Printed 09/29/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 09/15/2016

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

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F 000	INITIAL COMMENTS	F 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

An unannounced Medicare/Medicaid standard survey was conducted 09/13/16 through 09/15/16. Four complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 180 certified bed facility was 167 at the time of the survey. The survey sample consisted of 23 current Resident reviews (Residents #1 through #23) and 6 closed record reviews (Residents #24 through #29).

F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176	1. Resident #14 no longer self-administers medications. 2. Current residents who self-administer medications will be reviewed to ensure interdisciplinary assessment for ability to self-administer is complete. Corrections were made as necessary on 9/14/16. 3. Licensed nursing staff were	10/13/16

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This Requirement is not met as evidenced by:
Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide the self-administration of medication assessment for 1 of 29 residents (Resident #14).

The findings included:

The facility staff failed to provide the assessments for Resident #14's self-administration of eye drops (moisturizing).

The surveyor reviewed Resident #14's clinical record on 9/13/16 and 9/14/16. Resident #14 was admitted to the facility 8/17/14 and readmitted 1/13/16 with diagnoses that included

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

Administrator 10/10/16

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.

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F 176	Continued From page 1 but not limited to unspecified dementia without behavioral disturbances, glaucoma, left eye prosthesis, obstructive sleep apnea, chronic pain syndrome, Type 2 diabetes mellitus, unspecified psychosis, rheumatoid arthritis, depressive disorder, insomnia, gastroesophageal reflux disease, bipolar disorder, and mixed conductive and sensorineural hearing loss Resident #14's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/30/16 assessed the resident with a brief interview for mental status as 13 out of 15. The current comprehensive care plan created on 8/5/15 read "The resident has a physician's order for (unsupervised) self-administration of the following medications: eye drops (moisturizing). Goal: The resident will take medications safely and as prescribed through the review date. Interventions: Assess resident's ability to safely self-administer medications specified on admission/re-admission, quarterly, with change in medication orders and with significant changes in condition. Demonstrate correct administration as required. Review each med (medication) as necessary with the client. Rsd (resident) will keep medication in lockbox when not in use." The surveyor reviewed the clinical record both electronically and paper and was unable to locate the assessment forms for Resident #14's self-administration of eye drops and informed the administrator on 9/13/16 at 4:30 p.m. The surveyor interviewed the resident on 9/14/16 at 7:20 a.m. The resident stated the nursing staff started administering the eye drops again as her vision had worsened.	F 176	educated regarding policy for self-administration of medications. Residents who self-administer medications will be re-assessed quarterly to determine if continuation is appropriate. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10/13/16	

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The surveyor interviewed licensed practical nurse #3 on 9/14/16 at 11:30 a.m. L.P.N. #3 stated Resident #14 no longer administered the eye drops. L.P.N. #3 stated nursing started administering the eye drops as her eyesight had worsened.

The surveyor informed the administrator, director of nursing, the assistant director of nursing, and the corporate registered nurse of the above finding on 9/14/16 at 4:00 p.m.

The administrator stated the assessment for the self-administration of Resident #14's medication had been done but she could not locate the assessment. The administrator stated she knew the assessment had been done because the administrator had to sign the form. She stated she remembered because the facility did so few of the self-administration of medication assessments.

The surveyor requested the facility policy for self-administration of medications from the corporate registered nurse on 9/15/16.

The facility policy titled "Self-Administration of Medication at Bedside Effective Date 2/01/15" read "POLICY: A licensed nurse will assess patient's ability to self-administer medication. PROCEDURE: 1.The patient may request to keep medications at bedside for self-administration in a lock box. 2. Verify physician's order in the patient's chart for self -administration of specific medications under consideration. 3. Complete Self-Medication Request/Evaluation form. 4. The Interdisciplinary Team will review the assessment and will document during care plan. 5. Complete the Care Plan for approved self-administered drugs.

