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 12/16/2021

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/14/2021 through 12/16/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities	E 000	Berry Hill Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/14/2021 through 12/16/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. Complaint VA00053872 was unsubstantiated without any deficiencies. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 53 at the time of the survey. The survey sample consisted of 14 current resident reviews and three closed record reviews.	F 000	Berry Hill Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Berry Hill Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550	**F550 Resident Rights/Exercise of Rights** On 12/15/2021, the Administrator immediately removed restriction to confine residents to room, stop communal dining and activities. On 12/15/2021, the Social Worker notified all alert and oriented residents to include resident #36, #158, and #37 that the restriction for not leaving room had been lifted and communal dining and activities would resume.	1/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alexandra Bak | TITLE: LNHA | (X6) DATE: 1/10/2022

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
	495318	A. BUILDING _____ B. WING _____	C 12/16/2021

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 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview, staff interview and clinical record review, the facility staff failed to promote resident rights by confining residents to their rooms and not allowing communal activities for three of 17 residents in the survey sample. For over two weeks residents in the facility, including Resident #36, #158 and #37 were not allowed out of their rooms and had communal dining and activities	F 550	On 1/7/2022, the Social Worker completed questionnaires with all alert and oriented residents to include resident #36, #158, and #37 in regards to Resident Rights to include: in the past week have you been allowed out of your room for activities or dining? In the past week have you been allowed to go outside? The Social Worker and the Administrator will address all concerns identified during the audit. Audit will be completed by 1/30/2022. On 12/16/2021, the Facility Consultant in-serviced the Administrator and Director of Nursing in regards to (1) Facility Guidelines on Activities/Communal Dining and (2) Guidelines for Quarantine Residents. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses, nursing assistants (NA), dietary staff, housekeeping staff, therapy staff, maintenance staff, activity staff, Social Worker, Accounts Payable, Accounts Receivable, Medical records and receptionist in regards to Covid 19 *Guidelines on Activities/Communal Dining, Guidelines for Quarantine Residents, and resident rights.* In-service will be completed by 1/30/2022. All newly hired nurses, nursing assistants (NA), dietary staff, housekeeping staff, therapy staff, maintenance staff, activity staff, Social Worker, Accounts Payable, Accounts Receivable, Medical records and receptionist will be in-serviced by the Staff Facilitator during orientation in regards to Covid 19 *Guidelines on Activities/Communal Dining* and *Guidelines for Quarantine Residents.* The Social Worker will complete resident interviews with all alert and oriented residents weekly x 4 weeks then monthly x 1 month utilizing the *Resident Rights Audit Tool.* This audit is to ensure staff allow residents to leave room upon request, attend activities of choice and have meals	

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 12/16/2021

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 550	Continued From page 2 canceled. The findings include: 1. Resident #36 was admitted to facility on 11/18/16 with a re-admission on 12/29/20. Diagnoses for Resident #36 included schizoaffective disorder, bipolar disorder, depression, hypertension, osteoporosis, anxiety, chronic kidney disease and peripheral neuropathy. The minimum data set (MDS) dated 11/8/21 assessed Resident #36 with moderately impaired cognitive skills. On 12/14/21 at 11:43 a.m., Resident #36 was interviewed about quality of life in the facility. Resident #36 stated, "I'm tired of this room." Resident #36 stated she was no longer allowed out of her room and had to eat in her room. Resident #36 stated she liked to walk about with her walker. Resident #36 stated she thought staying in the room had something to do with COVID but she did not understand why she could not walk around. Resident #36 stated each time she went to leave her room, one of the girls at the desk told her to get back into the room. Resident #36 stated this had been going on for "about two months" and she was not allowed out even with her mask. Resident #36's clinical record documented no physician orders or care plan interventions regarding room confinement or any type of isolation precautions. An order signed by the physician on 12/7/21 documented, "May participate in B-day parties, council meal & facility functions w/o [without] diet restrictions...May visit outside facility w/ [with] permission of responsible party if condition permits..." The clinical record	F 550	served in the dining area without restrictions. The Social Worker will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will initial the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the *Resident Rights Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Resident Rights Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 550	Continued From page 3 documented the resident was partially vaccinated against COVID-19 with the first vaccine dose administered on 8/11/21. The resident's plan of care (revised 7/22/21) documented the resident had cognitive impairment and trouble with comprehension, reasoning difficulties, little attention span and had psychosocial adjustment difficulties due to mild intellectual disability. The care plan documented, "...likes to be with others socially and to feel connected with others. At times, resident will say 'Hey, hey' to get attention..." Interventions for prevent social isolation and minimize anxious mood/behaviors included, "Assist resident to attend activities programming or event...When resident is saying 'hey, hey', stop and ask what he/she needs and provide reassurance..." The care plan listed the resident wandered about the facility with use of a walker. 2. Resident #158 was admitted to the facility on 1/19/12 with a re-admission on 12/2/21. Diagnoses for Resident #158 included cerebral vascular accident (stroke) with hemiparesis, hypertension, hyperlipidemia, insomnia, anxiety and dry eye syndrome. The minimum data set (MDS) dated 10/29/21 assessed Resident #158 as cognitively intact. On 12/14/21 at 11:51 a.m., Resident #158 was interviewed about quality of life in the facility. Resident #158 stated, "I'm tired of sitting in this room. People in jail got more rights than we do." Resident #158 stated that residents were not allowed in the hallway or about in the facility and that had been in place for over two weeks. Resident #158 stated he was told the reason for the confinement was something to do with	F 550		

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 12/16/2021

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 550	Continued From page 4 COVID. Resident #158 stated his roommate got COVID-19 and then he got COVID-19 despite being vaccinated. Resident #158 stated he went to another facility for ten days and returned but never had any COVID-19 symptoms. Resident #158 stated residents were not allowed to go outside, get fresh air and going to the dining room was stopped. Resident #158 stated the facility no longer had an activity director and had not had group activities "in months." Resident #158 stated he wanted out of his room, to go outside, get some fresh air and be able to see other residents in the dining room. Resident #158 stated he wore his mask when out of his room. Resident #158's clinical record documented the resident was diagnosed with COVID-19 on 12/2/21 and was transferred to a sister-facility on 12/2/21 for a ten-day quarantine. The resident was readmitted to the facility on 12/12/21 with no orders for room confinement, isolation, quarantine or restriction of activities. The resident's readmission orders signed by the physician on 12/7/21 documented, "May participate in B-day parties, council meal & facility functions w/o [without] diet restrictions...May visit outside facility w/ [with] permission of responsible party if condition permits..." The clinical record documented Resident #158 was fully vaccinated for COVID-19 with the second dose administered on 2/8/21 and a booster dose on 10/12/21. Nursing notes documented the resident had no symptoms associated with the COVID-19 diagnosis. Resident #158's plan of care (revised 11/1/21) documented the resident was at risk and/or had COVID-19 infection. Interventions related to COVID-19 included, "...Encourage resident	F 550		

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 12/16/2021

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 550	Continued From page 5 compliance with infection control measures mask wearing when out of room..." The care plan listed the resident had, "Feelings of sadness, emptiness, anxiety...depression characterized by; ineffective coping, low self esteem, anxiety, little involvement in activities related to...CVA [cerebrovascular accident], loss of independence..." Interventions to improve mood and minimize anxiety/depression included, "...Encourage resident to attend group activities...Monitor and repot any changes in mental status, mood, or behaviors and notify physician...Offer activities of which resident has shown interest..." On 12/14/21 at 12:00 p.m., no residents were observed in the hallway. All residents were served lunch in their rooms with no residents in the day room, dining room or sitting out on the unit. On 12/14/21 at 12:41 p.m., the administrator was interviewed about residents not allowed out of their rooms. The administrator stated on 11/25/21 two employees tested positive for COVID-19 during routine testing. The administrator stated residents were tested on 11/25/21 due to the outbreak and Resident #158's roommate tested positive on that day. The administrator stated Resident #158 was placed on droplet precautions on 11/25/21 since he was exposed. The administrator stated when Resident #158 tested positive on 12/2/21, he was sent to a sister-facility to quarantine for ten days. The administrator stated that since 11/25/21 the residents had been told to stay in their rooms. The administrator stated the plan was for residents to stay in their rooms and not have group activities including dining, until 12/16/21	F 550		

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 12/16/2021

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 550	Continued From page 6	F 550		

which was 14 days after the last positive (on 12/2/21). When asked why the residents were not allowed out of their rooms since they were not on any type of transmission-based precautions, the administrator stated, "I don't know." The administrator stated, "We were following the old rules, keeping them in rooms for 14 days." The administrator stated they were trying to contain the spread of COVID-19 and stated there were no CDC guidelines that called for all residents to be quarantined based on the positive result on 12/2/21. The administrator stated there were ten residents in the facility unvaccinated and the remaining residents were fully vaccinated.

On 12/14/21 at 4:38 p.m., licensed practical nurse (LPN #2) was observed administering medications. Resident #19 had on a mask and was standing in the doorway to his room. LPN #2 stated at this time, "[Resident #19] aren't you supposed to be in that room?" The resident had money in his hand and stated he wanted to get some nabs. LPN #2 stated, "Wait a little bit please." LPN #2 was interviewed at this time about instructing the resident to stay in his room. LPN #2 stated the residents were on quarantine and had to stay in their rooms.

On 12/15/21 at 8:15 a.m., no residents were observed in the hallway or out of their rooms on the nursing unit. LPN #3 was interviewed at this time about the room confinement and no communal dining. LPN #3 stated she was told the residents had to stay in their rooms for 14 days from the last COVID-19 positive resident. LPN #3 stated residents were supposed to stay in their rooms until 12/16/21 and that communal dining had been canceled.

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 12/16/2021

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 550	Continued From page 7 On 12/15/21 at 10:37 a.m., the administrator was interviewed about resident activities. The administrator stated there had been no group activities since the activity director left on 11/5/21. On 12/15/21 at 2:52 p.m., the regional nursing consultant (administration staff #3) was interviewed about the residents' room confinement and no communal dining and/or activities since 11/25/21. The regional consultant stated she was not aware the residents were on lock-down. The regional director stated the company guidance stated if residents were vaccinated, they could participate in communal dining and be out of their rooms unless they had symptoms. The regional consultant stated that guidance was provided to administrators. The regional consultant stated she recently trained all the administrators with guidance stating that visitation and communal activities could not be restricted. On 12/15/21 at 3:57 p.m., the regional consultant and administrator were interviewed about the restrictions. The regional consultant stated the decision for residents to stay in their rooms came from the facility in response to COVID-19 outbreak. The regional consultant stated the facility was trying to keep residents socially distant and residents came out of the room for therapy and showers. The regional consultant stated the restrictions started "around Thanksgiving." The administrator stated the restrictions were not according to CDC guidance for management of COVID-19. On 12/16/21 at 1:25 p.m., the facility medical director (other staff #5) was interviewed by telephone about the restricted out of room	F 550		

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 12/16/2021

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 550	Continued From page 8 activities for residents. The medical director stated he did not order or recommend resident confinement or out of room restrictions. The medical director stated he thought the directive to keep residents in their room came from corporate. The facility's policy titled Guidelines for Dining and Communal Activities (dated 5/11/21) documented, "...Previously, restrictions issued by the CDC [Centers for Disease Control and Prevention] and CMS [Centers for Medicare & Medicaid Services] had limited options for group activities. Now, with some limited exceptions outlined below, communal dining and activities are encouraged for the mental and social well-being of residents so long as there are no factors that put residents at risk for contracting COVID-19..." The policy documented concerning communal dining, "...If all participating residents are fully vaccinated dining and other group activities may occur without social distancing and without face masks...If a resident is unvaccinated, or not fully vaccinated, chooses to participate in communal activities, then all residents, regardless of vaccination status, must wear a mask and socially distance, except for eating...The facility may not discriminate against fully vaccinated, unvaccinated, or not fully vaccinated residents, but may accommodate reasonable requests by the Resident Council and/or a specific patient or group or patients..." These findings were reviewed with the administrator on 12/15/21 at 2:19 p.m. The administrator stated at this time that there was no CDC guidance to keep residents in their rooms in response to the recent COVID-19 positive staff/residents. The administrator stated, "We	F 550		

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 12/16/2021

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 550	Continued From page 9 were just scared of COVID spreading. It was not CDC guidance." The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (updated 9/10/21) documents, "Unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP [health care personnel] caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator)...Fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested...Fully vaccinated residents and residents with SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority..." (1) (1) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. Centers for Disease Control and Prevention. 12/18/21. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html 3. Resident # 37 was admitted to the facility 12/15/15 with diagnoses to include, but were not limited to: history of stroke, diabetes, depression, and heart failure. The most recent MDS (minimum data set) was a	F 550		

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 12/16/2021

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 550	Continued From page 10	F 550		

quarterly assessment dated 11/8/21 and had Resident # 37 coded as cognitively intact with a score of 15 out of 15.

On 12/14/21 beginning at 11:00 a.m. during initial tour of the facility, there were no residents observed in the halls or in the dining room. Upon entering Resident # 37's room, when asked how she was doing, she stated "Well, I'd be a lot better if I could get out of this room for a bit." Resident # 37 stated, "There was a case of COVID, and they [facility staff] told us we had to stay in our rooms. If I am in my wheelchair and get close to the doorway, one of the workers hollers at me to get back in my room. No visitors, including singing groups like we used to have, are allowed in the building."

A meal observation was conducted on 12/14/2021 at approximately 12:30 p.m. on the 300 unit of the facility. All residents were observed dining in their rooms, no residents were observed in the dining room. One of the staff members who was passing out trays was asked why all the residents were eating in their rooms. She stated, "We are on quarantine until Thursday (12/16/2021). We had a COVID positive resident so now everyone has to stay in their rooms for fourteen days....no one is going to the dining room until then."

On 12/15/21 beginning at 3:00 p.m. a group interview was conducted with eleven cognitive residents (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11). All the residents stated the same information as provided by Resident # 37. The group stated "We have to stay in our rooms...we can't go out of our room because of the quarantine rule, and so all there is to do is

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 12/16/2021

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 550	Continued From page 11 watch TV and get fat." On 12/15/21 at approximately 4:30 p.m. the administrator confirmed the resident's statements. She stated due to fears of spreading COVID, residents were restricted to their rooms until 12/16/21 when the fourteen days were completed. The administrator stated she was not aware residents did not have to stay in their rooms, or that visitors could come in. No further information was provided prior to the exit conference.	F 550		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of	F 563	**F563 Right to Receive or Deny Visitors** On 12/15/2021, the Social Worker updated the resident representative for resident #38 on the visitation guidance to include visitation without restriction. On 1/7/2022, the Payroll Bookkeeper mailed a letter to all resident representatives to include resident #38 regarding the updated facility Visitation Guidelines without restrictions. This includes removing restrictions regarding frequency or length of visits, number of visitors or required advanced scheduling of visits. Letters will be mailed by 1/30/2022. On 1/7/2022, the Social Worker initiated questionnaires with all alert and oriented residents regarding visitation to include: In the past week, are you able to receive visitors of your choosing at the time of your choosing? The Social Worker will address all concerns identified during the audit. Audit will be completed by 1/30/2022.	1/30/2022

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 12/16/2021

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 563	Continued From page 12 residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, and facility document review, the facility staff failed to allow visitors for one of 17 residents, Resident #38. Findings were: Resident #38 was admitted to the facility on 11/03/2021 with the following diagnoses, including but not limited to: Arthropathy, dementia, prostatic hyperplasia, hypertension, syncope and collapse. His admission MDS (minimum data set) with an ARD (assessment reference date) of 11/10/2021 assessed him as severely impaired with a cognitive summary score of "07". Initial tour of the facility was conducted on 12/14/2021 at approximately 10:45 a.m. There were no visitors observed in the facility. All the residents were observed in their rooms. A meal observation was conducted on 12/14/2021 at approximately 12:30 p.m. on the 300 unit of the facility. All residents were observed dining in their rooms, no residents were observed in the dining room. One of the staff members who was passing out trays was asked why all the residents were eating in their rooms. She stated, "We are on quarantine until Thursday	F 563	On 12/15/2021, the Administrator initiated an in-service with all screeners, social workers, nurses, business office manager, accounts receivable, activity staff, and admission staff regarding *Visitation Guidelines*. Emphasis is on updated facility guidelines on visitation without restrictions to include removing restrictions in regards to frequency or length of visits, number of visitors or required advanced scheduling of visits. In-service will be completed by 1/30/2022. All newly hired screeners, social workers, nurses, business office manager, accounts receivable, activity staff, and admission staff will be in-serviced during orientation in regards to *Visitation Guidelines*. The Social Worker will interview 10 residents and/or resident visitors weekly x 4 weeks then monthly x 1 month utilizing the *Resident Rights Audit Tool*. This audit is to ensure residents are able to receive visitors at their choosing and at times, of their choosing. The Social Worker and Director of Nursing will address all concerns identified during the audit. The Administrator will review and initial the *Resident Rights Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the *Resident Rights Audit Tool* to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the *Resident Rights Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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 12/16/2021

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 563	Continued From page 13	F 563		

(12/16/2021). We had a COVID positive resident so now everyone has to stay in their rooms for fourteen days....no one is going to the dining room until then."

