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 02/14/2018

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 abbreviated standard survey conducted 1/3/18 through 1/4/18 was conducted 2/13/18 through 2/14/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. No complaints were investigated during the survey. The census in this 120 certified bed facility was 84 at the time of the survey. The survey sample consisted of ten current resident reviews (Residents 101 through 110).	{F 000}		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for one of 10 residents in the survey sample. Five doses of Resident #102's insulin were not given as ordered by the physician. The findings include:	F 684	Resident #102's physician was contacted on 2/13/18 and an order was obtained to hold insulin for blood sugar readings less than 110. An audit was conducted by the DON, ADON, Treatment nurse and Staff Development Coordinator on 2/13/18 of	2/23/18

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

Electronically Signed | 02/21/2018

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F 684	Continued From page 1 Resident #102 was admitted to the facility on 1/21/16 with a re-admission on 1/12/18. Diagnoses for Resident #102 included diabetes, pneumonia, epilepsy and chronic obstructive pulmonary disease. The minimum data set (MDS) dated 1/18/18 assessed Resident #102 as cognitively intact. Resident #102's clinical record documented physician orders dated 1/13/18 for the following insulin: Novolog 12 units to be administered each day at breakfast and lunch and Novolog 30 units to be given each day at dinner. Resident #102's medication administration record (MAR) documented the prescribed insulin was not given on the following dates and times as ordered: Novolog 12 units - not given at lunch on 2/7/18, 2/8/18 and 2/9/18. Novolog 30 units - not given at dinner on 2/6/18 and 2/9/18. Nurse notes on the back of the MAR documented the insulin was held on 2/7/18 at lunch due to the resident's blood sugar reading of 108. A note dated 2/8/18 documented the insulin was held at lunch due to a blood sugar reading of 64. A note dated 2/9/18 documented the insulin was held at dinner due to a blood sugar reading of 97. There was no documentation indicating why the insulin on 2/9/18 was held at lunch. The clinical record documented no physician's order to hold Resident #102's insulin or any documented parameters of when to hold and/or notify the physician.	F 684	all residents receiving short-acting insulin to ensure orders were in place to indicate when to hold the short acting insulin. The physician was contacted and gave an order to hold short acting insulin for any insulin dependent diabetic whose blood sugar reading is less than 110 and follow hypoglycemic protocol. All Nurses (RN's and LPN's) will be educated by the SDC on ensuring orders are present for when to hold insulin on or before 2/23/18. Any nurses not educated by this date will not be permitted to work until they are educated. The Administrative Nurses (DON, ADON, SDC, Quality Improvement nurse) will review orders during clinical meeting to ensure ongoing compliance that residents with short acting insulin have orders to indicate when to hold insulin based on blood sugar readings.	

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F 684	Continued From page 2 On 2/13/18 at 2:30 p.m., the licensed practical nurse (LPN #2) that held the doses of insulin as listed above was interviewed. LPN #2 stated, "Some orders will say to hold [insulin] if the blood sugar is under 130." LPN #2 reviewed Resident #102's clinical record and stated she did not see an order regarding holding the insulin. LPN #2 stated she felt if she gave Resident #102 insulin with low blood sugars, his sugar would "bottom out" and it was hard to get his blood sugar back to normal. When asked again about an order to hold the insulin or an order providing parameters for not giving the insulin, LPN #2 stated she did not see an order to hold the insulin. The Nursing 2017 Drug Handbook on page 789 and 790 describes Novolog as a rapid-acting insulin used to improve glycemic control for patients with diabetes. Listed under alerts for patients taking insulin on page 794, "Caution patient not to stop insulin abruptly or change amount taken without consulting prescriber..." (1) This finding was reviewed with the administrator on 2/13/18 at 4:00 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		2/23/18

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F 842	Continued From page 3	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 4 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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: Based on staff interview and clinical record review, facility staff failed to ensure an accurate clinical record for one of 10 residents in the survey sample. Resident #101's medication administration record (MAR) entry for Vitamin D3 documented an inaccurate number of tablets to be administered. The findings include: Resident #101 was admitted to the facility on 4/10/17 with a re-admission on 1/9/18. Diagnoses for Resident #101 include dementia, epilepsy, vitamin D deficiency and gastroesophageal reflux disease. The minimum data set (MDS) dated 12/15/17 assessed Resident #101 with severely impaired cognitive skills.	F 842	Resident 101 was receiving the correct dosage of medication/ Vitamin D as the pharmacy sent 1000 IU tabs and 2 tablets were required to obtain the ordered 2000 IU dose. On 2/13/18 the Medication Administration Record was re-written so that the Vitamin D indicated to administer 2 of the 1000 IU tabs daily. On 2/13/18 an audit was conducted by the ADON and SDC to ensure all residents receiving Vitamin D have the MAR written to indicate the dosage received from the pharmacy and how many tablets to give to obtain the ordered dose. No other concerns were identified. All licensed nurses (RN's and LPN's) will	

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F 842	Continued From page 5 Resident #101's clinical record documented a physician's order dated 1/9/18 for Vitamin D3 2000 units to be administered each daily for treatment of vitamin deficiency. The Vitamin D3 order entry on Resident #101's MAR for February 2018 listed the dosage of 2000 units per day as ordered by the physician but also included a handwritten note stating, "give 2." The MAR documented the Vitamin D3 was given each day at 8:00 a.m. On 2/13/18 at 2:45 p.m., the licensed practical nurse (LPN #1) administering medications routinely to Resident #101 was interviewed. LPN #1 stated the resident was given 2000 units each day as ordered. LPN #2 pulled the resident's supply of Vitamin D3 from the medication cart and stated the pharmacy supplied the Vitamin D3 in 1000 unit tablets so the resident was administered two tablets to meet the 2000 unit dose ordered. LPN #2 stated she did not write the note "give 2" on the MAR and the note was not correct. LPN #2 stated the "give 2" referred to giving two 1000 unit tablets as provided by the pharmacy but should not have been added to the 2000 units order. LPN #2 stated she always gave the resident 2000 units of Vitamin D3 as ordered. LPN #2 stated the MAR note was in error. This finding was reviewed with the administrator on 2/13/18 at 4:00 p.m.	F 842	be educated by the SDC on or before 2/23/18. Any nurses not educated by this date will not be permitted to work until they are educated. Education will include how to clarify an order on the MAR –i.e. not alter the typed MAR, they should discontinue the current order and clarify and re-write the correct order including dosage on the current MAR. The Administrative nurses will (DON, ADON, SDC, QI nurse) will review orders during clinical meeting and conduct audits of the MAR (medication administration record) to ensure they are transcribed correctly and match the dosage of medication received from the pharmacy.	