STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/15/2022 through 8/18/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 8/15/22 through 8/18/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Seven (7) complaints were investigated during the survey: 1. VA00051642 - Unsubstantiated 2. VA00052020 - Unsubstantiated 3. VA00054229 - Unsubstantiated 4. VA00054227 - Substantiated without deficient practice 5. VA00054996 - Unsubstantiated 6. VA00055268 - Unsubstantiated 7. VA00055837 - Unsubstantiated The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 166 at the time of the survey. The survey sample consisted of 34 current resident reviews and 8 closed record reviews.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F 582		9/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/06/2022

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
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 1 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 2 resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, it was determined the facility staff failed to provide Beneficiary Protection Notifications, when discharged from a Medicare covered Part A stay with benefit days remaining, for three (3) of three (3) residents sampled for beneficiary notice review (Resident #17, Resident #72, and Resident #225). The findings include: Three (3) residents (Resident #17, Resident #72, and Resident #225) were selected for review from the "Beneficiary Notice - Residents Discharged Within the Last Six Months" form completed by the facility staff. On 8/17/22 at 1:00 p.m., Administrative Staff Member (ASM) #6 reported the Beneficiary Protection Notifications for the aforementioned three (3) residents were not available. ASM #6 reported the Discharge Planner who was responsible for providing the notifications, in question, no longer worked at the facility. The following information was found as part of a facility policy titled "Notice of Medicare Non-Coverage (NOMNC)" (with an effective date of 4/1/22): "POLICY: A generic notice of non-coverage (NOMNC) must be given to any	F 582	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F582- Medicaid/Medicare Coverage/Liability Notice 1. Residents #17, #72, #225 representative have been made aware of ABN notifications not being completed prior to services ending. 2. A review of residents for the last 30 days who have been discharged from a Medicare A covered stay was conducted to ensure the ABN notification was issued prior to services ending. 3. The Administrator /designee will educate Discharge planning staff on requirement to issue ABN notice prior to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 3 patient with benefit days remaining who is no longer going to be receiving services covered by Medicare or a Medicare Advantage Plan. PROCEDURE: Medicare A: 1. The Discharge Planner or designee will complete and issue the Notice of Medicare Non-Coverage in advance of the Part A coverage ending date as determined by Center clinical personnel. a. The Medicare Notice of Non-Coverage must be issued no later than 2 days before the coverage will end ..." On 8/18/22 at 1:17 p.m., a survey team meeting occurred with the facility's Interim Administer, Director of Nursing, Vice President of Professional Development, Assistant Director of Nursing, and two (2) Regional Directors of Clinical Services. The failure of the facility staff to have evidence of providing Resident #17, Resident #72, and Resident #225 with the aforementioned Beneficiary Protection Notifications was discussed, for a final time, during this meeting. No additional information related to this issue was provide prior to the conclusion of the survey.	F 582	Medicare covered services ending. 4. Administrator or designee will complete weekly review of residents having services end to ensure ABN has been provided prior to services ending. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: Sept 29, 2022 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for 1 of 3 discharged residents reviewed for discharge process, Resident #163.	F 641	F641- Accuracy of Assessments 1-The MDS was modified to reflect accurate coding for section S0180 for Resident #163	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 For Resident #163, the facility staff coded the discharge MDS assessment indicating the resident was discharged to an acute hospital when in fact the resident had been discharged to an independent living facility. The findings included: Resident #163's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure, Acute on Chronic Combined Congestive Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Atrial Fibrillation, and Adult Failure to Thrive. The most recent discharge MDS assessment with an assessment reference date (ARD) of 5/24/22 coded the resident as being discharged to an acute hospital. A review of Resident #163's clinical record revealed a nursing progress note dated 5/24/22 at 6:45 pm stating in part "Patient discharged this shift. Left being pushed in wheel chair by family, left with all personal belongings ..." A 5/20/22 3:37 pm discharge planning progress note stated in part "Patient is to return back to (Name Omitted) Independent Living Facility on 5/24/22 ...Transportation has been arranged with the patient's (spouse) and (adult child) via private vehicle ..." On 8/17/22 at 3:09 pm, surveyor spoke with MDS registered nurse (RN) #1 regarding the coding of Resident #163's 5/24/22 discharge MDS assessment. MDS RN #1 returned to the surveyor at 3:20 pm and stated the discharge	F 641	2-An audit for MDS(s) completed in the last 30 days will be completed to ensure Section S0180 are coded accurately. 3-The Regional Director of Clinical Reimbursement/designee will educate the MDSC on accurately coding section S0180 4-The MDSC/designee will complete 5 MDS(s) weekly to ensure section S0180 to ensure accurate coding. 5-Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: Sept 29, 2022 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 MDS assessment had been modified and re-submitted. On 8/18/22 at 1:17 pm during a meeting with the facility management team including the Interim Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services #1 and #2, and the Vice President of Professional Development, surveyor discussed the concern of Resident #163's 5/24/22 discharge MDS coding. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/18/22.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide activities of daily living (ADL) care in regards to nail care for 2 of 34 Residents, Resident #146 and #144. For Resident #146, fingernails were observed to long and jagged with debris present. For Resident #144, fingernails and toenails were observed to long and jagged. The findings included: 1. Resident #146's diagnoses included, but were	F 677	F677-ADL Care Provided for Dependent Residents 1-Nursing staff immediately provided nail care for resident #144 and #146. 2- Current residents have the potential to be affected. Current resident nails were observed, and nail care provided as needed. 3-The DON/ designee will educate all Licensed Nurses and CNAs on providing nail care during daily care.	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 677