On 12/14/2021 at approximately 12:40 p.m., the administrator was interviewed. She stated that there had been two COVID positive staff members on 11/25/2021 and a positive resident on 12/02/2021. She stated they had stopped visitation at that time and the residents were being kept in their rooms. She was asked why that was being done. She stated, "To stop the spread."

On 12/15/2021 at approximately 9:50 a.m., Resident #38's wife was contacted by telephone for a family interview. She was asked how she thought Resident #38 was doing and about the quality of care he was receiving at the facility. She stated, "I can't tell you anything about how he's doing, or what they are doing. They won't let me in there to see him...we brought him home for Thanksgiving and he looked weaker to me, but on the phone they tell me he's doing better...I can't answer any of your questions because I can't get in there...[name of the administrator] told me that maybe by the end of the week if there aren't anymore COVID positive cases."

A meeting was held with the administrator and the corporate nurse consultant on 12/15/2021 at approximately 3:00 p.m. The above information was discussed. The nurse consultant stated that she had not been aware that visitation was not being allowed in the facility. She stated that she had done a training with the administrators about the most recent guidance that visitation could not be restricted in the facilities. She stated, [name 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 12/16/2021

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 563	Continued From page 14 the facility administrator] attended the training. The facility policy for COVID visitation was requested and presented. Per the facility policy, "Guidelines on Visitation for Nursing Homes" with the most recent update listed on each page as "12/09/2021", "Indoor Visitation: Facilities should allow indoor visitation at all times and for all residents...Visitation During an Outbreak: In the event a COVID positive case is identified, all visitation should be reviewed to provide allowed visitation while adhering to infection protocols..." On 12/15/2021 at approximately 4:00 p.m., the administrator was asked if families had been notified that they could come back into the facility. She stated, "I have my social worker working on it." No further information was obtained prior to the exit conference on 12/16/2021.	F 563		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565	**F565 Resident/Family Group and Response** On 12/15/2021, the shower room on 300 hall was immediately cleaned by housekeeping supervisor. On 1/7/2022, the Administrator initiated an audit of all resident council meeting minutes for the past 90 days. This audit is to identify any resident concerns voiced during a resident council meeting to ensure concerns were addressed, the resident council provided a written response per facility protocol and response reviewed during the next council meeting with documentation in the "Old Business" section of council meeting minutes. The Social Worker and/or Activity Director will address all concerns identified during the audit to include completion of a written grievance with a written follow up provided to the resident council president to be presented at the next resident council meeting. Audit will be completed by 1/30/2022.	1/30/2022

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 12/16/2021

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 565	Continued From page 15 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on group interview and staff interview, the facility staff failed to respond to identified concerns of the residents in the facility. Facility staff stated they were not made aware of concerns. Findings include: On 12/15/21 at 8:18 a.m., accompanied by licensed practical nurse (LPN) #3, the residents' shower room was inspected. The shower stall had dried feces on the floor not far from the drain. The floor and protective molding around the base of the shower were covered with black grime. Black stains were scattered on the wall grout from the handrails down to the floor. LPN #3 was interviewed at this time about the dirty shower	F 565	On 1/6/2022, the Regional Vice President completed an in-service with the Administrator, Director of Nursing, Activity Director and the Social Worker in regards to *Resident Grievance Policy*. Emphasis is on completing grievance investigation for all grievances voiced during resident council and that the Social Worker and/or Activities review grievance resolution during the next resident council meeting with documentation in the "Old Business" section of the council meeting minutes. The Social Worker and/or Activity Director will provide a written grievance summary to resident council following completion of grievance investigation. It is the Administrator's responsibility to ensure the grievance process is completed per facility protocol. All newly hired Administrator, Director of Nursing, Activity Director and/or Social Worker will be in-serviced during orientation in regards to the *Resident Grievance Policy*. The Administrator will review all resident council meeting minutes monthly x 2 months utilizing the *Resident Council Audit Tool*. This audit is to ensure all grievances voiced during resident council are investigated per facility protocol and that the Social Worker and/or Activity Director provide a written grievance summary with review of grievance resolution during the next resident council meeting with documentation in the "Old Business" section of the council meeting minutes. The Social Worker and/or Activity Director will address all concerns identified during the audit. The Administrator will review and initial the resident council meeting minutes and the *Resident Council Audit Tool* monthly x 2 months to ensure all concerns were addressed. The Administrator will forward the results of the *Resident Council Audit Tool* to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and	

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 12/16/2021

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 565	Continued From page 16 stall. LPN #3 stated the aides were supposed to clean the shower after each use. On 12/15/21 at 3:00 p.m. a meeting with the resident council was conducted with eleven cognitive residents in attendance (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11). Council minutes were reviewed prior to the meeting, which identified recurring issues from August 2021 through October 2021. The group was asked if the facility staff responded to the identified concerns, and they responded "No." The group further stated that if there's a problem, it goes unresolved. On 12/15/21 at approximately 4:30 p.m. the administrator was informed of the comments from resident council about the lack of follow-up from the facility regarding identified issues. The administrator stated "I was not aware of any issues." The administrator was asked if the previous activity director, who had been responsible for informing the administrator of any issues from the group, had done so. The administrator stated "No, she was supposed to let me know of anything needing follow-up from the group, and then she was to do a concern form and give to each department head of the area of concern." The administrator was asked if the department heads could come to the conference room 12/16/21 in the morning. The administrator was also advised that the resident concerns about the dirty shower room had been identified in August 2021, and continued to be a topic in September and October meetings. On 12/16/21 at approximately 10:15 a.m. a meeting was held with the department heads. Each department head stated they had not	F 565	review the *Resident Council Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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 12/16/2021

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 565	Continued From page 17 received any concern forms from the group. The housekeeping manager was asked specifically about the shower rooms. Her stated "They (the certified nursing assistants) were to clean up after giving a resident a shower." He further stated the housekeeping staff are to check the shower rooms each day and if dirty, are to clean it. He stated he did not know that was not being done until he saw the condition of the shower room the previous morning. On 12/16/21 at approximately 10:30 a.m. the administrator stated there would be more effort to follow up on resident concerns in the future. No further information was provided prior to the exit conference.	F 565		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576	**F576 Right to Forms of Communication with Privacy** On 12/15/2021, the Administrator directed immediate delivery of mail unopened to all residents that received mail. On 1/7/2022, the Social Worker initiated questionnaires with all alert and oriented residents regarding Send/Receiving Mail to include: In the past week, have you been able to send/receive mail? Do staff deliver mail unopened Monday-Saturday? Do you have any concerns regarding mail delivery that has not already been addressed? The Social Worker will address all concerns identified during the audit. Audit will be completed by 1/30/2022. On 1/7/2022, the Administrator initiated an in-service with activity staff and screeners in regards to *Resident Rights/Mail Delivery*. Emphasis is on the resident's right to send/receive mail unopened even on weekends. In-service will be completed by	1/30/2022

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 12/16/2021

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 576	Continued From page 18 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on group interview, staff interview, and facility document review, the facility staff failed to ensure mail delivery to residents. Findings include: On 12/15/21 beginning at 3:00 p.m. a group interview was conducted with eleven cognitive residents (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11). The group was asked about mail delivery in the facility, and if mail was received on Saturdays and also received unopened. The group responded "No." Resident # 11 stated "We haven't gotten any mail since the activity director left over a month ago. You know, it's close to Christmas, and we don't even know if we have gotten cards or anything."	F 576	1/30/2022. All newly hired activity staff and screeners will be in-serviced during orientation in regarding *Resident Rights/Mail Delivery*. The Social Worker will interview 10 alert and oriented residents weekly x 4 weeks then monthly x 1 month utilizing the *Resident Rights Audit Tool*. This audit is to identify any resident with concerns related to mail delivery. The Social Worker will address all concerns identified during the audit. The Administrator will review and initial the *Resident Rights Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the *Resident Rights Audit Tool* to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the *Resident Rights Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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 12/16/2021

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 576	Continued From page 19 On 12/15/21 at approximately 4:30 p.m. the administrator was asked about the mail delivery, and for a policy. The administrator stated she would look for a policy, and was not aware residents were not having mail delivered. The policy for mail delivery in the facility stated "Mail: Residents have the right to send and promptly receive mail that is unopened and have access to stationary, postage, and writing implements. Mail will be delivered to residents Monday through Saturday during regular business hours." The administrator and corporate consultant nurse were made aware of the above findings 12/16/21 at approximately 10:30 a.m. No further information was provided prior to the exit conference.	F 576		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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	F 580	**F580 Notify of Changes** On 12/15/2021, the DON notified the physician that compression hose were not available for resident #38. On 12/14/2021, the assigned nurse measured resident #38 for compression hose. Compression hose for resident #38 were ordered from an alternate vendor due to compression hose being out of stock from original vendor. Compression hose were received 12/15/2021 and placed on resident. On 1/6/2022, the Director of Nursing completed an audit of all physician orders for compression hose for the past 30 days. This audit is to identify all residents with compression hose orders to ensure orders were completed per physician orders and/or the physician was notified when the order cannot be completed for further	1/30/2022

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 12/16/2021

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 580	Continued From page 20 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician that compression stockings were not available for one of 17 residents, Resident #38. Findings were:	F 580	instructions. There were no additional concerns identified. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses regarding *Following Physician Orders*. Emphasis is on ensuring all physician orders are completed to include but not limited to orders for compression hose and/or the physician is notified when orders cannot be completed for further recommendations. In-service will be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regarding *Following Physician's Orders.* The Director of Nursing (DON) and/or Staff Facilitator will audit all physician orders to include physician orders for compression hose weekly x 4 weeks then monthly x 1 month utilizing the *Physician's Orders Audit Tool*. This audit is to ensure the physician orders completed to include but not limited to orders for compression hose and/or the physician notified when orders cannot be completed for further recommendations. The Director of Nursing (DON) and/or designee will address all concerns identified during the audit completing orders or notification of the physician when order cannot be completed for further recommendations. The DON will review and initial the *Physician's Orders Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the *Physician's Orders Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Physician's Orders Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 580	Continued From page 21 Resident #38 was admitted to the facility on 11/03/2021 with the following diagnoses, including but not limited to: Arthropathy, dementia, prostatic hyperplasia, hypertension, syncope and collapse. His admission MDS (minimum data set) with an ARD (assessment reference date) of 11/10/2021 assessed him as severely impaired with a cognitive summary score of "07". The clinical record was reviewed on 12/15/2021 at approximately 9:30 a.m. The physician order section contained the following order: "11/03/2021 Measure and apply compression stockings-apply every morning and remove at bedtime." At approximately 10:15 a.m. on 12/15/2021, Resident #38 was observed sitting in a chair in his room. He was asked if he was wearing compression stockings on his legs. He pulled up his pants legs and stated, "You want to see my socks?" He was wearing white cotton socks only, no compression stockings. At approximately 10:30 a.m., LPN (licensed practical nurse) #2 was interviewed. She was asked where the physician ordered compression stockings were documented as "on" or "off"; the TAR (treatment administration record) or the MAR (medication administration record). She stated, "They are on the MAR." She went to the medication cart and obtained the paper MAR book. She stated, "They are right here." The compression stocking order was handwritten on the MAR, but there were no entries for the month of December that they had been applied or removed. She was asked why there were no	F 580		

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 12/16/2021

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 580	Continued From page 22 entries. She stated, "We don't have them...(Name of LPN #1) measured him yesterday but I don't think they are here. LPN #1 was at the nurse's station and heard the conversation. She stated, "I did measure him yesterday...I was hoping they would come in last night but the pharmacy sent us a note that they are out [of stock]." She was asked why if the order was written on 11/03/2021, Resident #38 had not been measured or had his compression stockings ordered until the previous day (12/14/2021). LPN #2 stated, "I'll tell you why, we couldn't find a tape measurer...the DON (director of nursing) was down here and everything, we didn't have one." LPN #1 and LPN #2 were both asked if there was a backup plan for supplies when the pharmacy was out. They both shrugged their shoulders. They were asked if the physician had been notified that the compression stockings had not been applied for over a month since the initial order. LPN #2 stated, "I don't know if he knows or not." There was no documentation in the clinical record that the physician had been notified that Resident #38 had not been measured when the compression stockings were ordered, or that when he had been measured the stockings were not available from the pharmacy. On 12/15/2021 at approximately 3:00 p.m., the above information was discussed with the administrator. She stated, "He has them now. I sent someone over to [name] pharmacy and got them picked up." She was asked if the physician should have been notified. She shook her head up and down indicating "Yes." No further information was obtained prior to the exit conference on 12/16/2021.	F 580		

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 12/16/2021

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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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- §483.10(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. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	**F584 Safe Clean Comfortable Homelike Environment** On 12/15/2021, the housekeeping staff immediately clean the shower room on 300 hall. On 1/7/2022, the Housekeeping Supervisor initiated an audit of all shower rooms to ensure shower rooms were maintained in a clean, sanitary and orderly manner. The Staff Facilitator, assigned nurse, nursing assistant and/or housekeeping will address all concerns identified during the audit to include cleaning of shower room and education of staff. Audit will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses, nursing assistants and housekeeping staff in regards to Shower Rooms. Emphasis is on immediately cleaning shower rooms after each use to include removing of all soiled linen and trash and leaving shower room in a clean, sanitary and orderly manner. In-service will be completed by 1/30/2022. All newly hired nurses, nursing assistants and housekeeping staff will be in-serviced during orientation in regards to Shower Rooms. The Housekeeping Supervisor will audit all shower rooms 3 times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month utilizing the *Shower Room Audit Tool* This audit is to ensure shower rooms are cleaned after each use including removing all soiled linen and trash and leaving shower room in a clean, sanitary and orderly manner. The Housekeeping Supervisor and Administrator will address all concerns identified during the audit to include cleaning shower room when indicated and re-training of staff. The Administrator will review and initial the *Shower Room Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	1/30/2022

