STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

(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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 8/8/17 through 8/10/17. No complaints were investigated. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 85 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents # 1 through 14) and three closed record reviews (Residents # 15 through 17).	F 000		
F 156 SS=C	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -	F 156		8/22/17

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

Electronically Signed | 08/24/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1	F 156		

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older

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F 156	Continued From page 2	F 156		

Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3	F 156		

residents, resident representatives:

(i) 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; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 156	Continued From page 4	F 156		

understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not

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F 156	Continued From page 5 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, group interview and staff interview, the facility staff failed to post accurate advocacy contact information and ensure the information was accessible to all residents.	F 156	The advocacy information posters on the bulletin board near the front entrance of the facility was updated with the contact information for the local long-term care	

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F 156	Continued From page 6 The findings include: A private interview with a group of five cognitively intact residents was conducted on 8/9/17 at 1:30 p.m. Residents stated during this interview they were not sure of the local ombudsman's name or where the contact information for local advocacy groups was posted. On 8/10/17 at 9:20 a.m. the facility's postings were inspected during environmental observations of the facility. The resident rights poster on the bulletin board near the front entrance of the facility had no contact information for the local long-term care ombudsman or the local Area on Aging. The ombudsman's name and phone number were posted on the bulletin board in the hall near the medical records office. This posting was typed memo style in small print attached to a bulletin board that was above wheelchair height. The resident rights poster on unit 2 had no local ombudsman or local Area on Agency contact information. A former ombudsman's name was listed on a memo attached to this bulletin board. The current ombudsman's name was not listed on this board. This board and the posted information were high on the wall above standing eye level and not wheelchair height. On 8/10/17 at 10:00 a.m. accompanied by the administrator, the facility's postings and bulletin boards were observed. The administrator acknowledged the above findings and stated the information would be corrected and adjusted. These findings were reviewed with the administrator, director of nursing and corporate	F 156	ombudsman and the local Area Agency on Aging were updated 8/10/17 by the Social Worker. The bulletin board near the medical records office was updated with the information being more legible by the Administrator on 8/22/17. The resident rights poster on unit 2 has been updated with the local ombudsman and local area on agency contact information by the Social Worker on 8/17/17. This bulletin board was also moved to be visible and legible from wheelchair height by Maintenance on 8/18/17. A 100% audit of all areas in the facility with posting of state agency information for the local long-term care ombudsman and the local Area Agency on Aging was audited 8/17/17 by Administrator to ensure that the correct information to include contact information was posted. The Administrator corrected and reposted any information found to be inaccurate during the audit. The Administrator, Director of Nursing (DON) and Social Worker were educated on 8/17/17 by the Corporate Nurse Consultant on the required posting of information for the Advocacy Agencies and the accessibility for persons in wheel chairs. The Administrator or Director of Nursing will conduct audits of all advocacy information posting in all areas of the facility monthly x 3 months to ensure correct information to include contact information is posted utilizing an Advocacy & Grievance Officer Posting Quality Improvement (QI) Audit Tool. The Administrator or DON will correct and	

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F 156	Continued From page 7 consultant during a meeting on 8/10/17 at 11:40 a.m.	F 156	repost any information found to be inaccurate during the audit. The Executive Quality Improvement (QI) committee will meet monthly and review the Advocacy & Grievance Officer Posting QI Audits and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 157		8/30/17

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F 157	Continued From page 8 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to notify the physician of a significant weight loss for one of 17 residents in the survey sample, Resident # 9. Resident # 9 had a significant weight loss of 20 pounds (11.76%) from May 9, 2017 until June 29, 2017. An additional weight was obtained on 07/11/2017 and Resident # 1 was still at the weight identified on 6/29/2017 (150 pounds). The physician was not notified of the weight loss until it was identified by the survey team on 08/09/2017. Findings were:	F 157	The physician was notified of resident #9 significant weight loss on 8/9/17 by the Director of Nursing (DON). Orders were received for supplements and an appetite stimulant and implemented on 8/10/17 by floor hall nurse/Licensed Practical Nurse (LPN) A 100% audit was conducted by the Corporate Wound Care consultant on 8/9/17-8/10/17 to identify other residents with significant weight loss within the past six months who the physician was not notified of. The physician was made aware of the significant weight loss by the Assistant Director of Nursing (ADON) on	

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F 157	Continued From page 9 Resident #9 was originally admitted to the facility on 10/02/2009. His diagnoses included, but were not limited to: Vascular dementia, personality disorder, cerebral vascular accident (stroke) , hypertension and cardiac arrhythmia. He was most recently readmitted to the facility on 05/08/2017, following a hospitalization for a urinary tract infection. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/03/2017. Resident #9 was assessed as having a cognitive summary score of "14", indicating he was cognitively intact. The clinical record was reviewed on 08/09/2017. The weight section was observed. Resident #9's weights were obtained monthly. The following weights for 2017 were recorded as: January: none; February: 171; March: 170; April: 171; May 9: 170; June 29: 150; July 11: 150. There were no progress notes in the clinical record that the attending physician was notified of the weight loss. Review of the physician orders did not indicate the addition of any supplements or dietary changes to address Resident #9's weight loss. On 07/05/017, Resident #9 was seen by behavioral health and a recommendation was made to discontinue Resident #9's Risperdal due to abnormal body movements and weight loss. The Risperdal was discontinued as recommended on 07/05/2017. On 08/09/2017 at approximately 3:00 p.m., the DON (director of nursing) was asked if a weight could be obtained on Resident #9 at that time. The weight was obtained with the results of 144	F 157	8/14/17. The Corporate Nurse Consultant in serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set (MDS) nurse, and dietary manager on 8/17/17 regarding the weight committee responsibilities to include, ensuring the Physician and Resident Representative (RP) is immediately notified of significant weight loss with documentation in the medical records. All Residents identified with significant Weight loss to include Resident #9 will continue to be addressed during the Weekly Weight Quality Improvement (QI) Meeting weekly x 8 weeks then monthly x 1 month, by the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set (MDS) nurse, and dietary manager using the Weight Committee Meeting Quality Improvement (QI) Tool. Each resident□s weight status and interventions will be discussed in addition to ensuring the physician is notified of any significant weight change (5% in 30 days, 10% in 180 days) with documentation in the medical records. Any areas of concern will be addressed immediately by the Assistant Director of nursing to include physician notification and implementation of any orders received. The Director of Nursing will review and initial the audits for completion and to ensure all areas of concern were addressed weekly x 8 weeks and monthly x 1 month. The Director of Nursing is responsible for forwarding the results of the Weight	

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F 157	Continued From page 10 pounds. A total weight loss of 26 pounds or 15.29% in 90 days. The DON and the ADON (assistant director of nursing) wee asked if the weights could be backdated in the computer system. They both stated, "No." During an end of the day meeting on 08/09/2017 the DON and the administrator were notified of the above information. The ADON (assistant director of nursing) and the administrator were interviewed together on 08/10/2017 at approximately 9:30 a.m. The ADON stated that she had taken the weights over on 06/29/2017. She was asked what the weighing process was. She stated, "The CNA [certified nursing assistant] get the weights and enter them into the [computer] system. They are suppose to notify the nurse if the weight is abnormal or there are any variations...we print a weight exception weekly." The ADON was asked if she had any of the weekly reports that were run from 06/29/2017 through 07/26/2017. She stated that she did not keep the reports. She also stated, "He didn't show up on the reports until we ran it on July 26...I don't know why he didn't". The ADON was asked about the date range on the report that the RD used in July. She stated, "We just pick a date and run it." The administrator stated, "No, we need to run the report to include all the most recent weights." The administrator and the ADON were asked if the physician had been notified of the significant weight loss for Resident #1 prior to the survey. The administrator stated, "No." No further information was obtained prior to the exit conference on 08/10/2017.	F 157	Committee Meeting QI Tools to the Executive Quality Improvement (QI) committee monthly x 3 months. The Executive QI committee will meet monthly and review audits of the Weight Committee Meeting QI Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3 months.	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 166	Continued From page 11	F 166		
F 166 SS=C	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 166		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 166	Continued From page 12	F 166		

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 166	Continued From page 13 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, group interview and staff interview, the facility failed to identify and list contact information for the facility's designated grievance officer. The findings include: A private interview with a group of five cognitively intact residents was conducted on 8/9/17 at 1:30 p.m. The group stated they reported concerns or problems to the administrator or nurses on their unit but they did not know the designated grievance officer for the facility. On 8/10/17 at 9:20 a.m. the facility's postings were inspected during environmental observations of the facility. There were no postings in the facility identifying the designated grievance official for the facility. Resident rights posters located near the main entrance, on unit 1 and on unit 2 had designated spaces for the identified grievance official but these were all blank. The bulletin board near the medical records office failed to identify the grievance official.	F 166	Grievance Officer Information posters were updated 8/10/17 by the Social Worker to include who the grievance officer is and the contact information. Posters were relocated to be more visible for residents sitting in wheel chairs by the Maintenance Director on 8/18/17. Residents were advised of the facility grievance officer during the resident council meeting held on/or before 9/11/17. A 100% audit of all areas in the facility with posting of state agency information was audited 8/17/17 by Administrator to ensure that the Grievance Officer and contact information was posted. The Administrator corrected and reposted any information found to be inaccurate during the audit on 8/22/17. The Administrator and Director of Nursing (DON) were educated on 8/17/17 by the Corporate Nurse Consultant on the required posting of information for the Grievance Officer Agencies and the accessibility for persons in wheel chairs. The Director of Nursing will conduct audits of all advocacy information	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 166	Continued From page 14 On 8/10/17 at 10:00 a.m. the administrator was interviewed about a designated grievance official for the facility. The administrator stated she was responsible for oversight of any grievances. The administrator stated she had not been at the facility long and did not realize the grievance officer was not posted on the bulletin boards. These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 8/9/17 at 11:40 a.m.	F 166	posting in all areas of the facility to ensure the Grievance Officer and contact information is listed monthly x 3 months utilizing an Advocacy & Grievance Officer Posting Quality Improvement (QI) Audit Tool. The DON will correct and repost any information found to be inaccurate during the audit. The Executive Quality Improvement (QI) committee will meet monthly and review the Advocacy & Grievance Officer Posting QI Audits and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, group interview, and staff interview, the facility staff failed for two of 17 residents in the survey sample (Residents # 11 and 14) to maintain the dignity of the residents during family visits; failed to ensure reliable telephone communication between the residents, their families, and other individuals wishing to communicate with residents; and failed to offer to replace a broken item of personal property. Resident # 11 had a family visit interrupted and	F 241	Resident # 11 was interviewed by the Administrator on/before 8/31/17 to discuss concerns regarding family visits and personal telephone calls and what resolution the facility was doing. A written grievance response was provided to the resident on/before 9/11/17 by the Administrator. Resident # 14 bottle of cologne was replaced by the facility on 8/10/17. All alert and oriented residents were re-educated about the facilities	9/11/17

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F 241	Continued From page 15	F 241		

curtailed by a staff member who wanted to put the resident to bed, and failed to receive personal telephone calls from her family and attorney. Resident # 14, who had a bottle of cologne broken by a staff member, was informed the facility would not replace the cologne.