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F 176	Continued From page 3 6. Self-administration of meds must be reviewed by the Interdisciplinary Team quarterly and PRN (whenever needed) if change in status is noted (i.e. a new MDS or during an acute episode of illness such as the flu in which it would be necessary for the nursing staff to administer the medications for a temporary period of time). 7. Medications that are ordered by a physician to be self-administered will be identified on the MAR (medication administration record). 8. A licensed nurse will monitor and chart self-administered drugs, and will monitor for proper storage on each med pass. 9. When a patient becomes unable to self-administer meds, it must be brought to the attention of the appropriate staff via Shift Report 10. When a patient is unable to self-administer medication, the meds will be given by nursing staff until the patient can be reassessed by the Interdisciplinary Team." The surveyor informed the administrative staff of the above concern during a meeting on 9/15/16 at 12:00 noon. No further information was provided prior to the exit on 9/15/16	F 176		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, staff interview, and clinical	F 323	1. Resident #9's bed alarm has been discontinued on 9/14/16. 2. Current residents with bed alarm devices in use for fall prevention were reviewed to ensure use per plan of care. Corrections were made as necessary. 3. Licensed nursing staff were educated regarding use of bed	10/13/16

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F 323	Continued From page 4	F 323		

record review, the facility staff failed to ensure a hazard free environment for 1 of 29 residents (Resident #9). The facility staff failed to ensure Resident #9's bed alarm was attached to the bed and the resident

The findings included

The facility staff failed to ensure Resident #9's bed alarm was attached while the resident was in bed.

The clinical record of Resident #9 was reviewed 9/13/16 and 9/14/16. Resident #9 was admitted to the facility 7/6/11 and readmitted 5/10/16 with diagnoses that included but not limited to schizophrenia, delusional disorder, glaucoma, chronic pain, urinary tract infection, Type 1 diabetes mellitus, gastroesophageal reflux disease, chronic kidney disease, sepsis, enlarged prostate, Non-ST elevation, hypertension, hemiplegia, anxiety, insomnia, and dysphagia.

Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/1/16 assessed the resident with a brief interview for mental status as 14 out of 15. No concerns were assessed with delirium or psychosis.

The current comprehensive care plan identified the focus area that stated Resident #9 had an actual fall with increased risk for further falls r/t (related to) hx (history of) falls, gait/balance problems, incontinence- created on 7/9/14 with a revision date on 9/30/16. Interventions listed in part included "bed and chair alarms-created on 7/1/16."

The surveyor observed Resident #9 during the

alarm devices for fall prevention per plan of care. Nursing leadership will review devices in use by making 5 observations per day, 5 days per week for 8 weeks, then 5 observations per week for 4 months to ensure in place per plan of care. Any issues will be corrected immediately at the time of identification.

4. Process will be reviewed in QA committee for two quarters.
5. 10/13/16

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F 323	Continued From page 5 initial tour on 9/13/16 around 10:30 a.m. Resident #9 was observed on 9/14/16 at 7:35 a.m. in bed. No alarms were observed at that time. The surveyor observed Resident #9 at breakfast. The resident was in bed, head of bed elevated, eating breakfast. No alarm was observed. The surveyor observed Resident #9 again on 9/14/16 at 2:30 p.m. The resident was in bed; however, no bed alarm was observed. The surveyor interviewed registered nurse #2 at this time and asked where the bed alarm was placed. R.N. #2 walked around the bed and checked under the resident but was unable to locate any alarm. R.N. #2 stated the resident doesn't usually get out of bed. She stated she was unable to locate the bed alarm. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above finding on 9/14/16 at 4:00 p.m. No further information was provided by the facility regarding the failure to utilize the bed alarm for Resident #9 per the comprehensive care plan.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	1. Resident #5 has been seen by the podiatrist. Resident #14's oxygen is being administered as ordered by the physician. 2. Current residents with active physician orders for oxygen were reviewed to ensure in use per physician order. Corrections were made as necessary. Current residents	10/13/16

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This Requirement is not met as evidenced by:
Based on observation, staff interview and clinical record review it was determined the facility staff failed to follow physician's orders for 2 of 29 residents (Residents #5 and #14.)
-Failed to provide Resident #5 with podiatry services when needed.
-Failed to follow Resident #14's physician's orders for oxygen administration.