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 12/16/2021

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 584	Continued From page 24 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, group interview and staff interview, the facility staff failed to provide a clean shower environment on one of one nursing units. The residents' shower room was dirty with feces and grime. The resident council documented complaints about the dirty shower room since August 2021. The findings include: Review of resident council meeting minutes dated 8/13/21 revealed residents complained that the shower room was "filthy" and not routinely cleaned after use. The minutes documented linens were left in the floor and thrown into cabinets. Council minutes dated 10/26/21 documented ongoing concerns that the shower room remained dirty with soiled linen and dirty floors. On 12/14/21 at 3:00 p.m., an interview was conducted with eleven cognitively intact residents that routinely participated in the resident council (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11). Residents during the group meeting stated the shower room was dirty and had been so for months. The residents stated they had expressed concerns during council meetings and there had been no response or improvement in the cleanliness of the shower. On 12/15/21 at 8:18 a.m., accompanied by licensed practical nurse (LPN) #3, the residents' shower room was inspected. The shower stall had dried feces on the floor not far from the drain.	F 584	The Administrator will forward the results of the *Shower Room Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Shower Room Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 584	Continued From page 25 The floor and protective molding around the base of the shower were covered with black grime. Black stains were scattered on the wall grout from the handrails down to the floor. LPN #3 was interviewed at this time about the dirty shower stall. LPN #3 stated the aides were supposed to clean the shower after each use. On 12/15/21 at 8:21 a.m., accompanied by the housekeeping director (other staff #2), the dirty shower stall was observed. The housekeeping director stated he had a housekeeper on the day and evening shifts and housekeepers were supposed to check/clean the shower at least once per shift. The housekeeping director stated he was not aware of the condition of the shower stall. This finding was reviewed with the administrator on 12/15/21 at 4:00 p.m.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of facility personnel files, facility	F 607	**F607 Develop/Implement Abuse/Neglect Policies** The five employees will complete sworn disclosure statements by 1/30/2022 with oversight by the Administrator. By 1/30/2022 the AP/Payroll Bookkeeper will complete the six background checks for the new hires and place results in the employee files for staff sited. By 1/30/2022 the AP/Payroll Bookkeeper will complete the eighteen reference checks for staff sited. On 1/7/2022 the AP/Payroll Bookkeeper initiated an audit of all current employees hired within the past 6 months. This audit is to ensure criminal background checks, reference checks, and sworn statements are in all current employee files. The	1/30/2022

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 12/16/2021

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 607	Continued From page 26 policy and procedures, and staff interview, the facility failed to implement their policy and procedure to ensure applicants for employment completed a Sworn Disclosure Statement disclosing "...any criminal convictions or pending criminal charges...." for five of 25 records reviewed; failed to ensure criminal background checks were obtained within 30 days of hire for six of 25 records reviewed; and failed to complete reference checks for eighteen of 25 records reviewed. Findings include: 1. On 12/16/21 at 10:30 a.m. 25 employee files were reviewed for completeness. The files included 2 housekeeping staff, 2 LPN's (licensed practical nurses), and one RN (registered nurse), that did not have a signed Sworn Statement prior to obtaining a background check. Those five records also did not contain a criminal background report from the State police office within 30 days of hire, as well as, an additional file for an LPN. On 12/16/21 at 1:00 p.m. the payroll manager, OS (other staff) # 4, the staff responsible for ensuring employee files were complete and accurate, was interviewed about the missing information. A policy for the screening of new employees was also requested at that time. When asked about the Sworn Statements, OS # 4 stated, "Those particular files were done before I assumed this position, so I cannot tell you why they weren't signed. As far as the delay for the background checks not being obtained/late, that was also done prior to me assuming this position, but I can tell you that the previous staff couldn't get in the system to bill for them...there was really	F 607	AP/Payroll Bookkeeper addressed all concerns identified during the audit to include completing all applicable information and placing in the employees file. Audit will be completed by 1/30/2022. AP/Payroll Bookkeeper and Administrator were educated on 1/6/2022 by the Regional Vice President regarding state requirements for sworn statements and reference checks to be obtained prior to hire date of new employees and need for criminal background checks to be obtained within 30 days of hire for all new employees. All newly hired AP/Payroll Bookkeeper and Administrator will be in-serviced in regards to requirements for background and reference checks and sworn disclosure statements upon hire. The AP/Payroll Bookkeeper will audit all newly hired employees' files weekly x 4 weeks then monthly x 1 month utilizing the *Employee file Review Audit Tool*. This audit is to that sworn statements and reference checks were obtained prior to hire date of new employees and need for criminal background checks were obtained within 30 days of hire for all new employees. The AP/Payroll Bookkeeper and Administrator will address all concerns identified during the audit by ensuring the applicable information is obtained and placed in the employees' file. The Administrator will review and initial the *Shower Room Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the *Employee file Review Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Employee file Review Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 607	Continued From page 27 no one in this position...I assumed this in May 2021...and some of us were pitching in to try to get that done." The policy "Abuse, Neglect, or Misappropriation of Resident Property" included "Screening of Employees- Potential employees will be screened by the facility for abuse, neglect, exploitation, or misappropriation of property. This screening process will include the requesting of information from previous and/or current employers and checking with the appropriate licensing boards and/or registries." The administrator was informed of the above findings 12/16/21 at approximately 2:30 p.m. No further information was provided prior to the exit conference. 2. Review of the restorative nursing program was conducted. During the review the administrator was interviewed on 12/16/2021, at approximately 11:55 a.m. and asked when the restorative program had stopped. She stated, "We got an email from corporate that the CNA (certified nursing assistant) doing restorative had a felony charge come back on her annual background check and to let her go. She was terminated on 11/04/2021..." She was asked for the employee file. Review of the employee file showed that CNA #6 was hired on 04/07/2020. Her background check was sent out on 11/25/2020 and returned 12/11/2020, over six months post hire. The background check included information that CNA #6 had a felony charge of forging, uttering, and larceny of bank notes from April 1999. On 11/04/2021 an email was received from the	F 607		

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 12/16/2021

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 607	Continued From page 28 corporate office to the facility administrator stating that an annual criminal record check had been completed and due to felony charges, and CNA #6 needed to be terminated immediately. The administrator was interviewed at 1:00 p.m. regarding the felony charges. She stated, "Our company doesn't employ anyone with felony offenses. She was asked why the original background check had been sent out so late after her initial hire date, and why no action had been taken at the time it returned. She stated, "I don't know. I was told to terminate her due to the felony and for falsification of her employment record." No further information was obtained prior to the exit conference on 12/16/2021.	F 607		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	**F657 Care Plan Timing and Revision** On 12/15/2021, the MDS Coordinator updated the care plan for resident #55 to reflect accurately for individualized goals and interventions regarding recreational activities. On 1/7/2022, the Director of Nursing initiated an audit of care plans for all residents to include resident #55 for recreational activities. This audit is to ensure residents are care planned accurately for individualized goals and interventions regarding recreational activities to include resident preference for activities and need for 1:1 activities. The DON will address all concerns identified during the audit. Audit will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses in regards to *Care Plans*. Emphasis is on ensuring care plan is updated timely and accurately with all aspects of resident care to include but not limited to recreational	1/30/2022

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 12/16/2021

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 657	Continued From page 29 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for one of seventeen residents in the survey sample, Resident #55. Resident #55's plan of care was not revised with individualized goals and interventions regarding recreational activities. The findings include: Resident #55 was admitted to the facility on 9/22/17 with diagnoses that included bipolar disorder, schizophrenia, hypertension, osteoarthritis, neuralgia, major depressive syndrome, hypothyroidism, dysphasia, dementia, history of COVID-19 and chronic pain syndrome. The minimum data set (MDS) dated 11/26/21 assessed Resident #55 with short and long-term memory problems and severely impaired cognitive skills. The annual MDS dated 5/5/21 documented the resident was unable to respond to activity preference interview questions. Staff assessed the resident's preferences as bed bath, family involvement and listening to music. Resident #55's clinical record documented an activity assessment dated 11/13/21. This assessment listed the resident passively	F 657	activities and interventions. In-service will be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regards to *Care Plans*. The Interdisciplinary Team to include DON, Staff Facilitator and MDS Coordinator will review care plans for 10% of residents weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plans updated timely and accurately with all aspects of resident care to include but not limited to recreational activities and interventions. The assigned nurse, Nurse Supervisor, wound care nurse and MDS nurse will address all concerns identified during the audit to include updating care plans and/or re-training of staff. The Director of Nursing will review and initial the *Care Plan Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns identified. The Director of Nursing will forward the results of the *Care Plan Audit Tool* to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the *Care Plan Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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 12/16/2021

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 657	Continued From page 30	F 657		

participated in activities and did not participate in out of room activities. There were no group preferences listed and the form listed independent activities as "Listening to music." The assessment documented, "Resident receives one on one social interaction visits form [from] activities staff." (sic)

Resident #55's plan of care for activities was last updated on 10/12/21. The care plan listed the resident had, "Alteration in supervised/organize recreation characterized by little or no involvement, lack of attendance related to: Behaviors and cognitive disability." Interventions to meet goals of one to one weekly visits included, "Arrange 1:1 contacts...Assist resident in planning leisure-time activities. Encourage resident to plan own leisure-time activities...Post personal activity schedule in resident's room...Provide supplies for independent activities of resident's choice..."

The plan of care made no mention of the resident's preference for music and listed independent activity pursuits when the resident was assessed with severe cognitive impairment and need for one to one assistance.

On 12/15/21 at 11:06 a.m., the registered nurse (RN #2) responsible for MDS and care plans was interviewed about Resident #55's activities. RN #2 stated the resident was unable to respond to interview questions and the staff assessed the resident's preferences as bed bath, family involvement and music. RN #2 stated, "She [Resident #55] doesn't really do anything." RN #2 stated staff went to the resident's room and talked with her. RN #2 reviewed the current activity plan of care and stated the interventions did not apply

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 12/16/2021

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 657	Continued From page 31 to the resident. RN #2 stated the care plan had not been revised with current interventions regarding activities. This finding was reviewed with the administrator on 12/15/21 at 4:00 p.m.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, group interview, and staff interview, the facility staff failed to provide an ongoing activity program in the facility as identified by eleven cognitively intact residents (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11) during the group interview; and also failed to ensure resident specific activities for two of 17 residents, # 36 and # 158. Findings include: 1. An interview with the Resident Council was conducted in the facility 12/15/21 beginning at 3:00 p.m. with 11 cognitive residents (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11). The residents were asked if the group met	F 679	**F679 Activities Meet Interest/Needs Each Resident** Resident #18, #5, #24, #30, #22, #32, #36, #49, #31, #158, and #11 were offered and/or provided activities on 12/16/2021 with documentation in the electronic medical record. On 1/7/2022, the Administrator initiated an audit of activities provided for the past 7 days. This audit is to ensure all Residents are being provided ongoing Activities that are of interest to the residents in an effort to meet each Resident's needs that engage the Resident as evidenced by the facility Activity Calendar, In Room documentation or group participation documentation. The Administrator will assure activities are immediately provided as appropriate to the resident for any identified areas of concerns during the audit. Audit will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator in-serviced the Administrator, Director of Nursing, CNAs, nurses, and Activity Staff related to the requirement to provided Activities that are of interest to the Residents in an effort to meet each Residents needs and that engage the Resident in an group or in room activity. In-service will be completed by 1/30/2022. All newly hired Administrator, DON, CNAs, nurses and activity staff will be in-serviced during orientation in regards to *Activities*. The Accounts Receivable, Social Worker and Admission Director will review activity	1/30/2022

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 12/16/2021

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 679	Continued From page 32 monthly, and if facility staff helped to arrange those meetings. The resident council president, Resident # 158 stated "The activity director left 11/5/21. There has been no group meetings, or any activities, since she left. I did bingo a couple of weeks after she left, but I don't want to do that...some of us have been wanting to go outside and sit, but that hasn't happened either. The smokers get to go out 2-3 times a day, but if you don't smoke, you can't go out. We went out maybe one time this past fall, but that was it. Now, we've been told we can't come out of our rooms, so there's really nothing to do to pass the time..." Other comments from the group included: "All we can do right now is sit in our room, watch TV, and get fat...We haven't had any birthday parties, bingo games, singing groups...We haven't been able to have any visitors since December 2nd when we were told to stay in our rooms due to a COVID outbreak...There's nothing to do, and no mail delivery either so we don't even know if we have gotten cards, letters...heck, nobody even comes around with books or magazines so at least there would be something to read..." The administrator was made aware of the group comments 12/15/21 at 4:30 p.m. The administrator confirmed what the group said and stated, "The activity director left the first part of November. There has been an ongoing attempt to hire an activity director but we have not had any luck. We did hire someone, but they were here about 2 hours, left, and never came back." The administrator was asked if corporate was aware of the situation. The corporate nurse consultant was also present, and stated "We were aware the activity director left, and we knew someone had been hired and left. One of the	F 679	documentation and visual observation of in room and/or group activity participation for all residents weekly for 4 weeks then monthly x 1 month utilizing a *Activity Attendance Audit Tool* to ensure ongoing activities are being offered that engage the Resident. The Administrator will address all concerns identified during the audit to include re-training of staff and providing activities per resident preference. The Administrator will review and initial the *Activity Attendance Audit Tool* weekly for 4 weeks then monthly for 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of the *Activity Attendance Audit Tool* to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the to determine trends *Activity Attendance Audit Tool* and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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 12/16/2021

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 679	Continued From page 33 sister facilities was going to send someone a couple of days a week to help out, but that just hasn't happened yet." No further information was provided prior to the exit conference. 2. Resident #36 was admitted to facility on 11/18/16 with a re-admission on 12/29/20. Diagnoses for Resident #36 included schizoaffective disorder, bipolar disorder, depression, hypertension, osteoporosis, anxiety, chronic kidney disease and peripheral neuropathy. The minimum data set (MDS) dated 11/8/21 assessed Resident #36 with moderately impaired cognitive skills. The MDS dated 6/8/21 listed the resident's activities preferences included books, music, news, doing things with groups of people and religious events. On 12/14/21 at 11:43 a.m., Resident #36 was interviewed about quality of life in the facility. Resident #36 stated she did not think there were group activities anymore. Resident #36 stated she liked to read her Bible and walk about the facility. The resident stated she currently was not allowed out of the room and had to eat in her room. Resident #36 stated she thought staying in the room had something to do with COVID but she did not understand why she could not walk about the facility. Resident #36's most recent activity assessment was dated 10/4/21 and listed the resident's group activities included special events, religious activities, Bingo and spa day, and independent leisure activities were reading, watching television and listening to music. Resident #36's clinical record documented no	F 679		

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 12/16/2021

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 679	Continued From page 34 activity notes regarding the resident's participation with any of the assessed leisure activities. The resident's plan of care (revised 7/22/21) documented the resident had cognitive impairment, trouble with comprehension, reasoning difficulties, little attention span and had psychosocial adjustment difficulties due to mild intellectual disability. The care plan documented, "...likes to be with others socially and to feel connected with others. At times, resident will say 'Hey, hey' to get attention..." Interventions for prevent social isolation and minimize anxious mood/behaviors included, "Assist resident to attend activities programming or event...When resident is saying 'hey, hey', stop and ask what he/she needs and provide reassurance...Provide activities programming based upon resident's choices and past and present interests..." The care plan documented the resident had potential/actual mental psychosocial adjustment difficulties due to COVID-19 restrictions and change to resident's usual routines. Interventions to prevent psychosocial difficulties, aggression, anxious mood, social isolation, spiritual distress included, "Provide activities programming based upon resident's choices..." 3. Resident #158 was admitted to the facility on 1/19/12 with a re-admission on 12/2/21. Diagnoses for Resident #158 included cerebral vascular accident (stroke) with hemiparesis, hypertension, hyperlipidemia, insomnia, anxiety and dry eye syndrome. The minimum data set (MDS) dated 10/29/21 assessed Resident #158 as cognitively intact. The MDS dated 6/18/21 assessed the resident preferred activities included books, news, music,	F 679		

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 12/16/2021

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 679	Continued From page 35 doing things with groups of people, going outdoors and religious events. On 12/14/21 at 11:51 a.m., Resident #158 was interviewed about quality of life in the facility. Resident #158 stated there had been no activities in the facility "in months." Resident #158 stated the activity director quit several months ago and since then, there had been no activities. Resident #158 stated they no longer had Bingo, coloring or crafts. Resident #158 stated all he had to do was watching television and listening to the radio. Resident #158 stated the administration knew about the lack of activities and nothing had been done. Resident #158 stated he wanted to go outside to get fresh air, participate in Bingo and eat in the dining room. Resident #158 stated, "It's not fair. We can't go outside or nothing." Resident #158's most recent activity assessment was dated 6/18/21 listed the resident preferred group and in-room activities that included arts/crafts, gardening, woodworking, sports, Bingo, card games, religious activities, puzzles, music, news, outings, reading, sitting outdoors, field trips and movies/television. Resident #158's clinical record documented no activity notes regarding the resident's participation with his any of the assessed leisure activities. Resident #158's plan of care (revised 11/1/21) documented the resident had alteration in supervised/organized recreation characterized by little attendance related to impaired mobility due to stroke, "likes bingo and religious activities..." Recreational activities goals stated, "Participate in	F 679		

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 12/16/2021

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 679	Continued From page 36	F 679		

2-3 activities per week..." Interventions to meet activity goals included, "Assist resident in planning leisure-time activities. Encourage to plan own leisure-time activities likes to watch TV, conversation in hallway, reading...Establish daily routine with same activity personnel...Offer schedule of activities for resident to select choices...Offer activity program directed toward specific interests/needs of resident; current events, music...reading material birthday parties, outside activities, Bingo..."