The findings include:

1a. Resident # 11 in the survey sample, a 65 year-old female, was admitted to the facility on 12/15/15 with diagnoses that included congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, thyroid disorder, anxiety disorder, cerebrovascular accident with left hemiplegia, depression, hypokalemia, contractures of the left hand and wrist, edema, and generalized muscle weakness. According to an Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/16, and the most recent Quarterly MDS with an ARD of 9/19/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

During an interview conducted at 3:15 p.m. on 8/9/17, Resident # 11 related the events of a visit with her step-grandson that occurred several weeks prior to the survey. Resident # 11 said her step-grandson, who lives out of the area, came to visit her. "At about 6:00 p.m., a CNA (Certified Nursing Assistant) came to the door and wanted to put me to bed. I usually don't care, but I wanted to stay up and visit. The CNA just stood in the door, not saying a word until finally my step-grandson got up and left. I think he was intimidated by her standing there. It was very hurtful the way she just stood there," Resident # 11 said.

responsibility for resident's personal property by the Social Worker during the resident council meeting held on/or before 9/11/17.

100% of interview able residents were interviewed by the Social worker to determine if there were any concerns that were not resolved in regards to dignity and respect to include family visits, personal phone calls and/or items being broken on 8/23/17. A resident concern form will be completed by the social worker during the interview for any identified areas of concerns and forwarded to the administrator for follow up and resolution.

All staff (Nursing Staff, Administrative Staff, Dietary, Laundry and Housekeeping staff) have been re-educated on resident rights to family visits, personal telephone calls, choices in care, the facility policy related to resident personal items-valuables policy and reporting resident's personal broken items by the Staff Facilitator on or before 9/11/17. All newly hired staff , Nursing Staff, Dietary, Housekeeping, Laundry and Management) will be inserviced regarding family visits, personal telephone calls, choices in care, facility policy related to resident personal items-valuables policy and reporting resident's personal broken items during orientation by the staff facilitator.

The Social Worker will conduct audits through resident interviews of 10% of the residents to include residents #11 and resident #14 weekly x 8 weeks, then monthly x 1 month utilizing a Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 241	Continued From page 16 Resident # 11 went on the say, "They (staff) just come in and tell you to go to bed. You should be able to go to bed when you want to. They (staff) need to learn some etiquette." 1b. During the interview, the subject of telephone use was discussed. According to Resident # 11, "There is a telephone we can use, and there is privacy." Resident # 11 went on to say that she has missed telephone calls from her family and her lawyer because staff at the Nurses Station won't answer the telephone. "I have heard the phone at the Nurses Station ring," Resident # 11 said, "and the staff will say 'I'm not answering that,' and they get up and walk away from the Nurses Station. It usually happens at night." Resident # 11 also discussed this issue at the Group Interview conducted on 8/9/17. Other residents present at the Group Interview also voiced concerns about staff not answering the telephone and not forwarding calls or messages to them. During a meeting at 11:30 a.m. on 8/10/17 that included the Administrator, Director of Nursing, the Corporate Clinical Director, and the survey team, Resident # 11's concerns about visitation, bed time, and telephone use were discussed. 2. Resident #14's personal item, bottle of Aqua Di Gio cologne, was broken by a Certified Nursing Assistant during ADL (activities of daily living) care. Resident #14 was informed by the facility's previous administrator that it would not be replaced. Resident #14 was originally admitted to the facility	F 241	Dignity Quality Improvement (QI) Audit Tool to determine if residents have any concerns in regards to dignity and respect to include family visits, personal phone calls and/or items being broken. A resident concern form will be completed by the social worker during the interview for any identified areas of concerns and forwarded to the administrator for follow up and resolution. The Administrator will review and initial the Resident Dignity QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Resident Dignity QI Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Resident Dignity QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 241	Continued From page 17	F 241		

on 6/22/07 and readmitted on 2/14/17 with, but not limited to the following diagnoses: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Acquired absence of limb, bilateral above the knee amputation, (AKA). The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/17 was a quarterly assessment. The resident was assessed as a 15 for cognitive skills, independent in decision-making and able to make needs known.

On 8/9/17 at approximately 1:30 p.m. during the group meeting, Resident #14 voiced to the Surveyor that during his morning ADL care, his bottle of cologne was broken by a CNA. Resident #14 further stated that the previous administrator was made aware. When interviewed and asked what he was told, Resident #14 stated, "She said, 'I am not going to replace it' and that was it."

On 8/9/17 at approximately 3:30 p.m., Resident #14 was again interviewed regarding the above conversation with the Surveyor. Resident #14 stated, "Six months ago [CNA named] was getting me ready for church in a hurry. She was mad because she had to get me ready and when she picked up my bottle of cologne, she dropped it and broke it." When interviewed and asked the name of the cologne, Resident #14 stated, "It was a bottle of Aqua Di Gio." Resident #14 wheeled himself over to his sink and retrieved an empty box, labeled Aqua Di Gio, and stated, "It was in this box." Resident #14 stated, "I told [previous Administrator named] and she stated that she was not going to replace it." Resident #14 further stated, "The way she said it made me feel bad because it was a brand new bottle of cologne and it was my first time using it. She, previous

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F 241	Continued From page 18 administrator, made me feel as if she didn't care one way or the other." On 8/10/17 at approximately 9:57 a.m., the Assistant Director of Nursing (ADON) was made aware of the above findings. The ADON stated, "I was aware that it was broken and I felt bad but [Administrator named] said she wasn't going to replace it." When interviewed and asked if Resident #14 was informed of the reason the cologne was not going to be replaced, the ADON stated, "Not to my knowledge." On 8/10/17 at approximately 12:30 p.m., the administrative staff was made aware of the above findings. On 8/10/17 at approximately 12:45 p.m., Resident #14 was sitting in the dining room watching the television, this Surveyor was called over to the table by the resident. Resident #14 stated, "Thank you so much. I got my cologne."	F 241		
F 252 SS=D	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 252		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 252	Continued From page 19 (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to maintain a homelike environment for one of 17 residents in the survey sample. The three door cabinet in Resident #4's room was in disrepair. The findings include: Resident #4 was admitted to the facility on 3/30/15 with a re-admission on 3/5/17. Diagnoses for Resident #4 included multiple sclerosis with paraplegia, chronic pressure ulcers, anemia, diabetes, high blood pressure and depression. The minimum data set (MDS) dated 6/5/17 assessed Resident #4 as cognitively intact. On 8/8/17 at 4:15 p.m. with Resident #4's permission, the resident's room was inspected. The doors on the three door cabinet under the sink were in need of repair. The middle door under the sink was partially open and would not latch or remain closed. When latched, there were open gaps in the left and right doors of the cabinet. The finish on the entire cabinet was	F 252	The three door cabinet in resident #4 room was repaired on 8/9/17 by the Maintenance Director. A 100% observation was conducted of the resident cabinets by the housekeeping & maintenance supervisors on 8/9/17. Work orders were completed on 8/9/17 by Housekeeping Supervisor for notification to Maintenance for any identified areas of concern. The Maintenance Director corrected all identified areas of concerns from the audit on 8/9/17. The Maintenance Director and Maintenance Assistant were in-serviced by the Administrator on 8/17/17 regarding ensuring rooms are in good repair. All license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers were in-serviced by Staff Facilitator on/or before 9/11/17 to notify Maintenance of any areas in the facility in need of repair to include resident rooms furnishings by completing a work order slip. All newly hired license nurses, nursing assistants, dietary staff,	

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F 252	Continued From page 20 worn with noticeable scratches along the front of the cabinet doors. On 8/8/17 at 4:20 p.m. Resident #4 was interviewed about the condition of the cabinet. Resident #4 stated the latch on the middle door was broken and the door would not stay closed. Resident #4 stated the cabinet had been this way "for some time." On 8/9/17 at 10:35 a.m. the maintenance director was interviewed about the condition of Resident #4's three door cabinet. The maintenance director stated he currently had no work order for repair of the cabinet. The maintenance director stated new doors would need to be installed on the cabinet for repair. These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 8/9/17 at 4:15 p.m.	F 252	housekeeping staff, therapy staff, and department managers will be in-serviced by the staff facilitator regarding to notify Maintenance of any areas in the facility in need of repair to include resident's rooms by completing a work order slip during orientation. The housekeeping supervisor will monitor all areas of the facility to include 100% of all resident rooms, to include room 501 of resident #4 to ensure rooms and room furnishings are in good repair weekly x 8 weeks then monthly x 1 utilizing a Homelike Environment Quality Improvement (QI) Audit tool and complete a work order slip for all identified areas of concerns. The Maintenance Director will immediately address any identified areas of concern during the audit. The Administrator will review the Home like Environment QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Home like Environment QI Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet and review the Homelike Environment QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1)	F 279		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 21 483.20 (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 - (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	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 279	Continued From page 22 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 clinical record review and staff interview, the facility staff failed for one of 17 residents in the survey sample (Resident # 2) to include non-pharmacological interventions as part of a care plan for pain management. The care plan for Resident # 2, who had orders for and was taking as needed pain medications, did not include interventions for non-pharmacological interventions in lieu of the administration of pain medications. The findings were: Resident # 2 in the survey sample, a 53 year-old female, was admitted to the facility on 7/22/08, and most recently readmitted on 4/19/17 with diagnoses that included chronic obstructive pulmonary disease, chronic pain, anxiety,	F 279	Resident #2 was assessed for pain by the Quality Improvement (QI) Nurse/Registered Nurse (RN) on 8/18/17. Resident #2's care plan has been reviewed by Minimum Data Set Coordinator (MDS) on 8/21/17 and updated to include providing non-pharmacological interventions as part of pain management. 100% audit was conducted by Corporate Wound Care Consultant on 8/23/17 to identify all residents who has orders for and are receiving as needed (prn) pain medications, to include Resident #2. Care plans for each identified resident was updated to reflect non-pharmacological interventions to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 23 psychosis, arteriosclerotic dementia with depressive features, and depressive disorder. According to the most recent Annual Minimum Data Set, with an Assessment Reference Date of 6/1/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15. Resident # 2 had the following physician order, dated 4/20/17, for scheduled pain medication: Duragesic patch 25 mcg/hr (25 micro grams per hour), change patch every 72 hours. The resident also had the following prn (as needed) physician orders, dated 4/20/17, for pain medication: Tylenol (Acetaminophen) 325 mg (milligrams) tablets, 2=650 mgs by mouth every four hours as needed for pain. Ultram (Tramadol) 50 mg tablet, 1 by mouth every 12 hours as needed for pain. Percocet (Oxycodone/APAP) 5-325 mg tablet, 1 by mouth daily as needed. Review of the Medication Administration Record (MAR) for the month of June 2017 revealed Resident # 2 was administered prn Tylenol two times, and prn Percocet 11 times. For the month of July 2017, Resident # 2 was administered prn Percocet 10 times. She received no Tylenol during July. Interventions listed in Resident # 2's care plan for pain management included "Administer pain medication as per MD orders and note the effectiveness; Pain assessment for establishment	F 279	implement prior to the administration of pain medications on/or before 9/11/17 by the (MDS) Coordinator with oversite from the Director of Nursing. All license nurses were in serviced on/or before 9/11/17 by the Staff Facilitator (SF) to implement non-pharmacological interventions prior to the administration of prn pain medications with documentation in the medical records. Examples of non-pharmacological interventions were reviewed during the in-service. All newly hired licensed nurses will be in serviced during orientation by the staff facilitator to implement non-pharmacological interventions prior to administering prn pain medications with documentation in the medical records. Examples of non-pharmacological interventions will be reviewed during the in-service. The MDS coordinator was in serviced on 8/23/17 by Corporate Nurse Consultant to ensure that all residents who have orders for and/or are taking as needed pain medications, care plan must reflect non pharmacological interventions in lieu of the administration of the pain medication. 10% of resident's who has orders for and/or are receiving prn pain medications to include resident #2, care plan, will be reviewed by Administrative Nurses (Assistant Director of Nursing (ADON)/SF/MDS/QI Nurse) to ensure non-pharmacological interventions are care planned weekly x 8 weeks then monthly x 1 month utilizing a Pain Management Care plan Quality	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 279	Continued From page 24 of effective pain management program." There were no interventions in the Resident # 2's care plan to address the use of non-pharmacological interventions to address pain. During a meeting at 11:30 a.m. on 8/10/17, that included the Administrator, Director of Nursing, the Corporate Clinical Director, and the survey team, the lack of non-pharmacological interventions in Resident # 2's care plan was discussed.	F 279	Improvement (QI) Tool. The MDS Coordinator will be retrained immediately by Administrative Nurses (ADON/SF /MDS Nurse/MDS fill-in) for any identified areas of concern. The Director of Nursing will review and initial the Pain Management QI Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Director of Nursing will forward the results of the Pain Management Care plan QI Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Pain Management Care plan QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	
F 281 SS=E	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (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 staff interview, facility document review and clinical record review, the facility staff failed to follow standards of professional practice for	F 281	Resident #7 was interviewed on 8/21/17 by Assistant Director of Nursing (ADON) regarding preference of medications. The	9/11/17

