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 _____	R-C 09/13/2017

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 revisit to the standard survey conducted 8/8/17 through 8/10/17, was conducted on 9/13/17. No complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The census in this 120 certified bed facility was 92 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents # 101 through 111).	{F 000}		
{F 279} SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	{F 279}		10/15/17

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

Electronically Signed | 09/22/2017

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{F 279}	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop a	{F 279}	Resident #111 care plan was updated on/or before September 30, 2017 to	

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{F 279}	Continued From page 2 comprehensive plan of care for one of 11 residents in the survey sample. Resident #111 had no plan of care developed regarding use of a specialized "Rock and Go" wheelchair. The findings include: Resident #111 was admitted to the facility on 3/30/17 with diagnoses that included schizophrenia, seizures, cerebrovascular accident (stroke), diabetes and high blood pressure. The minimum data set (MDS) dated 7/7/17 assessed Resident #111 with severely impaired cognitive skills and to require the extensive assistance of two people for transfers. On 9/13/17 at 8:45 a.m. Resident #111 was observed seated in a specialized wheelchair in the hallway near the nursing station on his living unit. The back of the wheelchair was reclined. With his hands on the front wheels, Resident #111 was leaning forward in the wheelchair attempting to propel forward. The resident's feet were not supported and were approximately 5 inches from the floor. The foot rests on the wheelchair were in the up position with the left foot rest strapped up with a rubber band. The resident made repeated efforts to propel forward in the chair without any forward movement. Resident #111 was observed again on 9/13/17 at 9:30 a.m. and at 10:00 a.m. seated in the reclined wheelchair, leaning forward with his feet unsupported. The resident made repeated attempts to propel forward in the chair without success. Resident #111's clinical record documented the resident fell from the wheelchair while leaning forward on 9/6/17. A nursing note dated 9/6/17	{F 279}	reflect use of rock and go chair with interventions related to positioning of chair by Minimum Data Set (MDS) Coordinator/ Registered Nurse (RN). A 100% audit of all residents was conducted on/or before Sept. 30, 2017 by Administrative Nursing Staff (Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Quality Improvement Nurse and/or Minimum Data Set Nurse) to identify all residents who utilize a specialized chair. The careplans for each person identified was updated to reflect the use of the specialized chair with interventions to include positioning of the chair by the MDS nurse with oversight by the Director of Nursing before October 15, 2017. The interdisciplinary care plan team members (Dietary manager, MDS Coordinator, Social Services Director and Activities Director) have been re-educated by the Administrator on the requirements for completing a comprehensive care plan for each resident and ensure that specialized chairs are care planned with interventions to include positioning of the chair by October 5, 2017. An audit will be completed of 10% of care plans to include care plans for resident #111 weekly x 8 weeks then monthly x 1 month by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Quality Improvement Nurse to ensure all specialized chairs are care planned with intervention to include the positioning of the chair. The Administrator will review and initial the QI Care Plan Audit Tool weekly x 8 weeks	

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{F 279}	Continued From page 3 documented, "Resident in wheel chair at nurses station leaning forward and resident fell face first to the floor hitting left side of head on floor...no apparent injuries..." (sic) The resident was sent to the emergency room and returned to the facility the same day without injury from the fall. An occupational therapy evaluation was documented in response to the fall for review of the resident's wheelchair and positioning. An occupation therapy note dated 9/7/17 documented, "Pt [patient] appropriate for rock and go w/c [wheelchair]. Recommend to keep chair in reclined position when seated in chair and to be supervised..." Resident #111's plan of care (revised 8/8/17) documented no problems, goals and/or interventions regarding the rock and go wheelchair. The care plan documented the resident was at risk of falls due to a history of falling, impaired cognition, impaired mobility and the use of psychotropic medications. Interventions to prevent falls included, "Rock-n-go when out of bed" but included no interventions related to the positioning of the chair. On 9/13/17 at 10:15 a.m. the licensed practical nurse (LPN #1) caring for Resident #111 was interviewed about a plan of care or any instructions or settings for the rock and go chair. LPN #1 reviewed the care plan and stated the rock and go was listed as an intervention for fall prevention but there was nothing else about the chair on the care plan. LPN #1 stated the resident had used the rock and go wheelchair since his admission to the facility in March 2017. On 9/13/17 at 10:20 a.m. the rehabilitation (rehab) director was interviewed about Resident	{F 279}	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 QI Care Plan Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI Committee will meet and review the QI Care Plan 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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{F 279}	Continued From page 4	{F 279}		

#111's current positioning in the rock and go wheelchair. The rehab director stated the rock and go wheelchair was a specialized seating device and not the typical chair used with residents. The rehab director stated she had seen Resident #111 earlier today (9/13/17) and had noticed the foot rests were up and the resident was leaning forward. The rehab director stated she would get with the therapist that evaluated Resident #111 and review his positioning.