There was no activity director currently employed with the facility.

On 12/15/21 at 10:37 a.m., the administrator was interviewed about activities for Residents #36 and #158. The administrator stated there had been no activity director employed with the facility since 11/5/21. The administrator stated the MDS coordinator was supposed to be completing recreation assessments but there had been no formal activities since the director left on 11/5/21. The administrator stated nurses were playing music at times on the unit.

On 12/15/21 at 2:52 p.m., the regional nursing consultant (administration staff #3) was interviewed about the lack of activities. The regional consultant stated that corporate was working to hire a new activity director. The regional director stated they hired someone to start on 12/6/21 but that person quit after a few hours in the facility. The regional director stated she did not realize residents no longer had activities.

On 12/16/21 at 1:25 p.m., the medical director (other staff #5) was interviewed about lack 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 12/16/2021

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 679	Continued From page 37 activities in the facility. The medical director stated there had been hiring difficulties in the facility. The medical director stated even without an activity director, someone should have been doing activities. The medical director stated residents were at risk of increased depression related to COVID-19 restrictions and an effective activities program helped reduce depression. These findings were reviewed with the administrator and regional nursing consultant on 12/15/21 at 4:00 p.m.	F 679		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interview, group interview, and resident interview the facility staff failed to employ	F 680	**F680 Qualification of Activity Professional** On 12/16/2021, the Regional Vice President placed an Interim Activity Director at the facility and activities initiated for residents. On 1/6/2022, the interim Activity Director was hired as permanent Activity Director. On 1/7/2022, the Administrator initiated an audit of activities provided for the past 7 days. This audit is to ensure all Residents are being provided ongoing Activities that are of interest to the Residents in an effort to meet each Resident's needs that engage the Resident as evidenced by the facility Activity Calendar, In Room documentation or group participation documentation. The Administrator will assure activities are immediately provided as appropriate to the resident for any identified areas of concerns during the audit. Audit will be completed by 1/30/2022. An in-service was completed with the Administrator and Director of Nursing on 1/6/2022 by the Regional Vice President regarding the requirements to employing and Activities Director and steps to taken when the position is vacant.	1/30/2022

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 12/16/2021

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 680	Continued From page 38 a qualified activity professional for the facility. Findings include: The survey team entered the facility 12/14/21 at 10:45 a.m. During the initial tour, several cognitive residents stated there were no activities in the facility and the activity director had left. A resident council interview was conducted 12/15/21 beginning at 3:00 p.m. with eleven cognitively intact residents (Residents # 18, 5, 24, 30, 22, 32, 36, 49, 31, 158, and 11). The resident group voiced several issues about no activities in the facility, and also stated that since the activity director had left November 5th, 2021, no activities were being provided. During an interview 12/15/21 beginning at 4:30 p.m. with the administrator and corporate nurse consultant, the administrator confirmed the resident's concerns. She stated "Yes, the activity director resigned 11/5/21. We did hire a replacement, but after being here 2 hours, they left and did not return. We currently are advertising, but have not had much response." The corporate nurse stated "[name of administrator] made us aware that the activity director had resigned, and also made us aware of the individual that only stayed 2 hours. A sister facility was asked if they could send someone to help out until the position was filled, but that hasn't happened yet. That administrator called this morning to say he just hadn't had time to send anyone." No further information was provided prior to the exit conference.	F 680	The RVP and/or facility consultant will have calls weekly x 4 weeks then monthly x 1 month with the Administrator to review open positions to include the Activity Director position if applicable utilizing an *Open Position QA Audit Tool*. The RVP will ensure that if the Activity Director position is open, the facility has taken steps to employee a replacement and continue to provide ongoing activities until the replacement is hired. The Administrator will forward the results of the to the Executive QAPI Committee *Open Position QA Audit Tool* monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the to determine trends and / or issues that may need fur *Open Position QA Audit Tool* that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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 12/16/2021

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 684 F 684 SS=E	Continued From page 39 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 17 residents, Resident #38. Resident #38 did not have physician ordered compression stockings applied. Findings were: Resident #38 was admitted to the facility on 11/03/2021 with the following diagnoses, including but not limited to: Arthropathy, dementia, prostatic hyperplasia, hypertension, syncope and collapse. His admission MDS (minimum data set) with an ARD (assessment reference date) of 11/10/2021 assessed him as severely impaired with a cognitive summary score of "07". The clinical record was reviewed on 12/15/2021 at approximately 9:30 a.m. The physician order section contained the following order: "11/03/2021 Measure and apply compression stockings-apply every morning and remove at bedtime."	F 684 F 684	**F684 Quality of Care** On 12/15/2021, the Director of Nursing notified the physician that compression hose were not available for resident #38. On 12/14/2021, the assigned nurse measured resident #38 for compression hose. Compression hose for resident #38 ordered from an alternate vendor due to compression hose being out of stock from original vendor. Compression hose were received on 12/15/2021. On 1/6/2022, the Director of Nursing completed an audit of all physician orders for the past 30 days to include orders for compression hose. This audit is to ensure orders were completed per physician orders and/or the physician notified when order cannot be completed for further instructions. The Director of Nursing will address all concerns identified during the audit to include completing physician orders and/or notification of the physician when a consult could not be completed as ordered. Audit will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses in regards to *Following Physician Orders*. Emphasis is on ensuring all physician orders are completed to include but not limited to orders for compression hose and/or the physician is notified when orders cannot be completed for further recommendations. In-service will be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regards to *Following Physician's Orders*. The Director of Nursing (DON) and/or Staff Facilitator will audit all physician orders to include physician orders for compression hose weekly x 4 weeks then monthly x 1 month utilizing the *Physician's Orders Audit Tool*. This audit is to ensure the physician orders completed to include	1/30/2022

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 12/16/2021

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 684	Continued From page 40 At approximately 10:15 a.m. on 12/15/2021, Resident #38 was observed sitting in a chair in his room. He was asked if he was wearing compression stockings on his legs. He pulled up his pants legs and stated, "You want to see my socks?" He was wearing white cotton socks only, no compression stockings. At approximately 10:30 a.m., LPN (licensed practical nurse) #2 was interviewed. She was asked where the physician ordered compression stockings were documented as "on" or "off", the TAR (treatment administration record) or the MAR (medication administration record). She stated, "They are on the MAR." She went to the medication cart and obtained the paper MAR book. She stated, "They are right here." The compression stocking order was handwritten on the MAR, but there were no entries for the month of December that they had been applied or removed. She was asked why there were no entries. She stated, "We don't have them...(Name of LPN #1) measured him yesterday but I don't think they are here. LPN #1 was at the nurse's station and heard the conversation. She stated, "I did measure him yesterday...I was hoping they would come in last night but the pharmacy sent us a note that they are out [of stock]." She was asked why if the order was written on 11/03/2021, Resident #38 had not been measured or had his compression stockings ordered until the previous day (12/14/2021). LPN #2 stated, "I'll tell you why, we couldn't find a tape measurer...the DON (director of nursing) was down here, we didn't have one." LPN #1 and LPN #2 were both asked if there was a backup plan for supplies when the pharmacy was out. They both shrugged their shoulders.	F 684	but not limited to orders for compression hose and/or the physician notified when orders cannot be completed for further recommendations. The Director of Nursing and/or Staff Facilitator will address all concerns identified during the audit completing orders or notification of the physician when order cannot be completed for further recommendations. The DON will review and initial the *Physician's Orders Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the *Physician's Orders Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Physician's Orders Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 684	Continued From page 41 On 12/15/2021 at approximately 3:00 p.m., the above information was discussed with the administrator. She stated, "He has them now. I sent someone over to [name] pharmacy and got them picked up." No further information was obtained prior to the exit conference on 12/16/2021.	F 684		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide restorative nursing to one of 17 residents in the survey sample, Resident #34. Resident #34 was care planned to receive restorative care for ambulation and active range of motion exercises six to seven days per week. The facility did not have a	F 688	**F688 Increase/Prevent Decrease in ROM/Mobility** Resident #34 was referred to therapy services on 12/8/2021 by the MDS Coordinator to evaluate the need for restorative ambulation and active range of motion. A 100% audit was initiated of all care plans to identify residents that are care planned to receive restorative care. The Director of Nursing and/or Staff Facilitator will review restorative documentation to ensure all identified residents are receiving restorative per the care plan. The Director of Nursing and Staff Facilitator will address all concerns identified during the audit to include education of staff and placing therapy referrals for all identified residents not receiving restorative per the care plan to evaluate the need for continued restorative nursing or further interventions. Audit will be completed by 1/30/2022. The MDS consultant initiated an in-service with the MDS nurse, Director of Nursing, Administrator, and nursing assistants in regards to Restorative Nursing with emphasis on the requirement for an effective restorative program and documentation. In-service will be completed by 1/30/2022. All newly hired MDS nurse, DON, Administrator and NAs will be in-serviced during orientation in regards to *Restorative Nursing*.	1/30/2022

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 12/16/2021

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 688	Continued From page 42 restorative program in place. Findings were: Resident #34 was admitted to the facility on 01/25/2021 with the following diagnoses, including but not limited to: dementia, urine retention, with foley catheter heart failure with pacemaker, and most recently with ESBL (extended spectrum beta-lactamase) in his urine requiring IV antibiotics for fourteen days (beginning 12/08/2021) with the implementation of contact precautions. Resident #34's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/05/2021. He was assessed as cognitively intact with a summary score of "15". The care plan for Resident #34 was reviewed on 12/14/2021 at approximately 3:15 p.m. and included the following: "Requires assistance/potential to restore or maintain maximum function of self-sufficiency for MOBILITY characterized by the following functions; positioning, locomotion/ambulation related to: At risk for decline in ability to ambulate. Interventions: Ambulation Program: Ambulate resident 250' [feet] with FWW [front wheel walker] with SBA X 1 [stand by assistance]. If resident did not participate in restorative AMBULATION program document reason. AROM [active range of motion] Exercises: For ankle PF/DF [plantar flexion/dorsiflexion], knee flexion/extension, hip flexion/extension, abduction/adduction for 20 reps [repetitions] X 2 sets with GA [contact guard assistance] 6-7 days per week. If resident did not participate in restorative AROM program,	F 688	The Staff Facilitator and/or MDS nurse will review documentation for 10% of residents that are care planned to receive restorative services weekly x 4 weeks then monthly x 1 month utilizing a *Restorative Audit Tool*. This audit is to ensure that restorative is being completed and documented per the plan of care. The Staff Facilitator and/or MDS nurse will address all concerns identified during the audit by retraining staff and/or referring the resident to therapy as necessary. The DON will review and initial the *Restorative Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the *Restorative Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Restorative Audit Tools* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 688	Continued From page 43 document reason." On 12/16/2021 at approximately 8:15 a.m., the DON (director of nursing) was asked about the restorative program, where notes were located, who provided it, etc. She stated, "Our restorative CNA [certified nursing assistant] left within the last couple of months. We really don't have anyone here that is doing it." She was asked about the entries on Resident #34's care plan. She stated, "We should have relooked at the restorative program when she left and looked at the plans that were in place, modified them, referred back to therapy, it just didn't get done." She was asked if any of the CNAs had been cross trained to do restorative. She stated, "I don't know...I think some of them were...when she [the previous restorative CNA] left, we divided up her duties, I took the weights, everybody is trying to help...right now a lot of our CNAs are agency." She was asked if CNA #1 (the CNA assigned to Resident #34) was trained to do restorative. She stated, "Today is her last day, I don't know if she is or not." She was asked who was over the restorative program. She stated, "I don't know, I think the QA nurse was, but now we don't have a QA nurse." On 12/16/2021 at 8:30 a.m. CNA #1 was interviewed. She was asked about restorative. She stated, "I don't do that." She was asked to look at the CNA care plan. She pulled the electronic care plan up on the kiosk and looked at it. The above interventions for restorative were listed. She stated, "Nobody told me to do those things, so I haven't and I really don't know how...he might have therapy, or maybe somebody else does it, I don't know, today is my last day so I'm not worried about it."	F 688		

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 12/16/2021

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 688	Continued From page 44	F 688		

At 9:15 a.m. the rehab director (OS-other staff #3) was interviewed. She stated, "We do skilled therapy only...when we are done we turn it back over to nursing..I don't know who is in charge of restorative." She was asked what was the purpose of restorative care. She stated, "To keep them from declining...we've had an increase in our case load lately because of the quarantine..." She was asked if she could screen Resident #34 to see if he had declined. She stated, "Yes, I can do that right now...you might want to check with [name of MDS worker]...she looks at what the CNAs document on a daily basis to see if anyone has declined."

The MDS worker, RN (registered nurse) #2 was interviewed at 9:20 a.m. regarding Resident #34. She looked at his documentation and stated, "He hasn't really declined...he does stay in his room though." She stated, "I did put in a referral for a therapy screening last week though." She was asked why and she stated, "Because of being in quarantine." OS #3 came into the MDS office and stated, "I just screened him, he's fine. No decline." The MDS worker stated, "I am going to take that information off of his care plan about the restorative aid, we don't have anyone to do it."