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F 281	Continued From page 25 two of 17 residents in the survey sample. 1. Nurses failed to follow protocols for medication administration for Resident #7. There was no evidence if medications were administered or refused by Resident #7 for fifteen doses from 6/1/17 through 8/8/17. 2. For Resident # 2, the facility staff failed to document pain assessments at the time of the assessments. The findings include: 1. Nurses failed to follow protocols for medication administration for Resident #7. There was no evidence if medications were administered or refused by the resident for fifteen doses from 6/1/17 through 8/8/17. Resident #7 was admitted to the facility on 11/27/15 with diagnoses that included schizophrenia, paranoia, diabetes, high blood pressure, heart disease, gastroesophageal reflux disease, depression and chronic kidney disease. The minimum data set (MDS) dated 7/24/17 assessed Resident #7 as cognitively intact. Resident #7's clinical record documented current physician orders that included the following medications. 11/27/15 - Dulcolax 10 mg (milligrams) every 3 days for treatment of constipation 11/27/15 - Zyrtec 10 mg each day for allergies 11/27/15 - Aspirin 81 mg each day for peripheral vascular disease 11/27/15 - Norvasc 10 mg each day for treatment	F 281	Medical Doctor (MD) was consulted on 8/21/17 while in the facility, by the ADON regarding resident's preference of not taking certain medications. New orders were received to discontinue medications and medications were discontinued form the Medication Administration Record (MAR) per MD order on 8/21/17. Licensed Practical Nurse (LPN) #1 was in serviced on/or before 9/11/17 by Staff Facilitator (SF) regarding proper documentation on the MAR to include administration, as needed (prn) medications, and refusals. Resident #2 was assessed for pain by the Quality Improvement Nurse (QI) on 8/18/17 and such assessment was documented in the resident's clinical record at the time of the assessment. 100% audit of Medication Administration Records for the current month were audited by Corporate Nurse Consultant on 8/23/17 to identify other residents whose medication administration and/or refusals were not appropriately documented. The physician (MD) was notified by Director of Nursing on 8/23/17 of findings and any new orders received were carried out. 100% audit was completed by Corporate Nurse Consultant on 8/24/17 of all residents who had received prn pain medication and compared to the clinical record to determine if pain had been assessed and documented at the time of assessment. Any resident who had not been assessed for pain with documentation at the time of medication	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 281	Continued From page 26 of high blood pressure 3/8/16 - Humalog insulin 8 units at each meal for treatment of diabetes 12/27/16 - Lantus insulin 18 units at each bedtime for treatment of diabetes 7/8/17 - Levaquin 500 mg each day for 10 days for treatment of urinary tract infection Resident #7's medication administration records (MARs) for June 2017 through 8/8/17 were blank for fifteen doses of the above medications. The spaces for nurses' initials indicating administration of the medications were blank. There were no notes on the MAR or in the clinical record indicating if the medications were administered or refused by the resident. Documentation was missing for the following doses of prescribed medications for Resident #2 from during June 2017 through 8/8/17. Dulcolax 10 mg - 6/11/17, 6/23/17, 6/26/17, 6/29/17, 7/5/17, 7/8/17, 7/23/17 Zyrtec 10 mg - 7/15/17 Aspirin 81 mg - 7/15/17 Norvasc 10 mg - 7/15/17 Humalog insulin - 7/16/17 Lantus insulin - 7/9/17, 8/6/17 Levaquin 500 mg - 7/9/17, 7/23/17 On 8/9/17 at 9:30 a.m. the licensed practical nurse (LPN #1) routinely administering medications to Resident#7 was interviewed about whether the above doses of medication were administered or refused. LPN #1 sated the resident refused medications frequently. LPN #1 stated when medications were refused the nurse initials were circled on the MAR and a note made on the back of the MAR indicating the resident refused. When asked about the missing doses	F 281	administration, was re-assessed for pain by the Administrative Nurses/Registered Nurses, Director of Nursing (DON), ADON /SF/QI/ and/or Minimum Data Set (MDS) Coordinator on/or before 9/11/17. The physician (MD) was made aware of any negative findings of the pain assessment on/or before 9/11/17 by the Administrative Nurse. All license nurses to include LPN #1 and LPN # 2 were in serviced on/or before 9/11/17 by the staff facilitator on Medication Administration to include proper documentation on the MAR to include administration, as needed (prn) medications, and refusals and documenting the assessment of pain in the clinical record at the time of the assessment. All newly hired licensed nurses will be inserviced by the Staff Facilitator during orientation regarding Medication Administration to include proper documentation on the MAR to include administration, as needed (prn) medications, and refusals and documenting the assessment of pain in the clinical record at the time of the assessment. 10% of resident's Medication Administration Records to include resident #7 will be audited weekly x 8 weeks then monthly x 1 month by Administrative Nurses (ADON/SDC SF/MDS/QI Nurse) to ensure documentation of medication administration and/or refusals. 10% of residents, to include resident # 2, who receive pain medications, MARs, will be	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 281	Continued From page 27 with no documentation from June 2017 through 8/8/17, LPN #1 stated many times the resident stated she did not want the medications when scheduled and she "would take them later." LPN #1 stated sometime she got busy and forgot to go back or it was too late to give the scheduled dose. Concerning the doses with missing documentation, LPN #1 stated she was not sure what happened because there was no documentation. The facility's policy titled Medication Administration (revised 5/31/17) stated concerning documentation, "Document medications on the MAR after it has been given...All refusals should be initialed and circled on the front of the MAR and the reason should be written on the back...Medications must be administered within 1 hour before or after the time indicated on the MAR...Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals..." The Lippincott Manual of Nursing Practice 10th edition states on page 16, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reason for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." (1) These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 8/9/17 at 4:15 p.m. The administrator stated she and the	F 281	audited in comparison to the clinical record to ensure the pain assessment was documented at the time of the assessment. The licensed nurse will be retrained immediately by the Administrative Nurses (ADON/SF/MDS Nurse/MDS fill-in) for any identified areas of concern. The Director of Nursing will review and initial the Medication Administration Quality Improvement (QI) Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Director of Nursing will forward the results of the Medication Administration QI Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Medication Administration QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

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F 281	Continued From page 28	F 281		

director of nursing had conducted recent audits that indicated issues with missing documentation concerning medications.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

2. For Resident # 2, the facility staff failed to document pain assessments at the time of the assessments.

Resident # 2 in the survey sample, a 53 year-old female, was admitted to the facility on 7/22/08, and most recently readmitted on 4/19/17 with diagnoses that included chronic obstructive pulmonary disease, chronic pain, anxiety, psychosis, arteriosclerotic dementia with depressive features, and depressive disorder. According to the most recent Annual Minimum Data Set, with an Assessment Reference Date of 6/1/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

Resident # 2 had the following prn (as needed) physician orders, dated 4/20/17, for pain medication:

Tylenol (Acetaminophen) 325 mg (milligrams) tablets, 2 = 650 mgs by mouth every four hours as needed for pain.
Ultram (Tramadol) 50 mg tablet, 1 by mouth every 12 hours as needed for pain.
Percocet (Oxycodone/APAP) 5-325 mg tablet, 1 by mouth daily as needed.

According to the Medication Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 29	F 281		

Record's (MAR) for June and July 2017, Resident # 2 received prn Tylenol twice in June and none in July. She received Percocet 11 times in June and 10 times in July.

At 8:00 a.m. on 8/10/17, the surveyor was given a copy of a POC (Point of Care) Response History, which reflected the pain assessment data for each shift for the 30 day period from 7/11/17 through 8/9/17. A comparison of the POC Response History with the Nurse's Medication Notes portion of the MAR for the same period revealed the following:

On 7/11/17 at 5:00 p.m., the MAR noted prn Percocet was administered for "legs hurting." The POC Response History noted a pain assessment at 7:54 p.m. with no pain level noted.

On 7/16/17 at 5:00 p.m., the MAR noted prn Percocet was administered for "leg pain." The POC Response History noted a pain assessment at 9:56 p.m. with a pain level of 3.

