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 _____	07/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CEN	142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code the risk for	F 278	1. Resident 26 – MDS dated 5/11/2017 modified to correct coding of at risk of	8/1/17

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

Electronically Signed | 07/21/2017

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F 278	Continued From page 1 pressure ulcer development on an admission Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for pressure ulcers (Resident #26). Findings included: Resident #26 was admitted to the facility on 5/4/17. Active diagnoses included hypertension, thyroid disorder, arthritis, Alzheimer's disease, and depression. Review of a care plan dated 5/4/17 revealed Resident #26 was care planned as at risk for pressure ulcers due to new admission and incontinence of bowel and bladder. Review of a pressure ulcer risk evaluation dated 5/5/17 revealed Resident #26 had been assessed as at high risk to develop pressure ulcers. Review of Resident #26's admission Minimum Data Set assessment dated 5/11/17 revealed the resident was coded as not at risk for pressure ulcers. During an interview on 7/6/17 at 4:20 PM the MDS Nurse stated that she coded the resident as not at risk for developing pressure ulcers on the admissions MDS assessment dated 5/11/17 and it should have been coded as at risk for pressure ulcers. During an interview on 7/6/17 at 4:23 PM the Director of Nursing stated it was her expectation that if a resident was assessed as at risk for pressure ulcers, it would be reflected in the MDS assessment. She further stated that admission MDS dated 5/11/17 should have been coded as	F 278	pressure ulcers which was done on 07/06/2017. 2. MDS nurse to conduct 100% of all active residents to identify additional residents who may have been at risk for pressure ulcers who were not coded correctly. Residents who are found to have incorrect coding in section M will be modified to reflect accurate coding. 3. MDS nurse will ensure that any resident whose braden scales states high risk will be coded for at risk for skin breakdown in section M. MDS nurse will accurate assess and evaluate medical chart to ensure accurate coding of section M occurs for at risk for pressure ulcers. 4. Audit will be performed by DON for 5 residents each week x 4 weeks, then every other week x 4 weeks, then monthly x 3months to ensure accurate coding of section M until we reach 100% compliance. The sample will be expanded as needed based on results of audits. QA to follow at quarterly meetings. Any negative outcomes will be brought to QA.	

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F 278	Continued From page 2 at risk for pressure ulcers.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to administer medications on admission date as ordered by the physician which resulted in missed doses of medications for 1 of 5 residents reviewed (Resident #17). Findings included: Record review revealed Resident #17 was admitted to the facility from the hospital on 6/15/2017 with diagnoses which included Hypertension and a Cerebral Vascular Accident (stroke). Review of nursing notes revealed the resident was admitted 6/15/2017 at 5:00 PM by Nurse #1. The note indicated Resident #17 was alert, verbal and able to make some needs known. The note further indicated the resident's vital signs were stable. Review of the Physician orders dated 6/15/2017 revealed the medications were transferred to the Medication Administration Record (MAR) on 6/15/2017. Review of the resident's MAR included the following medications in which an "X" was documented in the MAR blocks on 6/15/2017 at	F 281	1. Resident 17 - All meds ordered at time at time of admit are in the facility and available for resident the next day after admit which was 6/16/2017. 2. All residents are at risk for not having meds available upon admission to the facility. All nurses in-serviced that if meds are not available upon admit, they are to call the MD and notify pharmacy. 3. DON or designee will review new/readmits after admission to validate meds were delivered and available per orders. If they were not available, ensure MD and pharmacy was notified and documentation was noted. 4. Weekly audit will be done by DON, ADON, or Unit Coordinator each week or new admits/readmits to ensure meds were available on admit x 4 weeks, then every every other week x 4 weeks, then monthly x 3 months. QA to follow at quarterly meetings. Any negative out comes will be brought to QA.	8/1/17

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F 281	Continued From page 3	F 281		

6:00 PM and midnight:
Lopressor 12.5 milligrams (mg) (a medication for Hypertension) to be administered at 6:00 AM, Noon, 6:00 PM and midnight
Cardizem 60mg (a medication for Hypertension) to be administered at 6:00 AM, Noon, 6:00 PM and midnight
Documentation on the back of the MAR at midnight on 6/15/2017 by Nurse #2 revealed the Lopressor and Cardizem were not available, the pharmacy was notified, the orders refaxed and the resident's blood pressure was 118/67.
Progress notes were reviewed for 6/16/2017. An entry noted at 7:00 AM by Nurse #2 documented the pharmacy was notified at midnight of the medications which were not available. The note indicated the physician's orders were refaxed to the pharmacy and the medications were delivered at 3:15 AM. The note further indicated the resident's blood pressure was checked at midnight, 3:00 AM and 6:00 AM and was within normal limits.
A telephone interview was conducted with Nurse #1 on 7/6/2017 at 11:50 AM. Nurse #1 did not recall the admission for Resident #17. Nurse #1 indicated when a resident was admitted on the 3:00 PM to 11:00 PM shift, the MARs were completed and the physician's orders were faxed to pharmacy by the day shift staff and the medications were usually delivered around 8:00 PM. Nurse #1 did not recall if Resident #17 missed any doses of medications during the 3:00 PM to 11:00 PM shift on 6/15/2017.
An interview was conducted with the Director of Nursing (DON) on 7/6/2017 at 3:52 PM. The DON reported she recalled being notified of an issue with Resident #17's medications not being available for administration on the night of her admission. The DON explained for new