The administrator was interviewed at approximately 11:55 a.m., regarding restorative. She was asked who reviewed the notes, made sure it was done, etc. She stated, "I really don't know...we don't have that many...therapy writes the plan, we discuss it in IDT [inter-disciplinary team]...I guess it would probable be the unit manager, but we don't have one right now, so I guess it would go to the DON." She was asked if the QA nurse had been over the program. She

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 12/16/2021

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 688	Continued From page 45 stated, "I don't think we've ever had a QA nurse." She was asked when the restorative program stopped. She stated, "We got an email from corporate that the CNA doing restorative had a felony charge come back on her annual background check and to let her go. She was terminated on 11/04/2021, we haven't done restorative since then." At approximately 12:45 p.m., the DON presented a list of ten additional residents (Resident #24, Resident #32, Resident #43, Resident #51, Resident #20, Resident #10, Resident #44, Resident #22, Resident #31, and Resident #56) who were care planned to receive restorative nursing. She stated, "We have referred everyone who was care planned for restorative nursing back to therapy for screening. If there is a decline they will pick them up for services. We are no longer providing restorative services, it will be taken off of the care plans." The medical director was interviewed on 12/16/2021 at approximately 1:30 p.m. He was asked if he was aware that the facility was not providing restorative nursing care. He stated, "I know we've been trying to hire for restorative, it is a very challenging area...[name of administrator] and I have talked about having therapy do more." He was asked if he was aware that the DON was planning to remove restorative services from the care plan and not provide the service. He stated, "No, I wasn't aware of that." No further information was obtained prior to the exit conference on 12/16/2021.	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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 12/16/2021

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 732	Continued From page 46 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 732	**F732 Posted Nurse Staffing Information** On 12/15/2021, The Administrator initiated the process for posting nursing staff information and posted the Daily Nursing Staff Sheet with complete staffing information and corrected resident census. On 12/15/2021, The Corporate Clinical Director verbally in-serviced the Administrator on requirements for posted nursing staffing in a visible area for visitors and residents to include accurate hours worked for nursing staff and accurate resident census for Medicare/Medicaid certified beds. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses, scheduler, and receptionist in regards to *Posting Nursing Staff Information* with emphasis on ensuring daily nursing staffing is posted at the beginning of the shift and post accurately reflects current staff hours worked and resident census for Medicare/Medicaid certified beds. In-service will be completed by 1/30/2022. All newly hired nurses, scheduler and receptionists will be in-serviced during orientation in regards to *Posting Nursing Staff Information*. The Administrator will review staff posting logs with staffing assignment sheets five times a week x 4 weeks then monthly x 1 month utilizing the *Daily Staffing Audit Tool*. This audit is to ensure nursing staffing hours are posted at the beginning of the shift and that staff posting accurately reflects current staff hours worked and resident census for Medicare/Medicaid certified beds. The Director of Nursing will address all concerns identified during the audit to include updating postings with accurate information as indicated and re-education of staff. The Administrator will review the staff posting weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	1/30/2022

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 12/16/2021

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 732	Continued From page 47 Based on observation and staff interview, the facility staff failed to post daily nurse staffing in a visible area in the facility readily accessible to residents and visitors. The findings include: On 12/15/2021 at approximately 10:15 a.m. the facility was observed for where nurse staffing was posted. The facility was operating one nursing unit only. No nurse staffing was observed posted anywhere around the nurse's station or in a visible area for the residents and/or visitors to see. Staff members were observed sitting at the nurse's station. LPN (Licensed practical nurse) #1 was asked if staffing was posted anywhere. She pointed to a clipboard laying on the desk and stated, "That's where it is." A piece of paper on the clipboard listed room numbers and which CNA (certified nursing assistant) and which nurse was assigned to each one. No other information was listed. LPN #1 stated, "We used to do that, but we don't do it anymore." The above information was discussed with the administrator at approximately 4:00 p.m., on 12/15/2021. She stated, "The staff told me we don't need to do that in Virginia. I will take care of it." She was asked if there was a policy regarding the posting of staffing. She stated, "No." No further information was obtained prior to the exit conference on 12/16/2021.	F 732	The Administrator will forward the results of the *Daily Staffing Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Daily Staffing Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		

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 12/16/2021

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 759	Continued From page 48 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on a medication pass observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 percent. Three medication errors were observed out of 34 opportunities resulting in an 8.8% error rate. The findings include: 1. A medication pass observation was conducted on 12/14/21 at 4:32 p.m. with licensed practical nurse (LPN #2) administering medications to Resident #15. Among the medications administered were Flonase nasal spray 50 micrograms and Advair 500/50 aerosol. LPN #2 handed the resident the bottle of Flonase spray and two sprays were applied to each nostril. There was no instruction from LPN #2 prior to or during the administration of the Flonase. LPN #2 activated the dose of Advair with the inhaler device and the resident inhaled the dose. The resident did not rinse her mouth after the administration of the Advair. There was no prompting or instruction from LPN #2 to rinse and spit after the Advair administration. Resident #15's clinical record documented a physician's order dated 9/22/21 for Advair Diskus aerosol 500/50 with instructions to inhale 1 puff by mouth twice per day and to rinse mouth after use for treatment of COPD (chronic obstructive pulmonary disease). The record documented a	F 759	**F759 Free of Medication Error Rate** Nurse #2 was in-serviced on medication pass to include giving instructions prior to administering Flonase, ensuring residents rinse after Advair administration, and how to properly checking the medications against the MAR prior to administration. 1/7/2022, the Director of Nursing and Staff Facilitator initiated medication pass observation with 100 % of all nurses to include nurse #2. This audit is to ensure all medications are administered per the physician orders and rights of medication administration with less than a 5% error rate. The Director of Nursing and Staff Facilitator will immediately educate the nurse during the observation for any identified areas of concern. Observations will be completed by 1/30/2022. On 1/7/2022, the Director of Nursing and/or Staff Facilitator initiated an in-serviced with all nurses in regards to *Rights of Medication Administration.* Emphasis is on reading the MAR and verifying medications, accurately administer the medication per the physician order and identifying/following medications with specific instructions. The in-service will be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regards to *Rights of Medication Administration.* The Director of Nursing and Staff Facilitator will complete medication pass observations with 10% of all nurses to include nurse #2 weekly x 4 weeks then monthly x 1 month utilizing the *Medication Pass Audit Tool.* The Director of Nursing and/or Staff Facilitator will retrain the nurse during the observation for any identified areas of concern. The Director of Nursing will review the *Medication Pass Audit Tools* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed	1/30/2022

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 12/16/2021

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 759	Continued From page 49 physician's order dated 9/22/21 for Flonase spray 50 micrograms with instructions to inhale 1 spray in each nostril twice per day for allergies. On 12/14/21 at 5:00 p.m., LPN #2 was interviewed about the Flonase and Advair administration to Resident #15. LPN #2 stated, "I don't know why she [Resident #15] did two [sprays]." LPN #2 stated the resident was supposed to get one spray in each nostril. Concerning the Advair, LPN #2 stated she usually reminded the resident to rinse and spit but did not during this observation. These findings were reviewed with the administrator on 12/15/21 at 4:00 p.m. 2. A medication pass and pour observation was conducted on 12/15/2021 at approximately 8:00 a.m., with LPN (licensed practical nurse) #2. She was observed preparing and administering medications to Resident #2. The medications that were not stock medications were prepared and labeled by the pharmacy in individual "pouches". LPN #2 obtained Resident #2's medications from the medication cart, checked them against the MAR (medication administration record), opened the pouch, and administered them to the resident. During the medication reconciliation the following order was observed: "ERGOCALCIFEROL VITAMIN D2 50,000 UN [units]/1.25mg [milligram] TAKE 1 CAPSULE BY MOUTH EVERY MONTH ON THE 15TH FOR SUPPLEMENT **(NOTE STRENGTH FIFTY THOUSAND UNITS)**" The medication was ordered for 8:00 a.m. Review of the medications given did not include the ERGOCALCIFEROL. LPN #2 was interviewed at approximately 8:30 a.m. and asked	F 759	The Director of Nursing will forward the results of the *Med Pass Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Med Pass Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 759	Continued From page 50 if the ERGOCALCIFEROL had been given earlier or had been rescheduled for a different time. She looked back at the MAR and stated, "Here it is, I didn't mark it." She then retrieved the opened pouch from the pile of discarded pouches on top of the cart. She stated, "It should have been in here from the pharmacy, but it isn't...I don't know what happened, today is the fifteenth, it should be here." She then removed a roll of pouches containing meds for Resident #2 and looked through them. She stated, "It isn't here." She was asked if that was something she should have noticed when she checked the medications against the MAR. She stated, "Probably." The above information was discussed with the administrator during an end of the day meeting on 12/15/2021. No further information was obtained prior to the exit conference on 12/16/2021.	F 759		
F 813 SS=E	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to develop and implement a policy regarding food storage for food brought or delivered for residents. Four expired half-pint containers of Pet whole milk were observed in Resident #18's refrigerator located in her room and one expired 25 ounce bottle of Ocean Spray Cran-Apple juice and one	F 813	**F813 Personal Food Policy** On 12/16/2021, the Housekeeper discarded all expired milk was removed and discarded from resident #18 refrigerator. On 12/16/2021, the Housekeeping Supervisor discarded all expired items to include Ocean Spray Cran-Apple juice and organic coconut bite chunks were removed and discarded from the refrigerator on Unit One. On 1/7/2022, the Housekeeping Supervisor initiated checks of all resident refrigerators and nourishment room refrigerators to ensure all refrigerators were free of expired items. The Housekeeping Supervisor will remove and discard any expired items observed during the audit. Audit will be completed by 1/30/2022.	1/30/2022

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 12/16/2021

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 813	Continued From page 51 expired 4.5 ounce bag of organic coconut bite chucks were observed in the nourishment refrigerator on Unit #1. The findings include: Resident #18 originally admitted to the facility on 02/9/2019 and readmitted on 12/20/2020 with diagnoses that included, multiple sclerosis, hypertension, depression, dysphasia, type 2 diabetes, right hand/elbow contracture and right side hemiplegia/hemiparesis. The most recent minimum data set (MDS) dated 10/13/2021 assessed Resident #18 as cognitively intact for daily decision making with a score of 15 out of 15. On 12/15/2021 at 9:15 a.m., Resident #18 was interviewed regarding the quality of life and quality of care since her admission to the facility. Resident #18 stated things were okay and she liked being at the facility. Observed on the countertop beside Resident #18's bed was a small dorm size refrigerator. Resident #18 was laying in the bed and stated "the milk in there is out of date." Resident #18 was asked if the refrigerator belonged to her. Resident #18 shook her head up and down as to indicate "yes". Resident #18 was asked for permission to open the refrigerator and look inside. Resident #18 said, "yes, you can." Observed in the refrigerator were containers of grape juice and fruit cups and containers of milk. The four half-pint containers of Pet milk were located on the top shelf with the dates facing outward. Observed were the following dates on the cartons of milk: 1 dated 7/22/21, 1 dated 10/12/21, and 2 dated 10/14/21. Resident #18 was asked if staff checked refrigerator for dates and temperatures. Resident	F 813	On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses, dietary staff and housekeeping staff in regards to *Monitoring Resident and Nourishment Refrigerators*. Emphasis is on ensuring items in refrigerators are monitored routinely and free of expired items. In-service will be completed by 1/30/2022. All newly hired nurses, dietary staff and housekeeping staff will be in-serviced during orientation in regards to *Monitoring Resident and Nourishment Refrigerators*. The Housekeeping Supervisor will audit all resident refrigerators to include resident #18 and all Nourishment room refrigerators weekly x 4 weeks then monthly x 1 month utilizing *Refrigerator Audit Tool*. This audit is to ensure all expired or soon to expired items are removed and discarded. The Administrator will review and initial the *Refrigerator Audit Tool*. The Administrator will forward the results of the *Refrigerator Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Refrigerator Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 813	Continued From page 52 #18 stated, "yes, I don't know who but they check it." Resident #18 was asked how often was the refrigerator checked. Resident #18 shrugged her shoulders as to indicate she didn't know. On 12/15/2021 at 9:39 a.m., the licensed practical nurse (LPN #1) who routinely provided care for Resident #19 was asked who was responsible for checking the resident refrigerators. LPN #1 stated housekeeping was responsible. LPN #1 was advised of the four containers of expired milk observed in Resident #18's refrigerator. LPN #1 stated, "I've notified the administrator and she is on the way around her and I'm going to throw away the milk." On 12/15/2021 at 9:50 a.m., accompanied by the Administrator and LPN #1, the nourishment refrigerator was checked on unit one. Observed in the nourishment refrigerator was the following expired items: one 25 ounce bottle of Ocean Spray Cran-Apple juice dated 09/2021 and one 4.5 ounce bag of organic coconut bite chunks dated 04/28/21. The Administrator and LPN #1 were asked if the nourishment refrigerator was for residents only. The Administrator stated, "yes, it should be." LPN #1, "stated, yes the staff have their own refrigerator" and pointed to a smaller dorm type refrigerator located on the counter top. LPN #1 stated, "I'm not sure but these 2 items may belong to staff but either way they shouldn't be here because they are both expired. I'm going to throw them away too." On 12/15/2021 at 9:54 a.m., the Administrator was asked who was responsible for checking resident refrigerators and the nourishment refrigerators on the unit. The administrator stated, "I believe it is either housekeeping or dietary staff.	F 813		

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 12/16/2021

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 813	Continued From page 53 I will have to check the policy to let you know." On 12/15/2021 at 2:45 p.m. the Administrator stated, "I can't locate a food storage policy for the nourishment refrigerator and resident personal refrigerators. I asked my corporate consultant what was the policy and she stated it varied according to the facility. I am going to implement housekeeping staff to check the resident's refrigerators and dietary and/or nursing will check the nourishment refrigerators." The Administrator was asked if this was supposed to happed prior to the implementation effective today. The Administrator stated, "I truly can't answer that. But I would suspect that housekeeping should have been checking the room refrigerators. I just can't locate a policy." No other information was provided to the survey team prior to exit on 12/16/2021 at 3:30 p.m.	F 813		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide effective administration in a manner to maintain the highest practicable well-being of each resident. The facility staff failed to employ staff in the following key positions: activities director and infection control	F 835	**F835 Administration** On 12/16/2021, the Regional Vice President placed an Interim Activity Director at the facility and activities initiated for residents. On 1/6/2022, the interim Activity Director was hired as permanent Activity Director. On 12/17/2021 the Administrator implemented an Infection Control Preventionist. The Infection Preventionist will complete required specialized training in Infection Control and Prevention at the next available training. On 1/7/2022, the Administrator and MDS Consultant initiated review of the facility Restorative Program. The Restorative by the Administrator. By 1/4/2022 the Administrator placed job postings for all key vacant positions.	1/30/2022