On 7/25/17 at 4:00 p.m., the MAR noted prn Percocet was administered for "leg pain." The POC Response History noted a pain assessment at 5:37 p.m. with a pain level of 8.

On 7/27/17 at 4:30 p.m., the MAR noted prn Percocet was administered for "butt hurting." The POC Response History noted a pain assessment at 6:03 p.m. with a pain level of 8.

On 7/29/17 at 8:00 p.m., the MAR noted prn Percocet was administered for "tooth ache." The POC Response History noted a pain assessment at 6:36 p.m. with no pain level noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 281	Continued From page 30 On 7/30/17 at 2:15 p.m., the MAR noted prn Percocet was administered for "leg pain." The POC Response History noted a pain assessment at 5:23 p.m. with no pain level noted. At approximately 10:40 a.m. on 8/10/17, LPN # 2 (Licensed Practical Nurse), who worked on the unit where Resident # 2's room was located, was interviewed regarding the difference in times between the MAR Nurses Medication Notes and the times listed on the POC Response History. LPN # 2 was first asked if surveyors had access to the POC Response History. LPN # 2 replied, "No." Regarding the times listed on the POC Response History, LPN # 2 said, "The times listed (on the POC Response History) are not the times the actual pain assessment was done. The times listed are the times the nurse documented the assessment." The Potter-Perry Fundamentals of Nursing notes the following regarding nursing documentation: "The record needs to describe exactly what happened to a client. This is best achieved when you chart immediately after providing care...Nurses need to indicate all assessments, interventions, client responses, instructions, and referrals in the medical record." (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, page 387.) During a meeting at 11:30 a.m. on 8/10/17, that included the Administrator, Director of Nursing, the Corporate Clinical Director, and the survey team, the issue of nursing documentation was discussed.	F 281		
F 309	PROVIDE CARE/SERVICES FOR HIGHEST	F 309		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 309 SS=G	Continued From page 31 WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 309	Continued From page 32 Based on clinical record review, resident interview, and staff interview, the facility failed for one of 17 residents in the survey sample (Resident # 2) to ensure the resident had an effective pain management program. 1. Resident # 2's request for pain medication for a toothache was refused. This constituted harm. 2. The facility staff also failed to offer non-pharmacological interventions to address Resident # 2's pain. The findings include: 1. Resident # 2's request for pain medication for a toothache was refused. This constituted harm. Resident # 2 in the survey sample, a 53 year-old female, was admitted to the facility on 7/22/08, and most recently readmitted on 4/19/17 with diagnoses that included chronic obstructive pulmonary disease, chronic pain, anxiety, psychosis, arteriosclerotic dementia with depressive features, and depressive disorder. According to the most recent Annual Minimum Data Set, with an Assessment Reference Date of 6/1/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15. Resident # 2 had the following physician order, dated 4/20/17, for scheduled pain medication: Duragesic patch 25 mcg/hr (25 micro grams per hour), change patch every 72 hours.	F 309	Resident #2 was assessed for pain by the Quality Improvement Nurse (QI) on 8/18/17. The physician was made aware of findings by Minimum Data Set (MDS) Nurse on/or before 8/31/17. Non-pharmacological pain interventions prior to the administration of pain medications were discussed with resident #2 on/or before 9/11/17 by MDS Nurse. Resident #2 care plan was updated to reflect non-pharmacological interventions to implement prior to the administration of pain medications by the MDS Coordinator on 8/18/17. 100% of all residents to include resident #2, were assessed for signs and symptoms of pain with documentation on a pain assessment form by Administrative Nurses, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, MDS, or Quality Improvement Nurse (DON/ADON/SF/MDS/QI) on/or before 9/11/17. The physician was notified of any resident identified with pain that is unrelieved by pain medication on/or before 9/11/17 by Administrative Nurses (DON/ADON/SF/MDS/QI Nurse). 100% of residents receiving as needed (prn) pain medications, to include resident #2, Medication Administration Record (MAR) and nurse progress notes were reviewed for the past 30 days to ensure non-pharmacological interventions were offered with documentation in the medical records prior to the administration of pain medications, pain was relieved after the administration of pain medication, and/or pain medication was administered if	

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F 309	Continued From page 33 The resident also had the following prn (as needed) physician orders, dated 4/20/17, for pain medication: Tylenol (Acetaminophen) 325 mg (milligrams) tablets, 2 = 650 mgs by mouth every four hours as needed for pain. Ultram (Tramadol) 50 mg tablet, 1 by mouth every 12 hours as needed for pain. Percocet (Oxycodone/APAP) 5-325 mg tablet, 1 by mouth daily as needed. Review of the electronic portion of Resident # 2's clinical record revealed the following Progress (Nurses) Notes entry: 7/27/17 - 11:56 p.m. "Resident up at station demanding Tylenol for a 'toothache.' Explained to resident she had already taken something for pain on the previous shift. Resident became irate and screamed, 'I don't give a damn I want some more.' Explained that it was too soon for more medicine. Resident stated 'Well I'll just sit up here until I can have some more.' " According to the Medication Administration Record (MAR) for July 2017, Resident # 2 received prn Percocet at 4:30 p.m. on 7/27/17. The reason listed on the Nurse's Medication Notes portion of the MAR for the administration of the Percocet was "C/O (Complained of) butt hurting." At the time Resident # 2 requested the Tylenol, 11:56 p.m. according to the Nurses Note, it was approximately seven and one-half hours after the Percocet was administered at 4:30 p.m. According to the July 2017 MAR, no other prn	F 309	requested. The physician was notified of any resident identified with pain that was unrelieved by pain medication on/or before 9/11/17 by Administrative Nurses. The care plans for each resident were updated to reflect non-pharmacological interventions to implement prior to the administration of pain medications on/or before 9/11/17 by MDS Nurse for all residents who receive prn pain medications. 100% of licensed nurses to include Licensed Practical Nurse (LPN) #2 were educated by the staff facilitator on/or before 9/11/17 regarding If a resident request pain medication, the resident's pain must be assessed by the nurse, non-pharmacological interventions must be offered first, pain medication administered as appropriate, and the physician must be contacted if it is out of time frame for administration of pain medication or for unrelieved pain with pain medication, and documentation in the medical records. All newly hired licensed nurses will be inserviced during orientation by the staff facilitator If a resident request pain medication, the resident's pain must be assessed by the nurse, non-pharmacological interventions must be offered first, pain medication administered as appropriate, and the physician must be contacted if it is out of time frame for administration of pain medication or for unrelieved pain with pain medication, and documentation in the medical records.	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 309	Continued From page 34 pain medication was administered to Resident # 2 on 7/27/17 between 4:30 p.m. and 11:56 p.m. At approximately 10:40 a.m. on 8/10/17, LPN # 2 (Licensed Practical Nurse), who worked on the unit where Resident # 2's room was located, was interviewed regarding the 7/27/17 Nurses Notes entry. LPN # 2 identified the nurse who wrote the note as working the evening shift, from 7:00 p.m. to 7:00 a.m. At approximately 9:00 a.m. on 8/10/17, Resident # 2 was interviewed. At the time of the interview, the resident was in her room, lying in bed. Asked if she remembered asking for pain medication at night about two weeks ago, the resident said "Yes. I had a toothache and they wouldn't give me anything." Asked what she did, Resident # 2 said, "I toughed it out." The resident went on to say she never did get any pain medication that night. During a meeting at 11:30 a.m. on 8/10/17, that included the Administrator, Director of Nursing, the Corporate Clinical Director, and the survey team, the failure of the staff to administer Tylenol to Resident # 2 for a reported toothache was discussed. There was no response when the Administrator, Director of Nursing, and the Corporate Clinical Director were asked why the Tylenol would not have been administered, The failure of staff to honor Resident # 2's request for pain medication for a toothache constituted harm. 2. The facility staff The facility staff also failed to offer non-pharmacological interventions to	F 309	25% of resident's to include resident # 2 who are ordered and/or receive pain medications, pain assessments, progress notes and Medication Administration Records will be audited weekly x 8 weeks then monthly x 1 month by Administrative Nurses (DON/ADON/SF/MDS/QI Nurse) to ensure pain management protocol is followed to include pain assessed, offered non pharmacological interventions prior to the administration of pain medication, administered pain medication per resident request, contacted the physician if outside of time frame for pain medication administration and/or unrelieved pain and proper documentation in the medical records utilizing a Pain Quality Improvement (QI) Audit Tool. The licensed nurse will be retrained immediately by Administrative Nurses (DON/ADON/SF/MDS Nurse/MDS fill-in) for any identified areas of concern. The Director of Nursing will review and initial the Pain QI Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Director of Nursing will forward the results of the Pain QI Audit Tool to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Pain QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

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F 309	Continued From page 35	F 309		

address Resident # 2's pain.

Review of the electronic portion of Resident # 2's clinical record revealed the following Progress (Nurses) Notes entry:

6/7/17 - 1:47 a.m. "Resident came down to station with her eyes closed up tight. C/O them hurting. PRN Tylenol given. No further c/o pain or discomfort."

According to the MAR's for June and July 2017, Resident # 2 received prn Tylenol twice in June and none in July. She received Percocet 11 times in June and 10 times in July. With the exception of the Nurses Note for the administration of Tylenol on 6/7/17, there were no other Nurses Notes related to the administration of prn pain medication for the months of June and July. In addition, there were no Nurses Notes to indicate the resident was offered non-pharmacological interventions to address her pain in lieu of the administration of pain medication.

During a meeting at 4.00 p.m. on 8/9/17, that included the Administrator, Director of Nursing, the Corporate Clinical Director, and the survey team, the failure of the staff to off non-pharmacological interventions to address Resident # 2's pain was discussed.

