STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING **01, 02** B. WING _____	R **10/06/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Description of structure: The facility is one story, noncombustible construction. Construction Type: II (000) Sprinkler status: Fully Sprinklered, with standard response sprinkler heads. An unannounced Life Safety Code revisit to the standard survey conducted on 09/13/2017 and 09/14/2017 was conducted on 10/06/2017, in accordance with 42 Code of Federal Regulation, Part 483: Requirements for for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Health Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B. Description of structure: The facility is one story with a partial basement, noncombustible construction. Patients are located on the main floor only. Construction Type: II (000) Sprinkler status: Fully Sprinklered, with standard response sprinkler heads. An unannounced Life Safety Code revisit to the standard survey conducted on 09/13/2017 and 09/14/2017 was conducted on 10/06/2017, in accordance with 42 Code of Federal Regulation, Part 483: Requirements for for Long Term Care Facilities. The facility was surveyed for	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING **01, 02** B. WING _____	R **10/06/2017**

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{K 000}	Continued From page 1 compliance using the LSC 2012 Health Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.	{K 000}		