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 12/16/2021

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 835	Continued From page 54 preventionist; and failed to have a restorative program in place. The findings include: An onsite survey was conducted from 12/14/2021 through 12/16/2021. During the survey deficient practice was identified in the areas of residents rights and activities including F550, F565, F576, F679, and F680 which were related to the facility not employing an activities director since 11/5/2021. The survey revealed deficient practice in the area of infection control including F880, F881, F882, F883, and F887 which were related to the facility not employing an infection control preventionist since 09/08/2021. The survey revealed deficient practice in the area of quality of care including F688, related to the facility not having a restorative program in place. 1. On 12/14/2021 at 11:00 a.m., during the entrance conference the Administrator stated the facility had not employed an activity director since 11/5/2021. The Administrator stated a new activities director started on 12/6/2021; however, she quit within 2 hours of working in the facility. The administrator was asked what type of activities were being held at the facility. The Administrator stated the nurses were playing music at times, but because the facility had been on quarantine since the week of Thanksgiving due to positive Covid-19 cases, activities were put on hold. The Administrator stated that corporate was working to hire a new activity director; however, they had not located a qualified person yet due to hiring challenges in the area. On 12/15/2021 at 10:30 a.m. the Administrator was interviewed regarding the lack of activities at	F 835	On 1/6/2022, the Regional Vice President (RVP) educated the Administrator and Director of Nursing in Effective Management of the Facility with emphasis on monitoring facility needs and effectively utilizing resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This included areas of Activity, Infection Control and restorative nursing. The RVP and/or facility consultant will review with the Administrator all key open positions within the facility weekly x 4 weeks then monthly x 1 month utilizing the *Facility Assessment Audit Tool*. This audit is to ensure facility needs addressed and the Administrator is effectively utilizing resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well- being of each resident. The Administrator will forward the results of the *Facility Assessment Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Facility Assessment Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 835	Continued From page 55 the facility. The Administrator stated the facility was doing the best they could. The Administrator was asked if other facility staff were being utilized to assist with the activities department. The Administrator stated, "We play music at times. My social worker is new and isn't familiar with the activities program. The first couple of weeks the resident council president assisted with bingo and certain other activities, but then we had the COVID positive cases and he stopped helping with activities." The Administrator was asked if the corporate consultant was aware the facility was not providing a consistent activities program. The Administrator stated, "They are working to hire someone for the position, but we just can not locate anyone in this area." On 12/15/2021 at 2:50 p.m., the regional nurse consultant (Administration Staff #3) was interviewed about the facility's lack of activities. The regional consultant stated the corporate regional vice president was working to hire a new activities director. The regional consultant stated she was not aware the residents were not receiving activities. On 12/15/2021 at 3:58 p.m., during a meeting, the above finding was discussed with Administrator, director of nursing (DON) and corporate nurse consultant. The Administrative team were interviewed about the facility's efforts to incorporate activities into daily activities. The Administrator stated, "Corporate has placed an ad with Indeed and are monitoring the ad for potential applicants." The regional nurse consultant stated she had spoken with the corporate regional vice president and another facility had agreed to loan the facility an activity assistant until someone was hired.	F 835		

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 12/16/2021

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 835	Continued From page 56 On 12/16/2021 at 1:16 p.m., the facility's medical director (OS #5) was interviewed about the lack of activities in the facility. OS #5 stated he had discussed with the Administrator that corporate was using hiring opportunities such as job fairs and online applications. OS #5 stated the area was challenged with hiring difficulties. OS #5 stated his concern was the residents may have an increase in depression related to COVID-19 restrictions and having an ongoing activities program would help reduce depression. 2. During the survey entrance, infection prevention and control program policies and procedures, including the surveillance plan, antibiotic stewardship, COVID-19, influenza and pneumonoccocal immunization, and testing and immunization records, were requested. On 12/14/2021 at 11:00 a.m., the Administrator stated the facility did not currently have a trained infection control preventionist (ICP). The Administrator stated the previous ICP was on leave of absence in August and later resigned and did not return to work as scheduled on 9/8/2021. The Administrator stated the facility had not employed an ICP since 9/8/2021. The Administrator was asked who was monitoring the facility's infection control program. The Administrator stated the director of nursing (DON) and staff development coordinator (RN #1) were handling various parts of the infection control program. The Administrator stated the infection control program was reviewed by the quality assurance (QA) committee and discussed in daily/morning meetings. On 12/15/2021 at 2:50 p.m., the regional nurse	F 835		

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 12/16/2021

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 835	Continued From page 57 consultant (administrative staff #3) was interviewed regarding the facility's ICP position. The nurse consultant stated the corporate regional vice president was working to hire for this position. On 12/16/2021, the infection control program was reviewed including surveillance and antibiotic stewardships. The review revealed no infection surveillance data for January and February 2021; no individual resident infection reports for the period of April 2021 through November 2021, and none of the logs identified infectious organisms. Additional review of the infection control program revealed no evidence of an antibiotic stewardship program. There was no evidence of analysis or review of the antibiotics indicating if the prescribed medications met stewardship criteria. On 12/16/2021 at 10:15 a.m. the DON was interviewed about the ICP position. The DON stated currently the facility did not have an assigned trained infection preventionist. The DON was asked who was coordinating and monitoring infection control at the facility. The DON stated, "We discuss infection control during our daily meetings and at the QA meetings and [RN #1] the staff development coordinator assists with infection surveillance." On 12/16/2021 at 10:16 a.m., RN #1 was interviewed about the facility's infection surveillance. RN #1 stated she was assigned to oversee the vaccination program not the infection surveillance or the antibiotic stewardship program. On 12/16/2021 at 2:30 p.m. the above findings were discussed with the Administrator, DON, and	F 835		

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 12/16/2021

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 835	Continued From page 58 corporate nurse consultant. 3. On 12/16/2021 at 8:15 a.m. the DON was interviewed regarding who was responsible for providing restorative nursing and the location of progress notes for the restorative program. The DON stated the, "our restorative certified nursing assistant (CNA) left within the last couple of months. We really don't have anyone here that is doing it. We should have relooked at the restorative program when she left and looked at the plans that were in place, modified them, referred back to therapy, it just didn't get done..." On 12/16/2021 at approximately 11:55 a.m., the Administrator was interviewed regarding who reviewed restorative notes and oversaw the program to make sure it was implemented and followed. The Administrator stated, "I really don't know...we don't have that many...therapy writes the plan, we discuss it in the IDT (inter-disciplinary team)...I guess it would probably be the unit manager, but we don't have one right now, so I guess it would go to the DON." The Administrator was asked when the restorative program ended. The Administrator stated, "We got an email from corporate that the CNA (certified nursing assistant) doing restorative had a felony charge come back on her annual background check and had to let her go. She was terminated on 11/04/2021, we haven't done restorative since then." On 12/16/2021 at 1:16 p.m., the facility's medical director (OS #5) was interviewed and asked if he was aware the facility was not providing restorative nursing care. OS #5 stated, "I know we've been trying to hire for restorative, it is a very challenging area... [Administrator] and I have	F 835		

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 12/16/2021

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 835	Continued From page 59 talked about having therapy do more..." No additional information was provided to the survey team prior to exit on 12/16/2021 at 3:30 p.m.	F 835		
F 842 SS=E	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 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;	F 842	**F842 Resident Records-Identifiable Information** On 12/16/2021, the nurse educated resident #4 on fluid restriction. Resident verbalized understand and agree to compliance. On 12/20/2021, the Director of Nursing obtained weight for resident #4. The physician was notified of resident current weight and on-going non-compliance with fluid restriction. On 12/21/2022, the RD initiated an audit and clarified orders for all residents currently on fluid restriction to include resident #4. The assigned nurse will update the MAR to accurately reflect fluids provided by dietary and nursing. Audit will be completed by 1/30/2022. On 1/7/2022, the DON initiated an audit of all resident weights to include resident #4. This audit is to ensure weights were obtained per facility protocol. The Staff Facilitator will address all concerns identified during audit to include obtaining weight when indicated and notification of the physician for significant weight changes. Audit will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses and nursing assistants in regards to (1) *Weight Monitoring*. Emphasis is on obtaining weight on admission then monthly and/or with weight significant weight changes per facility protocol and (2) *Documentation of Liquid/Meal Intake* with emphasis on documenting accurately fluid and meal intake each shift to include liquids provided by nurse and NA. In-	1/30/2022

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 12/16/2021

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 842	Continued From page 60 (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 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 resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure a complete and accurate record for one of 17	F 842	service will be completed by 1/30/2022. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to *Weight Monitoring* and *Documentation of Liquid/Meal Intake.* On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses in regards to *Following Physician Orders*. Emphasis is on documentation of fluid intake for residents on fluid restriction and notification of the physician when resident exceeds fluid restriction limit or is non-compliant with fluid restriction. In-service with be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regards to Following Physician Orders. The Interdisciplinary Team to include the Director of Nursing and Staff Facilitator will audit 10% of residents on fluid restriction to include resident #4 weekly x 4 weeks then monthly x 1 month utilizing the *Physician's Order Audit Tool*. This audit is to ensure staff are documenting fluid intake each shift and that the physician is notified when resident exceeds or is non-compliant with fluid restriction. The Staff Facilitator will address all concerns identified during the audit. The DON will review the *Physician's Order Audit Tool* weekly x4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will review weights on 5 residents weekly x 4 weeks then monthly x 1 month utilizing the *Weight Audit Tool*. This audit is to ensure weights are obtained per facility protocol with documentation in the electronic record. The DON and/or Staff Facilitator will address all concerns identified during the audit. The DON will review the *Weight Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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 12/16/2021

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 842	Continued From page 61 residents in the survey sample, Resident #4. Findings include: a. Resident #4 was originally admitted to the facility on 10/21/2019 and readmitted on 07/15/2020 with diagnoses that included hypothyroidism, chronic pain, chronic obstructive pulmonary disease, psychotic disorder, neuromuscular bladder, acquired absence of left leg above knee, depression, anxiety, congestive heart failure, hyperlipidemia, and non-pressure chronic right calf ulcer. The most recent minimum data set (MDS) dated 12/10/2021 was a quarterly assessment and assessed Resident #15 as cognitively intact for daily decision making with a score of 15 out of 15. On 12/14/2021 Resident #4 was interviewed regarding her quality of life and quality of care since admission to the facility. Resident #4 stated she had resided at the facility for approximately two and half years and was previously on hospice due to having congestive heart failure and difficulty breathing. Resident #4 stated she was discharged from hospice earlier this year because her health had improved. Resident #4 stated the staff assisted her with most of her ADLs (activities of daily living) because of her left leg amputation and having an ulcer on her right leg. Resident #4 stated staff used a hoyer lift for transfers, however she did not get up too often because she was required to have her right leg elevated to help heal the ulcer. Resident #4 stated she had a reacher device to help with most of the things she needed or wanted located near her bed. Resident #4 stated sometimes she required staff to help get her sodas out of her personal refrigerator and reach certain items in her closet area, but she	F 842	The Administrator will forward the results of the *Physician's order Audit Tool* and *Weight Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Physician's Order Audit Tool and Weight Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 842	Continued From page 62 had learned to reach most things on her own. On 12/15/2021, Resident #4's clinical record was reviewed. Observed on the weight summary report were the following weights: "3/18/2021 305.4 Lbs (pounds), 10/27/2021 311.0 Lbs, 11/17/2021 312.2 Lbs..." There were no documented refusals by Resident #4 to have weights taken. The weight summary report did not have any weights documented for the period of April 2021 through September 2021. Observed on Resident #4's care plan was the following: "State of nourishment; more than body requirement characterized by weight gain, obesity, excessive appetite related to: Morbid Obesity, unstable health condition. Date Initiated/Created: 10/30/2019. Interventions:..."Refer to dietitian for evaluation/recommendation. Report to nurse food brought in by family/visitors. Weigh per facility protocol..." On 12/16/2021 at 9:00 a.m., the director of nursing (DON) was interviewed regarding the weight policy protocol and Resident #4's missing weights for the period of April 2021 through September 2021. The DON was asked how often Resident #4 was supposed to be weighed and how the weights was obtained. The DON stated staff weighed Resident #4 using the hoyer lift and the weights were done monthly. The DON stated, "she (Resident #4) will often refuse care and treatment including weights." The DON was advised that the clinical record did not document Resident #4 refusing to have weights taken during the period of April 2021 through	F 842		

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 12/16/2021

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 842	Continued From page 63 September 2021. On 12/16/2021 at approximately 10:30 a.m., the above findings were reviewed with the administrator, the DON and the corporate consultant. The DON stated, "I took over the weight review last month (November) and we have a PIP (performance improvement plan) for weights after we realized we had a concern with weights not being taken and/or documented consistently." The DON was asked if there was a concern with weights during April 2021 through September 2021. The DON stated, "I'm not sure, the previous person who was responsible for weight reviews quit a couple of months ago and that is when we realized there was an issue. I can't say what may have happened earlier this year and why [Resident #4] weights weren't taken and/or documented unless she was refusing." A review of the facility's policy titled "Weight Policy (Version 8/2012)" documented the following: "It is the policy of the facility to weigh residents upon admission and on a monthly basis. When weight changes occur, the frequency of weight monitoring will be specified as the resident's condition warrants, as directed by the physician, or as determined by the QI Weight Committee...." b. Resident #4's electronic clinical record included the following order: "FLUID RESTRICTION: 1500CC DIETARY PROVIDING 750CC NURSING PROVIDING 750CC. Directions: every shift. Start Date: 2/24/2021. Revision Dated: 2/24/2021." Observed on the paper chart physician's orders was the following order: "FLUID RESTRICTION	F 842		

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 12/16/2021

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 842	Continued From page 64 1500ML. Hour 7-3. 3-11. 11-7." Observed on Resident #4's care plan was the following: "Potential for ineffective Breathing Pattern R/T (related to): Chronic Bronchitis/COPD (chronic obstructive pulmonary disease). Date Initiated/Created: 01/13/2021. Interventions: ..."Monitor intake and output per facility protocol as ordered by the physician..." Observed within the electronic clincial record were the following progress notes: "12/8/2021 10:06 Dietary Progress Note Text: resident is on a regular CCD (carbohydrate controlled diet), fluid restriction diet. she has a 80-100% meal intake. weight stable at this time. obesity formula used cause BMI is greater then 29. amputee formula also used left leg amputee." "12/14/2021 12:19 RD (Registered Dietitian) Progress Note Text: Wound/Fluid Restriction Review: 54 yr old resident has an arterial ulcer on the front of right lower leg that is unchanged, per wound flowsheet on 12/7. There are no new wounds present from most recent skin check (12/13). Residents current diet is CCD (carbohydrate controlled diet), Regular texture, thin liquids. PO (by mouth) intake is good, approx. (approximately) 79%. Resident is on a 1500 mL fluid restriction with 750 mL coming from dietary and 750 mL from nursing. Labs reviewed from 12/1: Sodium: 132 (L) Recommendations/Plan of Care: Clarify fluid restriction to have 1080 mL coming from Dietary and 360 from Nursing, 120 mL per shift. Will monitor and follow up PRN (as needed)." On 12/15/2021 at 8:45 a.m. the staff development	F 842		

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 12/16/2021

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 842	Continued From page 65 coordinator (RN #1) was asked where the staff documented fluid input and output. RN #1 stated, "The information should be documented in the electronic health record by both the nurses and CNA (certified nursing assistants)." The licensed practical nurse (LPN #1) who routinely provided care for Resident #4 was standing nearby and stated, "It's documented under the POC (plan of care) and tasks section of PCC (electronic record). If you're talking about [Resident #4] she is often non-complaint with her fluid intake. She keeps sodas in her personal refrigerator and will have visitors who bring in food/drinks to her. We monitor her the best we can and have educated her about her fluid restrictions." At 12/15/2021 at 3:00 p.m. the Administrator was asked to provide fluid intake records for the months of October 1, 2021 through current date of December 15, 2021. On 12/16/2021 the requested fluid intake records were reviewed. The following dates and shifts were missing documented fluid intakes: October 4, 15, 18, 21, 23, 29, and 31 for the 3 p.m. to 11 p.m. shift. November 1, 5, 9, 15, 17, 19, 26, 27, 28, and 29 for the 3 p.m. to 11 p.m. shift. December 3 and 4 for the 3 p.m. - 11 p.m. shift. On 12/16/2021 at 9:00 a.m. the DON was interviewed regarding the missing fluid intake documentation. The DON stated, "I'm not sure if anyone told you but she is non-complaint with her fluid restriction. We have educated her about the importance of following her plan of care, but it is difficult. The dietitian is reviewing her record and will clarifying the fluid restriction and the new order will be written today." The DON was asked	F 842		

