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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/29/17 through 8/31/17. Three complaints were also investigated during the survey. Corrections are required with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 155 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #1 through 21 and 25 through 26) and 3 closed record reviews (Residents 22 through 24).	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		9/29/17

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

Electronically Signed | 09/25/2017

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F 279	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical	F 279	The statements made in this plan of	

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F 279	Continued From page 2 record review facility staff failed to develop and implement a CCP (comprehensive care plan) to address denture care for 1 of 26 residents (Resident #8). Findings: Facility staff failed to develop a CCP to address denture care for Resident #8. The resident's clinical record was reviewed on 8/29/17 at 3:15 PM. Resident #8 was admitted to the facility on 4/7/17. Her diagnoses included dementia, hypertension, anxiety, depression and psychotic disorder. The resident's admission screening documentation included "upper dentures". The latest MDS (minimum data set) assessment, dated 7/6/17 coded the resident with severe cognitive impairment. She required the assistance or oversite of at least one nursing staff member for all the ADLs (activities of daily living). There is no coding in the MDS to indicate whether or not a resident has dentures. The latest CCP (comprehensive care plan) reviewed and revised on 4/25/17 documented the resident had an ADL self care deficit r/t (related to) dementia and had a potential for oral health problems r/t her being edentulous. The CCP interventions included providing mouth care at least daily and assisting with toileting as necessary. The resident's CCP did not document the resident with dentures or indicate any interventions to care and clean them. The CNA Kardex Report for the daily care of the resident	F 279	correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. 1. The CCP was immediately updated for resident #8. 2. The CCPs for current residents with dentures were audited with corrections made as necessary. 3. Nursing staff members were educated that upon admission, readmission, or change in dental status, they must ensure that the CCP includes appropriate care interventions. 4. Unit Managers (or designee) will ensure care-planned interventions while reviewing admissions 5 days per week. ADON (or designee) will conduct an audit of CCPs of residents with dentures weekly x8 weeks. Review in quarterly QA x2 quarters. 5. Completion: September 29, 2017	

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did not indicate the presence of dentures or address their care. The ADL sheets reviewed did specify denture care.

On 8/30/17 at 8:30 AM during an observation in Resident #8's room, CNA I was interviewed about the assistance she provided the resident with regards mouth care. CNA I told the surveyor she tried to get the resident to brush her teeth or use mouthwash every day. She said some days the resident was willing to do so and other days she was not.

The surveyor asked the CNA if the resident had all her own teeth or if she had dentures and what was the process to clean them. CNA I stated, "She won't let us take them out. I think she's afraid we'll lose them." The CNA said the resident slept in her dentures all night.

CNA I then removed the resident's dentures from her mouth, washed them off and returned them to the resident. Resident #8 did not complain or resist during this procedure.

The resident did not have any denture cup or cleaner in her bedside drawers or elsewhere in her room.

On 8/30/17 at 9:15 AM, RN I was asked about denture care in the facility. RN I said the CNAs were supposed to remove the dentures at night and put them in a solution to soak overnite and clean. She said she thought the CNAs were all taught that during orientation after they were hired--but she wasn't sure, so she would have to check on that.

When asked how a new CNA or one filling in for

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F 279	Continued From page 4 the usual staff would know this resident required denture care, RN I said they should get that on the 24 hour report. When asked to see this report, the response was "It's all verbal". On 8/30/17 at 4:15 PM the administrator and DON were informed of the surveyor's findings. No additional information was provided.	F 279		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and clinical record review it was determined facility staff failed to provide sufficient grooming assistance for 1 of 26 residents (Resident #9). Findings: Facility staff failed to provide grooming assistance for Resident #9. The resident's clinical record was reviewed on 8/29/17 at 3:30 PM. Resident #9 was admitted to the facility on 8/24/14. Her diagnoses included hypertension and dementia. The latest MDS (minimum data set) assessment, dated 7/12/17, coded the resident with cognitive impairment. She required nursing staff assistance for all the ADLs (activities of daily living) and	F 312	1. Resident #9 was immediately assisted with removing unwanted chin hair. 2. Current residents were visualized for grooming needs and staff ensured that resident care was consistent with preferences. 3. Nursing staff members were educated that they must provide care to maintain grooming standards per resident preferences. 4. Unit Managers (or designee) will audit residents weekly to ensure appropriate grooming standards are maintained and report to DON or ADON x8 weeks. Review in quarterly QA x2 quarters. 5. Completion: September 29, 2017.	9/29/17