Continued From page 6

not limited to, unspecified injury of head, aphasia, dysphagia, contracture right hand, seizures, and personal history of traumatic brain injury.

Section C (cognitive patterns) of Resident #146 annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/03/22 was coded 1/1/3 to indicate the resident had problems with long and short-term memory and was severely impaired in cognitive skills for daily decision-making. Section G (functional status) was coded 4/2 for personal hygiene indicating the resident was totally dependent on one person to complete this task. Range of motion was coded to indicate the resident had impairment on both sides of the upper and lower extremities.

The residents comprehensive care plan included the focus areas-impaired communication related to aphasia, contracture of right hand, resistive to care, and refuses nail care.

08/15/22, during initial tour Resident #146's fingernails were observed to be long and jagged on their right hand.

08/16/22 12:20 p.m., checked nails with Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #1 nails left hand long and jagged with debris present. Nails on right hand long and jagged, contracture's bilateral hands. CNA #1 stated they would cut Resident #146's nails.

08/17/22 a.m., 7:55 a.m., checked nails with registered nurse (RN) #1 nails remain long and jagged.

08/17/22 2:00 p.m., LPN #5, stated the CNA did

F 677

4-The Unit Manager/ designee will observe residents weekly to ensure nail care has been provided.

5- Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis.

6. Date of compliance: Sept 29, 2022

The Administrator and Director of Nursing are responsible for implementation of the plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7 not cut nails yesterday, she forgot and it has been addressed. 08/17/22 8:05 a.m., the Director of Nursing (DON) made aware of issue with Resident #146's nails. 08/17/22 2:55 p.m., during an end of the day meeting with the DON, Interim Administrator, Regional Director of Clinical Services #1 and #2, and Vice President of Professional Development the issue regarding Resident #146's nail care was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Resident #144's face sheet listed diagnoses which included but not limited to morbid obesity, rheumatoid arthritis, type 2 diabetes mellitus, and depression. Resident #144's admission minimum data set with an assessment reference date of 07/26/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section G, functional status,	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 8	F 677		

coded the resident as needing extensive assistance of one person physical assist, in the area of personal hygiene.

Resident #144's comprehensive care plan was reviewed and contained a care plan for "The resident has an ADL self-care performance deficit r/t (related to) weakness".