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F 281	Continued From page 4	F 281		

admissions the hospital discharge summary was faxed to the physician for review of the medications, the physician reviewed the medication list, made changes if needed, signed the medication list and sent the medication list back to the facility by fax. The MARS were completed by the returned list and the information was faxed to the pharmacy. The DON indicated there should be documentation of the transactions in the resident's chart but the chart was reviewed and there was no confirmation of the process. The DON reported she did not know why the evening nurse had not notified the pharmacy of the unavailability of the 6:00 PM medications on 6/15/2017. The DON stated the expectation was the process for physician ordered medications would be followed to ensure medications were available for administration.

An interview was conducted with Nurse #2 on 7/7/2017 at 7:38 AM. Nurse #2 reported she recalled working the night of 6/15/2017. Nurse #2 stated when she realized the medications were not available for Resident #17 she called the back- up pharmacy. Nurse #2 stated the back-up pharmacy said they did not have the faxed orders so Nurse #2 refaxed the orders and confirmed the receipt of the orders with the back-up pharmacy. Nurse #2 indicated the medications were delivered around 3:15 AM. Nurse #2 further indicated she checked the resident's vital signs several times during the shift to make sure her blood pressure was not elevated. Nurse #2 reported the resident rested and was stable during the shift. Nurse #2 indicated she did not notify the physician of the missed medications since the resident was stable with no blood pressure issues during the night shift. Nurse #2 also indicated she informed the nurse manager of

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F 281	Continued From page 5 the issue with the medications prior to leaving the facility on the morning of 6/16/2017. An interview was conducted with the resident's physician on 7/7/2017 at 10:07 AM. The physician stated she would not expect the staff to notify her of Resident #17's missed doses of Lisinopril and Cardizem unless her blood pressure was elevated or the medications were unavailable for administration on the following day. The physician indicated she assessed the resident on a regular basis and reviewed her vital signs each time. The physician indicated the resident's vital signs remained consistently within her normal range. The physician stated the expectation was for ordered medications to be available for administration. The physician also stated a more effective system was needed to ensure medications were available for administration.	F 281		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		8/1/17

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F 520	Continued From page 6 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain and monitor interventions that were put into place 10/21/2016. These interventions was in an area originally cited in the recertification survey of 10/21/2016 and recited in the recertification survey of 7/7/2017. The deficiency was in the area of services to meet professional standards. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program.	F 520	1. Facility failed to maintain and monitor interventions that were put into place 10/21/2016 for failure of facility to sustain an effective QAA process. 2. All residents are at risk for not having meds as ordered by physician. All nurses in-serviced that if meds are not available upon admit, they are to call the MD and notify pharmacy. 3. DON or designee will review new/readmits after admission to validate meds were delivered and available per orders. If they were not available, ensure MD and pharmacy was notified and	

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F 520	Continued From page 7 Findings included: This citation is cross referenced to: F281- Based on record review and staff and physician interviews, the facility failed to administer medications on admission date as ordered by the physician which resulted in missed doses of medications for 1 of 5 residents reviewed (Resident #17). The facility was cited during the 10/21/2016 recertification survey F281 for failing to administer medications as ordered by the physician. During the current survey, the facility was cited for failure to administer medications as ordered by the physician. During an interview on 7/7/17 at 11:30 AM, the Director of Nursing and Assistant Director of Nursing stated the QAA Committee met quarterly and identified, developed and implemented plans of action to correct identified quality deficiencies. The Director of Nursing stated that she did not feel the current identified area of concern was similar to the concern that was cited on 10/21/16. The Assistant Director of Nursing stated the QAA committee met quarterly and the facility was committed to ensuring quality issues were corrected.	F 520	documentation was noted. 4. Weekly audit will be done by DON, ADON, or Unit Coordinator each week or new admits/readmits to ensure meds were available on admit x 4 weeks, then every other x 4 weeks, then monthly x 3 months. QA to follow at quarterly meetings. Any negative outcomes will be brought to QA.	