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F 312	Continued From page 5 set-up and oversite only to eat. Resident #9's CCP, reviewed and revised on 8/7/17 documented the resident with an ADL self-care performance deficit r/t (related to) dementia. The interventions included "....Personal Hygiene/Oral Care: The resident is able to assist with care. Set up and cue with assist x 1 as needed..... On 8/29/17 at 3:05 PM the resident was observed in her bedroom. She was lying in her bed. The resident was observed to have difficulty hearing, but answered questions appropriately when the surveyor spoke slowly and distinctly. The resident was clean and odor-free but was observed to have an abundance of long white chin hairs. When the surveyor asked her if she wanted some help to trim the chin hairs the resident stated, "I gotta do something about that. The resident said the nursing staff would not assist her to trim the hairs on her chin. On 8/30/17 at 4:25 PM the administrator and DON were informed of the surveyor's findings. The DON stated, "You won't see them tomorrow." At 4:40 PM the DON returned and informed the surveyor, "We shaved her." No additional info was provided.	F 312		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its-	F 332		9/29/17

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F 332	Continued From page 6 (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than 5%. There were 3 errors out of 33 opportunities for a medication error rate of 9% that affected 2 of 26 residents (Resident #25 and Resident #26). The findings included: 1. The facility staff failed to administer medication as ordered by the physician for Aspirin, and failed to follow manufacturer's recommendations for the administration of Flonase for Resident #25. Resident #25 was originally admitted to the facility on 1/27/16 but had a readmission date of 6/3/16. The resident was admitted with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, atrial fibrillation, gout and benign prostatic hyperplasia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/15/17, Resident #25 was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for dressing, toilet use and bathing. During the medication pass and pour observation made by the surveyor on 8/30/17 at 9:10 am, Licensed Practical Nurse (LPN) #2 administered "ASA (Aspirin) 81 mg (milligram) chewable tablet" to Resident #25. The surveyor also observed LPN #2 administer "Flonase 2 sprays in both nostrils one time a day". LPN #2 did not have the	F 332	1. Medication errors were completed for residents #25 and #26. The medical director was notified and no new orders were given. 2. Licensed nurses in the facility at the time of the medication errors were immediately educated regarding Flonase recommendation and ensuring the appropriate form of aspirin is administered. 3. Remaining licensed nurses were educated regarding Flonase recommendation and ensuring the appropriate form of aspirin is administered. 4. SDC (or designee) will perform 3 medication pass observations per week and report findings to DON or ADON x8 weeks. Review in quarterly QA x2 quarters. 5. Completion: September 29, 2017.	

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resident clear his nostrils before administering the Flonase nasal spray.

A clinical record review was completed by the surveyor on 8/30/17 at 10 am. Resident #25 had the following physician order noted by the surveyor: "Aspirin EC (Enteric Coated) Tablet Delayed Release 81 mg ...Give 1 tablet by mouth one time a day for Prophylaxis." The MAR (Medication Administration Record) for the month of August, 2017 was also reviewed by the surveyor. LPN #2 had documented with her initials that the above order for "Aspirin EC Tablet Delayed Release 81 mg ...Give 1 tablet by mouth one time a day ..." had been administered to the resident.

According to the manufacturer's package insert for Flonase nasal spray, it read in part, under "How to Use, ...Blow your nose gently to clear nostrils."

LPN #2 was notified of the above documented findings during the medication pass and pour observation at 1 pm. LPN #2 stated, "I was so nervous with you watching me."

The administrative team was notified of the above documented findings by the surveyor on 8/30/17 at 3:55 pm in the conference room.

No further findings were provided to the surveyor prior to the exit conference on 8/31/17.

2. The facility staff failed to administer medication as ordered by the physician for Aspirin to Resident #26 during the medication pass and pour observation made by the surveyor on 8/30/17.

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Resident #26 was readmitted to the facility on 6/15/16 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, peripheral vascular disease, dementia, anxiety disorder, depression atrial fibrillation, and chronic obstructive pulmonary disease. The resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #26 was also coded as requiring supervision of 1 staff member for dressing and limited assistance of one staff member for personal hygiene.

During the medication pass and pour observation on 8/30/17 at 9:25 am, the surveyor observed LPN (Licensed Practical Nurse) #2 give Resident #26 Aspirin 81 mg (milligram) by mouth. This tablet was noted by the surveyor to be taken out of the floor stock bottle of Aspirin which was not a chewable tablet.

At 10 am on 8/30/17, the surveyor reviewed the clinical record of Resident #26 and noted the following physician order: "Aspirin Tablet Chewable 81 mg Give 1 tablet by mouth on time a day".

The surveyor also reviewed the MAR (Medication Administrative Record) for the month of August, 2017. LPN #2 initialed the box with her initials to represent that "Aspirin Tablet Chewable 81 mg Give 1 tablet by mouth on time a day" was given as ordered by the physician for 8/30/17 at 0900 (9:00 am).