Surveyor spoke with Resident #144 on 08/15/22 at 8:15 pm. Surveyor observed resident's fingernails, which were extremely long. Surveyor asked Resident #144 if staff assisted them with nail care, and Resident #144 stated, "Will they do that?" and also stated that the length of nails bothered them. Resident #144 asked surveyor if staff would cut their toenails as well, and showed surveyor that toenails were long and thickened.

Surveyor, along with director of nursing (DON), spoke with Resident #144 again on 08/17/22 at 9:15 am. Resident #144 again stated that the length of their fingernails bothered them. DON stated to resident that they would cut the nails for resident. Resident asked DON about cutting toenails as well and DON stated they would look at them and cut them, if they could. After exiting resident's room, surveyor asked DON who is responsible for cutting residents' nails and DON stated that all staff are.

The concern of not providing nail care was discussed with the interim administrator, director of nursing, assistant director of nursing, regional director of clinical services, and vice-president of professional development on 08/17/22 at 2:55 pm.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=D	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 observation, staff interview, clinical record review and during a medication pass and pour the facility staff failed to follow physician's orders for 1 of 34 Residents, Resident #15. For Resident #15, the facility staff failed to follow physician's orders for the administration of the medication, venlafaxine 25 mg. Venlafaxine is a medication used to treat, depression, generalized anxiety disorder and panic disorder. The findings included: Resident #15's face sheet listed diagnoses which included but not limited to schizophrenia, insomnia and depression. Resident #15's most recent annual minimum data set with an assessment reference date of 05/18/22 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #15's comprehensive care plan was reviewed and contained a care plan for "The	F 684	F684-Quality of Care 1-MD was notified of resident #15 not receiving ordered medication, no new orders were given. 2. Current residents MARS were audited, and MD notified of any medications not given. 3. DON/Designee will in-service licensed staff importance of following MD orders for medication administration. 4. DON/Designee will monitor missing administration report daily to ensure that medications orders were followed. 5- Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: Sept 29, 2020	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 resident has potential for impaired thought processes r/t (related to) Disease Process, has dx (diagnosis) of schizophrenia". Interventions for this care plan include "Give medications as ordered". Surveyor observed licensed practical nurse (LPN) #3 during a medication pass and pour on 08/16/22 at 8:35 am. While preparing Resident #15's medications, LPN #3 stated to surveyor that they could not locate resident's 25 mg venlafaxine in the medication cart, and would need to ask the unit manager what they should do. LPN #3 did not look in the medication room to see if they could locate the medication. LPN #3 informed unit manager that they could not locate Resident #3's venlafaxine, and unit manager advised LPN #3 to contact the physician and obtain an order to hold the medication. LPN #3 contacted physician and an order was obtained to hold the medication for one day. Surveyor reconciled Resident #15's medications on 08/16/22. The resident's physician's order summary contained and entry, which read in part "Venlafaxine HCl 25 mg. Give 1 tablet by mouth two times a day related to SCHIZOPHRENIA, UNSPECIFIED (F20.9) for 2 weeks". This order had a start date of 08/15/22 at 6 pm. Surveyor spoke with pharmacy tech on 08/17/22 at 3:20 pm. Surveyor asked pharmacy tech when Resident #15's venlafaxine was dispensed and pharmacy tech stated that the medication was dispensed on 08/15/22 at 11:18 pm. On 08/18/22, director of nursing (DON) provided the surveyor with a copy of a pharmacy manifest that indicated the medication was out for delivery	F 684	The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 from the pharmacy on 08/15/22 at 11:18 pm and delivered to the facility on 08/16/22 at 2:29 am. DON stated they did not know why the medication was not placed on the medication cart or why LPN #3 did not look in the medication room for the medication. The concern of not following the physician's orders was discussed with the interim administrator, DON, assistant director of nursing, regional director of clinical services and vice president of professional development during a meeting on 08/18/22 at 1:20 pm. No further information was provided prior to exit.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent 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	F 842		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12	F 842		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 13 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 8 closed record reviews, Resident #362 and Resident #163. Resident #362's clinical record did not include a discharge summary or a discharge order. Resident #163's clinical records did not include a physicians discharge order. The findings included: 1. Resident #362 had been discharged from the facility in December of 2021. Resident #362 diagnoses included, but were not limited to, chronic atrial fibrillation, asthma, moderate protein-calorie malnutrition, hypertensive heart disease, bilateral aural vertigo, and major depressive disorder. Section C (cognitive patterns) of Resident #362 admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/20/21 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. During the clinical record review, the surveyor was unable to find a discharge order or physicians discharge summary for this resident.	F 842	F842- Resident Records 1-Resident #163 and #362 have been discharged from the facility. 2-Resident scheduled for discharge in next 7 days have been reviewed and orders obtained from MD to discharge from facility. 3-DON/designee will in-service all licensed nurses to obtain MD orders for any planned or unplanned discharges. 4.DON/designee will review all discharged medical records to ensure MD orders have been obtained. 5- Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: Sept 29, 2022 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 14	F 842		