Findings:

1. Resident #5 was admitted to the facility on 3/15/16. Her diagnoses included: hypertension, arthritis, anxiety and depression. The resident's clinical record was reviewed on 9/14/16 at 9:00 AM.

Resident #5's MDS (minimum data set) dated 8/19/16 documented the resident had significant cognitive impairment. The resident required staff assistance for all the ADLs (activities of daily living.)

This resident's CCP (comprehensive care plan) reviewed and revised on 9/14/16 documented Resident #5 had the following care issues:
1. ADLs - Lack of ADL self-care performance deficit r/t/ Limited mobility and ROM (range of motion.) The interventions included the staff assisting this resident with all the basic ADL care, to include personal hygiene/oral care. No specifics were provided as to any type of nail care.
2. The resident has a terminal prognosis r/t dementia. Resident admitted to hospice care on 8/9/16. The interventions included working with the hospice team as ordered to ensure the were observed to determine the need for podiatric care. Residents in need were placed on list to be seen by the podiatrist.
3. Licensed nursing staff were educated regarding following physician orders for oxygen. Nursing staff was educated regarding toenail care and notification of podiatry as needed. Nursing leadership will make 5 observations per day, 5 days per week for 8 weeks, then 5 observations per week for 4 months in regards to both toenails and oxygen settings. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for two quarters.
5. 10/13/16

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resident's spiritual, emotional, intellectual, physical and social needs are met.

The hospice CCP, dated 8/9/16, was reviewed. No specific mention of nails was made in the hospice care plan.

Resident #5's physician orders, signed and dated 3/15/16, included an order for a podiatrist consult (as needed.)

On 9/14/16 at 2:00 PM, LPN I was observed while changing the dressings on Resident #5's right foot and sacrum. The resident was observed to have long ragged toenails on both feet. LPN I told the surveyor she thought the podiatrist had been declined on his last trip to see the resident.

Resident #5 was asked about her long toenails (if they had been trimmed) and she stated, "They have a doctor coming to do that-- But, they said it may take awhile."

The documentation in Resident #5's clinical record did not indicate this resident had ever (previously) been scheduled for a podiatry consult or that one had been obtained and she had turned it down. There was no current/upcoming appointment on the calendar for this resident.

On 9/14/16 at 4:30 PM the facility administrator, DON (director of nursing) and the CNC (corporate nurse consultant) were informed of the surveyor's findings.

On 9/15/16 at 9:30 AM the CNC told the surveyor they had looked at Resident #5's toenails. The CNC said the resident's nails were so thick the staff did not have anything to cut them.

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No additional information was provided prior to the survey team exit.
2. The facility staff failed to follow physician orders for the administration of oxygen for Resident #4.

The clinical record of Resident #4 was reviewed 9/13/16 and 9/14/16. Resident #4 was admitted to the facility 3/31/15 and readmitted 2/26/16 with diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, atrial fibrillation, cerebrovascular disease, Vitamin D deficiency, hypertension, mood disorder, urinary tract infection, anxiety, obesity, depressive disorder, gastroesophageal reflux disease, dorsalgia, hypokalemia, insomnia, pneumonia, and chronic pain.

Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/3/16 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Cognitive Summary. Section O Special Treatments, Procedures and Programs revealed Oxygen therapy was marked.

The August 2016 physician orders provided by the facility read "Oxygen therapy at 4 liters per minute via nasal cannula every shift for SOB (shortness of breath)."