At 8:00 a.m. on 8/10/17, the surveyor was given a copy of the following Nurses Note:

8/9/17 - 8:01 p.m. "Talked with resident and discussed possible non-pharmacological pain interventions such as massage, leg elevation, repositioning and resident refused anything

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F 309	Continued From page 36 stating 'That will only make my pain worse. I've tried all that myself. I've been taking pain medication for 20 years.' " During the interview with Resident # 2 at 9:00 a.m. on 8/10/17, the use of non-pharmacological interventions to address her pain was discussed. The resident was non-responsive when asked if she would be willing to try other interventions instead of pain medication. During a meeting at 11:30 a.m. on 8/10/17, that included the Administrator, Director of Nursing, the Corporate Clinical Director, and the survey team, the failure of the staff to offer Resident # 2 non-pharmacological pain interventions and the importance of non-pharmacological interventions as a part of an effective pain management program were discussed.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		9/11/17

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F 314	Continued From page 37 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to accurately assess and treat a facility acquired pressure ulcer for one of 17 residents, Resident #1. Resident #1 was hospitalized from 07/20/2017 and returned to the facility on 08/03/2017. On 08/07/2017 a non-blanchable reddened area was identified as a SDTI (suspected deep tissue injury) by the facility wound nurse, RN (registered nurse) # 1. Treatments ordered included betadine to the site every day. On 08/09/2017, the wound nurse stated that she had been "re-educated" and the area was now considered blanchable erythema and no longer required the betadine treatment. During an interview on 08/10/2017, the Corporate Director of Wound Care stated that there was "no such thing' as blanchable erythema and reassessed the wound as a Stage I pressure ulcer with a darkened center. Findings were: Resident #1 was originally admitted to the facility on 12/23/2016. His diagnoses included, but were not limited to: Epilepsy, anxiety, nontraumatic subdural hematoma, schizophrenia, depression, and hypertension. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/12/2017. Resident #1 was assessed as having a cognitive summary score of "15", indicating he was cognitively intact.	F 314	Resident #1 pressure ulcer was assessed by the physician and/or nurse practitioner on/or before 9/11/17 and accurately staged. Any new orders were carried out by the Treatment Nurse. Registered Nurse #1 the Treatment nurse was re-educated by the Corporate Wound Care Consultant on 8/8/17 and again on 8/23/17 by the Corporate Nurse Consultant of how to correctly stage wounds. Preventative measure of Prevalon Boot was added to the left heel to prevent further pressure ulcers to resident # 1 on 8/9/17 by the treatment nurse with updates for the resident care guide and care plan by the Minimum Data Set (MDS) Nurse. The physician was notified on 8/9/17 and new treatment orders were initiated. 100% head to toe assessments was completed on all residents to include resident #1 on/or before 9/11/17 by the Assistant Director of Nursing and other Administrative Nurses (Quality Improvement Nurse, Minimum Data Set Nurse, and Staff Facilitator) to ensure all identified pressure ulcers noted have been assessed, staged correctly, Medical Doctor (MD) notified, treated appropriately per MD order or wound care protocol with documentation in the medical records, and appropriate documentation for admission verses in house wound. The Assistant Director of Nursing will	

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F 314	Continued From page 38 The clinical record was reviewed on 08/08/2017. The nursing readmission assessment dated 08/03/2017 was reviewed. The following information was documented: "Resident arrived at facility @ [at] 2130 [9:30 p.m.] via stretcher...skin warm and dry to touch. Flaky redness noted to head and face. Sacral area red. Duoderm intact...." Also observed in the progress note section of the electronic record was a note dated 08/07/2017, which contained the following information: Readmission assessment completed resident notes to have a SDTI wound noted to the left inner heel. The area is red and non blanchable. No open areas noted. Treatment for the area is bunny boots while in bed as tolerated and swab with betadine Q [every] day." This note was signed by RN # 1, the wound nurse. Also observed in the record was a "Wound Ulcer Flowsheet" dated 08/07/2017, that was completed and signed by the wound nurse. Information on the flow sheet included but was not limited to: "Wound/Ulcer Details: Admitted with; Units of measure: Centimeters: Site: Left inner heel Type: Pressure Length: 1 [cm] Width 2 [cm] Stage: Suspected Deep Tissue Injury...Comments: noted on readmission". On 08/08/2017 at approximately 4:00 p.m., RN # 1 was interviewed regarding her assessment of Resident #1's heel. She was asked about the readmission assessment she completed on 08/07/2017. She stated that she had been off when Resident #1 had returned to the facility and she had not done the assessment until 08/07/2017. RN # 1 was asked how she determined that the area on Resident #1's heel	F 314	immediately address all identified areas of concern with corrections in documentation in the medical record. 100% audit was completed by the Corporate Wound Care Consultant 8/8/17-8/9/17 of all residents with actual pressure ulcers to include resident #1 to ensure accurate staging. The physician and/or nurse practitioner will review all wounds on/or before 9/11/17 to ensure correct staging. The treatment nurse will immediately address all identified areas of concern with correct documentation of staging in the medical records. A 100% audit was completed by Corporate Wound Care Consultant on 8/23/17 to ensure residents at risk or with pressure ulcers have preventive measures in place to prevent pressure sores. Preventative measure were immediately put into place and added to the resident care guide and care plan by the treatment nurse and Minimum Data Set (MDS) nurse on/or before 9/11/17 for all identified areas of concerns during the audit. 100% of license nurses and nursing assistants were re-educated by Administrative Nurses (Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Staff Facilitator (SF)/Quality Improvement (QI)/Treatment (TX) nurse and/or Minimum Data Set (MDS) coordinator) on/or before 9/11/17 regarding ensuring preventive measure to prevent pressure sores are provided upon admission including heel boots and float heels per the resident care guide/care plan. A complete head to toe assessment	

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F 314	Continued From page 39 had been present on readmission to the facility on 08/03/2017 when it was not documented by the nurse who had assessed him at admission and she (RN # 1) had not seen the area until four days after his admission. She stated, "I am a treatment nurse, I have had special training to see that type of area that a medication nurse might not see...the area is small and may have been mistaken as part of the coloring of his foot." She was asked if she had asked the nurse who did the admission assessment if she had looked at that area. She stated, "No, but my mentality is that when I did the readmission assessment it was there so he was readmitted with it." On 08/09/2017 at approximately 10:30 a.m., this surveyor accompanied RN # 1 to Resident #1's room to observe his heel. RN # 1 removed Resident #1's bunny boot from his left foot, as well as his sock. She stated, "I have been re-educated today by the corporate wound nurse...I'm just going to show you what we found." RN # 1 lifted up Resident #1's foot. A small brown area was noted on his heel. RN # 1 pressed on the brown area and the area round it. She stated, "This is blanchable." Resident #1 pulled his foot away when she pressed on the area. She stated, "He is ticklish." Resident #1 stated, "That don't tickle...it hurts." RN # 1 stated, "Since this is blanchable we are calling it blanchable erythema...not a suspected deep tissue injury. We don't put betadine on healthy tissue so we are changing it to cleaning it with wound cleanser and lotion...we are going to use a prevalon boot too." RN # 1 cleaned the area, applied lotion and placed the prevalon boot on his left foot. She stated, "We are going to call this facility acquired since it wasn't found at the time of his readmission."	F 314	must be completed by the admitting nurse and documented in the clinical record to include any wounds observed. The treatment nurse was in serviced by the facility nurse consultant on 8/23/17 regarding wound measurements, requirements for documentation of pressure sores, weekly assessment, staging, in house verse admission wounds, and care planning of pressure ulcers. All newly hired license nurses and nursing assistants will be in serviced during orientation by the Staff Facilitator regarding ensuring preventive measures to prevent pressure sores are provided upon admission, including heel boots and float heels per the resident care guide/care plan. A complete head to toe assessment must be completed by the admitting nurse and documented in the clinical record to include any wounds observed. The Administrative Nurses (DON/ADON/SDC SF/QI and/or MDS coordinator) will complete resident rounds on residents at high risk for pressure ulcers and with actual pressure ulcers utilizing the Preventative Interventions Quality Improvement (QI) Tool weekly x 8 weeks then monthly x 1 month to ensure residents are provided intervention to prevent pressure sores. The Administrative Nurses (DON/ADON/SDC SF/QI and/or MDS coordinator) will address any identified areas of concern immediately during the audit by ensuring interventions are in place and retraining with the license nurse or nursing	

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F 314	Continued From page 40 The above information was discussed during an end of the day meeting with the DON (director of nursing) and the administrator on 08/09/2017. This surveyor asked if any interventions had been put into place at the time of Resident #1's readmission to the facility to prevent the development of pressure areas. The administrator stated she would check. On 08/10/2017, at approximately 7:45 a.m., the administrator came to the conference room to present information to the survey team. The administrator stated, "There were no preventative measures put into place for [name of Resident #1]." The administrator was asked about the assessment completed by the admitting nurse on 08/03/2017 and if she felt it was accurate. She stated, "It is the expectation that all nurse's do a thorough assessment." The administrator also presented documentation regarding pressure ulcers and wound protocol used at the facility. There was no mention of "blanchable erythema" on the information. The wound nurse was interviewed at approximately 8:15 a.m., regarding Resident #1's heel. She was asked about the term "blanchable erythema" and was this a stage I pressure ulcer. She stated, "No, it is not a stage I...it is blanchable erythema...it can be caused by friction or pressure...we are not calling it a pressure wound." The wound nurse was asked if she could provide information to this surveyor on "blanchable erythema." At approximately 8:20 a.m., the wound nurse and the Corporate Director of of Wound Care Services came to the conference room to speak	F 314	assistant. 10% of all residents to include resident #1 will be assessed from head to toe to include newly admitted residents and/or residents with pressure ulcers in comparison to wound documentation to ensure pressure ulcers were identified during admission as appropriate, correct staging of pressure ulcer documented and correct documentation of admission verse in house wound by Administrative Nurses (DON/ADON/SDC SF/QI/ and/or MDS coordinator) weekly x 8 weeks then monthly x 1 month using a Quality Improvement QI Wound Documentation Audit Tool. Any concerns will immediately be addressed by the Administrative Nurses (DON/ADON/SDC SF/QI and/or MDS coordinator) with reeducation of the treatment nurse and/or license nurse and completion of the appropriate wound documentation. The DON will review and initial the Preventative Interventions Quality Improvement (QI) Tool and the QI Wound Documentation Audit Tool weekly x 8 weeks then monthly x 1 month to ensure compliance. The Director of Nursing will forward the results of the Preventative Interventions QI Tools and the QI Wound Documentation Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Preventative Interventions QI Tools and the QI Wound Documentation Tools and address any issues, concerns and/or trends and to make changes as needed, to include	

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F 314	Continued From page 41 to this surveyor. The Corporate nurse stated, "There is no such thing as blanchable erythema...the original assessment of the area is inaccurate...I re-educated [name of RN # 1] on staging ... when I looked at it on Monday it was a Stage I, non-blanchable erythema...the next time I looked at it was yesterday [Wednesday] and it was blanching..." At approximately 8:30 a.m., the corporate wound nurse, the facility wound nurse and this surveyor went to Resident #1's room to look at the area on his heel. The corporate wound nurse removed Resident #1's prevalon boot from his left foot and his sock. The corporate wound nurse pointed to Resident #1's heel and stated, "I didn't see that dark area yesterday..it wasn't there...it is dark and looks purple...I would call that a deep tissue injury." She then pressed on the area that was darker and the surrounding area on Resident #1's heel. Resident #1 pulled his foot away when the area was pressed on. He was asked if that hurt and he stated, "Yes." This surveyor did not see any difference in the appearance of the heel from the observation done the previous day [Wednesday, 8/09/2017]. A suggestion was made to the corporate wound nurse and the facility wound nurse to turn on a light so better visualization of the area could be obtained. The corporate wound nurse pulled the bedside curtain back allowing sunlight to come into the area around Resident #1's bed. She stated, "Well with the light, it looks brown and blanchable...It's not purple...I don't think it is a deep tissue injury...we are going to call that a Stage I with a dark area in the center." The above information was discussed during a meeting with the DON (director of nursing) and	F 314	continued frequency of monitoring x 3 months.	