08/16/22 2:20 p.m., the Director of Nursing (DON) stated they did not have a discharge summary for this Resident.

08/16/22 4:22 p.m., during an end of the day meeting with the Interim Administrator, Regional Director of Clinical Services #1 and #2, DON, Assistant Director of Nursing (ADON), and Vice President of Professional Development the issue regarding the missing discharge summary was reviewed.

08/17/22 11:20 p.m., the DON stated they did not have a discharge order for this Resident.

08/17/22, the Regional Director of Clinical Services provided the survey team with a copy of their policy titled, "DISCHARGE PLANNING POLICES AND PROCEDURES MANUAL" updated April 20, 2022. This policy read in part, "...Charts are deficient until all of the following items are completed. Charts are considered delinquent if items are not complete within 30 days from the Discharge Date..." Number 5 on this list was "Physician's Order for Discharge." Number 6 was "Physician's Discharge Summary has been completed."

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

2. Resident #163's diagnosis list indicated diagnoses, which included, but not limited to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 15	F 842		

Chronic Respiratory Failure, Acute on Chronic Combined Congestive Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Atrial Fibrillation, and Adult Failure to Thrive.

The most recent discharge MDS assessment with an assessment reference date (ARD) of 5/24/22 coded the resident as being discharged to an acute hospital, however, Resident #163 was discharged to an independent living facility.

A review of Resident #163's clinical record revealed a nursing progress note dated 5/24/22 at 6:45 pm stating in part "Patient discharged this shift. Left being pushed in wheel chair by family, left with all personal belongings ..."

A 5/20/22 3:37 pm discharge planning progress note stated in part "Patient is to return back to (Name Omitted) Independent Living Facility on 5/24/22 with a 30-day supply of medications through (Name Omitted) as (his/her) insurance has authorized a discharge date. Transportation has been arranged with the patient's (spouse) and (adult child) via private vehicle ..."

Surveyor reviewed Resident #163's physician's orders and was unable to locate an order for discharge from the facility. On 8/18/22 at 10:33 am, surveyor spoke with the Director of Nursing (DON) regarding a physician's order for discharge for Resident #163. Surveyor asked the DON if the resident should have an order for discharge and they stated yes. On 8/18/22 at 11:47 am, the DON returned and stated they did not have a discharge order for Resident #163.

Surveyor requested received the facility policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING ______ B. WING ______	C 08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 16 entitled "Discharge Planning" which included a "Discharge Audit Worksheet" which stated in part "Charts are deficient until all of the following items are completed", Number five (5) on the worksheet stated "Physician's Order for Discharge". On 8/18/22 at 1:17 pm during a meeting with the facility management team including the Interim Administrator, DON, Assistant DON, Regional Director of Clinical Services #1 and #2, and the Vice President of Professional Development, surveyor discussed the concern of Resident #163 not having a physician's order for discharge. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/18/22.	F 842		