The surveyor observed Resident #4 at various times during the survey from 9/13/16 through 9/15/16. During the initial tour on 9/13/16 at 10:30 a.m., Resident #4 was observed in bed with oxygen at 2 liters per nasal cannula. Resident #4 was observed again on 9/14/16 at 7:20 a.m. in bed with oxygen at 2 liters per nasal cannula. The oxygen concentrator was observed on the left side of the bed. Resident #4 stated

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F 328	Continued From page 9 she could not use the left hand/arm. The surveyor observed Resident #4 on 9/14/16 at 11:05 a.m. The resident was in bed, eyes closed. The oxygen concentrator was set at 2 liters per nasal cannula. Resident #4 was observed on 9/14/16 at 1:20 p.m. The resident was in bed with the oxygen concentrator set at 2 liters per nasal cannula. The surveyor asked licensed practical nurse #3 to confirm the amount of oxygen Resident #4 was receiving via the nasal cannula. L.P.N. #3 stated the oxygen concentrator was set at 2 liters. The surveyor informed L.P.N. #3 the physician order was 4 liters per nasal cannula. L.P.N. #3 asked the resident how she felt. Resident #4 stated she was a little short of breath. L.P.N. #3 adjusted the liters from 2 to 3. The oxygen saturation levels were reviewed. The last oxygen saturation level was obtained on 9/1/16 at 3:32 a.m. The summary did not specify the liters of oxygen. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above finding on 9/14/16 at 4:00 p.m. No further information was provided prior to the exit conference on 9/15/16.	F 328		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363	1. Resident #3 currently is receiving meal tray items based on dietary meal ticket. 2. Current residents were reviewed to ensure meal tray items served are according to	10/13/16

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F 363	Continued From page 10 and be followed. This Requirement is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide dietician approved menus for facility residents for 1 of 29 residents in the survey sample (Residents #3). 1. The facility staff failed to provide the items listed on the diet ticket for Resident #3 and provided foods on the tray not listed on the tray ticket. The clinical record of Resident #3 was reviewed 9/13/16 and 9/14/16. Resident #3 was admitted to the facility 9/5/07 and readmitted 6/4/16 with diagnoses that included but not limited to abnormal weight loss, adult failure to thrive, chronic pain, gastroesophageal reflux disease, depressive disorder, encephalopathy, cerebrovascular disease, vascular dementia with behavioral disturbances, dysphagia, hypertension, and urinary tract infection. Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/13/16 assessed the resident with a cognitive summary score of 01 out of 15. Resident #3 was assessed to need supervision of one person for eating and assessed to have impairments in functional range of motion in both upper and lower extremities. Resident #3's current comprehensive care plan created 6/4/16 and revised 7/10/16 identified that the resident was at risk for weight fluctuation due to recent hospitalization and recent admission to center, pureed diet d/t (due to) dysphagia.	F 363	dietary meal ticket. Corrections were made as necessary. 3. Dietary staff will be educated regarding accuracy of meal tray items based on meal tickets. Dietary staff will compare meal trays to tickets during tray line to ensure accuracy. Any issues will be addressed immediately at the time of identification. Unit managers and dietary leadership will make 5 observations per day, 5 days per week for 8 weeks, then 5 observations per week for 4 months to ensure implementation. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10/13/16	

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Interventions Provide pureed diet as ordered Monitor intake and record each meal. Offer substitute when intake less than 50%, weights as ordered.

The September 2016 physician orders identified Resident #3 was ordered a regular diet pureed texture, regular liquids consistency, superfoods/206 juice breakfast/house shake.

The surveyor observed Resident #3 on 9/14/16 at 8:20 a.m. Resident #3 was observed in bed, head of the bed elevated. Breakfast tray was positioned on the over the bed table. The surveyor reviewed the diet ticket. The diet ticket read "Puree/Superfoods." Items on the ticket were pureed strawberries, yogurt, pureed Belgian waffle, margarine, syrup, pureed sausage patty, whole milk, 206 juice, sugar, gravy in bowl on side, pepper. The surveyor observed the food on Resident #3's tray-pureed strawberries, pureed Belgian waffle, pureed sausage, and scrambled eggs. The tray did not contain these food items as per the ticket: yogurt, 206 juice, and gravy in bowl on the side. Included on the tray but not on the ticket were scrambled eggs.

