

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2024
NAME OF PROVIDER OR SUPPLIER  Berkshire Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  705 Clearview Drive Vinton, VA 24179	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>21227</p> <p>Based on interviews and document review, the facility staff failed to ensure clinical documentation supported the need for the resident's transfer for one (1) of 40 sampled residents (Resident #219).</p> <p>The findings include:</p> <p>Resident #219's clinical documentation failed to include information to support the need for the resident to be transferred to a local hospital under an emergency custody order (ECO).</p> <p>Resident #219's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/6/23, was signed as completed on 7/13/23. Resident #219 was assessed as able to make self understood and as able to understand others. Resident #219's Brief Interview for Mental Status (BIMS) summary score was documented as a five (5) out of 15; this indicated severe cognitive impairment. Resident #219 was assessed as requiring supervision with dressing, eating, toilet use, and personal hygiene.</p> <p>Review of Resident #219's clinical documentation failed to reveal documentation detailing the events on 8/10/23 which resulted in the facility staff obtaining an ECO for Resident #219. No documentation was found to indicate that a licensed nurse had assessed Resident #219 when the resident was exhibiting behaviors on 8/10/23 prior to the ECO being issued. No documentation was found to indicate what if any interventions were attempted for Resident #219, on 8/10/23, prior to obtaining the ECO.</p> <p>On 6/13/24 at 9:20 a.m., the facility's current Director of Discharge Planning reported the previous Director of Discharge Planning managed Resident #219's ECO. (The previous Director of Discharge Planning was not a licensed nurse and did not have the required education/experience to independently function as the facility's social worker.)</p> <p>The following information was found in a facility policy and procedure titled Behavioral Assessment/Behavior Monitor [sic] (with an effective date of 1/29/24):</p> <p>- POLICY . Behaviors will be assessed and monitored. Factors influencing behaviors, as well as management interventions will be evaluated, and care planned.</p> <p>- PROCEDURE . 1. Patients will be observed by nursing staff on all shifts and any unusual, increased, or change in behaviors will be reported and documented in the medical record . 5. A licensed nurse will document targeted behaviors, side effects, and interventions in the medical record.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 1:32 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the absence of documentation supporting the need to transfer Resident #219 to a local hospital under an ECO.</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>21227</p> <p>Based on interviews and the review of documents, the facility staff failed to provide behavior health care/interventions to address changes in condition for one (1) of 40 sampled residents (Resident #219).</p> <p>The findings include:</p> <p>The facility staff failed to ensure that medical provider orders/guidance were implemented related to Resident #219's alleged behaviors on 8/2/23. The facility staff failed to ensure a licensed nurse was involved when Resident #219 was experiencing an alleged change of condition which resulted in the request for an emergency custody order (ECO) on 8/10/23.</p> <p>Resident #219's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/6/23, was signed as completed on 7/13/23. Resident #219 was assessed as able to make self understood and as able to understand others. Resident #219's Brief Interview for Mental Status (BIMS) summary score was documented as a five (5) out of 15; this indicated severe cognitive impairment. Resident #219 was assessed as requiring supervision with dressing, eating, toilet use, and personal hygiene.</p> <p>The following information was found in Resident #219's clinical documentation in a progress note documented by a nurse practitioner on 8/2/23 at 4:59 p.m.: Staff member called on-call psych provider to alert her of this patient threatening to kill (the patient's) roommate. Staff state they were immediately separated and they are in separate rooms now. This note also indicated the nurse practitioner was informed Resident #219 was experiencing a lot of confusion and impaired reasoning. The nurse practitioner gave orders for Resident #219 to receive 30-minute checks until the resident was seen by a provider. No evidence was found to indicate that Resident #219 received the ordered 30-minute checks.</p> <p>Clinical documentation indicated that Resident #219's roommate was interviewed by staff after the aforementioned event on 8/2/23, Resident #219's roommate did not wish to change rooms. Resident #219's roommate denied concerns with their safety and reported they were alright with Resident #219. Resident #219's roommate did not have a room change until the next day, on 8/3/23.</p> <p>On 6/11/24 at 4:14 p.m., the survey team met with the facility's Administrator, Regional Director of Clinical Services (RDCS), Director of Nursing (DON), and the Assistant DON. The DON reported the documentation of the 30-minutes checks was not found. The RDCS reported no behaviors had been documented on Resident #219's medication administration records (MARs).</p> <p>Review of Resident #219's clinical documentation failed to reveal documentation detailing the events on 8/10/23 which resulted in the facility staff obtaining an ECO for Resident #219. No documentation was found to indicate that a licensed nurse had assessed Resident #219 when the resident was exhibiting behaviors, on 8/10/23, prior to the ECO being issued. No documentation was found to indicate what if any interventions were attempted for Resident #219, on 8/10/23, prior to obtaining the ECO.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/13/24 at 9:20 a.m., the facility's current Director of Discharge Planning reported the previous Director of Discharge Planning managed Resident #219's ECO. (The previous Director of Discharge Planning was not a licensed nurse and did not have the required education/experience to independently function as the facility's social worker.)