On 9/13/17 at 10:50 a.m. the occupational therapist (OT) and rehab director assessed Resident #111 while he was seated in the rock and go wheelchair. The OT stated the back of the rock and go chair was reclined too far and was not positioned as recommended. The OT stated, "He [Resident #111] is dipped way more that he is supposed to be." The OT stated the resident's feet were supposed to be on the foot rests. The OT stated after reviewing the resident, "I found him [Resident #111] super reclined today and not like he was when we evaluated him. He should be more straight up." The OT proceeded to move the back of the rock and go wheelchair to a more upright position and placed the resident's feet on the foot rests. The resident was immediately able to move the wheelchair forward on his own. When asked how the proper positioning was communicated to direct care staff, the OT stated they documented the recommendations in the clinical record and nursing was responsible for reviewing the recommendations. The rehab director stated to contact nursing regarding a plan of care about the chair.

On 9/13/17 at 11:15 a.m. the certified nurses'

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aide (CNA #1) caring for Resident #111 was interviewed about positioning the resident in the rock and go wheelchair. CNA #1 stated she had assisted Resident #111 into the rock and go chair earlier in the morning. When asked about how she positioned the chair for Resident #111, CNA #1 stated the resident was leaning forward so she reclined the back of the chair. CNA #1 stated, "I put him back like that to keep him from falling." When asked about the up position of the foot rests, CNA #1 stated, "That's just the way they [foot rests] are." CNA #1 stated she did not know anything about the rubber band being on the left foot rest. When asked if anyone had communicated or shown her how far to recline the chair or how to position the resident in the rock and go chair, CNA #1 stated, "No." CNA #1 stated she used the "care card" posted inside the resident's closet as a guide for care. Resident #111's care card documented, "Rock 'N Go - padded leg rests" but listed no instructions about reclining the chair.

On 9/13/17 at 1:20 p.m. the director of nursing (DON) was interviewed about Resident #111's inability to self-propel in the rock and go wheelchair while reclined and without foot rests. The DON stated therapy usually evaluated and made recommendations for safe seating positioning. The DON stated they usually implemented whatever therapy recommended without a getting a physician's order. The DON stated the recommendations from therapy were usually communicated to nursing verbally during meetings.

On 9/13/17 at 2:30 p.m. the registered nurse (RN #1) responsible for care plan development was interviewed about a plan of care for Resident

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{F 279}	Continued From page 6 #111's rock and go wheelchair. RN #1 stated the chair was listed as an intervention for fall prevention. RN #1 stated there were no other entries on the care plan about the chair. These findings were reviewed with the administrator and director of nursing during a meeting on 9/13/17 at 3:20 p.m.	{F 279}		
F 310 SS=D	ADLS DO NOT DECLINE UNLESS UNAVOIDABLE CFR(s): 483.24(a)(b) (a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: (1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, … (b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: (1) Hygiene -bathing, dressing, grooming, and oral care, (2) Mobility-transfer and ambulation, including walking,	F 310		10/15/17

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F 310	Continued From page 7 (3) Elimination-toileting, (4) Dining-eating, including meals and snacks, (5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide wheelchair positioning that enabled self-sufficiency for one of 11 residents in the survey sample. Resident #111 was unable to self-propel while seated in a specialized "Rock N Go" wheelchair due to improper positioning of the chair. The findings include: Resident #111 was admitted to the facility on 3/30/17 with diagnoses that included schizophrenia, seizures, cerebrovascular accident (stroke), diabetes and high blood pressure. The minimum data set (MDS) dated 7/7/17 assessed Resident #111 with severely impaired cognitive skills and to require the extensive assistance of two people for transfers. On 9/13/17 at 8:45 a.m. Resident #111 was observed seated in a specialized wheelchair in the hallway near the nursing station on his living unit. The back of the wheelchair was reclined. With his hands on the front wheels, Resident	F 310	The specialized rock and go chair for resident #111 was repositioned on 9/13/17 by the therapy director to allow the resident to self-propel. The Maintenance director made adjustments to the chair on 9/13/17 to ensure staff are not able to recline the chair to the point that resident #111 is reclined too far and unable to self-propel. An audit of 100% of residents will be conducted on/or before Sept. 30, 2017 by Administrative Nursing Staff (Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Quality Improvement Nurse and/or Minimum Data Set Nurse) to identify all residents who utilize a wheelchair or other seating device to ensure proper positioning and to identify if they are able to self-propel the chair. Any resident identified as not being able to self-propel will be referred to Occupational Therapy to screen for proper seating to ensure maximum level self-sufficiency of each resident.	