The surveyor spoke with the activity assistant #1 when she entered Resident #3's room. The activity assistant #1 was informed that the tray did not have the juice, gravy, or yogurt as listed on the ticket and that Resident #3 had scrambled eggs not on the ticket. L.P.N. #4 entered the room at this time and L.P.N. #4 was informed of the food concerns. The activity assistant #1 stated she would get the juice.

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the

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F 363	Continued From page 12 above finding on 9/14/16 at 4:00 p.m. The surveyor requested to interview the dietary aide who read the ticket for the cook to plate the food. The surveyor was unable to interview the dietary aide but did interview the corporate registered dietician (RD) on 9/15/16 at 7:50 a.m. The corporate RD stated the ticket goes down the line. There were 5 different positions. The corporate RD stated the 206 juice had been pulled the previous night but the juice was still frozen. The dietary aide couldn't send it out because it was still frozen. She was trying to thaw the 206 juice under cool water. The corporate RD stated she had no explanation for the bowl of gravy not on the tray or the yogurt. The corporate registered dietician stated the eggs were an idea from the previous manager. The previous manager had told dietary staff to put the eggs on pureed trays so the tray would have a "better presentation." No further information was provided prior to the exit conference on 9/15/16.	F 363		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	1. Resident #5 is currently receiving care following standards of practice for infection control. 2. Current residents with wounds to lower extremities were observed to ensure dressings are clean, intact, and that extremity is covered to protect dressing. Corrections were made as necessary.	10/13/16

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F 441	Continued From page 13 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: Based on observation, staff interview, facility documents and clinical record review, it was determined the facility staff failed to follow standard infection control protocols with regards to wounds/daily hygiene requirements for 1 of 29 residents (Resident #5.) Findings: Resident #5 was admitted to the facility on 3/15/16. Her diagnoses included: hypertension, arthritis, anxiety and depression. The resident's clinical record was reviewed on 9/14/16 at 9:00 AM.	F 441	3. Nursing staff were educated regarding infection control practices related to protection of lower extremity wounds covered by dressings. Residents with wounds to lower extremities covered by dressings will be observed daily by nurses to ensure clean, intact, and covered. Nursing leadership will observe 5 residents with wounds weekly. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10/13/16	

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Resident #5's MDS (minimum data set) dated 8/19/16 documented the resident had significant cognitive impairment. The resident required staff assistance for all the ADLs (activities of daily living.) The MDS indicated the resident had a Stage III pressure ulcer 3.5 cm x 3.0 cm x 0.2 cm (depth.)

This resident's CCP (comprehensive care plan) reviewed and revised on 6/22/16 and 9/14/16 documented Resident #5 had the following care issues:
1. The resident has actual skin impairment: pressure ulcer to right heel (stage III) and sacrum (stage II) ..... The goal was for the resident to develop clean and intact skin by the review date. The interventions included educating the resident/family/caregivers of causative factors and measures to prevent skin injury.
2. ADLs - Lack of ADL self-care performance deficit r/t/ Limited mobility and ROM (range of motion.) The interventions included the staff assisting this resident with all the basic ADL care to include personal hygiene/oral care.
3. The resident has a terminal prognosis r/t dementia. Resident admitted to hospice care on 8/9/16. The interventions included working with the hospice team as ordered to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met.

Resident #5's physician orders, signed and dated 8/7/16, included an order for a pressure ulcer treatment to the right heel, "Apply to right heel topically for pressure wound. Clean right heel with NS (normal saline) and apply aquaseal, cover with abdominal pad then wrap with kling. AND apply to right heel topically as needed for wound care every day shift for wound care."