</p> <p>On 6/13/24 at 10:15 a.m., the Licensed Practical Nurse (LPN) #9 stated they recalled Resident #219 being discussed during the 'daily clinical meeting' on the day the resident was transferred under an ECO. LPN #9 stated it was reported the resident was exhibiting the following behaviors: (a) more difficult to redirect, (b) ambulating laps around the building, (c) would jump or lunge at others, and (d) told another resident I hope you choke and die (expletive omitted). Documentation of these behaviors was not found in Resident #219's clinical record. Documentation of the facility's response to address these behaviors was not found in Resident #219's clinical record.</p> <p>On 6/12/24 at 8:33 a.m., the Director of Nursing (DON) provided the surveyor with a Criminal Incident Information Release Form from the local police department. This form indicated the local police transported Resident #219 to a local hospital due to the issue of an ECO. This document did not address the resident's behaviors and/or symptoms which resulted in the ECO being issued. The History of Present Illness - Psychiatric Illness form, dated 8/10/23, from the local hospital indicated the resident was admitted for further psychiatric care due to acting erratically at the nursing home and very agitated.</p> <p>On 6/13/23 at 10:37 a.m., the facility's Medical Director reported they were aware of and in agreement with obtaining an ECO for Resident #219. The Medical Director reported that Resident #219 had become physically aggressive. The Medical Director was unable to provide details related to Resident #219 being physically aggressive; the Medical Director reported they did not document a note when contacted by the facility staff. Resident #219's clinical documentation did not include documentation to indicate the resident was physically aggressive.</p> <p>The following information was found in a facility policy and procedure titled Significant Change of Condition (with an effective date of 1/29/24):</p> <ul style="list-style-type: none"> <li>- POLICY . All staff members will communicate any information about patient status to appropriate licensed nurse immediately upon observation.</li> <li>- PROCEDURE . 1. A licensed nurse will assess the patient for signs and symptoms of change of condition. 2. Notify provider and document in Progress Notes.</li> </ul> <p>The following information was found in a facility policy and procedure titled Behavioral Assessment/Behavior Monitor [sic] (with an effective date of 1/29/24):</p> <ul style="list-style-type: none"> <li>- POLICY . Behaviors will be assessed and monitored. Factors influencing behaviors, as well as management interventions will be evaluated, and care planned.</li> <li>- PROCEDURE . 1. Patients will be observed by nursing staff on all shifts and any unusual, increased, or change in behaviors will be reported and documented in the medical record . 5. A licensed nurse will document targeted behaviors, side effects, and interventions in the medical record.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 1:32 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the absence of documentation to detail the facility staff's assessment and subsequent interventions related to Resident #219's aforementioned alleged behaviors.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>21227</p> <p>Based on interviews and document review, the facility staff failed to maintain complete and/or accurate clinical documentation for one (1) of 40 sampled residents (Resident #219).</p> <p>The findings include:</p> <p>Resident #219's clinical documentation failed to include documentation of the resident's behaviors which resulted in the facility staff requesting an emergency custody order (ECO) on 8/10/23.</p> <p>Resident #219's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/6/23, was signed as completed on 7/13/23. Resident #219 was assessed as able to make self understood and as able to understand others. Resident #219's Brief Interview for Mental Status (BIMS) summary score was documented as a five (5) out of 15; this indicated severe cognitive impairment. Resident #219 was assessed as requiring supervision with dressing, eating, toilet use, and personal hygiene.</p> <p>Review of Resident #219's clinical documentation failed to reveal documentation detailing the events on 8/10/23 which resulted in the facility staff obtaining an ECO for Resident #219. No documentation was found to indicate that a licensed nurse had assessed Resident #219 when the resident was exhibiting behaviors on 8/10/23 prior to the ECO being requested. No documentation was found to indicate what if any interventions were attempted for Resident #219, on 8/10/23, prior to obtaining the ECO.</p> <p>On 6/12/24 at 9:04 a.m., the Regional Director of Clinical Services (RDCS) stated the individual who initiated the ECO would have been responsible to document the events which resulted in the need for the ECO.</p> <p>The following information was found in a facility policy and procedure titled Significant Change of Condition (with an effective date of 1/29/24):</p> <ul style="list-style-type: none"> <li>- POLICY . All staff members will communicate any information about patient status to appropriate licensed nurse immediately upon observation.</li> <li>- PROCEDURE . 1. A licensed nurse will assess the patient for signs and symptoms of change of condition. 2. Notify provider and document in Progress Notes.</li> </ul> <p>The following information was found in a facility policy and procedure titled Behavioral Assessment/Behavior Monitor [sic] (with an effective date of 1/29/24):</p> <ul style="list-style-type: none"> <li>- POLICY . Behaviors will be assessed and monitored. Factors influencing behaviors, as well as management interventions will be evaluated, and care planned.</li> <li>- PROCEDURE . 1. Patients will be observed by nursing staff on all shifts and any unusual, increased, or change in behaviors will be reported and documented in the medical record . 5. A licensed nurse will document targeted behaviors, side effects, and interventions in the medical record.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 1:32 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the absence of documentation of Resident #219's behaviors which resulted in the need for transfer under an ECO.</p>