LPN #2 was notified of the above documented findings during the medication pass and pour observation at 1 pm. LPN #2 stated, "I was so

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F 332	Continued From page 9 nervous with you watching me." The administrative team was notified of the above documented findings by the surveyor on 8/30/17 at 3:55 pm in the conference room. No further findings were provided to the surveyor prior to the exit conference on 8/31/17.	F 332		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		9/29/17

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F 441	Continued From page 10 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 441	1. Medical director was notified of	

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F 441	Continued From page 11 interview, facility document review and clinical record review, the facility staff failed to provide a surveillance system for communicable diseases of the facility's residents and failed to provide appropriate hand hygiene during the care of 1 out of 26 residents in the survey sample (Resident #8). The findings included: 1. During the entrance conference on 8/29/17, the surveyor requested the infection control line list (tracking form for facility infections) from September, 2016 through July, 2017 from the assistant administrator. . When the infection control line listing was provided to the surveyor by the infection control nurse, the form was found to be incomplete. The infection control line listing form was missing in part or whole as follows: 1) Did not provide the information if the infection was community or facility acquired, 2) The organism/culture results or 3) If the infection had been resolved or continued to be ongoing. On 8/30/17 at 3:55 pm, the surveyor requested from the director of nursing services any other information that could be provided to support that the facility tracked and trended infections, whether they were acquired in the community or in the facility and when the infection had been resolved or continued to be ongoing. The director of nursing services stated "I will talk with the infection control nurse and see what we can provide to you regarding this." On 8/31/17 at 11:10 am, the surveyor met with the infection control nurse and the director of	F 441	breach in infection control practice and gave no new orders at that time. 2. (1)CNA 1 was immediately educated regarding hand hygiene. (2) SDC was educated regarding proper infection control line listing documentation. 3. Current nursing staff members were provided with hand hygiene education. 4. (1)DON (or designee) will perform hand hygiene audits 3 times per week x8 weeks. (2)SDC (or designee) will provide a copy of infection control line listing documentation to DON or ADON weekly x8 weeks. Review in quarterly QA x2 quarters. 5. Completion: September 29, 2017.	

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nursing services. The surveyor was given a copy of the "Antibiogram" log for January through December, 2016 that the facility had also been using. The surveyor noted that the form continued to be incomplete with the above missing documentation that is required to be on the infection control line form. The infection control nurse stated "I can start making sure these areas are completed on the monthly infection surveillance information.

No further information was provided to the surveyor prior to the exit conference on 8/31/17.
2. Facility staff failed to practice appropriate hand hygiene during care for Resident #8. The resident's clinical record was reviewed on 8/29/17 at 3:15 PM.

Resident #8 was admitted to the facility on 4/7/17. Her diagnoses included dementia, hypertension, anxiety, depression and psychotic disorder.

The latest MDS (minimum data set) assessment, dated 7/6/17 coded the resident with severe cognitive impairment. She required the assistance or oversite of at least one nursing staff member for all the ADLs (activities of daily living).

The latest CCP (comprehensive care plan) reviewed and revised on 4/25/17 documented the resident had an ADL self care deficit r/t (related to) dementia and had a potential for oral health problems r/t her being edentulous. The CCP interventions included providing mouth care at least daily and assisting with toileting as necessary.

On 8/30/17 at 8:30 AM during an observation in Resident #8's room, CNA I was interviewed about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the assistance she provided the resident with regards mouth care. CNA I told the surveyor she tried to get the resident to brush her teeth or use mouthwash every day. She said some days the resident was willing to do so and other days she was not.

The surveyor asked the CNA if the resident had all her own teeth or if she had dentures and what was the process to clean them. CNA I stated, "She won't let us take them out. I think she's afraid we'll lose them." The CNA said the resident slept in her dentures all night.

Asked where the mouth care supplies (toothbrush, toothpaste, denture cup/adhesives) were kept--the CNA responded, "We get her a new toothbrush every day. She uses it to scrub her furniture with if we leave one in the room." She went to the supply closet and got a toothbrush, toothpaste and mouthwash to demonstrate how she provided mouthcare for the resident.

CNA I then donned gloves, assisted Resident #8 to the bathroom, lowering her briefs and seating her on the toilet. She came out of the room with the soiled brief, which she stuck in the trash and discarded her gloves. The CNA then started assembling the toothbrush and toothpaste on the sink, without washing her hands.

She again donned gloves walked back into the bathroom and removed the resident's dentures from her mouth while she was seated on the toilet and brought them out to the sink, rinsed them with water and returned them to the resident's mouth. She then finished wiping the resident's bottom before assisting her out of the bathroom

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and to the sink.

She removed her gloves, placing them in the trash and removed the trash bag from the container with her bare hands. CNA I did not was her hands after providing incontinence care or handling the soiled trash, but proceeded to assist the resident by handing her a toothbrush with toothpaste on it. After the resident washed her hands and returned to her bed, the CNA I then proceeded to thoroughly wash her own hands.

On 8/30/17 at 4:15 PM the administrator and DON were informed of this observation.

The facility policy for handwashing requirements was reviewed. It contained the following: "....1. Hand Hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub. Hand hygiene 1.The following is a list of some situations that require hand hygiene: .....before and after assisting a patient with personal care (e.g., oral care. bathing) .....Before and after assisting a patient with toileting (handwashing with soap and water)..."