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On 9/14/16 at 1:05 PM the resident was observed seated in the dining room. The resident was in a geri-chair that had the bottom foot rest flipped back under the chair--so it did not support the resident's feet. The resident's right foot was observed to be bare, except for the dressing wrapped around it -- and was resting on the floor. The resident's left foot, with a sock on it, was also resting on the floor.

The right foot protruding from beneath the dressing was observed to be swollen and the resident's toenails were long and ragged. The resident was asked if her feet were cold or hurting. Resident #5 denied her feet were cold or painful.

A CNA came to remove the resident from the dining room and did not replace the foot lift on the chair prior to doing so. The surveyor observed the resident being pushed down the hallway with both feet dragging the floor. The CNA then left the resident in the living room area with her feet still on the floor.

On 9/14/16 at 1:50 PM the surveyor revisited the living room and Resident #5 was still in there with both feet, the right one bandaged, on the floor. The resident was then moved to her bedroom by a nursing staff member-- with both feet dragging the floor the entire way back to her room.

On 9/14/16 at 2:00 PM, LPN I was observed while changing the dressings on Resident #5's right foot and sacrum. The resident's right foot dressing was dirty and did not have a date on it for the previous day. LPN I explained the resident would move around and sometimes the dressing would come off.

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F 441	Continued From page 16 LPN I stated, "I changed it yesterday and I dated the dressing on her right foot. Someone else must have replaced it for some reason and they did not date it." On 9/14/16 at 4:30 PM the facility administrator, DON (director of nursing) and the CNC (corporate nurse consultant) were informed of the surveyor's findings On 9/15/16 at 9:30 AM the CNC provided the surveyor with the facility policy regarding wound care. The policies, dated 2/1/15 did not include any directive to facility staff with regards to allowing a resident's bare feet to sit directly on or drag across the facility floor. In reference to that, the CNC stated, "I think that should just be common sense." No additional information was provided prior to the survey team exit.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by:	F 514	1. Resident #26 no longer resides in the facility. Nurse practitioner was notified of verbal order transcription error for antibiotic for Resident #4 on 9/14/16. No new orders received. Resident #12's current bowel movement records are accurate. 2. Current residents receiving IV fluids were reviewed to ensure MD has been notified for any complications. Current residents with active antibiotic	10/13/16

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F 514	Continued From page 17 Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to maintain a complete and accurate clinical record for 3 of 29 residents (Resident #26, Resident #4, and Resident #12). The findings included: 1. The facility staff failed to document when the physician was informed that the facility was unable to start intravenous therapy for Resident #26 as ordered on 3/30/16 and failed to write an order given by the physician to "push fluids" on 3/30/16. The clinical record of Resident #26 was reviewed 9/13/16 and 9/14/16. Resident #26 was admitted to the facility 3/17/14 and readmitted 4/7/16 with diagnoses that included but not limited to hypertension, type 2 diabetes mellitus, depressive disorder, insomnia, anemia in chronic kidney disease, urinary tract infection, cough, altered mental status, anxiety, gastroesophageal reflux disease, mood, sepsis, bladder disorder, chronic pain, and bipolar disorder. Resident #26's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/25/16 assessed the resident with a cognitive summary score of 15 out of 15. The annual MDS with an ARD of 4/20/16 assessed the resident with a cognitive summary score of 14 out of 15. The physician order dated 3/30/16 read "D5NS (dextrose 5 normal saline) @ (at) 50 ml/hr (milliliter/hour) x 1 L (liter)." The progress note dated 3/30/16 at 12:28 read "MD (medical doctor) #1 in and observed rsd (resident) this shift also reviewed recent labs. New orders for D5NS @50	F 514	orders were reviewed to ensure orders were transcribed accurately. Current residents were reviewed to ensure bowel movements have been recorded accurately. Corrections were made as necessary. 3. Nursing staff were educated regarding policy and procedures for IV management, physician order transcription, and bowel movement documentation requirements. Charge nurses will notify MD immediately for complications with intravenous sites – nursing administration will monitor new orders 5 days per week for 6 months. Nursing leadership will review new orders and bowel movement records daily 5 X weekly for 6 months to ensure antibiotic orders and bowel movements have been transcribed/documented accurately. Any issues will be addressed immediately at the time of identification.	

