fracture to her lower body, During an interview with the MDS Coordinator on 08/15/19 at 3:53 PM, she revealed she had been completing MDS Assessments since 2012 and reviewed the history and physical and discharge summary from the hospital to complete the section regarding falls and fractures. She reported she could not determine why Resident #44's Admission MDS was coded inaccurately regarding falls and fractures but surmised it was due to her overlooking information in her history and physical, and discharge summary. The MDS Coordinator indicated she would immediately make the correction to her assessment and resubmit it. During an interview with the Director of Nursing on 08/15/19 at 4:36 PM, she revealed that she expected MDS Assessments be completed accurately and coded correctly. She reported if there was information in Resident #44's history and physical from the hospital regarding Resident #44's history of falls and fractures, then the MDS	F 641	Resident # 68: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment) with Assessment /Reference Date (ARD) [7/22/2019] was modified with a Corrective Attestation Date of 8/16/2019. The assessment was submitted to the state QIES system on 8/16/2019 and was accepted on 8/16/2019 Submission ID: 17292091 Resident # 44: Resident Minimum Data Set (MDS) assessment (Admission Assessment) with Assessment /Reference Date (ARD) [7/9/2019] was modified with a Corrective Attestation Date of 8/16/2019. The assessment was submitted to the state QIES system on 8/16/2019 and was accepted on 8/16/2019 Submission ID: 17292091 Identification of other residents who may be involved with this practice: All current residents on hospice services, or on antiplatelet medications or new admissions/readmissions to the facility have the potential to be affected by the alleged practice. On 8/26/2019 through 8/29/2019 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who have hospice services provided have Section O0100K Hospice Care coded accurately. On 8/26/2019 through 8/29/2019 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in	

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F 641	Continued From page 2 Assessment should have accurately reflected that information. During an interview on 08/15/19 at 5:13 PM, the Administrator stated it was her expectation for the MDS to be coded accurately based on information in the resident's medical record. 2. Resident #69 was admitted to the facility on 07/21/18 with diagnoses which included type 2 diabetes, visual loss, dementia, anxiety and depression. A review of a Physician's order dated 01/15/19 indicated a Hospice Consult to evaluate and treat due to a diagnosis of adult failure to thrive. A review of a significant change Minimum Data Set (MDS) dated 01/24/19 revealed Resident #69 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #69 was coded for Hospice. A review of a quarterly MDS dated 07/24/19 revealed hospice care was not coded for Resident #69. The MDS also indicated Resident #69 had a life expectancy of less than 6 months. During an interview on 08/15/19 at 1:38 PM, Hospice Nurse #1 revealed she visited with Resident #69 on a weekly basis to assess her. She confirmed she communicated with the facility staff and let them know about any changes she felt should be made and she talked with staff who were assigned to Resident #69 to find out how she was doing. During an interview on 08/15/19 at 3:53 PM, the MDS Coordinator verified after review of the	F 641	the last 6 months to ensure that all residents who have anticoagulants and antiplatelet provided have Section N0410E Anticoagulant coded accurately. On 8/26/2019 through 8/29/2019 an audit was completed by the MDS Nurse Consultant to review all Admission Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who are new admission or readmissions with fall history have section J1700 coded accurately. This was completed on 8/29/2019. Systemic Changes: On 8/26/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section O0100K, Hospice care Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Section N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was	

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F 641	Continued From page 3 Significant Change MDS dated 01/24/29 that Hospice was indicated in Section 0 for Resident #69 and confirmed she had documented a note which indicated Hospice was started on 01/23/19. After review of the quarterly MDS dated 07/24/19 she confirmed hospice had not been coded because it was missed. She stated she was not sure how it had been missed. During an interview on 08/15/19 at 4:38 PM, the Director of Nursing verified an error had occurred and Hospice was coded incorrectly for Resident #69. She further stated she would have expected for it to have been corrected. During an interview on 08/15/19 at 5:13 PM, the Administrator stated it was her expectation for the MDS to be coded accurately based on information in the resident's medical record. 3. Resident #68 was admitted to the facility on 04/04/19 with diagnoses which included diabetes and cerebral vascular accident. Review of Resident #68's quarterly Minimum Data Set (MDS) assessment dated 07/22/19 revealed, the Resident was coded as having received an anticoagulant medication (a blood thinner) for 7 days of the look back period. Review of Resident #68's Physician Orders from 07/01/19 through 07/31/19 indicated, there were no anticoagulants ordered to be administered during the 7 day look back period of the Resident's 07/22/19 MDS assessment. During an interview conducted with MDS Nurse #2 on 08/15/19 at 4:18 PM she confirmed that	F 641	received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. Section J1700 Fall History on Admission/Entry or Reentry, Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry? Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident□s entry date item (A1600). Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident□s entry date item (A1600). Code 9, unable to determine: if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred. Coding Instructions for J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission/Entry or Reentry? Code 0, no: if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident□s entry date item (A1600). Code 1, yes: if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-180 days) preceding the	

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F 641	Continued From page 4 she completed Resident #68's 07/22/19 MDS. The MDS Nurse explained, she mistakenly coded the MDS for anticoagulation because Resident #68 was on the medication Plavix (an antiplatelet) and she thought the medication should be coded on the MDS. The MDS Nurse stated, she realized afterwards that it should not have been coded as an anticoagulant but forgot to correct it. The MDS Nurse stated, she would make a correction to the MDS. An interview with the Director of Nursing (DON) on 08/15/19 at 4:39 PM revealed, she reviewed all of the MDS assessments with the MDS nurses and remembered MDS Nurse #2 had miscoded Resident #68's MDS as having received and anticoagulant medication in the 7 day look back period. The DON explained, she educated MDS Nurse #2 that Plavix should not be considered an anticoagulant that should be coded on the MDS and instructed the Nurse to change the coding but the MDS Nurse forgot to correct the MDS. The DON stated, her expectation was for the MDS assessments to be coded accurately. During an interview on 08/15/19 at 5:13 PM, the Administrator stated it was her expectation for the MDS to be coded accurately based on information in the resident's medical record.	F 641	resident□s entry date item (A1600). Code 9, unable to determine: if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred. This in service was completed by 8/29/2019. Any The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission , Annual or Quarterly Assessment to ensure that section O0100K Hospice Care, Section N0410E Anticoagulant and Section J1700 Fall History on Admission/Entry or Reentry is coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly	

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F 641	Continued From page 5	F 641	QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 8/29/2019	