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 12/16/2021

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 842	Continued From page 66 if fluid intake should be documented each shift even if the resident did not consume any fluids. The DON stated, "yes, our doctor signs off on the orders and we are to follow those orders. But we can do so much when the resident is non-complaint." A review of the facility's policy titled "INTAKE AND OUTPUT (Version 8/2012) documented the following: "It is the policy of the facility that residents will be placed on Intake and Output as ordered by the physician or at the discretion of the Director of Nursing and/or the RN Supervisor or Unit Nurse as the resident's condition warrants." On 12/16/2021 at approximately 10:30 a.m., the above findings were reviewed with the administrator, the DON and the corporate consultant. No additional information was received by the survey team prior to exit on 12/17/2021 at 3:30 p.m.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880	**F880 Infection Control** On 12/14/2021, nurse #2 completed hand hygiene under the oversight of the Staff Facilitator On 12/15/2021, the Staff Facilitator educated the social worker on PPE use in quarantine rooms. On 12/15/2021, a trash receptacle with appropriate liner was placed in resident #34 room. On 12/17/2021, the Administrator re-implemented the Infection Control Program to include guidance related to Covid 19, Antibiotic Stewardship Program and a designated Infection Control Preventionist. The Infection Preventionist	1/30/2022

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 12/16/2021

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 880	Continued From page 67 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed	F 880	will complete the CDC's Infection Preventionist training in CDC-Train in order to help facilitate enhanced compliance with infection control and prevention. Training will be completed no later than 1/30/2022. On 1/7/2022, the Director of Nursing initiated an audit of facility infection control monitoring logs from 12/1/2021 to 1/6/2022. This audit is to ensure the facility monitored all infections/potential infections utilizing the individual infection sheets, infection control log, facility mapping, monitoring of antibiotic use with specific organism tracking. The DON will address all concerns identified during the audit and update infection control monitoring tools as indicated. Audit will be completed by 1/30/2022. On 1/7/2022, the housekeeping staff initiated an audit of all resident rooms to include resident #34. This audit is to ensure all rooms have trash receptacles with appropriate trash bags for quarantine rooms/isolation indicated. The housekeeping staff will address all concerns identified during the audit to include placing trash receptacles with appropriate liner when indicated. Audit will be completed by 1/30/2022. On 1/720/21, the Infection Preventionist and Director of Nursing under the oversight of the Facility Consultant implemented a system with tools for monitoring and tracking all resident and staff for communicable and respiratory infections to include resident/staff tracking logs, antibiotic stewardship with organism identification and individual tracking sheets. The facility will continue to monitor all infections for both staff and residents for Covid 19 with corporate, health department and state notifications when indicated with documentation on respiratory tracking logs	

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 12/16/2021

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 880	Continued From page 68 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control policies for hand hygiene during a medication pass observation, failed to provide an ongoing program of infection surveillance, and failed to follow infection protocols for PPE (personal protective equipment) use for one of seventeen residents in the survey sample, Resident #34. The findings include: 1. A medication pass observation was conducted on 12/14/21 at 4:32 p.m. with licensed practical nurse (LPN #2) administering medications to three residents. LPN #2 prepared medications and administered them to Resident #15. Oral medications were administered in addition to nasal spray, Advair diskus aerosol inhaler, and eye drops. LPN #2 handled and disposed of the resident's medication and drinking cup after the resident touched the cups to her mouth. LPN #2 put on gloves prior to administering the eye	F 880	On 1/7/2022, the Facility Consultant initiated an in-serviced the Director of Nursing, Administrator and Staff Facilitator/Infection Preventionist in regards to *Infection Control Policy* and *Role of Infection* Preventionist. Emphasis was placed on Administrator and DON responsibility to ensure the facility implemented and maintained an effective Infection Control Policy and Program that included an qualified designated Infection Preventionist, an Antibiotic Stewardship Program and an effective system for monitoring infection prevention within the facility. In-service also include the Infection Preventionist role in Infection Control to include (1) surveillance for identification, investigation and documentation of facility/community acquired infections utilizing the individual infection control sheets/infection control logs/facility mapping, (2) analyzing facility data for trends with monthly QA review, (3) Antibiotic Stewardship with organism monitoring/tracking, (4) monitoring of immunizations to include Covid 19 vaccines, and (5) educating staff on infection control policies/procedures and new guidance on Covid 19 based on CDC recommendations. In-service will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator/Infection Preventionist initiated an in-service with all include nurses to include nurse #2, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records, receptionist, screener, social worker and maintenance staff in regards to *Handwashing with Return Demonstration*. Emphasis is on correct procedure for washing/sanitizing hands between resident contacts. In-service will be completed by 1/30/2022. All newly hired nurses, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records,	

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 12/16/2021

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 880	Continued From page 69 drops. LPN #2 removed the gloves, left the room and discarded items in the cart trash compartment. LPN #2 did not perform hand hygiene after medication administration to Resident #15 and then prepared and administer medications to the next resident (Resident #35). On 12/14/21 at 4:40 p.m., LPN #2 was interviewed about hand hygiene between resident contact. LPN #2 stated she usually used hand sanitizer between residents when giving medications. The facility's policy titled Handwashing Procedure (dated 3/10/20) documented, "...You should wash your hands...Before and after contact with residents...After coming in contact with any body fluids...After handling contaminated items..." This finding was reviewed with the administrator on 12/15/21 at 4:00 p.m. 2. There was no staff person designated as the infection preventionist during the current survey. On 12/15/21 at 2:00 p.m., the administrator stated the facility had not had a designated/qualified infection preventionist since 9/8/21. The administrator stated the registered nurse staff development coordinator (RN #1) would assist with review of the infection surveillance program. The infection control program was reviewed on 12/16/21 including surveillance of infections. There was no infection surveillance data for January 2021 and February 2021. Three infections were listed on a tracking sheet for March 2021. Infection data from April 2021 through November 2021 included no individual	F 880	receptionist, screener, social worker and maintenance staff will be in-serviced during orientation in regards to *Handwashing*. On 1/7/2022, the Infection Preventionist initiated an in-service with all nurses, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records, receptionist, screener, social worker and maintenance staff in regards to facility *Guidelines for PPE Use*. Emphasis is on appropriate donning/doffing PPE to include but not limited to gowns/gloves and use of PPE when enter resident rooms and/or quarantine rooms based on CDC guidelines. In-service will be completed by 1/30/2022. After 1/30/2021, any staff who has not received the in-service will be in-serviced upon next scheduled work shift. All newly hired staff will be in-serviced during orientation in regards to facility Guidelines for PPE Use. The Director of Nursing will review infection control monitoring weekly x4 weeks then monthly x 1 month utilizing the *Infection Control Audit Tool*. This audit is to ensure the facility maintained a system for surveillance for identification, investigation and documentation of facility/community acquired infections utilizing individual infection control sheets/infection control logs/facility mapping, analyzing facility data for trends with monthly QA review, antibiotic stewardship with organism monitoring and tracking, monitoring of immunization per facility protocol and ongoing education of staff on infection control policies/procedures to include guidance for Covid 19. The DON will address all concerns identified during the audit to include retraining of the Infection Preventionist. The Administrator will review the *Infection Control Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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 12/16/2021

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 880	Continued From page 70 infection reports indicating the date, resident name, diagnoses/contributing factors, nature of infection, date of onset, infectious organism, treatments implemented, requirement for precautions or any mention of meeting and/or not meeting antibiotic stewardship criteria. The infection data provided had monthly summaries documented from January 2021 through May 2021. These sheets had tally marks indicating infections in the facility by type but there were no individual resident reports to match the monthly summaries. There were monthly logs documented for October 2021 and November 2021 listing resident name, onset, symptoms, type of infection and treatment. There were no infectious organisms identified on any of the logs. The November 2021 infection log made no mention of Resident #159 who diagnosed with COVID-19 on 11/25/21. On 12/16/21 at 10:15 a.m., RN #1 was interviewed about the infection surveillance in the facility. RN #1 stated she had been asked to oversee the vaccination program but was not assigned infection tracking/surveillance. On 12/16/21 at 10:16 a.m., the director of nursing (DON) was interviewed about infection tracking. The DON stated there was no staff person currently assigned to infection control but the quality assurance committee reviewed infections. On 12/16/21 at 11:36 a.m., RN #1 was interviewed again about the infection surveillance. RN #1 reviewed the documented sheets and stated some of the information was missing and incomplete. RN #1 stated there was supposed to be individual infection sheets completed for each person with suspected infections. RN #1 stated	F 880	The Staff Facilitator/Infection Preventionist, Director of Nursing, and MDS nurse will complete 10 staff observations weekly x 4 weeks then monthly x 1 month utilizing the *Handwashing/PPE Audit Tool*. This audit is to ensure staff are washing hands before/after each resident contact and that staff utilizing the appropriate PPE for the type of precautions required for quarantine and/or isolation rooms. The Staff Facilitator/Infection Preventionist and MDS nurse will address all concerns identified during the audit to include retraining of staff. The DON will review the *Handwashing/PPE Audit Tool* weekly x 4 weeks then monthly x 1 month to ensue all concerns were addressed. The Administrator will forward the results of the *Infection Control Audit Tool* and *Handwashing/PPE Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Infection Control Audit Tool* and *Handwashing/PPE Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 880	Continued From page 71	F 880		

this information was supposed to be entered onto the monthly log and a summary report completed at least quarterly for review by the quality assurance committee.

The facility's policy titled Infection Control Surveillance Policy (dated 3/10/20) documented, "This facility should monitor residents that display signs and symptoms of infection. The designated staff member (i.e., unit nurse, unit supervisor, RN Supervisor) should initiate an Infection Control Surveillance form (BN-2201) and inform the designated infection control preventionist and/or the Director of Nursing of this occurrence...The designated ICP [infection control preventionist] should complete the Individual Infection Control Surveillance form (BN-2201). Upon analysis, the data will be entered on the Monthly Infection Log (BN-2202) by the ICP for tracking purposes..."

This finding was reviewed with the administrator and director of nursing on 12/16/21 at 2:30 p.m.

3. Resident #34 was admitted to the facility on 01/25/2021 with the following diagnoses, including but not limited to: dementia, urine retention with foley catheter, heart failure with pacemaker, and most recently with ESBL (extended spectrum beta-lactamase) in his urine requiring IV antibiotics for fourteen days (beginning 12/08/2021) with the implementation of contact precautions.

Resident #34's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/05/2021. He was assessed as cognitively intact with a summary score of "15".

On 12/14/2021 at approximately 10:45 a.m.,

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 12/16/2021

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 880	Continued From page 72 Resident #34 was observed in his room. A sign on the door indicated he was on "Contact Precautions". Instructions to anyone entering the room, included: "Perform hand hygiene before entering and before leaving room and/or directly after leaving room; wear gloves when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated surfaces..." An organizer was hanging on his door which contained gowns, gloves, red bags, masks, and other items needed for his care. On 12/15/2021 at approximately 9:35 a.m., a staff member was observed in the room with Resident #34. She was making his bed, rearranging the bedside table, and tidying up the room. She was not wearing a gown or gloves. When she exited the room she was interviewed. She identified herself as the facility social worker. She was asked what PPE (personal protective equipment) she needed to use to enter Resident #34's room. She stated, "A gown and gloves." She was asked why she had not been wearing the appropriate PPE when she was in there. She stated, "I don't know, I should have been...I went in to make his bed, just trying to help out, I should have had it on." On 12/15/2021 at approximately 2:30 p.m., Resident #34 was interviewed regarding life at the facility. Upon leaving the room, there was not a trash can or trash bin available to dispose of the used isolation gown and gloves. Observed from the door, which was in front of the nurse's station, staff at the nurses station was asked where the used isolation gowns were to be disposed. LPN (licensed practical nurse) #1 told one of the CNAs (certified nursing assistants) to bring a trash can	F 880		

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 12/16/2021

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 880	Continued From page 73	F 880		

to the room. A trash can without a lid or a red bag was brought to the doorway for disposal of the used items. LPN #1 stated, "Ask (name of LPN #3)." LPN #3 was down the hall giving medications. She was asked what was supposed to be done with used PPE. She stated, "I'll show you what I do." She went to Resident #34's doorway and pointed at the red bags, "I get one of these and put my things in it and tie it up. Then I go down here with the bag," she stated as she walked down the hallway to the used utility room. "I open this door and I put the bag in here in that big trash bin." She pointed to a large trash can/bin with a red bag in it. She was asked why there wasn't a place in the resident's room. She stated, "I don't know."

The above information was discussed with the administrator and the corporate nurse consultant during an end of the day meeting on 12/15/2021. The administrator stated, "She [the social worker] told me what happened. She should have been wearing her PPE." The corporate nurse consultant stated, "There should have been a receptacle in the room with a red bag for disposing of the PPE."

The facility policy regarding "Contact Precautions", included the following but was not limited to:
Utilize clean gloves when entering resident's room and during care.
Remove gloves and perform hand hygiene before leaving resident area.
Wear a gown when entering room and caring for the resident.
Remove and dispose of gown before leaving resident room.

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 12/16/2021

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 880	Continued From page 74 No further information was received prior to the exit conference on 12/16/2021.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to implement an antibiotic stewardship program for the facility. The findings include: There was no staff person designated as the infection preventionist during the current survey. On 12/15/21 at 2:00 p.m., the administrator stated the facility had not had a designated/qualified infection preventionist since 9/8/21. The administrator stated the registered nurse staff development coordinator (RN #1) would assist with review of the infection control program. The infection control program was reviewed on 12/16/21 and revealed no evidence of an antibiotic stewardship program. Infection tracking information was missing for January 2021 and February 2021. Three infections were listed on a tracking sheet for March 2021 but there was	F 881	**F881 Antibiotic Stewardship** On 12/17/2022, the Administrator implemented an Infection Control Preventionist. The Infection Preventionist will complete the CDC's Infection Preventionist training in CDC-Train in order to help facilitate enhanced compliance with infection control and prevention. Training will be completed no later than 1/30/2022. On 1/7/2022, the Director of Nursing and Infection Preventionist initiated an audit of all current residents with orders for antibiotic therapy for the past 30 days. This audit is to ensure the facility monitored antibiotic use per the Antibiotic Stewardship Protocol. The DON and Staff Facilitator will address all concerns identified during the audit. Audit will be completed by 1/30/2022. On 1/7/2022, the Facility Consultant initiated an in-service with the Director of Nursing and Infection Preventionist in regards to Antibiotic Stewardship. Emphasis is on monitoring and tracking antibiotic use within the facility. In-service will be completed by 1/30/2022. All newly hired DON and Infection Preventionist will be in-serviced during orientation in regards to Antibiotic Stewardship. The Director of Nursing will review all antibiotic use within the facility weekly x4 weeks then monthly x 1 month utilizing the Antibiotic Audit Tool. This audit is to ensure the facility maintained a system for monitoring and tracking antibiotic use within the facility. The DON will address all concerns identified during the audit to include retraining of the Infection Preventionist. The Administrator will review the Antibiotic Audit Tool	1/30/2022