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F 514	Continued From page 18 ML/hr 1L and Keflex 500 mg tid (three times a day) x 10 days. RP (responsible party) notified and stated she doesn't want her on Keflex she has an intolerance to it (she gave an example that the last time momma was on it she was putting her straw in her drink upside down and seemed confused) MD #1 notified and Keflex d/c-ed (discontinued). RP requests that nephrologist name (omitted) be notified and order meds for UA (urinalysis). We are currently awaiting culture initial UA sent to nephrolcgist with no new orders at this time. MD #1 aware." Progress note dated 3/30/16 at 20:30 (8:30 p.m.) read "MD notified of multiple failed attempts to start an IV (intravenous); gave order to push fluids. RP in to visit rsd (resident) this shift and voiced concerns of not being able to have IV fluids started. RP requested that rsd be sent to the ED (emergency department) for IV to be placed. MD #2 notified of family's request and gave order to send to ED. VS (vital signs) 128/62 (blood pressure) 77 (pulse) 18 (respirations) 97.2% (oxygen saturation) on RA (room air). Rsd left facility at approximately 8:00 p.m. via ambulance transport. RP aware." The surveyor interviewed the assistant director of nursing on 9/15/16 at 10:00 a.m. The ADON stated the physician should have been informed initially after several IV attempts that the IV could not be started. The ADON stated the nurse who entered the order for the IV was a "desk nurse" who entered orders into the computer most of the day. The ADON stated the order for the normal saline IV was entered around 3:00 p.m. From 12:28 p.m. when the physician was documented to have seen the resident until 8:30 p.m. when L.P.N. #7 notified the physician that the facility staff was unable to start an IV, 8 hours lapsed.	F 514	4. Process will be reviewed in QA committee for two quarters. 5. 10/13/16	

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Between those times, the facility staff had failed to document the number of attempts made to start an IV the location where the IV attempts were made, notification to the MD of the failure to start the IV or written the physician order to "push fluids" as documented in the 3/30/16 20:30 (8:30 p.m.) progress note.

The surveyor interviewed licensed practical nurse #7 on 9/15/16 at 10:10 a.m. and the assistant director of nursing. L.P.N. #7 stated after reviewing the documentation written on 3/30/16 at 8:30 p.m. that she should have written when she attempted the IV and how the staff pushed fluids She stated anytime a staff would go by the resident's room, they would offer fluids. She stated "She loved Pepsi." L.P.N. #7 stated MD #1 always calls between 4:30 p.m. and 5:00 p.m. and "I'm sure I gave him an update but I didn't document that."

The surveyor interviewed the unit manager registered nurse #1 on 9/15/16 at 10:52 a.m. R.N. #1 stated the order was given around 12:30 p.m. or 1:00 p.m. for the IVs. She stated she attempted to start the IV x2 or maybe one additional attempt. Another nurse (R.N. #3) attempted to start the IV before she left at 4:30 p.m.

None of the above attempts to start the IV on Resident #26 were documented in the clinical record.
The surveyor reviewed the facility's IV therapy policy titled "Peripheral IV Site Management." The policy read in part "5. If complications are observed, the licensed nurse will immediately contact the physician and follow physician orders. Problem (s), interventions, and orders are to be completely, accurately, and timely documented in

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the patient's medical record."

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the failure to document IV concerns and to transcribe a telephone order to push fluids on Resident #26 in an end of the day meeting on 9/15/16 at 12:10 p.m

No further information was provided prior to the exit conference on 9/15/16

This is a complaint deficiency.

2. The facility staff failed to transcribe the verbal order as obtained from the physician accurately to the clinical record for Resident #4.