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F 314	Continued From page 42 the administrator on 08/10/2017 at approximately 11:30 a.m. No further information was obtained prior to the exit conference on 08/10/2017.	F 314		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, the facility staff failed to ensure acceptable parameters of nutritional status to prevent a significant weight loss for one of 17 residents in the survey sample, Resident # 9. Resident # 9 had a significant weight loss of 20 pounds (11.76%) from May 9, 2017 until June 29, 2017. The weight loss was not addressed by the	F 325	The physician was notified of resident #9 significant weight loss on 8/9/17 by the Director of Nursing (DON). Orders were received for supplements and an appetite stimulant and implemented on 8/10/17 by Hall Nurse/ Licensed Practical Nurse. The Registered Dietician (RD) was made aware of the significant weight loss and reviewed resident # 9 on/or before	9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 325	Continued From page 43 RD (registered dietitian) , nor the dietary manager until it was identified by the survey team. The survey team requested that Resident # 9 be weighed during the survey. On 08/09/2017, the ADON (assistant director of nursing) reported that Resident #9's weight was a 144 pounds, a loss of an additional 6 pounds. This was a total of 26 pounds (15.29%) in ninety days. Findings were: Resident #9 was originally admitted to the facility on 10/02/2009. His diagnoses included, but were not limited to: Vascular dementia, personality disorder, cerebral vascular accident (stroke) , hypertension and cardiac arrhythmia. He was most recently readmitted to the facility on 05/08/2017, following a hospitalization for a urinary tract infection. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/03/2017. Resident #9 was assessed as having a cognitive summary score of "14", indicating he was cognitively intact. The clinical record was reviewed on 08/09/2017. The weight section was observed. Resident #9's weights were obtained monthly. The following weights for 2017 were recorded as: January: none; February: 171; March: 170; April: 171; May 9: 170; June 29: 150; July 11: 150. The dietary notes were reviewed. The RD wrote a readmission note on 05/31/2017 which contained the following: "Ht: 68 in [inches]. Wt 5/09 of 170#. BMI [body mass index] of 25.8. Diet order: Regular. No pertinent	F 325	8/24/17. New recommendations received from the RD for resident #9 were implemented on/or before 9/11/17. A 100% audit was conducted by the Corporate Wound Care consultant on 8/9/17-8/10/17 to identify other residents with significant weight loss within the past six months who the physician was not notified of, had not been addressed with appropriate interventions, had not been addressed by the Registered Dietician and dietary Manager, and that had not been identified when the weight loss occurred. The physician was made aware on 8/14/17 and RD was made aware on 8/24/17 of the significant weight loss and interventions implemented with documentation in the medical records by the Director of Nursing for all identified areas of concern by 9/11/17. All Residents to include resident #9 with current weight loss will be reviewed by the RD by 9/11/17 to verify current interventions utilized are appropriate interventions for preventing weight loss based on the individual Resident's condition. The Corporate Nurse Consultant in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set (MDS) nurse, and dietary manager on 8/17/17 regarding the weight committee responsibilities to include, identifying and addressing residents weight loss when the weight loss occurs, monitoring of residents for significant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 325	Continued From page 44 meds...Resident acceptance of meals as fed by self varies between 25 % - 75 %. Wt relatively stable past 6 months. BMI wal [within acceptable limits]. No wounds. Labs on 5/12 noted-notable for mildly depleted albumin of 2.9. Est [estimated] kcal needs: 77 kg X 25 kcals/kg =~ 1900 kcals/day. Est. protein needs: 77 kg X 1.2 =92 gm/day. Est. fluid needs: 77 kg X 30 cc/kg =~2300 cc/day. Recommendations/Plan of Care: Suggest adding prostat 30 cc bid for protein support d/t [due to] depleted albumin. Otherwise, recommend continuing current regimen. Monitor per protocol." There were no additional entries in the clinical record from the RD. Physician orders revealed that Prostat had been ordered per the RD recommendation for Resident #9 but discontinued due to his refusal to take it. Observed in the clinical record were assessments, "Dietary Supplemental 4" completed by the dietary manager. An assessment completed on 04/03/2017 contained the following information: "Eating Pattern/Nutritional Problem: Eats Between Meals; Refuses to eat occasional; Complains about many foods; Leaves 25% food uneaten at most meals...Eating Ability: Partial assistance...Chewing Problem: Yes...Ideal Body weight: Low-149 High 159; Usual Body Weight: Low-170 High-173 Current Weight-170...Additional Comments: Resident receives regular diet eating 14 to 61% of meals. Resident complains about many foods. Resident has trouble chewing because of having no teeth but prefers regular texture. Residents friends bring in food from outside facility." The next assessment completed by the dietary	F 325	weight changes, have interventions that address any avoidable weight loss and that interventions must be carried out fully, must not be discontinued prematurely and must be effective in preventing harm from further weight loss, ensuring the Physician, RD, and Resident Representative (RP) is immediately notified of significant weight loss with documentation in the medical records. All Residents to include resident #9 will be weighed on a monthly or weekly basis as appropriate by the DON. The DON will review the monthly and weekly weights when obtained to identify any resident with a significant weight loss at the time of occurrence. The DON will immediately report the identified residents with significant weight loss to the weight committee. The identified resident with significant Weight loss will continue to be addressed during the Weekly Weight Quality Improvement (QI) Meeting weekly x 8 weeks then monthly x 1 month, by the weight committee members using the Weight Committee Meeting Quality Improvement (QI) Tool. Each resident's weight status and interventions will be discussed in addition to ensuring the physician and RD is notified of any significant weight change (5% in 30 days, 10% in 180 days) with documentation in the medical records. The implementation and effectiveness of interventions in place as evidenced by the resident's current weight, cooperation with the plan of care or ability to participate with the plan of care. The implementation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 45 manager dated 07/03/2017 contained the following information: "Eating Pattern/Nutritional Problem: Eats Between Meals; Refuses to eat occasional; Complains about many foods; Leaves 25% food uneaten at most meals; 5% weight loss or gain in 30 days; 10 % weight loss or gain in 180 days...Eating Ability: Partial assistance...Chewing Problem: Yes...Ideal Body Weight: Low-149 High-159; Usual Body Weight: Low-150 High-171 Current Weight-150...Additional Comments: Resident receives regular diet eating 29 to 71% of meals. Resident complains about many foods. Resident has trouble chewing because of having no teeth but prefers regular texture. Residents friends bring in food from outside facility." On 07/03/2017 the dietary manager made the following entry in the progress note section of the clinical record: "Met with resident to update food preferences. Some changes at this time. Resident receives a regular diet eating 29-71 % of meals. Resident complains about many foods. Resident's friend bring [sic] food from outside facility." There was no mention of the Resident #9's weight loss of 20 pounds. Review of the physician orders did not indicate the addition of any supplements or dietary changes to address Resident #9's weight loss. On 07/05/017, Resident #9 was seen by behavioral health and a recommendation was made to discontinue Resident #9's Risperdal due to abnormal body movements and weight loss. The Risperdal was discontinued as recommended on 07/05/2017. The care plan was reviewed. A focus area: "State of nourishment; less than body	F 325	recommendations made by the committee for changes in interventions and subsequently the plan of care will be recorded on the Weight Committee QI tool and the Resident Care Plan will be reviewed at the time of the Weight Committee Weekly meeting. The Director of Nursing will review and initial the Weight committee Meeting QI Tool for completion and to ensure all areas of concern were addressed weekly x 8 weeks and monthly x 1 month. The Director of Nursing is responsible for forwarding the results of the Weight Committee Meeting QI Tools to the Executive Quality Improvement (QI) committee monthly x 3 months. The Executive QI committee will meet monthly and review audits of the Weight Committee Meeting QI Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3 months.	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 325	Continued From page 46	F 325		

requirements characterized by weight loss, decreased intake, decreased appetite related to: refuses some meals at times (fluctuating weights). Interventions included: Assess for/provide food preferences; Diet as ordered; monitor and record percentage of meal intake; offer substitutions for uneaten food; refer to dietitian for evaluation/recommendations; set up tray and encourage consumption of meal; weight per facility protocol."

The dietary manager was interviewed on 08/09/2017 at approximately 11:00 a.m. She was asked about Resident #9's weight loss. She stated that she was aware of the weight loss. She was asked if the RD was aware. She stated that the RD gets weight reports and comes to the facility monthly. She stated that they RD should have seen him by now. The DM was asked if supplements were available at the facility. She stated that they had magic cups and and shakes but that she didn't think he would take them. She was asked if the supplements or fortification of foods had been attempted. She stated, "No, but he gets snacks when he wants them."

The RD was interviewed on 08/09/2017 at approximately 2:00 p.m., over the telephone. She stated that she had not been aware of Resident #9's weight loss until she had been contacted by the dietary manager that day (08/09/2017). She stated. "I am at the facility every month....I see residents who trigger for significant weight loss, residents who are showing a downward trend, and actually start looking at them if they have a 3 percent loss...this wasn't on the report that I looked at when I was there in June or July...it is my understanding that they can backdate the weights, so it may look like the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 325	Continued From page 47	F 325		

weight was available when I was there when it actually wasn't...I asked [name of dietary manager] to look at the report I used in July when I made my recommendations, I haven't heard back from her yet." The RD was asked what she would have done if she had been aware of the weight loss. She stated, "I would have recommended supplements for him...I made that recommendation today when I found out about the weight loss...we are starting Resource 2.0 twice a day."

At approximately 3:00 p.m., the DON (director of nursing) was asked if a weight could be obtained on Resident #9 at that time. The weight was obtained with the results of 144 pounds. A total weight loss of 26 pounds or 15.29% in 90 days. The DON and the ADON (assistant director of nursing) were asked if the weights could be backdated in the computer system. They both stated, "No."

At approximately 3:30 p.m., Resident #9 was interviewed. He was observed sitting in his wheelchair in his room. Resident #9 was observed as thin. He was asked about his meals. He stated that he hadn't eaten lunch because it was meatloaf. "I don't like meatloaf." He was asked if he asked for anything else or was offered anything else. He stated, "No." This surveyor asked Resident #9 if he was trying to lose weight. He stated, "No." He was asked what he liked to eat. He stated, "Spaghetti". He was asked if he got that very often. He stated, "Sometimes." He was asked about soups. He stated that he liked tomato and chicken noodle soup. He was asked if he like ice cream. He stated, "Yes." He was asked if he got that very often and he replied, "Every once in a while." Resident #9 was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 325	Continued From page 48	F 325		

about his teeth. He stated that he had not been to the dentist in a while. He was asked if he thought having teeth would help him eat. He stated, "Probably so."