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 12/16/2021

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 881	Continued From page 75 nothing documented regarding antibiotic use. Infection data from April 2021 through November 2021 included no individual infection reports indicating the date, resident name, diagnoses/contributing factors, nature of infection, date of onset, infectious organism, treatments implemented, requirement for precautions or any mention of meeting and/or not meeting antibiotic stewardship criteria. The infection data provided had monthly summaries documented from January 2021 through May 2021. These sheets had tally marks indicating infections in the facility by type but there were no individual resident reports to match the monthly summaries. There were monthly reports from the pharmacy documenting antibiotics prescribed listed by resident name. There was no evidence of analysis and/or review of the antibiotics indicating if the prescribed medicines met stewardship criteria. On 12/16/21 at 10:15 a.m., RN #1 was interviewed about the antibiotic stewardship program in the facility. RN #1 stated she had been asked to oversee the vaccination program but was not assigned antibiotic stewardship. RN #1 stated the pharmacy provided a monthly report indicating which residents were on antibiotics. RN #1 stated she had no information currently showing evidence the antibiotic stewardship policies were implemented. On 12/16/21 at 10:16 a.m., the director of nursing (DON) was interviewed about the infection control program including antibiotic stewardship. The DON stated no person was currently assigned to oversee the infection programs but the quality assurance committee reviewed infections.	F 881	weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Antibiotic Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Antibiotic Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 881	Continued From page 76 The facility's policy titled Antibiotics Stewardship (dated 3/10/20) documented, "As a component of this facility's IPCP [infection prevention and control program], the antibiotic stewardship program supports the appropriate and safe use of antibiotics in the treatment of residents' infections with a focus on the development and reduction of antibiotic-resistant organisms...The core elements of the Antibiotics Stewardship Program are...Utilization of the pharmacy consultant and/or other regarding the appropriate use of antibiotics...Monitoring and analysis of antibiotic use...Monitoring and/or the review of antibiotic use should occur...When a resident is new to the facility...When a resident re-enters the facility following hospitalization...During each monthly medication regimen review...The monitoring of antibiotic prescribing, use, and resistance may include...Clinical justification for antibiotic use beyond initial duration ordered...Tracking of antibiotic-resistant or other significant organisms related to antibiotic use...Adverse drug events related to antibiotic use..." This finding was reviewed with the administrator and director of nursing on 12/16/21 at 2:30 p.m.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882	**F882 Infection Preventionist Qualifications/Role** On 12/17/2021, the Administrator implemented an Infection Control Preventionist. The Infection Preventionist will complete the CDC's Infection Preventionist training in CDC-Train in order to help facilitate enhanced compliance with infection control and prevention. Training will be completed no later than 1/30/2022. The Administrator will immediately notify the Regional Vice President and/or Facility Consultant for any vacancy related to Infection Preventionist.	1/30/2022

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 12/16/2021

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 882	Continued From page 77 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to designate a qualified infection preventionist for the facility. The findings include: On 12/15/21 at 2:00 p.m., the administrator was interviewed about the facility's designated infection preventionist. The administrator stated they currently had no staff person qualified and/or trained to be the infection preventionist. The administrator stated the previous infection preventionist was out of leave during August 2021, resigned and did not work after 9/8/21. The administrator stated they had not had an infection preventionist since 9/8/21. On 12/15/21 at 2:52 p.m., the regional nurse consultant (administration staff #3) was interviewed about an infection preventionist for	F 882	On 1/7/2022, the Facility Consultant initiated an in-serviced the Administrator, Director of Nursing and Staff Facilitator/Infection Preventionist in regards to Role of Infection Preventionist. Emphasis on (1) surveillance for identification, investigation and documentation of facility/community acquired infections utilizing the individual infection control sheets/infection control logs/facility mapping, (2) analyzing facility data for trends with monthly QA review, (3) Antibiotic Stewardship, (4) monitoring of immunizations to include Covid 19 vaccines, and (5) educating staff on infection control policies/procedures and new guidance on Covid 19 based on CDC recommendations. The Director of Nursing will review infection control monitoring weekly x4 weeks then monthly x 1 month utilizing the Infection Control Audit Tool. This audit is to ensure facility maintained a system of surveillance for identification, investigation and documentation of facility/community acquired infections utilizing individual infection control sheets/infection control logs/facility mapping, analyzing facility data for trends with monthly QA review, antibiotic stewardship with organism monitoring and tracking, monitoring of immunization per facility protocol and ongoing education of staff on infection control policies/procedures to include guidance for Covid 19. The DON will address all concerns identified during the audit to include retraining of the Infection Preventionist. The Administrator will review the Infection Control Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Infection Control Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Infection	

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 12/16/2021

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 882	Continued From page 78 the facility. The nurse consultant stated the regional vice president was actively working to fill vacancies in the facility. On 12/16/21 at 10:16 a.m., the director of nursing (DON) was interviewed about an infection preventionist. The DON stated no person was currently assigned as the infection preventionist but the quality assurance committee reviewed infections. The facility's policy titled Infection Control Preventionist (dated 3/10/20) documented, "The facility will designate an Infection Control Preventionist in compliance with federal, state, or local laws...responsibilities may include...surveillance for the identification, investigation, and documentation of facility acquired infections, community acquired infections, and communicable disease outbreaks...Reviews and analyzes facility data...Reports infections and outbreaks...Makes periodic rounds to monitor infection control practices..." This finding was reviewed with the administrator on 12/15/21 at 4:00 p.m.	F 882	Control Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883	**F883 Influenza and Pneumonia Immunizations** DON and Infection preventionist will clarify immunization history to include flu, pneumonia, and COVID for residents #25, #26, #48. The resident or resident representative will be education on the risk and benefits, consent obtained, and MD notified to obtain order per resident preference. Immunizations will be provided per physician's order by 1/30/2022.	1/30/2022

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 12/16/2021

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 883	Continued From page 79 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883	On 1/7/2022, the Director of Nursing initiated an audit of all Influenza and Pneumonia immunizations for all current residents. This audit was to identify any resident who had not been provided a Influenza or Pneumonia vaccine or have a documented refusal of immunization per facility protocol. The DON and assign nurse will address all concerns identified during the audit. Audit will be completed by 1/30/2022. On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses in regards to *Immunizations.* Emphasis on educating resident on risks and benefits of vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regards to *Immunizations.* Administrator will audit 10% of resident immunization record weekly x4 weeks then monthly x 1 month utilizing the *Immunization Audit Tool.* This audit is to ensure residents were educated on risks and benefits of Influenza and Pneumonia vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. The Staff Facilitator and assigned nurse will address all concerns identified during the audit. The DON will review the *Immunization Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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 12/16/2021

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 883	Continued From page 80 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to implement protocols and provide accurate documentation of influenza and pneumonoccocal immunizations for three of five residents reviewed for vaccination compliance, Resident #25, #26, and #48. Resident #25, not immunized for pneumonia prior to admission, had no evidence the pneumonoccocal vaccine was offered, administered and/or refused. Resident #26 had conflicting documentation of her pneumonoccocal immunization status. Resident #48 had incomplete documentation concerning the influenza vaccine and no evidence the pneumonoccocal was offered and/or refused. The findings include: During the review of five residents for compliance with the facility's immunization protocols, three residents were identified with issues related to the administration of pneumonoccocal vaccine and incomplete documentation concerning vaccines. Resident #25's clinical record documented an admission assessment dated 7/20/21 stating the resident had not received a pneumonoccocal vaccine. The immunization tab in the resident's electronic health record listed no administration or history of a pneumonoccocal vaccination. The record included a consent form dated 7/20/21	F 883	The Director of Nursing will forward the results of the *Immunization Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Immunization Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 883	Continued From page 81 with the consent for the pneumonoccocal vaccine marked "yes" but there was no resident or resident representative signature on the form. There was no evidence the resident received the vaccine or was offered and/or refused the pneumonoccocal immunization. Resident #26's clinical record documented an admission assessment dated 10/13/21 stating the resident had previously received the pneumonoccocal vaccine. The immunization tab in the resident's electronic health record included no status of the resident's pneumonoccocal vaccination. Resident #48's clinical record documented an admission assessment dated 11/9/21 stating the resident had not previously received a pneumatically vaccine and had received an influenza vaccine. The immunization tab in the resident's electronic health record did not list the resident had received an influenza vaccine and there was no evidence in the clinical record that the pneumatically vaccine was offered, administered and/or refused. There was no designated infection control preventionist in the facility. On 12/15/21 at 9:54 a.m., the administrator was interviewed about vaccine status and documentation for Residents #25, #26 and #48. The administrator stated when residents were admitted, education was provided and/or sent to the resident and/or the family. The administrator stated if consents for vaccines were not returned, then staff tried to call and get verbal consent to give the immunizations. The administrator stated these residents came from other facilities and	F 883		

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 12/16/2021

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 883	Continued From page 82 should have been offered the vaccines upon admission. On 12/15/21 at 11:19 a.m., the administrator stated Resident #25 had a consent form completed in July 2021 for the pneumatically vaccine and the vaccine had not been administered. The administrator stated she had no consent or refusal form for Resident #26 regarding the pneumatically vaccine. The administrator stated Resident #48's consent form was sent to the resident's family and never returned. The administrator stated the vaccination status should have been determined at the time of admission and documented in the clinical record. On 12/15/21 at 11:52 a.m., the registered nurse (RN #1) currently responsible for the facility's immunization program was interviewed about Residents #25, #26 and #48. RN #1 stated Resident #26 was "fairly new" and had not been offered the pneumatically vaccine. RN #1 stated she was working on getting the vaccines administered but "haven't gotten there yet." RN #1 stated Resident #48 had not been administered the pneumatically vaccine and she thought the resident refused. There was no refusal form presented for Resident #48. RN #1 stated Resident #25 was administered the influenza vaccine but had not been offered the pneumatically vaccine. RN #1 stated she did not know why Resident #25 had not been given the pneumatically vaccine. RN #1 stated the electronic records for these residents might not have been updated accurately regarding immunization status. The facility's policy titled Immunizations (dated	F 883		

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 12/16/2021

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 883	Continued From page 83 10/2/20) documented, "...Before offering the influenza or pneumatically vaccines, residents or residents' legal representatives will be provided education regarding the benefits and potential side effects of these immunizations with documentation in the medical record...Documentation of the immunizations will be noted in the resident's medical record ...Consent forms should be obtained, as appropriate..." This policy documented concerning pneumatically immunizations, "...Resident will be offered the immunization upon admission, unless it is medically contraindicated or the resident has already been immunized, and the resident or the resident's representative refuses after receiving appropriate education and consultation regarding the benefits of pneumatically immunization." This finding was reviewed with the administrator on 12/16/21 at 2:30 p.m.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each	F 887	**F887 COVID 19 Immunization** DON and Infection preventionist will clarify immunization history to include flu, pneumonia, and COVID for residents #25, #26, #48. The resident or resident representative will be education on the risk and benefits, consent obtained, MD notified to obtain order per resident preference. Immunizations will be provided per physician's order by 1/30/2022. On 1/7/2022, the Director of Nursing initiated an audit of all Covid 19 vaccine for all current residents. This audit was to identify any resident who had not been provided a Covid 19 vaccine or have a documented refusal of immunization per facility protocol. The DON and assign nurse will address all concerns identified during the audit. Audit will be completed by 1/30/2022.	1/30/2022

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 12/16/2021

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 887	Continued From page 84 resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for	F 887	On 1/7/2022, the Staff Facilitator initiated an in-service with all nurses in regards to *Immunizations.* Emphasis on educating resident on risks and benefits of vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 1/30/2022. All newly hired nurses will be in-serviced during orientation in regards to *Immunizations.* Administrator will audit 10% of resident immunization record weekly x4 weeks then monthly x 1 month utilizing the *Immunization Audit Tool.* This audit is to ensure residents were educated on risks and benefits of Covid 19 vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. The Staff Facilitator and assigned nurse will address all concerns identified during the audit. The DON will review the *Immunization Audit Tool* weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the *Immunization Audit Tool* to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the *Immunization Audit Tool* to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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 12/16/2021

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 887	Continued From page 85 Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to implement protocols and provide accurate documentation of COVID-19 immunizations for three of five residents reviewed for vaccination compliance, Resident #25, #26, and #48. Resident #25 listed as not vaccinated for COVID-19 upon admission, had no evidence the vaccine was offered and/or refused. Residents #26 and #48 had conflicting documentation of their COVID-19 immunization status. The findings include: During the review of five residents for compliance with the facility's immunization protocols, three residents were identified with missing and/or inaccurate information regarding their COVID-19 immunization status. Resident #25's clinical record documented an admission assessment dated 7/20/21 indicating the resident had not been immunized against COVID-19. There was no documentation the resident's clinical record that the resident was offered and/or refused the vaccine. The immunization tab in the resident's electronic health record included no COVID-19 immunization status. Resident #26 was included on a list provided by the facility of COVID-19 unvaccinated residents. Resident #26's clinical record documented an admission assessment dated 10/13/21 indicating the resident was previously immunized against	F 887		

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 12/16/2021

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 887	Continued From page 86 COVID-19. The immunization tab in the resident's electronic health record included no COVID-19 immunization status. Resident #48 was included on a list provided by the facility of COVID-19 unvaccinated residents. Resident #48's clinical record documented an admission assessment dated 11/9/21 indicating the resident was previously vaccinated against COVID-19. The immunization tab in the resident's electronic health record included no COVID-19 immunization status. There was no designated infection control preventionist in the facility. On 12/15/21 at 9:54 a.m., the administrator was interviewed about COVID-19 vaccine status and documentation for Residents #25, #26 and #48. The administrator stated when resident were admitted, education was provided and/or sent to the resident and/or the family. The administrator stated the COVID-19 vaccinations were provided by local pharmacy during scheduled clinics. The administrator stated consents/refusals were obtained prior to the clinic dates. The administrator stated she thought there was a consent signed for Resident #25 in July 2021 for the COVID-19 vaccine. The administrator stated she had no refusal documented for the Resident #25 and vaccination clinics had been held at the facility since July 2021. The administrator stated she did not have a consent or refusal form from Resident #26. The administrator stated she was not sure about Resident #48's status and that COVID-19 immunization status should be determined upon admission and accurately entered in the clinical record.	F 887		

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 12/16/2021

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 887	Continued From page 87 On 12/15/21 at 11:52 a.m., the registered nurse (RN #1) currently responsible for the immunization program was interviewed about Residents #25, #26 and #48. RN #1 stated she did not know why Resident #25 had not been immunized or offered the COVID-19 vaccine. RN #1 stated the resident was admitted in July (2021) and there had been immunization clinics provided by the local pharmacy since then. RN #1 stated the most recent COVID-19 vaccines were administered on 10/12/21. RN #1 stated Resident #26 was "relatively new" and would get the vaccine offered to her at the next clinic. When asked about the next COVID-19 vaccine clinic since Resident #26 had been in the facility for two months, RN #1 stated she was working on getting a clinic scheduled. RN #1 stated Resident #48 was partially vaccinated for COVID-19 as he received a first vaccine dose just prior to his admission. RN #1 presented a form documenting Resident #48 was administered the first dose of COVID-19 vaccine on 11/10/21. RN #1 stated she thought she had updated Resident #48's clinical record with his COVID-19 vaccination status. RN #1 stated an accurate immunization status for all vaccines was supposed to be documented under the immunization tab in the electronic health records. The facility's policy titled Guidelines for Vaccination Education, Documentation, & Reporting (dated 5/27/21) documented, "...facilities must ensure that each resident, resident representative, and staff member/healthcare provider is provided education about vaccinations sufficient to meet their informational needs and that vaccines are provided to all residents and staff that elect them...each facility should...Offer the vaccine	F 887		

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 12/16/2021

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 887	Continued From page 88 unless it is medically contraindicated, or the resident or staff member has already been immunized and...Maintain appropriate documentation to reflect that the facility provided the required COVID-19 vaccine education, and whether the resident and staff member received the vaccine..." These findings were reviewed with the administrator on 12/16/21 at 2:30 p.m.	F 887		