The clinical record of Resident #4 was reviewed 9/13/16 and 9/14/16. Resident #4 was admitted to the facility 3/31/15 and readmitted 2/26/16 with diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, atrial fibrillation, cerebrovascular disease, Vitamin D deficiency, hypertension, mood disorder, urinary tract infection, anxiety, obesity, depressive disorder, gastroesophageal reflux disease, dorsalgia, hypokalemia, insomnia, pneumonia, and chronic pain.

Resident #4 s quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/3/16 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Cognit ve Summary

The progress note dated 8/27/16 at 21:35 (9:35 p.m.) read "Other #2 (FNP-family nurse practitioner) called unit and ordered Macrobid 100

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mg bid (twice a day) x's 7 days for UTI (urinary tract infection). Resident own RP (responsible person) and made aware." The amount of Macrobid ordered was 14 doses.

The 8/27/16 physician order dated 8/27/16 read 'Macrobid capsule 100 mg (milligram) Give 100 mg by mouth every morning and at bedtime for uti until 09/03/2016 at 23:59." The amount ordered was 15 doses.

The August 2016 and September 2016 eMARs documented fifteen doses of Macrobid administered.

The surveyor interviewed licensed practical nurse #5 on 9/15/16 at 8:15 a.m. L.P.N. #5 stated the nurse practitioner gave her the order for Macrobid 100 mg twice a day for 7 days. She stated she gave one Macrobid that evening.

The surveyor interviewed the assistant director of nursing on 9/14/16 at 11:25 a.m. The ADON stated she spoke with the nurse practitioner who gave the order. The nurse practitioner had told L.P.N. #5 if Macrobid was in the stat box to go ahead and give one and then continue with the medication twice a day for 7 days. L.P.N. #5 did not inform the surveyor of that statement made by the nurse practitioner and that order was not included in the progress note documentation.

L.P.N. #5 failed to write the order for the stat dose of Macrobid administered 8/27/16 at 8:00 p.m.

The facility administrative staff were informed of the discrepancy in transcription of the physician orders for Macrobid in an end of the day meeting on 9/14/16 at 4:00 p.m.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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No further information was provided prior to the exit conference on 9/15/16.
3. For Resident #12, the facility staff failed to keep an accurate record of the Resident's BM's (bowel movements). The clinical record indicated the Resident did not have a BM from 08/16-08/25/16.

The record review revealed that Resident #12 was admitted to the facility 12/15/12. Diagnoses included, but were not limited to, dementia with behaviors, insomnia, iron deficiency anemia, and atherosclerotic heart disease.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/07/16 included a BIMS (brief interview for mental status) score of 7 out of a possible 15 points. Section H (bladder and bowel) was coded (2) to indicate the Resident was frequently incontinent of bowel.

A review of the Resident's physician's order summary indicated that Resident #12 was receiving docusate sodium 100 mg 1 capsule orally at bedtime for bowel regulation.

The Residents CCP (comprehensive care plan) included the focus area ADL (activities of daily living) self-care performance deficit r/t (related to) dementia. Interventions included-for toilet use: 'The resident is toileted q (every) 2 h (hours) and PRN (as needed) with supervision to staff assist X1."

A review of the Residents bowel record indicated that the facility staff had documented not applicable, no bowel movement, or refused from 08/16-08/25/16. The surveyor was unable to

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locate any further documentation to indicate the Resident had a BM during this timeframe or that any interventions had been put into place.

The administrative staff were notified of the concerns regarding the Resident's BM's during a meeting with the survey team on 09/14/16 at approximately 4:05 p.m.

The surveyor interviewed CNA (certified nursing assistant) #1 on 09/15/16 at approximately 7:45 a.m. During this interview CNA #1 verbalized to the surveyor that on "Some days he goes on his own so we just put in the computer not applicable." When asked if she asked the Resident if he had a BM she stated "Not really." CNA #1 stated that Resident #12 did not have any problems with BM's and never voiced any complaints of being constipated.

No further information regarding this issue was provided to the survey team prior to the exit conference.