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F 310	Continued From page 8 #111 was leaning forward in the wheelchair attempting to propel forward. The resident's feet were not supported and were approximately 5 inches from the floor. The foot rests on the wheelchair were in the up position with the left foot rest strapped up with a rubber band. The resident made repeated efforts to propel forward in the chair without any forward movement. Resident #111 was observed again on 9/13/17 at 9:30 a.m. and at 10:00 a.m. seated in the reclined wheelchair, leaning forward with his feet unsupported. The resident made repeated attempts to propel forward in the chair without success. Resident #111's clinical record documented the resident fell from the wheelchair while leaning forward on 9/6/17. A nursing note dated 9/6/17 documented, "Resident in wheel chair at nurses station leaning forward and resident fell face first to the floor hitting left side of head on floor...no apparent injuries..." (sic) The resident was sent to the emergency room and returned to the facility the same day without injury from the fall. An occupational therapy evaluation was documented in response to the fall for review of the resident's wheelchair and positioning. An occupation therapy note dated 9/7/17 documented, "Pt [patient] appropriate for rock and go w/c [wheelchair]. Recommend to keep chair in reclined position when seated in chair and to be supervised..." Resident #111's clinical record documented no physician's order for a "rock and go" wheelchair. The resident's plan of care (revised 8/8/17) documented the resident was at risk of falls due to a history of falling, impaired cognition, impaired mobility and the use of psychotropic medications.	F 310	All Nursing staff Certified Nursing Assistants (CNA's), Licensed Practical Nurses (LPN's) and (RN's) have been educated by the Staff Development Coordinator on the requirements for providing proper positioning for resident's that utilize specialized seating equipment that enable the maximum level of self-sufficiency by October 15, 2017. An audit will be completed of 10% of residents to include resident #111 weekly x 8 weeks then monthly x 1 month by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Quality Improvement Nurse to ensure all residents that utilize specialized seating equipment are able to function at their highest level of self-sufficiency in mobility. The Administrator will review and initial the QI Seating 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 QI Seating Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI Committee will meet and review the QI Seating 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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Interventions to prevent falls included, "Rock-n-go when out of bed." There were no problems, goals and/or interventions in the care plan about the use of the chair or the resident's positioning in the specialized chair.

On 9/13/17 at 10:15 a.m. the licensed practical nurse (LPN #1) caring for Resident #111 was interviewed about the resident's positioning in the rock and go chair with no support for his feet. LPN #1 stated Resident #111 had been in the rock and go chair since his admission. LPN #1 stated the resident fell recently from the chair while leaning forward. LPN #1 stated since therapy evaluated the resident on 9/7/17 the back of the chair had been reclined. When asked about the resident's feet not being on the floor or on foot rests, LPN #1 stated when the back of the chair was in the up position the resident's feet were on the floor. LPN #1 stated the resident was able to self-propel in the rock and go chair. LPN #1 stated she did not know why the rubber band was on the left foot rests. LPN #1 stated she did not see a physician's order for the specialized chair.

On 9/13/17 at 10:20 a.m. the rehabilitation (rehab) director was interviewed about Resident #111's current positioning in the rock and go wheelchair. The rehab director stated the rock and go wheelchair was a specialized seating device and not the typical chair used with residents. The rehab director stated she had seen Resident #111 earlier today (9/13/17) and had noticed the foot rests were up and the resident was leaning forward. The rehab director stated she would get with the therapist that evaluated Resident #111 and review his positioning.

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On 9/13/17 at 10:50 a.m. the occupational therapist (OT) and rehab director assessed Resident #111 while he was seated in the rock and go wheelchair. The OT stated the back of the rock and go chair was reclined too far and was not positioned as recommended. The OT stated, "He [Resident #111] is dipped way more that he is supposed to be." The OT stated the resident's feet were supposed to be on the foot rests. The OT stated after reviewing the resident, "I found him [Resident #111] super reclined today and not like he was when we evaluated him. He should be more straight up." The OT proceeded to move the back of the rock and go wheelchair to a more upright position with a slight recline and placed the resident's feet on the foot rests. The resident was immediately able to move the wheelchair forward on his own. When asked how the proper positioning was communicated to direct care staff, the OT stated she documented the recommendations in the clinical record and nursing was responsible for reviewing the recommendations.

On 9/13/17 at 11:15 a.m. the certified nurses' aide (CNA #1) caring for Resident #111 was interviewed about positioning the resident in the rock and go wheelchair. CNA #1 stated she had assisted Resident #111 into the rock and go chair earlier in the morning. When asked about how she positioned the chair for Resident #111, CNA #1 stated the resident was leaning forward so she reclined the back of the chair. CNA #1 stated, "I put him [Resident #111] back like that to keep him from falling." When asked about the up position of the foot rests, CNA #1 stated, "That's just the way they [foot rests] are." CNA #1 stated she did not know anything about the rubber band on the

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left foot rest. When asked if anyone had communicated or shown her how far to recline the chair or how to position the resident in the rock and go chair, CNA #1 stated, "No." CNA #1 stated she used the "care card" posted inside the resident's closet as a guide for care. Resident #111's care card documented, "Rock 'N Go - padded leg rests" but listed no instructions about reclining the chair.

On 9/13/17 at 11:45 a.m. Resident #111 was observed in the rock and go wheelchair with his feet on the foot rests and the back of the chair with a slight recline. The resident was slowly self-propelling in the chair down the hall of his living unit.

On 9/13/17 at 1:20 p.m. the director of nursing (DON) was interviewed about Resident #111's inability to self-propel in the rock and go wheelchair while reclined and without foot rests. The DON stated therapy usually evaluated and made recommendations for safe seating positioning. The DON stated they usually implemented whatever therapy recommended without a getting a physician's order. The DON stated the recommendations from therapy were usually communicated to nursing verbally during daily meetings.

These findings were reviewed with the administrator and director of nursing during a meeting on 9/13/17 at 3:20 p.m.