Review of the consults in clinical record showed that a dental visit was done with Resident #9 by a mobile dental clinic at the facility on 06/20/2017. The results of that visit were not in the computer system and were requested from the administrator. The administrator reported that the visit information was not available to the facility due to change in ownership with dental company, but that she would attempt to get it.

During an end of the day meeting on 08/09/2017 the DON and the administrator were notified of the above information. Any additional information regarding Resident #9's weight loss was requested, as well as the information from the dental visit if it could be obtained. The DON and the administrator were informed of the weight loss of 15.29 % in 90 days, the lack of RD involvement regarding the weight loss, the lack of interventions being put into place to address the weight loss, and the facility's failure to identify the weight loss when it first occurred in June.

On 08/10/2017 at approximately 8:30 a.m., the administrator came to the conference room to speak with the survey team and present additional information. Items presented included the report regarding weight loss used by the RD during her visit on July 26, 2017. The report, "Weights and Vitals Exceptions" included names of all residents, including Resident #1 who had a three percent or greater change in weight during the date range on the report. The date range was 05/01/2017 to June 30, 2017. The run date for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 325	Continued From page 49	F 325		

the report was July 26, 2017, meaning that any weights captured after June 30 would not show up on the report. The following information was listed for Resident #1: "[Name] ...Height: 68.0 inches Current BMI: 22.8 Admission Date: May 8, 2017 June 29, 2017 150 .0 lbs Weight 5/9/2017, 170.0 lbs, -11.8%, -20 Lbs" Attached to the report were progress notes written by the RD during her visit to the facility on 07/26/2017. There were no notes from the RD regarding Resident #1. Also presented were orders obtained on 08/09/2017 from the physician for the following: "Resource BID [twice a day] PO [by mouth] between meals; weekly weights X [times] 4 weeks; Brighter Day Assessment [mental health] and treatment if indicated; Dental eval for possible need of dentures; Magic Cup TID [three times a day] between meals, Dx[diagnosis] weight loss; Double portions with all meals; Remeron 7.5 mg 1 po Q HS [at bedtime]"

The ADON (assistant director of nursing) and the administrator were interviewed together on 08/10/2017 at approximately 9:30 a.m. The ADON stated that she had taken the weights over on 06/29/2017. She was asked what the weighing process was. She stated, "The CNA [certified nursing assistant] get the weights and enter them into the [computer] system. They are suppose to notify the nurse if the weight is abnormal or there are any variations...we print a weight exception weekly." The ADON was asked if she had any of the weekly reports that were run from 06/29/2017 through 07/26/2017. She stated that she did not keep the reports. She also stated, "He didn't show up on the reports until we ran it on July 26...I don't know why he didn't". The ADON was asked about the date range on the report that the RD used in July. She stated, "We

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 325	Continued From page 50 just pick a date and run it." The administrator stated, "No, we need to run the report to include all the most recent weights." The administrator and the ADON were asked if the physician had been notified of the significant weight loss for Resident #1 prior to the survey. The administrator stated, "No." The ADON stated, "This was an oversight at that time." This surveyor asked why Remeron was being started. The ADON stated, "To help his appetite." It was pointed out to the ADON and the administrator that according to the dietary assessments completed by the DM in April and July, there had not been a decrease in Resident #1's appetite and in fact per her documentation his appetite had slightly increased from "eating 14 to 61% of meals' in April to "eating 29 to 71% of meals" in July. On 08/10/2017 at approximately 10:25 a.m., this surveyor was asked to speak via telephone with the Pharmacist who was the director of clinical services for the facility. He stated that he wanted to talk about the use of Remeron for Resident #9. He stated that he did not know the resident nor had he reviewed the chart. The off label use of Remeron was discussed. He stated, that normally he would agree that starting with supplements and dietary preferences would be a good place to start with weight loss, but due to the fact that Resident #9 had lost so much weight, he felt the addition of Remeron in a low dose (7.5 mg QHS) would be a good idea for a short time. No further information was obtained prior to the exit conference on 08/10/2017.	F 325		
F 431	DRUG RECORDS, LABEL/STORE DRUGS &	F 431		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 431 SS=D	Continued From page 51 BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 431	Continued From page 52 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure a controlled substance with the potential for abuse was locked in an affixed box inside the refrigerator in the medication room on one of 2 units, Unit one (1). The findings include: A container with two vials of Lorazepam 2 mg (milligrams) was observed in the refrigerator sitting on top of a container labeled suppositories and not in the lock box that was permanently affixed inside of the refrigerator. On 8/9/17 at approximately 9:30 p.m., the medication room was observed with a Licensed Practical Nurse, who will be identified as LPN #2, on Unit 1. Stored in the refrigerator was a container containing two (2) vials of Lorazepam 2 mgs. The medication was observed sitting on top of a container of suppositories and out of the	F 431	The Ativan in the medication room on unit #1 was placed in the secure/locked box located inside the locked medication refrigerator on 8/10/17 by the Assistant Director of Nursing. A 100% audit was conducted of all controlled drugs to include Ativan by the RN Corporate Nurse Consultant on 8/17/17 to ensure all controlled medications were properly stored to include in an affixed box as necessary. The controlled medications were properly stored immediately during the audit by the floor (Hall) nurse/ (Licensed Practical Nurse/Registered Nurses (LPN/RN) for any identified areas of concerns. 100% of licensed nurses to include LPN #2 will be educated on the requirements of storage of controlled medications to include being stored in an	

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 53 permanently affixed locked box located inside of the refrigerator. LPN #2 was interviewed regarding the medication not being inside of the locked box that was affixed inside of the refrigerator. LPN #2 stated, "It is supposed to be in the locked box." LPN #2 removed the container from on top of the box of suppositories and placed it inside of a black box that was permanently affixed to the refrigerator. On 8/9/17 at approximately 3:00 p.m., the administrative staff were made aware of the above findings. A copy of the facility's policy for "Medication Storage" was requested and reviewed to include the following: "C. Controlled Substances shall be stored under double lock in the controlled substance drawer of the medication cart and shall be counted at each shift change, as described on page 179..." On 8/9/17 at approximately 3:15 p.m., the Assistant Director of Nursing was interviewed and asked if there was a policy for the storage of refrigerated controlled substance. The ADON stated, "I think what you have is our policy for medication storage."	F 431	affixed container as necessary by the Staff Facilitator on/or before 9/11/17. All newly hired license nurses will be inserviced during orientation by the Staff Facilitator regarding the requirements of storage of controlled medications to include being stored in an affixed container as necessary. The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will conduct an audit of all medication rooms and medication carts to ensure controlled substances are stored appropriately to include in an affixed container as necessary weekly x 8 weeks then monthly x 1 month utilizing a Controlled Medication Storage Quality Improvement (QI) Tool. The license nurse will be retrained immediately by the DON or ADON for any identified areas of concern. The Administrator will review and initial the Controlled Medication Storage QI Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Administrator will forward the results of the Controlled Medication Storage QI Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Controlled Medication Storage QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 514	Continued From page 54	F 514		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 514		9/11/17

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	495318	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 514	Continued From page 55 Based on staff interview and clinical record review, the facility staff failed to ensure complete and accurate clinical records for five of 17 residents in the survey sample. 1. Resident #4's clinical record included hospital documents for another resident. 2. Resident #7's clinical record failed to include an assessment and documentation of an incident on 6/10/17 of rape allegations and involvement by the local police. 3. Resident #12's clinical record documented an inaccurate resuscitation status on multiple physician order summary sheets. 4. Resident #13's record documented conflicting resuscitation orders. 5. Resident#6's clinical record inaccurately documented the resident's allergies. The findings include: 1. Resident #4's clinical record included hospital records for another resident. Resident #4 was admitted to the facility on 3/30/15 with a re-admission on 3/5/17. Diagnoses for Resident #4 included multiple sclerosis with paraplegia, chronic pressure ulcers, anemia, diabetes, high blood pressure and depression. The minimum data set (MDS) dated 6/5/17 assessed Resident #4 as cognitively intact. Resident #4's clinical record was reviewed on 8/8/17. Hospital discharge records dated 3/6/17 were included in the record. The first two pages	F 514	The other resident's record in resident #4's chart was removed on 8/8/17 by medical records. Resident #7's allegation of rape had been investigated and the Emergency Room (ER) report was uploaded to the clinical chart on 8/9/17 by medical Records. The code status for resident #12 was clarified by the Director of Nursing (DON) on 8/18/17 and the record was updated accordingly. The code status for resident #13 was clarified and records updated 8/10/17 by the DON. Resident #6's allergies were updated and accurately recorded by the Assistant Director of Nursing (ADON) on 8/8/17. An audit of 100% of all current resident clinical charts was conducted on/or before 9/11/17 by the Administrator to identify any resident with misfiled records of another resident in their chart. Any adverse findings were immediately corrected during the audit by the Administrator. An audit of 100% of all current resident's allergies was conducted on 8/9/17 by the Corporate Clinical Director to identify any other resident's whose allergies were incorrectly recorded. All negative findings were clarified with the physician and record updated accordingly by the Corporate Clinical Director and/or Director of Nursing. An audit of all current resident's code status as recorded on the Medication Administration Record (MAR) ,Physician order sheet, and electronic Medical record was completed by the Social worker on 8/11/17. All discrepancies were clarified by the Social Worker and/or Administrative Nurse	

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F 514	Continued From page 56 of the hospital summary included a history and physical for another resident. This resident had previously discharged from the facility. These two pages listed the previous resident's admission date as 4/6/17 and included the former resident's birth date, medical diagnoses, past medical history, surgeries and the assessment/treatment performed at the hospital. These pages were combined with medication records and discharge papers from Resident #4's hospital stay on 3/2/17 through 3/5/17. On 8/9/17 at 8:00 a.m. the medical records clerk was interviewed about another resident's documents in Resident #4's clinical record. The medical records clerk stated hospital discharge records were scanned and uploaded to computerized clinical records. The medical records clerk stated the hospital records from the previous resident must have been mixed up with Resident #4's records when scanned and imported. These findings were reviewed with the administrator, director of nursing and corporate consultants during a meeting on 8/9/17 at 4:15 p.m. 2. Resident 7's clinical record failed to include an assessment and documentation of an incident on 6/10/17 of rape allegations and involvement by the local police. Resident #7 was admitted to the facility on 11/27/15 with diagnoses that included schizophrenia, paranoia, diabetes, high blood pressure, heart disease, gastroesophageal reflux disease, depression and chronic kidney disease.	F 514	(DON/ADON) on or before 8/31/17. A 100% audit of all incidents from 6/1/17-8/22/17 were audited by the Administrator on/or before 9/11/17 to ensure that documentation of the incident and all assessments of the resident related to the incident were documented in the clinical records. A recapitulation of the incident will be documented in the resident's clinical record during the audit by 9/11/17 for any identified areas of concern. Medical Records was educated by the Corporate Nurse Consultant on 8/18/17 regarding ensuring resident's records are filed accurately. 100% of Licensed nurses were educated on/or before 9/10/17 by Staff Facilitator to review hospital discharge summary upon admission of resident to determine allergies. Allergies should be appropriately recorded in the electronic medical record and on the Admission Orders Form by the license nurse. The Admissions Director and Social Worker was educated by the Administrator on 8/23/17 to ensure that the resident's code status is appropriately and accurately recorded in the resident's records and any changes in code status are recorded and the record updated that day. Also the Social Worker was educated that code status needs to be verified and updated at least annually. The Administrator, Director of Nursing, and 100% of license nurses were inserviced by the Corporate Nurse Consultant and/or Staff Facilitator regarding ensuring that all incidents to	

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F 514	Continued From page 57 The minimum data set (MDS) dated 7/24/17 assessed Resident #7 as cognitively intact. Resident #7's clinical record documented a nursing note dated 6/10/17 stating, "Send to ER [emergency room] to eval [evaluate] & tx [treat] per [nurse practitioner]." The record documented no assessment of the resident or any information about why the resident was sent to the emergency room. The record included no hospital discharge summary or any documented rationale for the emergency room visit. On 8/9/17 at 9:30 a.m. the licensed practical nurse (LPN #1) routinely caring for Resident #4 was interviewed about why the resident was sent to the emergency room on 6/10/17. LPN #1 reviewed the record and stated she did not know why the resident was sent to the emergency room. LPN #1 stated there was "nothing in the notes" and she was not sure what prompted the emergency room visit. On 8/9/17 at 9:45 a.m. the social worker was interviewed about Resident #7's emergency room visit on 6/10/17. The social worker stated the resident called the police on 6/10/17 and stated she had been raped in the facility during the night. The social worker stated the resident was sent to the emergency room for evaluation following this allegation. The social worker did not know why the incident was not documented in the clinical record. On 8/9/17 at 9:55 a.m. the administrator was interviewed about the note on 6/10/17 indicating Resident #7 was sent to the hospital emergency room. After researching, the administrator stated on 6/10/17 the resident called the police to the	F 514	include allegations and the assessment of the resident related to the incident are documented in the medical records. All newly hired license nurses will be inserviced regarding confirming and entering resident allergies in the electronic medical record and on the Admission Orders Form as reported by family on admission/ and or per hospital discharge summary and ensuring that all incidents to include allegations and the assessment of the resident related to the incident are documented in the medical records. 10% of current residents to include residents #4, 6, 7, 12, & 13 as well as new admissions will be audited by the DON and/or ADON using a Complete/ Accurate Medical Record Quality Improvement (QI) Audit Tool to ensure resident allergies are appropriately documented by reviewing hospital discharge summary and comparing with medical record, Code Status is accurately recorded and no mis-filed records are in the chart weekly x 1 month, then bi- weekly x 1 month, then monthly x 1 month. Any discrepancies will be clarified with the family and/or physician as indicated by the DON and/or ADON during the audit. The Administrator will review and initial the Complete/ Accurate Medical Record QI Audit Tool for completion and to ensure all identified areas of concern were addressed. 10% of all incidents to include allegations will be reviewed weekly x 8 weeks then monthly x 1 month by the DON to ensure the incident was documented in the medical record along with the assessment of the	

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F 514	Continued From page 58 facility and alleged she had been raped. The administrator presented an investigation file concerning the incident on 6/10/17. This filed included a documented "head to toe" physical assessment of the resident at the time of the allegation performed by the assistant director of nursing. The file included an interview with the resident and witness statements from the staff members caring for the resident around the time of the allegation. A facility reported incident form was also documented with evidence of notification to the state agency and local authorities. This file also included the emergency room discharge summary report dated 6/10/17 documenting the hospital assessment/treatment following the allegation. On 8/9/17 at 10:40 a.m. the administrator was interviewed about why the assessment and documentation of the incident were not in the resident's clinical record. The administrator stated she reviewed the clinical record and did not find any notes or assessments regarding the incident on 6/10/17. The administrator stated the documented assessment of the resident was only in the quality assurance investigation file. The facility's policy titled Documentation (version 8/2012) stated, "It is the policy of the facility that a resident's medical record will contain...Acute episodes chart every shift for 24 hours and/or until resolved...Admission/Re-entry Summary by nursing upon admission. This summary will include ADL [activities of daily living] and skin condition..." These findings were reviewed with the administrator, director of nursing and corporate consultants during a meeting on 8/9/17 at 4:15	F 514	resident. Retraining will be conducted with the license nurse by the DON during the audit for any identified areas of concern. The Administrator will review and initial the QI Complete/ Accurate Medical Record Audit Tool for completion and to ensure all identified areas of concern were addressed. The Administrator will forward the results of the Complete/ Accurate Medical Record QI Audit Tools to the Executive Quality Improvement (QI) Committee Monthly x 3 months. The Executive QI committee will meet monthly and review the Complete/Accurate Medical Record QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

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F 514	Continued From page 59	F 514		

p.m.

3. Resident #12's clinical record documented an inaccurate resuscitation status on multiple physician order summary sheets.

Resident #12 was admitted to the facility on 1/19/12 with diagnoses that included cerebrovascular accident (stroke), depression, heart failure, anxiety and insomnia. The minimum data set (MDS) dated 7/11/17 assessed Resident #15 as cognitively intact.

Resident #12's clinical record documented a physician's order dated 2/22/17 for the resident's resuscitation status to be "Full Code." The resident's plan of care (revised 2/23/17) listed the resident's resuscitation as "CPR [cardiopulmonary resuscitation] Full Code." The resident's clinical record documented no advance directives indicating to withhold CPR in case of cardiac or respiratory cessation.

Physician order summary sheets signed by the physician in May 2017, June 2017 and July 2017 inaccurately listed the resident's resuscitation status as "DNR" (Do Not Resuscitate). The physician order summary sheets signed by the physician on 5/3/17, 6/14/17 and 7/15/17 documented the resident code status as "DNR."

On 8/10/17 at 8:30 a.m. the licensed practical nurse (LPN #2) routinely caring for Resident #12 was interviewed about the resident's resuscitation status. LPN #2 stated Resident #12 was a full code and was to get CPR if his heart or breathing stopped. When asked about the DNR orders on the signed physician order summaries, LPN #2

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F 514	Continued From page 60	F 514		

stated the resident had no advanced directives and no signed orders for DNR status. LPN #2 stated the order summary sheets came from pharmacy and she did not know why they documented Resident #12 as a DNR. LPN #2 stated the resident had a specific order dated 2/22/17 for "full code" status.

These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 8/10/17 at 11:40 a.m.

4. Resident # 13 had conflicting resuscitation orders on her clinical record.

Resident # 13 was originally admitted to the facility on 01/14/2016. Her diagnoses included, but were not limited to: Acute kidney failure, COPD (Chronic obstructive pulmonary disease), dysphagia, depression, diabetes mellitus and hypertension.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (Assessment reference date) of 05/15/2017. Resident # 13 was assessed as having a cognitive summary score of "10", indicating moderate impairment with her cognitive status.

Review of the clinical record on 08/10/2017 at approximately 9:00 a.m., showed conflicting information regarding Resident # 13's resuscitation status. The Physician order sheet dated 08/01/2017 through 08/31/2017 had orders for Resident #13 to be a DNR (Do Not Resuscitate). The care plan contained interventions listing Resident #13 as a full code. There was no paper work on the clinical record

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F 514	Continued From page 61	F 514		

indicating that Resident #13 was a DNR.

The MDS nurse, RN # 2 was at the nurse's station and was asked what the correct resuscitation status was. She stated she would find out.

During an end of of the day meeting on 08/10/2017, the DON (director of nursing) and the administrator were notified of the above information.

At approximately 12:40 p.m., the DON presented a physician's order that Resident #13 was a full code. She stated, "I don't know where that DNR order came from that was on the chart."

No further information was obtained prior to the exit conference on 08/10/2017.

5. Resident #6's allergy to Metoprolol was not updated in the clinical records.

Resident #6 was originally admitted to the facility on 2/22/16 and readmitted on 7/7/17 with, but not limited to, the following diagnoses: diabetes type two (2), peripheral vascular angioplasty, urine retention and history of Cerebrovascular disease. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/26/17 was a quarterly assessment. The resident was assessed as being a nine (9) moderately impaired in decision-making skills.

On 8/8/17 at approximately 2:20 p.m., Resident #6's clinical record was reviewed. An allergy sticker was located on the front of the clinical

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F 514	Continued From page 62	F 514		

record indicating that the resident was allergic to Metoprolol, a medication used to treat high blood pressure, and heart failure. The allergy was listed throughout the clinical record.

On 8/8/17 at approximately 2:25 p.m., a Physician's Telephone Order dated 8/6/17 and 8/7/17 was reviewed to include the following:

"8/6/17 10 pm Give Metoprolol 50 mg (milligrams) by mouth x 1 dose..."

"8/7/17 1545 (3:45) 1. Metoprolol 50 mg po (by mouth) BID (twice a day)..."

On 8/8/17 at approximately 2:30 p.m., the Medication Administration Records (MARs) were reviewed for Resident #6. Metoprolol was documented as being administered on 8/6 and again on 8/7/17 at 8:00 a.m. and again at 8:00 p.m.

On 8/8/17 at approximately 2:30 p.m., the medication nurse, who was a Licensed Practical Nurse and will be identified as LPN #1 was interviewed regarding the allergy sticker and the administration of Metoprolol. LPN #1 reviewed the MARs and the clinical record and stated, "He was given three doses, one on yesterday and 2 on today." When interviewed and asked if the resident was allergic to the medication, LPN #1 stated, He sure is."

On 8/8/17 at approximately 2:34 p.m., LPN #1 approached this Surveyor and stated, "I spoke with [Assistant Director of Nursing] named and she said the doctor does not think this is a true allergy. He took the medication and did not have a reaction to it. We are in the process of taking

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F 514	Continued From page 63 the allergy documentation off the chart. [ADON] named can explain it to you." On 8/8/17 at approximately 2:38 p.m., the ADON approached this Surveyor and stated, "The doctor d/c'd (discontinued) the order on yesterday." When interviewed and asked the reason the information was still in the clinical record, the ADON stated, "We are working on it now." On 8/9/17 at approximately 3:00 p.m., the administrative staff were made aware of the above findings.	F 514		